

WHC (2002) 19

WELSH HEALTH CIRCULAR



**Cynulliad Cenedlaethol Cymru
The National Assembly for Wales**

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Issue date: 19th February 2001

Status: Action

Title: Welsh Assembly Government's Response to the Report on Bristol Royal Infirmary

For Action by: See attached list

Action required : See Paragraphs 7-8

For Information to: See attached list

Sender: Dr Bernadette Fuge, Head of NHS Quality Division

National Assembly contact(s) : Mrs Heulwen Evans (029) 2082 3365 or Mr Colin Hedges (029) 2082 5215

Enclosure(s): Welsh Assembly Government Response, Background Paper & Action Plan Proforma

Welsh Assembly Government's Response to the Report on Bristol Royal Infirmary

Dear Colleague

Purpose

1. This circular provides you with the Welsh Assembly Government's response to the Report on Bristol Royal Infirmary and details of the arrangements for monitoring progress towards the response.

Background

2. The Kennedy Report was published on 18 July. The Inquiry, chaired by Professor Ian Kennedy, was asked to look at children's heart surgery at the Bristol Royal Infirmary between 1984 and 1995 and to draw wider lessons for the health service as a whole.
3. The Report exposes considerable flaws in the systems, culture and management arrangements in place at the time; and highlights a culture where little account was taken of the views and concerns of parents, there was a shortfall in clinical audit practices, management actively discouraged open discussion and resolution of concerns raised by staff and early warnings were brushed to one side.
4. The Report concludes that there was a tragic combination of key clinicians failing to reflect on their practice (the senior staff concerned got things wrong not least because they assumed that in time things were bound to come right); senior management failing to grasp the seriousness of what was going wrong; and people in a range of capacities failing to act.
5. The recommendations are a considered attempt to shift the culture of the NHS to one where it can be acknowledged that medicine is not a perfect science and that even the best people can make mistakes. It describes a future culture where appropriate systems and relationships are in place to provide a safe framework within which clinical care can be provided to a high and recognised standard; outcomes can be monitored and evaluated; staff are well regulated, trained and supported for the tasks expected of them; error is minimised but when it does occur lessons are learnt and shared; and above all where patients are genuine partners in the decision making process.

Response

6. The Welsh Assembly Government is committed to ensuring that such a tragedy never happens again. It has prepared its own response [attached] which, while in many ways parallels the Government's response, sets out to reflect the context in Wales. It is clear from the response where action is already ongoing and where the Assembly has and will take further steps. It is for the NHS with its partners to develop an action plan based on the recommendations and the response.

Examples of action already taken by the Welsh Assembly Government

- Jointly setting up the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) as England and Wales bodies.
- We are closely involved in the National Patient Safety Agency (NPSA) and have set up an NHS led Implementation Group that will oversee and advise the Assembly on the key issues that will need to be considered before we can establish a clinical adverse event reporting system in Wales.
- Developing inter-professional training courses
- Piloting pathfinder projects for the complaints process
- Issued guidance on good practice on the content of web-sites

Further action to be taken by the Welsh Assembly Government

- Issue detailed guidance on consent to treatment
- Issue a Code of Practice for NHS Managers from April 2002
- Develop the Children's NSF
- Appoint a National Director for Children's Healthcare
- Develop an accreditation scheme for health information leaflets
- Explore the potential for a network of expert patients
- Developing a Wales Quality Forum
- Provide a framework of best practice to support the development of more user-friendly information

Next Steps

7. You are asked to consider both the recommendations and the responses and identify an action plan to take forward in your Health Authority, Trust or Local Health Group. This action plan should form an integral part of your overall approach to clinical governance. It will be monitored via the Performance Management Framework and the quarterly reviews.
8. Your responses should be returned no later than the 2nd April 2002 and should be addressed to:

Heulwen Evans,
 NHS Clinical Standards Development Branch,
 NHS Quality Division
 Cathays Park,
 Cardiff,
 CF10 3NQ

A template for completion is attached. While I would ask that you use this as a basis for a response and address the issues raised, please add more information if you think it is relevant. We will also be seeking feedback on progress from you at the next Quarterly Review.

Further Information

9. If you would like further information about the Welsh Assembly Government Response, contact Heulwen Evans (029) 2082 3365 or Colin Hedges (029) 2082 5215.

A handwritten signature in black ink that reads "Bernadette Fuge". The signature is written in a cursive style with a period at the end.

Dr Bernadette Fuge
Head of NHS Quality Division/Medical Director

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DISTRIBUTION LIST

For Action By:

Chairs and Chief Executives of Health Authorities
Chairs and Chief Executives of NHS Trusts
Chairs and General Managers of Local Health Groups
Directors of Social Services

For Information:

All Wales Health Care Professionals
All Wales Medicines Committee
All Wales Medicines Strategy Group
All Wales Principal Pharmacists
Association of Welsh Community Health Councils
Audit Commission
British Dental Association in Wales
British Medical Association (Wales)
Centre for Health Leadership
Medical Directors
Clinical Governance Leads
Community Health Councils in Wales
Community Pharmacy Wales
Department of Health
IHSM Welsh Division
Local Research Ethics Committee
Multi Research Ethics Committee
NHS Confederation in Wales
Patients' Association
Royal Colleges (Wales)
University of Wales College of Medicine
Wales Association of Community and Town Councils
Wales Council for Voluntary Action
Wales TUC
Welsh Dental Committee
Welsh Consumer Council
Welsh Executive, Royal Pharmaceutical Society of Great Britain
Welsh Local Government Association
Welsh Medical Committee
Welsh Pharmaceutical Committee
Welsh Scientific Committee

Bristol Royal Infirmary Recommendations - Master Sheet

| No | Recommendation | Response |
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| Respect and honesty | | |
| Partnership: Involving patients | | |
| 1 | In a patient-centred healthcare service patients must be involved, wherever possible, in decisions about their treatment and care. | Accepted: Improving Health in Wales provides a commitment to ensuring the delivery of services which are sensitive to patients needs and take full account of their views and preferences about their own healthcare. In support of this we will be issuing guidance to the NHS about consent issues later this year, including a model consent form. The guidance will cover when consent should be sought, written information for patients, and the availability of training for healthcare professionals. This is a wide-ranging recommendation requiring a multi-faceted approach. We will ensure that the development of information systems enables the provision of comparative information on specific procedures to enable patients to make informed judgements on likely outcomes of treatment. The Strategy of Nursing for Wales set out a range of recommendations in this important area. |
| 2 | The education and training of all healthcare professionals should be imbued with the idea of partnership between the healthcare professional and the patient. | Accepted: It is essential that the patient is the focus of all team-working and inter-professional care. We are working to ensure that this principle lies at the heart of all education and training programmes for professional and other healthcare staff. We anticipate that our plans for inter-professional training will include courses in common core skills such as communication both to the patient and fellow healthcare colleagues. Communication skills training will be strengthened both in initial and in service training of health professionals |
| 3 | The notion of partnership between the healthcare professional and the patient, whereby the patient and the professional meet as equals with different expertise, must be adopted by healthcare professionals in all parts of the NHS, including healthcare professionals in hospitals. | Accepted: It is important that the relationship between healthcare professionals and their patients, families and carers is one that should be built upon mutual respect and has to improve . The Welsh Assembly Government recognises that there have been developments in this area and is committed to building on the good work. We are actively seeking to instil this approach in the training and education of healthcare professionals and other staff. We expect to see all areas of the NHS committed to working towards this goal. We will be exploring the potential for a network of expert patients across Wales from 2003. |
| Keeping patients informed about treatment and care | | |

| No | Recommendation | Response |
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| 4 | Information about treatment and care should be given in a variety of forms, be given in stages and be reinforced over time. | <p>Accepted:</p> <p>Improving Health in Wales underlines our commitment to the provision of 'patient awareness' training to front line NHS staff and more user friendly information to patients/public. In addition the forthcoming Health and Social Care Guide will provide a commitment to patients being given information in a format or language to suit individual and collective needs as well as ensuring that they are fully involved in decisions about their care and treatment.</p> |
| 5 | Information should be tailored to the needs, circumstances and wishes of the individual. | <p>Accepted:</p> <p>The forthcoming Health and Social Care Guide will provide a commitment to ensuring that information is available to patients in a form that is relevant and easy to read. A framework of best practice focussing of health information will be issued to the service in early 2002 which will give guidance on the development and use of health information.</p> |
| 6 | Information should be based on the current available evidence and include a summary of the evidence and data, in a form which is comprehensible to patients. | <p>Accepted:</p> <p>We are committed to ensuring that information is available to patients about their healthcare in a form that is relevant and easy to read. Health of Wales Information Services (HOWIS) on the internet is working to provide information in a form that can be easily understood through linking to other organisations such as the National Institute for Clinical Excellence and NHS Direct.</p> |
| 7 | Various modes of conveying information, whether leaflets, tapes, videos or CDs, should be regularly updated, and developed and piloted with the help of patients. | <p>Accepted:</p> <p>We will ensure that patients are provided with information in a format which best suits their individual needs. This includes the use of technologies such as interactive CDs, videos, the internet, etc. In 2002 we will act on the outcome of a review of health information to produce a framework of best practice. This will help the NHS to develop (with patients) better and more user-friendly information. It will include written and electronic information, helplines, etc. We will monitor the effectiveness of the information from the patient's perspective and we will ensure that examples of good practice are widely disseminated throughout the NHS.</p> |
| 8 | The NHS Modernisation Agency should make the improvement of the quality of information for patients a priority. In relation to the content and the dissemination of information for patients, the Agency should identify and promote good practice throughout the NHS. It should establish a system for accrediting materials intended to inform patients. | <p>This is a recommendation for an English body. However, we are committed to developing a framework for best practice in the provision of written information for patients and the public, and are working on a range of ways of ensuring that patients receive good quality information.</p> <p>Guidance will be issued by the Assembly to NHS organisations to ensure that the design and content of the internet sites is in a form that can be easily understood. Consideration is being given to networking the patient liaison aspects of the Sharing Clinical Information in a Primary Care Team (SCIPiCT) information project across Wales.</p> |

| No | Recommendation | Response |
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| 9 | The public should receive guidance on those sources of information about health and healthcare on the Internet which are reliable and of good quality: a kitemarking system should be developed. | <p>Accepted:</p> <p>We will make it easier for patients to access information about their healthcare services and ensure that this information is easily understood.</p> <p>NHS organisations have been issued with guidance on good practice in connection with websites. An audit of compliance will be completed in 2001. Health of Wales Information Service (HOWIS) branding ensures awareness of NHS corporacy. Kitemarked guidance is available on the NHS Direct website.</p> <p>We will develop an accreditation system for health information leaflets in 2003.</p> |

Communicating with Patients

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| 10 | Tape-recording facilities should be provided by the NHS to enable patients, should they so wish, to make a tape recording of a discussion with a healthcare professional when a diagnosis, course of treatment, or prognosis is being discussed. | <p>Rejected</p> <p>Improving Health in Wales commits us to ensuring that we improve the way we communicate with patients. It is vital that patients are kept fully informed of issues surrounding their care and treatment and that they are aware of where they can access easily understood information in a format that suits their individual needs. It is equally important that patients and NHS staff are able to communicate with each other in an environment of honesty and mutual respect. This recommendation has the potential to undermine the relationship between patients and professionals.</p> |
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| 11 | Patients should always be given the opportunity and time to ask questions about what they are told, to seek clarification and to ask for more information. It must be the responsibility of employers in the NHS to ensure that the working arrangements of healthcare professionals allow for this, not least that they have the necessary time. | <p>Accepted:</p> <p>We:</p> <ul style="list-style-type: none"> • will provide patient awareness training to all front line NHS staff by 2003; • will be issuing guidance to the NHS in Wales about consent issues later this year and will be working with our partners to identify further areas which would benefit from additional guidance; • will ensure that patients are supported through patient advocacy and liaison, Community Health Councils and by information on the internet; • will reinforce the provision of adequate support in the forthcoming Health and Social Care Guide; • will be exploring the potential for a network of expert patients across Wales; • will shortly be piloting a number of 'pathfinder' projects across Wales where patient support staff will be employed to act as facilitators to ensure that healthcare professionals communicate more effectively with patients and with one another. |
| 12 | Patients must be given such information as enables them to participate in their care. | |
| 13 | Before embarking on any procedure, patients should be given an explanation of what is going to happen and, after the procedure, should have the opportunity to review what has happened. | |
| 14 | Patients should be supported in dealing with the additional anxiety sometimes created by greater knowledge. | |
| 15 | Patients should be told that they may have another person of their choosing present when receiving information about a diagnosis or a procedure. | |
| 16 | Patients should be given the sense of freedom to indicate when they do not want any (or more) information: this requires skill and understanding from healthcare professionals. | |

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| 17 | Patients should receive a copy of any letter written about their care or treatment by one healthcare professional to another. | Accepted in principle: The I Assembly is working with a UK wide group looking at best ways of taking this forward, bearing in mind confidentiality, legal and resource implications. |
| 18 | Parents of those too young to take decisions for themselves should receive a copy of any letter written by one healthcare professional to another about their child's treatment or care. | |
| 19 | Healthcare professionals responsible for the care of any particular patient must communicate effectively with each other. The aim must be to avoid giving the patient conflicting advice and information. | Accepted: Patients must be the central focus of care. See earlier responses. |

Support services for patients

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| 20 | The provision of counselling and support should be regarded as an integral part of a patient's care. All hospital trusts should have a well-developed system and a well-trained group of professionals whose task it is to provide this type of support and to make links to the various other forms of support (such as that provided by voluntary or social services) which patients may need. | Accepted in principle: We will ensure that professionals in training are taught to offer support to patients and families/carers, and this is already included in all Welsh pre-registration nursing education. Patient Support Managers (shortly to be trialled in Wales) will support patients in their dealings with NHS staff at any point in the delivery of their care, or afterwards Our Fundamentals of Care project will also provide a framework for the provision of emotional support. |
| 21 | Every trust should have a professional bereavement service. (We also reiterate what was recommended in the Inquiry's Interim Report: 'Recommendation 13: As hospitals develop websites, a domain should be created concerned with bereavement in which all the relevant information concerning post-mortems can be set out in an appropriate manner.')) | Accepted in principle: The provision of a bereavement service to families should be developed as best practice. The I Assembly will work with those agencies already known for their ability to handle bereavement well and will review current practice in NHS Trusts in Wales with a view to producing sensitive and appropriate guidance for health care professionals and others. Patient Support Managers (shortly to be trialled in Wales) might act as facilitators to ensure that NHS staff are well equipped to support patients, families and carers. |

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| 22 | Voluntary organisations which provide care and support to patients and carers in the NHS (such as through telephone helplines, the provision of information and the organisation of self-help groups) play a very important role. Groups which meet the appropriate standards as laid down by the NHS should receive appropriate funding from the state for the contribution they make to the NHS. | Accepted: The voluntary sector plays a vital role in supporting patients and their families. Where appropriate the Assembly will consider the funding of national helplines, as it has done for example, via the CALL helpline. The Assembly with colleagues in DoH will explore issues of good practice in the development of advice and information for patients and their families/carers and seek to identify standards that indicate good practice. |
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Consent to treatment

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| 23 | We note and endorse the recent statement on consent produced by the DoH: 'Reference guide to consent for examination or treatment', 2001. It should inform the practice of all healthcare professionals in the NHS and be introduced into practice in all trusts. | Accepted: We will ensure that communication with parents and patients will provide them with sufficient information to enable them to reach informed decisions in consenting for treatments and examinations. We: <ul style="list-style-type: none">• will issue this guidance, which is applicable to the whole of the NHS early in 2002;• will be working with our partners to identify areas which require further guidance and will develop an action plan, by December 2001, for the development and dissemination of further guidance and a compliance monitoring system;• will ensure that the development of information systems enables the provision of comparative information on specific procedures to enable patients to make informed judgements on likely outcomes of treatment. Clinicians will be encouraged to present any alternative modes of treatment that may be available. |
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| 24 | The process of informing the patient, and obtaining consent to a course of treatment, should be regarded as a process and not a one-off event consisting of obtaining a patient's signature on a form. | |
| 25 | The process of consent should apply not only to surgical procedures but to all clinical procedures and examinations which involve any form of touching. This must not mean more forms: it means more communication. | |
| 26 | As part of the process of obtaining consent, except when they have indicated otherwise, patients should be given sufficient information about what is to take place, the risks, uncertainties, and possible negative consequences of the proposed treatment, about any alternatives and about the likely outcome, to enable them to make a choice about how to proceed. | |
| 27 | Patients should be referred to information relating to the performance of the trust, of the speciality and of the consultant unit (a consultant and the team of doctors who work under his or her supervision). (See further the Recommendations on care of an appropriate standard). | |
| Feedback from patients | | |
| 28 | Patients must be given the opportunity to pass on views on the service which they have received: all parts of the NHS should routinely seek and act on feedback from patients as to their views of the service. In addition, formal, systematic structured surveys of patients' experience of their care (not merely satisfaction surveys) should be routinely conducted across the NHS and the results made public. | <p>Accepted:</p> <p>We are committed to ensuring that there is continuous feedback from the public about the services they receive from the NHS and that the service acts upon them.</p> <p>Improving Health in Wales proposes the introduction of patient questionnaires on leaving hospital. Feedback on patients' satisfaction/complaints should also be fed into 'baseline assessments' as part of the NHS' public involvement mechanisms. In due course these will be fed into the 'patient prospectus' for each NHS organisation. The use of the Internet is also being encouraged to provide user feedback and will be monitored.</p> |
| 29 | NHS trusts and primary care trusts must have systems which ensure that patients know where and to whom to go when they need further information or explanation. | <p>Accepted:</p> <p>There needs to be an identifiable person to whom patients can turn to if they have concerns about their healthcare or need further information. To support this process we are trialling a number of patient support and advocacy projects in association with the NHS and community health councils across Wales who can be used as link between health professionals and patients.</p> |
| 30 | We endorse the initiative in 'The NHS Plan' to establish a Patient Advocacy and Liaison Service in every NHS trust and primary care trust. The establishment of this service should be implemented in full as quickly as possible. Once established, patient advocacy and liaison services must be given secure funding to enable them to provide an effective service to patients. | <p>Accepted in principle:</p> <p>We are trialling a different structure in Wales; this includes the provision of Patient Support Officers in NHS Trusts and Local Health Groups and complaints advocates in Community Health Councils. The pilot projects are funded by the Assembly.</p> |
| 31 | Trusts and primary care trusts must have systems for publishing periodic reports on patients' views and suggestions, including information about the action taken in the light of them. (See further the Recommendations on care of an appropriate standard.) | <p>Accepted:</p> <p>Improving Health in Wales commits NHS Trusts and Local Health Groups to publish annual plans which include patients' views and action taken as a result of feedback. This is supported by guidance from the Assembly on public involvement, issued in October 2001.</p> |

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| 32 | So as to provide for patients an effective, efficient and seamless information and advocacy service, consideration should be given to how the various patient advocacy and liaison services in a given geographical area could most effectively collaborate, including in relation to the provision of information for patients and the public. | <p>Accepted:</p> <p>We will be evaluating pathfinder schemes for patient advocacy and support to determine how best to ensure effective collaboration.</p> |
| Responding to the patient when things go wrong | | |
| 33 | A duty of candour, meaning a duty to tell a patient if adverse events have occurred, must be recognised as owed by all those working in the NHS to patients. | <p>Accepted:</p> <p>Open and honest communication with patients is also being pursued through the implementation of the Assembly's policy on Clinical Governance and will be an important element of the new National Patient Safety Agency's work to establish a national clinical adverse events reporting and learning system. The Welsh Risk Pool has recently issued guidance to the NHS in Wales on giving apologies and explanations to patients and their families.</p> |
| 34 | When things go wrong, patients are entitled to receive an acknowledgement, an explanation and an apology. | <p>Accepted:</p> <p>Patients must be treated with consideration and respect, and this means an acknowledgement, a proper explanation and an apology when things go wrong.</p> |
| 35 | There should be a clear system, in the form of a 'one-stop shop' in every trust, for addressing the concerns of a patient about the care provided by, or the conduct of, a healthcare professional. | <p>Accepted:</p> <p>One of the roles of the intended Patient Support Officers being piloted in Local Health Groups and Trusts across Wales is to act as the first, most visible, point of contact and liaise with healthcare professionals to address these concerns.</p> |
| 36 | Complaints should be dealt with swiftly and thoroughly, keeping the patient (and carer) informed. There should be a strong independent element, not part of the trust's management or board, in any body considering serious complaints which require formal investigation. An independent advocacy service should be established to assist patients (and carers). | <p>Accepted in part:</p> <p>The Assembly is piloting two pathfinder projects to test out arrangements for independent support for people wishing to make a complaint against the NHS. We want to see the outcome of these before moving forward. Improving Health in Wales commits us to acting on the outcome of the UK wide evaluation of the complaints procedure which includes proposals to make the process easier to use, more independent and impartial.</p> |

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| 37 | There should be an urgent review of the system for providing compensation to those who suffer harm arising out of medical care. The review should be concerned with the introduction of an administrative system for responding promptly to patients' needs in place of the current system of clinical negligence, and should take account of other administrative systems for meeting the financial needs of the public. (See further the Recommendations on the safety of care). | <p>Accepted in principle:</p> <p>We want to make the system faster and fairer and are keen to look at alternatives to clinical negligence legal actions. The Auditor General for Wales' report on the subject called for greater use of mediation and other alternative methods of dispute resolution. The Assembly is working with the Department of Health to consider alternatives to the current system. We will be looking at the conclusions and their applicability to Wales, with a view to issuing a joint England and Wales White Paper in 2002.</p> |
| A Health Service which is well led | | |
| 38 | The DoH's roles in relation to the NHS must in future be made explicit. The DoH should have two roles. It should be the headquarters of the NHS. It should also establish an independent framework of regulations that will assure the quality of the care provided in and funded by the NHS, and the competence of healthcare professionals. | <p>Accepted in principle:</p> <p>We accept the need for leadership and for managing the maintenance and improvement of services, against a background of rigorous and impartial monitoring by the Assembly.</p> <p>We also accept the need for a strong regulatory framework which will ensure consistency for the protection of the public. We are working with the Department of Health to ensure that the interests of the public and the NHS shape this framework.</p> |
| The regulation of the quality and safety of healthcare | | |
| 39 | The framework of regulation must consist of two overarching organisations, independent of government, which bring together the various bodies which regulate healthcare. A Council for the Quality of Healthcare should be created to bring together those bodies which regulate healthcare standards and institutions (including, for example, the Commission for Health Improvement (CHI), the National Institute for Clinical Excellence (NICE) and the proposed National Patient Safety Agency). A Council for the Regulation of Healthcare Professionals should be created to bring together those bodies which regulate healthcare professionals (including, for example, the General Medical Council (GMC), and the Nursing and Midwifery Council); in effect, this is the body currently referred to in 'The NHS Plan' as the Council of Healthcare Regulators. These overarching organisations must ensure that there is an integrated and co-ordinated approach to setting standards, monitoring performance, and inspection and validation. Issues of overlap and of gaps between the various bodies must be addressed and resolved. | <p>Accepted :</p> <p>We welcome the publication of the Government's consultation document Modernising Regulation in the Health Professions. It outlines a proposal for the creation of the Council for the Regulation of Health Care Professionals. The new Council will work with the regulatory bodies to build and manage a strong system of self-regulation. We are working with the Department of Health to ensure that the interests of the public and the NHS in Wales are fully represented.</p> <p>We will be looking to ensure full participation in the Council for the Quality of Healthcare. It is vital that co-operation between these key bodies continues and develops.</p> <p>In Wales I intend to hold an Annual Quality Forum where issues relating to the quality of healthcare will be discussed, success can be celebrated and areas for improvement can be highlighted and progressed. I will expect the regulatory bodies to participate in this forum.</p> |
| 40 | The two Councils should be independent of government and report both to the DoH and to Parliament. There should be close collaboration between the two Councils. The DoH should establish and fund the Councils and set their strategic framework, and thereafter periodically review them. | |
| 41 | The various bodies whose purpose it is to assure the quality of care in the NHS (for example, CHI and NICE) and the competence of healthcare professionals (for example, the GMC and the Nursing and Midwifery Council) must themselves be independent of and at arm's-length from the DoH. | |

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| 42 | All the various bodies and organisations concerned with regulation, besides being independent of government, must involve and reflect the interests of patients, the public and healthcare professionals, as well as the NHS and government. | <p>Accepted:</p> <p>The need for inclusion, involvement and openness is fundamental to the Assembly's policy of putting the public at the heart of decision making across the whole spectrum of Government. Considerable work is underway to encourage greater public participation. Many organisations already regularly encourage and involve lay views, for example the General Medical Council, the Dental Council, the Royal Pharmaceutical Society for Great Britain and many Royal Colleges. We regularly seek the views of the public and patients and will continue to seek opportunities for doing this. The National Institute for Clinical Excellence is developing a framework for a Citizens Council which will ensure representative public involvement in the process of developing standards.</p> <p>We must ensure that all NHS organisations recognise the value and importance of learning from patients' experiences.</p> |
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The management of the NHS at the local level : contractual relations between trusts and employees

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| 43 | The contractual relationship between trusts and consultants should be redefined. The trust must provide the consultant with the time, space and the necessary tools to do the job. Consultants must accept that the time spent in the hospital and what they do in that time must be explicitly set out. | <p>Accepted:</p> <p>We are playing our full part in the current negotiations with the British Medical Association on a new contract, which will include a more explicit job plan and endorse the principles of this recommendation.</p> |
| 44 | The system of Distinction Awards for hospital consultants should be examined to determine whether it could be used to provide greater incentives than exist at present for providing good quality of care to patients. The possibility of its extension to include junior hospital doctors should be explored. | <p>Accepted:</p> <p>There is currently a review of this process underway which builds on the Government's proposals to develop a scheme that is transparent, fair and based on clear evidence; is open and accessible to all consultants; provides better rewards to those who contribute most to the NHS, and supports the practical application skills and knowledge for the benefit of patients. We do not feel it would be appropriate to extend the system to junior doctors who are considered to be in training and under the continual supervision of consultants.</p> |
| 45 | The doctors' Code of Professional Practice, as set down in the GMC's 'Good Medical Practice', should be incorporated into the contract of employment between doctors and trusts. In the case of GPs, the terms of service should be amended to incorporate the Code. | <p>For further consideration:</p> <p>The required national documentation for the consultants' contracts explicitly included the headings in <i>Good Medical Practice</i>, so that evidence against all these areas can be considered during appraisal and by the GMC during its own revalidation process, due to start in 2003-04. We will be looking at this issue further.</p> |
| 46 | The relevant codes of practice for nurses, for professions allied to medicine and for managers should be incorporated into their contracts of employment with hospital trusts or primary care trusts. | <p>Accepted:</p> <p>All regulated professionals are required to meet the requirements of their professional code and failure to do so puts their continued registration and therefore their employment into question. We will check with NHS employers regarding how this is to be incorporated into employment contracts. A Code of Practice will be developed for managers and incorporated into their contracts.</p> |
| 47 | Trusts should be able to deal as employers with breaches of the relevant professional code by a healthcare professional, independently of any action which the relevant professional body may take. | <p>Accepted:</p> <p>Trusts are already able to deal with breaches of the relevant professional code. New disciplinary procedures will be introduced for consultants.</p> |

The chief executive and senior management

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| 48 | The security of tenure of the chief executive and senior managers of trusts should be on a par with that of other senior professionals in the NHS. | <p>Accepted:</p> <p>We fully support this recommendation and will ensure that Chief Executives and senior managers have appropriate contractual arrangements in future.</p> |
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| The Trust Board | | |
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| 49 | The criteria and process for selection of the executive directors of a trust board must be open and transparent. Appointments should be made on the basis of ability and not on the basis of seniority. | Accepted: We believe that appointments within the NHS should be made on the basis of the skills, knowledge, competence and experience of the candidates for appointment and it is not appropriate for any appointments to be made on the basis of seniority. Systems are in place to ensure that appointments are made on the basis of ability. |
| 50 | The NHS Leadership Centre, in conjunction with trusts, should develop programmes of training and support for clinicians and others who seek to become executive directors. | Accepted: Tailored programmes for clinicians and managers who wish to become executive directors will be further developed and refined in conjunction with the NHS Wales Leadership Centre. |
| 51 | As recommended in 'The NHS Plan', there should be an NHS Appointments Commission responsible for the appointment of non-executive directors of NHS trusts, health authorities and primary care trusts. | Rejected: We have taken an approach that is designed to suit Welsh circumstances. In Wales we have developed its own policy for the appointment of chairs and non-executive directors and will not be pursuing the suggestion in the English NHS Plan. |
| 52 | Newly appointed non-executive directors of trusts, health authorities and primary care trusts should receive a programme of induction: this should refer to the principles and values of the NHS and their duties and responsibilities with regard to the quality of care provided by the trust. This programme should be provided through the NHS Leadership Centre. | Accepted: A centrally funded programme of induction training for newly appointed non-executive directors has been established by the Health Leadership Centre for Wales. The training focuses directly on their duties and responsibilities as board members and the values set out in the NHS Plan. |
| 53 | A standard job description should be developed by the NHS for non-executive directors, as proposed in 'The NHS Plan'. | Accepted: A standard job description has already been developed by Trusts and Health Authorities for non-executive directors. |
| 54 | Throughout their period of tenure, non-executive directors should be provided with training, support and advice organised and co-ordinated through the NHS Leadership Centre. | Accepted: Chairs will be holding annual reviews with non-executive directors to identify any support and development needs as set out in Improving Health in Wales. The Health Leadership Centre for Wales will develop appropriate support programmes accordingly. |
| 55 | The Chairs of trust boards should have a source of independent advice (or mentor) during their period of office, drawn from a pool of experts assembled by the NHS Leadership Centre. | Accepted: The Health Leadership Centre for Wales will be asked to suggest appropriate mentoring and shadowing opportunities for trust chairs. |
| 56 | Arrangements should be in place in the standing orders of trust boards to provide for proper continuity in the management of the trust's affairs in the period between the cessation of the Chair's term of office and the commencement of that of a successor. | Accepted: We expect all existing standing orders already make provision for the election of a Vice Chair or other Director pending the appointment of a new Chair. |
| Competent healthcare professionals | | |
| Broadening the notion of professional competence | | |

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| 57 | <p>Greater priority than at present should be given to non-clinical aspects of care in six key areas in the education, training and continuing professional development of healthcare professionals:</p> <ul style="list-style-type: none"> ◆ Skills in communicating with patients and with colleagues; ◆ Education about the principles and organisation of the NHS, and about how care is managed, and the skills required for management; ◆ The development of teamwork; ◆ Shared learning across professional boundaries; ◆ Clinical audit and reflective practice; ◆ And leadership. | <p>Accepted:</p> <p>The Assembly is actively seeking to develop common-core training and an inter-professional education framework for Wales which is closely aligned to the needs of NHS Wales, its patients and the Higher Education sector. A working group has been established to consider the way forward in this area. Education providers are being asked to work together in developing common core training and inter-professional learning in these 6 areas. The National Assembly will be providing support to develop projects that address these goals and take into consideration all professional groups across Wales.</p> <p>Further, guidance in the form of a Lifelong Learning Strategy is being prepared for issue to all NHS staff. The document will be a high level, all-embracing strategy applicable to all professions. The Strategy will include measurable objectives. We will monitor progress.</p> |
| 58 | <p>Competence in non-clinical aspects of caring for patients should be formally assessed as part of the process of obtaining an initial professional qualification, whether as a doctor, a nurse or some other healthcare professional.</p> | <p>Accepted:</p> <p>There is a need for all healthcare professions to demonstrate competence in all aspects of caring. We expect all education providers in Wales to ensure this is included within their programmes. Benchmark standards have been developed in partnership with the QAA for nursing, midwifery and health professional programmes, at undergraduate level. Work is under way to produce standards for undergraduate medicine, dentistry and pharmacy. We expect to commence similar benchmarking work for post registration education. Performance is monitored and will be included in the annual reviews that form part of the contractual arrangements between the education providers and the Assembly. We also expect that non-clinical aspects of care will be included in the development of common core training.</p> |
| 59 | <p>Education in communication skills must be an essential part of the education of all healthcare professionals. Communication skills include the ability to engage with patients on an emotional level, to listen, to assess how much information a patient wants to know, and to convey information with clarity and sympathy.</p> | <p>Accepted:</p> <p>We recognise the importance of communication skills for all healthcare professionals. The Assembly is asking all education providers in Wales to include the development and assessment of communication skills within the development of common core and inter-professional education. Further, this issue will be comprehensively covered in the Lifelong Learning Strategy for the purpose of CPD.</p> |
| 60 | <p>Communication skills must also include the ability to engage with and respect the views of fellow healthcare professionals.</p> | <p>Accepted:</p> <p>We agree that this is important and expect all education providers to ensure that such skills are developed through common core training and inter-professional learning. Further, this issue will be comprehensively covered in the Lifelong Learning Strategy for the purpose of CPD.</p> |
| 61 | <p>The education, training and Continuing Professional Development (CPD) of all healthcare professionals should include joint courses between the professions.</p> | <p>We are committed to the development of inter-professional learning at all stages, for all healthcare professions. The lead in times for planning and delivering shared and inter-professional education needs to be acknowledged.</p> |
| 62 | <p>There should be more opportunities than at present for multi-professional teams to learn, train and develop together.</p> | <p>We are committed to ensure that all healthcare professionals receive education in management of healthcare and the Centre for Health Leadership in Wales already provides courses for Specialist Registrars.</p> |
| 63 | <p>All those preparing for a career in clinical care should receive some education in the management of healthcare, the health service and the skills required for management.</p> | |
| 64 | <p>Greater opportunities should be created for managers and clinicians to 'shadow' one another for short periods to learn about their respective roles and work pressures.</p> | <p>Accepted:</p> <p>We support this and have asked the Centre for Health Leadership in Wales to develop a 'shadowing' framework.</p> |

| Leadership: skills and capacity | | |
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| 65 | An early priority for the new NHS Leadership Centre should be to offer guidelines as to leadership styles and practices which are acceptable and to be encouraged within the NHS, and those which are not. | Accepted in principle: The code of practice for NHS managers in Wales will be implemented by April 2002 as part of the Performance Framework. The competencies for Chief Executives have been updated and will also be implemented from April 2002. |
| 66 | Steps should be taken to identify and train those within the NHS who have the potential to exercise leadership. There needs to be a sustained investment in developing leadership skills at all levels in the NHS. | Accepted: A full development programme which underpins the need to "talent spot" is being implemented as part of the reform of the NHS in Wales. |
| 67 | The NHS's investment in developing and funding programmes in leadership skills should be focused on supporting joint education and multi-professional training, open to nurses, doctors, managers and other healthcare professionals. | Accepted: We fully support this and, through the Centre for Health Leadership in Wales, have for some years had multi-professional leadership training programmes in place which are open to all professions. |
| 68 | The NHS Leadership Centre should be involved in all stages of the education, training and continuing development of all healthcare professionals. | Accepted in principle: We recognise the need to develop leadership skills in all healthcare professionals and through the Centre for Health Leadership in Wales, have for some years had leadership training programmes in place which are open to all professions. We expect Higher Education Institutions to work with the Centre for Health Leadership in order to ensure that appropriate training in this area is included in pre-registration training programmes. |
| The system for assuring competence | | |
| 69 | Regulation of healthcare professionals is not just about disciplinary matters. It should be understood as encapsulating all of the systems which combine to assure the competence of healthcare professionals: education, registration, training, CPD and revalidation as well as disciplinary matters. | Accepted in part: We welcome the publication of the Government's consultation document Modernising Regulation in the Health Professions. It outlines a proposal for the creation of the Council for the Regulation of Health Care Professionals. The new council will work with the regulatory bodies to build and manage a strong system of self-regulation. The Assembly is working with the Department of Health to ensure that the interests of the public and the NHS in Wales are fully represented. |
| 70 | For each group of healthcare professionals (doctors, nurses and midwives, the professions allied to medicine, and managers) there should be one body charged with overseeing all aspects relating to the regulation of professional life: education, registration, training, CPD, revalidation and discipline. The bodies should be: for doctors, the GMC; for nurses and midwives, the new Nursing and Midwifery Council; for the professions allied to medicine, the re-formed professional body for those professions; and for senior healthcare managers, a new professional body. | Accepted in part: We agree with the need for regulatory bodies for all groups of healthcare professionals. The National Assembly will work with the Department of Health to ensure that the regulatory framework for all groups covers all aspects of competence required of healthcare practitioners. We will be discussing the need for a new professional body for senior healthcare managers at a national level. |
| 71 | In addition, a single body should be charged with the overall co-ordination of the various professional bodies and with integrating the various systems of regulation. It should be called the Council for the Regulation of Healthcare Professionals. (In effect, this is the body currently proposed in 'The NHS Plan', and referred to as the Council of Healthcare Regulators.) (See Recommendation 39.) | Accepted: We agree with the need for co-ordination of all healthcare regulatory bodies in order to ensure consistency of standards and that all regulatory bodies should operate within a framework of principles of good practice. |

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| 72 | The Council for the Regulation of Healthcare Professionals should be established as a matter of priority. It should have a statutory basis. It should report to Parliament. It should have a broadly-based membership, consisting of representatives of the bodies which regulate the various groups of healthcare professionals, of the NHS, and of the general public. | Please also see the response to recommendation 39. |
| 73 | The Council for the Regulation of Healthcare Professionals should have formal powers to require bodies which regulate the separate groups of healthcare professionals to conform to principles of good regulation. It should act as a source of guidance and of good practice. It should seek to ensure that in practice the bodies that regulate healthcare professionals, behave in a consistent and broadly similar manner. | |
| 74 | It should be a priority for the Council for the Regulation of Healthcare Professionals to promote common curricula and shared learning across the professions. | <p>Accepted:</p> <p>We are committed to the development of common core training and shared learning across all healthcare professions and would welcome the promotion of this by the Council for the Regulation of Healthcare Professionals and all regulatory bodies.</p> |

| The education of healthcare professionals | |
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| 75 | <p>Pilot schemes should be established to develop and evaluate the feasibility of making the first year's course of undergraduate education common to all those wishing to become healthcare professionals.</p> |
| 76 | <p>Universities should develop closer links between medical schools and schools of nursing education with a view to providing more joint education between medical and nursing students.</p> |
| 77 | <p>Universities should develop closer links between medical and nursing schools and centres for education and training in health service and public sector management, with a view to enabling all healthcare professionals to learn about management.</p> |
| 78 | <p>Access to medical schools should be widened to include people from diverse academic and socio-economic backgrounds. Those with qualifications in other areas of healthcare and those with an educational background in subjects other than science, who have the ability and wish to do so, should have greater opportunities than is presently the case, to enter medical schools.</p> |
| 79 | <p>The attributes of a good doctor, as set down in the GMC's 'Good Medical Practice', must inform every aspect of the selection criteria and curricula of medical schools.</p> |
| 80 | <p>The NHS and the public should be involved in (a) establishing the criteria for selection and (b) the selection of those to be educated as doctors, nurses and as other healthcare professionals.</p> |
| <p>Accepted:</p> <p>We are working with education providers to develop common core training and inter-professional learning throughout all healthcare education programmes in Wales. Whilst we are committed to the principles of common core training throughout all healthcare programmes we recognise that this is a long term project that will require changes in curricula and development of the infrastructure of higher education institutions</p> <p>We:</p> <ul style="list-style-type: none"> are committed to the development of shared learning between all healthcare professionals; will ensure that the Centre for Health Leadership Wales will work with education providers in order to ensure that skills are developed on an all Wales perspective and ensuring consistency across Wales; agree with the principle of widening access to medical school. Developments are currently being discussed with the University of Wales College of Medicine, which includes graduate entry in the proposed clinical school at Swansea; will require the University of Wales College of Medicine to adhere to this Code of Practice in the selection of students and in the development of curricula; will require education providers to involve the NHS in the selection of students for healthcare programmes. We are exploring ways of expanding this involvement and including the public in this process. <p>Accepted:</p> <p>See responses to recommendations 75-76.</p> | |
| Post – qualification training and continuing professional development | |

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| 81 | In relation to doctors, we endorse the proposal to establish a Medical Education Standards Board (MESB), to co-ordinate postgraduate medical training. The MESB should be part of and answerable to the GMC which should have a wider role. (See Recommendation 70.) | Reject: Post graduate training must take into account the needs of the service as well as individual clinicians, and it is right that there should be closer ties between the MESB and the NHS as the report suggests. |
| 82 | CPD, being fundamental to the quality of care provided to patients, should be compulsory for all healthcare professionals. | Accepted: We agree with these recommendations. It is the intention of the Assembly to develop a lifelong learning strategy that would be applicable to all staff employed in NHS Wales. The strategy will provide a framework for the education of healthcare workers ranging from support workers to continuing professional development for those with professional qualifications. It will identify opportunities for progression at all levels. |
| 83 | Trusts and primary care trusts should provide incentives to encourage healthcare professionals to maintain and develop their skills. The contract (or, in the case of GPs, other relevant mechanism) between the trust and the healthcare professional should provide for the funding of CPD and should stipulate the time which the trust will make available for CPD. | |
| 84 | Trusts and primary care trusts must take overall responsibility through an agreed plan for their employees' use of the time allocated to CPD. They must seek to ensure that the resources deployed for CPD contribute towards meeting the needs of the trust and of its patients, as well as meeting the professional aspirations of individual healthcare professionals. | |
| Appraisal | | |
| 85 | Periodic appraisal should be compulsory for all healthcare professionals. The requirement to participate in appraisal should be included in the contract of employment. | Accepted: All health professionals undergo appraisal but practice varies as to whether it is a contractual requirement. Improving Health in Wales commits us to issuing guidance on good practice on current appraisal and requiring Health organisations to report annually on the appraisal process. The issue of including it in all contracts of employment will be considered in partnership with DoH. |
| 86 | The commitment in 'The NHS Plan' to introduce regular appraisal for hospital consultants must be implemented as soon as possible. | Accepted: The development of clinical governance and the proposals by the GMC to introduce revalidation for all doctors has underlined the need for a comprehensive annual appraisal scheme for medical and dental staff. This became a contractual requirement for consultants from 1 April 2001. |
| 87 | The requirement to undergo periodic appraisal should also be incorporated into GPs' terms of service. | Accepted: This will form part of the current negotiations on the new GP contract. |
| Revalidation | | |
| 88 | Periodic revalidation, whereby healthcare professionals demonstrate that they remain fit to practise in their chosen profession, should be compulsory for all healthcare professionals. The requirement to participate in periodic revalidation should be included in the contract of employment. | Accepted: <i>This is a UK issue. The Government is working with the GMC to introduce revalidation for all doctors and will work with the other regulatory bodies and, where appropriate, the professional bodies, to ensure that the approach taken for all health professions is consistent and to the highest standards.</i> |

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| 89 | The public, as well as the employer and the relevant professional group, must be involved in the processes of revalidation. | Accepted: The introduction of revalidation will include the provision of lay people assessing individual doctors and this should provide a benchmark for other professions. |
| 90 | The new Council for the Regulation of Healthcare Professionals should take as a further priority an early review of the various systems of revalidation and re-registration to ensure that they are sufficiently rigorous, and in alignment both with each other and with other initiatives to protect the public. The Council should also seek ways to incorporate managers (as healthcare professionals) into the systems of CPD, appraisal and revalidation. | Accepted: We agree with this recommendation. See response to recommendation 69. |
| Managers | | |
| 91 | Managers as healthcare professionals should be subject to the same obligations as other healthcare professionals, including being subject to a regulatory body and professional code of practice. (See Recommendation 70.) | Accepted in principle: There is merit in this recommendation. The practicalities of implementing it would need to be considered with the Department of Health. In the meanwhile, in conjunction with the Centre for Health Leadership in Wales, we are developing a code of practice for healthcare managers. |
| Clinicians who hold managerial positions | | |
| 92 | Where clinicians hold managerial roles which extend beyond their immediate clinical practice, sufficient protected time in the form of allocated sessions must be made available for them to carry out that managerial role. | Accepted: The variance in current practice needs to be addressed and will be discussed as part of the current negotiations on the new consultant contract. |
| 93 | Any clinician, before appointment to a managerial role, must demonstrate the managerial competence to undertake what is required in that role: training and support should be made available by trusts and primary care trusts. | Accepted: The new annual appraisal process will identify those clinicians suitable for undertaking this role in future. Training and support for clinicians wishing to undertake a managerial role has been provided for some time by the Health Leadership Centre for Wales. We would expect that any clinicians that undertake managerial roles would have received this training. |
| 94 | Clinicians should not be required or expected to hold managerial roles on bases other than competence for the job. For example, seniority or being next in turn are not appropriate criteria for the appointment of clinicians to managerial roles. | Accepted: Clinicians will be selected for managerial roles on the basis of competencies shown in this field and not on the basis of seniority. The annual appraisal process will further assist in this process in future. |
| 95 | The professional and financial incentives for senior clinicians to undertake full-time senior managerial roles should be reviewed: the aim should be to enable senior clinicians to move into a full-time managerial role, and subsequently, if they so wish, to move back into clinical practice after appropriate retraining and revalidation. | Accepted: The current review of discretionary points and distinction awards systems will consider the financial incentives for the undertaking of senior managerial roles. The new consultant contract will reflect professional incentives. Key stakeholders will be consulted about arrangements for re-training and revalidation for those who wish to return to clinical practice |

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| 96 | To protect patients, in the case of clinicians who take on managerial roles but wish to continue to practise as clinicians, experts together with managers from the NHS should issue advice as to the minimum level of regular clinical practice necessary, to enable a clinician to provide care of a good quality. Clinicians not maintaining this level of practice should not be entitled to offer clinical care. This rule should also apply to all other clinicians who, for whatever reason, are not in full-time practice, and not only to those in part-time managerial roles. | Reject: We do not believe it is possible to prescribe a minimum level of regular clinical practice to suit all specialities or all managerial positions. Health professionals will need to provide evidence that they are competent to practice when revalidating or re-registering. Advisory and support services will be available as part of the appraisal process for those outside substantive employment. |
| 97 | To facilitate the movement of clinicians in and out of managerial positions, the proposed systems for the revalidation (and re-registration) of doctors, nurses and professions allied to medicine should distinguish between professionals who are managers and also maintaining a clinical practice and those who are not. Those who are not maintaining a clinical practice should be entitled to obtain the appropriate revalidation (and re-registration) to restart a clinical practice, after retraining, and should be assisted in doing so. (See Recommendation 95). | Accepted:: Health professionals should provide, when revalidating or registering, evidence that they are competent to practise in their chosen field and this evidence will be tested regularly during annual appraisal. |
| 98 | The relevant professional regulatory bodies should make rules varying the professional duties of those professionals, whose registration they hold, who are in full-time managerial roles, so as to take account of the fact that, while occupying such roles, they do not undertake responsibility for the care of patients. | Reject : Professional credibility and status depends on revalidation and appraisal to secure continuing registration. |
| The acquisition and development of new clinical skills | | |
| 99 | Any clinician carrying out any clinical procedure for the first time must be directly supervised by colleagues who have the necessary skill, competence and experience until such time as the relevant degree of expertise has been acquired. | <i>Accepted:</i> <i>This is a professional obligation now. We will work with the NHS and the profession in Wales to ensure that not only this occurs but that it is monitored.</i> |
| 100 | Before any new and hitherto untried invasive clinical procedure can be undertaken for the first time, the clinician involved should have to satisfy the relevant local research ethics committee that the procedure is justified and it is in the patient's interests to proceed. Each trust should have in place a system for ensuring that this process is complied with. | Accepted in principle: The principal safeguard for ensuring that the introduction of new surgical techniques is managed safely is currently the Safety and Efficacy Register of New Intervention Procedures (SERNIP). This will come under the umbrella of the National Institute of Clinical Excellence (NICE) from April 2002 where it's role will be enhanced. |
| 101 | Local research ethics committees should be re-formed as necessary so that they are capable of considering applications to undertake new and hitherto untried invasive clinical procedures. | LRECs will need to consider any studies of new procedures as advised by NICE. |
| 102 | Patients are always entitled to know the extent to which a procedure which they are about to undergo is innovative or experimental. They are also entitled to be informed about the experience of the clinician who is to carry out the procedure. | Accepted: Wales will ensure that communication with parents and patients will provide them with sufficient information to enable them to reach informed decisions in consenting for treatments and examinations. |

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| 103 | The Royal College of Surgeons of England should, in partnership with university medical schools and the NHS, be enabled to develop its unit for the training of surgeons, particularly in new techniques. It should also explore the question of whether there is an age beyond which surgeons, specifically in areas such as paediatric cardiac surgery, should not attempt new procedures or even should not continue in a particular field of surgery. | <p>Accepted:</p> <p>We will work with our partners to review the need for further development of the RCS training unit, in the light of NICE guidance on training requirements for new intervention procedures.</p> |
| Discipline | | |
| 104 | In the exercise of their disciplinary function the professional regulatory bodies must adopt a more flexible approach towards what constitutes misconduct. They must deal with cases, as far as possible, at a local level and must have available a range of actions which both serve the interests of the public and the needs of the professional. | <p>Accepted:</p> <p>Disciplinary matters are best dealt with at a local level with agreed standards of performance and behaviour within an overall framework. We agree that regulatory bodies must have a flexible and effective system with regards to their disciplinary functions. We are in the process of drawing up revised disciplinary procedures for consultants which will reflect our relationship with the National Clinical Assessment Authority.</p> |
| 105 | The need to involve the public in the various professional regulatory bodies applies as much to discipline as to all the other activities of these bodies (see Recommendation 42). | |

| The Safety of Care | | |
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| 106 | We support and endorse the broad framework of recommendations advocated in the report 'An Organisation with a Memory' by the Chief Medical Officer's expert group on learning from adverse events in the NHS. The National Patient Safety Agency proposed as a consequence of that report should, like all other such bodies which contribute to the regulation of the safety and quality of healthcare, be independent of the NHS and the DoH. | <p>Accepted in part:</p> <p>Clinical Governance is fundamental in our approach to the continuous improvement of the services provided by the NHS in Wales and is key to very many of the recommendations.</p> <p>We welcome the establishment of the National Patient Safety Agency [NPSA] which re-inforces the continuing culture change which is taking place in the NHS, not only in Wales, but throughout the UK. The NPSA will have a significant role to play in creating a learning environment where the emphasis is on improvements through learning and not blame</p> <p>The NPSA was set up in July 2001 as a Special Health Authority and we feel that this provides the degree of independence necessary to carry out its function. We do not feel there is a need to change these arrangements.</p> <p>It will operate at arms length from the Assembly and the Department of Health and will provide unfettered analysis and advice to the NHS on sentinel events.</p> <p>Developments are at an early stage and we are working with our colleagues in the Department of Health on the arrangements for the Agency's operation.</p> |
| 107 | Every effort should be made to create in the NHS an open and non-punitive environment in which it is safe to report and admit sentinel events. | |
| 108 | Major studies should, as a matter of priority, be carried out to investigate the extent and type of sentinel events in the NHS to establish a baseline against which improvements can be made and measured. | |
| A National reporting system | | |
| 109 | There should a single, unified, accessible system for reporting and analysing sentinel events, with clear protocols indicating the categories of information which must be reported to a national database. | <p>Accepted:</p> <p>The NHS Wales is involved in developing and piloting the new reporting system and a service-led project board will oversee and steer implementation in Wales and provide expert advice to the National Assembly on clinical risk management operational issues.</p> |
| 110 | The national database of sentinel events should be managed by the National Patient Safety Agency, so as to ensure that a high degree of confidence is placed in the system by the public. | <p>Accepted:</p> <p>See response to recommendation 106.</p> |

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| 111 | The National Patient Safety Agency, in the exercise of its function of surveillance of sentinel events, should be required to inform all trusts of the need for immediate action, in the light of occurrences reported to it. The Agency should also be required to publish regular reports on patterns of sentinel events and proposed remedial actions. | |
| 112 | All sentinel events should be subject to a form of structured analysis in the trust where they occur, which takes into account not only the conduct of individuals, but also the wider contributing factors within the organisation which may have given rise to the event. | Accepted: See the responses to recommendations 106 & 109. |
| Incentives to encourage the reporting of sentinel events | | |
| 113 | The reporting of sentinel events must be made as easy as possible, using all available means of communication (including a confidential telephone reporting line). | Accepted in principle These are all key elements to encouraging a culture change, which we are going to test out and work up detailed procedures and protocols with the service via the new project board and pilots in England & Wales. We will need to give further consideration to how situations where the information provided highlights either criminal or civil offences are dealt with. |
| 114 | Members of staff in the NHS should receive immunity from disciplinary action by the employer or by a professional body if they report a sentinel event to the trust or to the national database within 48 hours, except where they themselves have committed a criminal offence. | |
| 115 | Members of staff in the NHS who cover up or do not report a sentinel event may be subject to disciplinary action by their employer or by their professional body. | |
| 116 | The opportunity should exist to report a sentinel event in confidence. | |
| 117 | There should be a stipulation in every healthcare professional's contract that sentinel events must be reported, that reporting can be confidential, and that reporting within a specified time period will not attract disciplinary action. | |
| 118 | The process of reporting of sentinel events should be integrated into every trust's internal communications, induction training and other staff training. Staff must know what is expected of them, to whom to report and what systems are in place to enable them to report. | |
| The system of clinical negligence | | |

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| 119 | In order to remove the disincentive to open reporting and the discussion of sentinel events represented by the clinical negligence system, this system should be abolished. It should be replaced by an alternative system for compensating those patients who suffer harm arising out of treatment from the NHS. An expert group should be established to advise on the appropriate method of compensation to be adopted. | <p>Accepted in principle:</p> <p>See recommendation 37.</p> |
| Designing for safety | | |
| 120 | The proposed National Patient Safety Agency should, as a matter of urgency, bring together managers in the NHS, representatives of the pharmaceutical companies and manufacturers of medical equipment, members of the healthcare professions and the public, to seek to apply approaches based on engineering and design so as to reduce (and eliminate to the extent possible) the incidence of sentinel events. | <p>Accepted in principle:</p> <p>Assembly officials are meeting the Agency shortly to discuss how it will operate in Wales and to make sure it identifies the Welsh bodies it must link up with, for example, the proposed All Wales Medicine Strategy Group</p> |

| Incorporating a concern for safety into systems and policies | | |
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| 121 | At the level of individual trusts, an executive member of the board should have the responsibility for putting into operation the trust's strategy and policy on safety in clinical care. Further, a non-executive director should be given specific responsibility for providing leadership to the strategy and policy aimed at securing safety in clinical care. | <p>Accepted in principle:</p> <p>This will be discussed with the All Wales Implementation Group for Clinical Incident Reporting.</p> |
| Care of an appropriate standard | | |
| 122 | One body should be responsible for co-ordinating all action relating to the setting, issuing and keeping under review of national clinical standards: this should be NICE, suitably structured so as to give it the necessary independence and authority. | <p>Rejected:</p> <p>NICE has a vital role to play in the standard setting process. However, there are many organisations who contribute to improvements in the service by researching and developing standards of care. We do not agree that NICE should be the only clinical standard setting body, we would prefer to see NICE working alongside other organisations to establish a more consistent approach to standard setting.</p> <p>We will be strengthening NICE via a number of routes:</p> <ul style="list-style-type: none"> • Increasing the involvement of the public in the process by initiating the Citizen's Council • Removing the veto which Ministers currently have on the dissemination of NICE guidance • Putting a statutory duty on organisations to support the provision of drugs and treatments identified by NICE |
| 123 | Once the recommended system is in place, only NICE should be permitted to issue national clinical standards to the NHS. The DoH (as the headquarters of the NHS) while issuing, for example, National Service Frameworks and supplementary guidance, should not be able to rescind or detract from the standards issued by NICE. | |
| 124 | NICE should pursue vigorously its current policy of involving as wide a community as possible, including the public, patients and carers, in the work to develop and keep under review clinical standards. In particular, the special expertise of the Royal Colleges and specialist professional associations should be harnessed and supported. Account should also be taken of the expertise of the senior management of the NHS. | <p>Accepted:</p> <p>NICE has a policy of actively involving stakeholders including senior managers in the work. It has established six National Collaborating Centres based on the Royal Colleges, to develop clinical guidelines. We are committed to an NHS that puts the patient at centre stage. This can only be achieved if all partners in care work together to develop and implement standards aimed at improving services provided to patients.</p> |
| 125 | National standards of clinical care should reflect the commitment to patient-centred care and thus in future be formulated from the perspective of the patient. The standards should address the quality of care that a patient with a given illness or condition is entitled to expect to receive from the NHS. The standards should take account of the best available evidence. The standards should include guidance on how promptly patients should get access to care. They should address the roles and responsibilities of the various healthcare professionals who will care for the patient. They should take account of the patient's journey from primary care, into the hospital system (if necessary), and back to primary and community care, and of the necessary facilities and equipment. | <p>Accepted in principle:</p> <p>We support the principle that standards of care should be built around the patient; this is the fundamental message contained within Improving Health in Wales, the Welsh Assembly Government's plan for the NHS over the next 10 years. National Service Frameworks are, of course, key to this recommendation, and we have announced a range of NSFs and will be building on a programme for Wales. The Assembly however feels that it should work with key stakeholders to develop and issue standards where this is in the best interest of patients in Wales. The Assembly also considers that it should take the lead in developing care pathways</p> |

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| 126 | Such standards for clinical care as are established should distinguish clearly between those which are obligatory and must be observed, and those to which the NHS should aspire over time. | <p>Rejected:</p> <p>We accept that standards take time to implement fully and that some NHS organisations will be able to meet the standards sooner than others. However tackling health inequalities is a key priority for the Welsh Assembly Government and while it is recognised that the service should be given sufficient time to adopt standards fully across Wales, it does not however feel that there should be a formal distinction between obligatory and optional standards. If standards are based on best practice then all patients should expect to receive care of that standard.</p> |
| 127 | A timetable over the short, medium and long term should be published, and revised periodically, for the development of national clinical standards, so that the public may be consulted and kept aware of those areas of healthcare which are covered by such standards and those which will be covered in the future. Target dates should be set by which clinical standards will have been prepared for all major conditions and illnesses. | <p>Accepted in principle:</p> <p>However we must ensure that NICE has the capacity to deliver any agreed programme and that there is sufficient flexibility to amend the schedule in light of shifting priorities and available resources. We are also working with NICE and DoH to consider how we can ensure transparency of the process.</p> |
| 128 | Resources, and any necessary statutory authority, must be made available to NICE to allow it to perform its role of developing, issuing and keeping under review national clinical standards. | <p>Accepted:</p> <p>We have supported this by providing extra funding for Health Authorities as a contribution towards implementing NICE guidance. However as all other organisations, NICE needs to operate within agreed funding arrangements. Any changes to the agreed funding will be considered in light of business cases submitted by NICE.</p> |
| 129 | Standards of clinical care which patients are entitled to expect to receive in the NHS should be made public. | <p>Accepted:</p> <p>NICE already publishes its guidance and it is available to the public. National Service Frameworks are public documents which set national standards for topics or client groups. We have set out standards for coronary heart disease in an NSF and are developing further NSFs for mental health, older people, diabetes and children.</p> |
| Standards of care : NHS organisations | | |
| 130 | There must be a single, coherent, co-ordinated set of generic standards: that is, standards relating to the patient's experience and the systems for ensuring that care is safe and of good quality (for example corporate management, clinical governance, risk management, clinical audit, the management and support of staff, and the management of resources). Trusts must comply with these standards. | <p>Accepted in principle:</p> <p>Clinical governance provides the framework by which we judge an organisation's ability to deliver continuous improvement in the quality of services and standards. We shall ask NICE to work alongside other organisations to establish a more consistent approach to standard setting. We are currently working on a project on the fundamentals of care which seeks to develop generic standards for the fundamentals of care in both health and social care settings. The aim is to produce standards on eleven aspects of care. Monitoring these standards will be done in an integrated way, by using existing frameworks.</p> |

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| 131 | <p>The current system of inspection of trusts and primary care trusts should be changed to become a system of validation and periodic revalidation of these trusts. The system should be supportive and flexible. Its aim should be to promote continued improvement in the quality of care.</p> | <p>Reject:</p> <p>[131-141]</p> <p>There are a number of recommendations in the report about CHI's future role. We are keen to see CHI's role strengthened in Wales and to ensure that any new proposals will meet our needs in Wales.</p> <p>In summary CHI's new powers will be to:</p> <p>Undertake a new inspection role which is in response to Kennedy's suggested validation. This will be included as a new part of the review process and be undertaken simultaneously with the existing clinical governance reviews not to over burden the NHS.</p> <p>Have a new Office for Health Care Information that will support The Assembly's performance management arrangements by producing an independent assessment of performance</p> <p>Provide the Assembly with an annual report into the state of the NHS</p> <p>Be able to undertake its work in non NHS premises if NHS services are being provided</p> |
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| 132 | One body should be responsible for validating and re-validating NHS trusts and primary care trusts. This body should be CHI, suitably structured so as to give it the necessary independence and authority. Other bodies (for example the NHS Litigation Authority) which are currently concerned with setting and requiring compliance with those generic standards which should fall within the authority of CHI, should carry out their role in this respect under the authority of and answerable to CHI. | |
| 133 | Validation and revalidation of trusts should be based upon compliance with the generic standards which relate to the patient's experience and the systems for ensuring that care is safe and of good quality. | |
| 134 | The standards against which trusts are to be validated, and the results of the process of validation or revalidation, should be made public. | |
| 135 | Any organisation in the voluntary or private sector which provides services to NHS patients should be required to meet the standards for systems, facilities and staff which organisations in the NHS must meet. The aim should be that, wherever care is funded by the NHS, there is a single system of validation which indicates to the public that the organisation meets the necessary standards. | |
| 136 | The validating body should have the power to withdraw, withhold or suspend a trust's validation if standards fall such as to threaten the quality of care or the safety of patients. Any trust or organisation whose validation may be affected in this way must be given the opportunity to take appropriate remedial action. It must then satisfy CHI that it has taken remedial action before its continued validation can be confirmed. | |
| 137 | CHI should consider how it might work with the providers of those programmes of accreditation already adopted by a significant number of trusts. In the future, where required standards are met, CHI should accept as part of its validation process the accreditation obtained through these programmes. | |
| 138 | The process of validation of trusts should, in time, be extended to cover discrete, identifiable services within trusts. This extension of validation should first be piloted and evaluated. | |
| 139 | The pilot exercise for this form of validation should include children's acute hospital services and paediatric cardiac surgery. | |
| 140 | Should the pilot exercise be successful, the category of discrete services which should be a priority for this form of validation are those specialist services which are currently funded or meet the criteria for funding by the National Specialist Commissioning Group (the successor to the Supra Regional Services Advisory Group). | |

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| 141 | For discrete services, whether specialist services or otherwise, to be validated trusts they must be able to demonstrate that all relevant aspects of the service can currently be met, rather than that the trust aims to develop so as to be able to do so at some point in the future. Trusts which do not meet the necessary standards to ensure the safety of patients and a good quality of care should not be permitted to offer, or continue to offer, the relevant service. | |
| 142 | Where the interests of securing quality of care and the safety of patients require that there be only a small number of centres offering a specialist service, the requirements of quality and safety should prevail over considerations of ease of access. It is and should be the responsibility of the NHS to assist patients, and their families or carers, with the cost of transport and accommodation when they have to travel away from home to receive specialist services. Such support should not be the subject of a means test. (See further Recommendations 181 and 182 on specialist services for children). | <p>Accepted in principle:</p> <p>There are no plans to change the statutory Hospital Travel Costs Scheme but health authorities and trusts may pay these costs at their discretion for patients. We recognise the importance of visits to the wellbeing of sick people in hospital, which must be balanced against the need for the NHS to devote as much as possible of its funding to direct patient care. We will encourage health authorities, where appropriate, to use their discretionary powers to support families accompanying their children.</p> <p>See Recommendation 182.</p> |
| Monitoring standards and performance : local monitoring | | |
| 143 | The process of clinical audit, which is now widely practised within trusts, should be at the core of a system of local monitoring of performance. Clinical audit should be multidisciplinary. | <p>Accepted:</p> <p>We are currently looking at how we might take this recommendation forward to help enhance clinical audit arrangements and broaden the involvement of other non-medical health care professionals.</p> |
| 144 | Clinical audit must be fully supported by trusts. They should ensure that healthcare professionals have access to the necessary time, facilities, advice and expertise in order to conduct audit effectively. All trusts should have a central clinical audit office which co-ordinates audit activity, provides advice and support for the audit process, and brings together the results of audit for the trust as a whole. | <p>Accepted in principle:</p> <p>Clinical audit is a vital component of clinical governance arrangements. We shall be supporting organisations through the work programme of the Clinical Governance Support and Development Unit, to help them develop the audit skills of clinicians to ensure they make the best use of audit, and that lessons learnt as a result of clinical audit are shared and used to improve the quality of care.</p> |
| 145 | Clinical audit should be compulsory for all healthcare professionals providing clinical care and the requirement to participate in it should be included as part of the contract of employment. | <p>Accepted:</p> <p>Healthcare professionals should participate in clinical audit activities. We will need to explore with the NHS the best mechanisms for taking this forward. It will also be considered as part of the ongoing consultant negotiations.</p> |
| National monitoring | | |
| 146 | The monitoring of clinical performance at a national level should be brought together and co-ordinated in one body: an independent Office for Information on Healthcare Performance. This Office should be part of CHI. | <p>Accepted:</p> <p>This will be an essential tool in pulling together the wide ranging information that is currently fragmented, and we are working with CHI to develop a coherent and co-ordinated approach to national audits. We shall also be working closely with CHI to ensure that the Assembly is fully involved in the development of the Office for Information. We must ensure that the information needs of Wales are fully considered and data is obtained and assessed in a way that is meaningful to Wales whilst allowing appropriate comparisons to be made with England where this is practicable and would be helpful to Wales. The Office will provide an independent assessment that will support our performance management arrangements.</p> |

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| 147 | The Office for Information on Healthcare Performance should supplant the current fragmentation of approach through a programme of activities involving the co-ordination of the various national audits. In addition to its other responsibilities, the new system should provide a mechanism for surveillance whereby patterns of performance in the NHS which may warrant further scrutiny can be identified as early as possible. | <p>Accepted:</p> <p>See answer to recommendation 146.</p> |
| Information Systems | | |
| 148 | The current 'dual' system of collecting data in the NHS in separate administrative and multiple clinical systems is wasteful and anachronistic. A single approach to collecting data should be adopted, which clinicians can trust and use and from which information about both clinical and administrative performance can be derived. | <p>Accepted:</p> <p>Better Information, Better Health sets out our recognition of the need to synchronise the approach to collecting data. We are conducting a range of work, including pilots with Trusts, to ensure that this is delivered for the NHS in Wales. We must move from administrative systems as the core of secondary care systems, to have clinical systems as the core. The National IM&T Development Plan, scheduled for release in January 2002, will identify how NHS Wales can progress towards this goal.</p> |
| 149 | Steps should be taken nationally and locally to build the confidence of clinicians in the data recorded in the Patient Administration Systems in trusts (which is subsequently aggregated nationally to form the Hospital Episode Statistics). Such steps should include the establishment by trusts of closer working arrangements between clinicians and clinical coding staff. | <p>Accepted:</p> <p>As part of Improving Health in Wales we have tasked the Information Task and Finish Group to develop a coding strategy which will have the aim of ensuring that there can be close working relationships between clinicians and clinical coding staff.</p> |
| 150 | The Hospital Episode Statistics database should be supported as a major national resource which can be used reliably, with care, to undertake the monitoring of a range of healthcare outcomes. | <p>Accepted:</p> <p>PEDW [Patient Episode Database Wales] will have improved support. The processes by which data is captured and fed back into PEDW will form part of the National IM&T Development Plan.</p> |
| 151 | Systems for clinical audit and for monitoring performance rely on accurate and complete data. Competent staff, trained in clinical coding, and supported in their work are required: the status, training and professional qualifications of clinical coding staff should be improved. | <p>Accepted:</p> <p>Accurate and complete data is vital to ensure we have a clear picture of outcomes for patients. Coding is a very important part of the process for capturing the data for statistical analysis. The role of coders should be recognised and supported. A programme to improve the education, training and recognition of coders is in place.</p> |
| 152 | The system of incentives and penalties to encourage trusts to provide complete and validated data of a high quality to the national database should be reviewed. Any new system must include reports of each trust's performance in terms of the quality and timeliness of the submission of data. The systems within a trust for producing data of a high quality, and its performance in returning such data in a timely manner to the national database, should be taken into account in the process of validating and revalidating the trust. | <p>Accepted:</p> <p>The National IM&T Development Plan will include performance targets in relation to information quality. Systems are being implemented to ensure that feedback on PEDW is given in a timely and accessible manner.</p> |
| 153 | At national level, the indicators of performance should be comprehensible to the public as well as to healthcare professionals. They should be fewer and of high quality, rather than numerous but of questionable or variable quality. | <p>Accepted:</p> <p>We accept the need for transparent reporting of performance, but this must be evaluated in the round, using qualitative as well as quantitative indicators and aiming too to assess and encourage improvement. The new Welsh Performance Framework will need to accommodate these issues. It is imperative that we ensure clear information for patients and professionals. HOWIS objectives focus on the need to make this information available widely via the CymruWeb and the internet in formats appropriate to target audiences.</p> |

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| 154 | The need to invest in world-class IT systems must be recognised so that the fundamental principles of data collection, validation and management can be observed: that data be collected only once; that the data be part and parcel of systems used to support healthcare professionals in their care of patients; and that trusts and teams of healthcare professionals receive feedback when data on their services are aggregated. | Accepted: High quality IT systems must fundamentally support the clinical process. The National IM&T Development Plan will outline how we intend to work together in Wales to procure and implement clinical information systems which improve the information available directly to clinicians to support the care of patients. |
| Publication of information about performance and standards | | |
| 155 | Patients and the public must be able to obtain information as to the relative performance of the trust and the services and consultant units within the trust. | Accepted: We will ensure that communication with parents and patients will provide them with sufficient information to enable them to reach informed decisions in consenting for treatments and examinations. |
| 156 | As part of their Annual Reports trust boards should be required to report on the extent of their compliance with the national clinical standards. These reports should be made public and be made available to CHI. | Accepted: We accept the principle of annual monitoring, but also the need to explore how best to do so and make the results public without excessive bureaucracy. |
| Public Involvement through empowerment | | |
| 157 | The involvement of the public in the NHS must be embedded in its structures: the perspectives of patients and of the public must be heard and taken into account wherever decisions affecting the provision of healthcare are made. | Accepted: The Assembly is committed to ensuring that there is continuous feedback from the public about the services they receive from the NHS. We will monitor the mechanisms by which the NHS involves the public. |
| 158 | Organisations which are not part of the NHS but have an impact on it, such as Royal Colleges, the GMC, the Nursing and Midwifery Council and the body responsible for regulating the professions allied to medicine, must involve the public in their decision-making processes, as they affect the provision of healthcare by the NHS. | Accepted: The need for inclusion, involvement and openness is fundamental to the Welsh Assembly Government's policy of putting the public at the heart of decision making across the whole spectrum of Government. Considerable work is underway to encourage greater public participation. Many organisations already regularly encourage and involve lay views for example the General Medical Council, the Dental Council, the Royal Pharmaceutical Society for Great Britain and many Royal Colleges. We regularly seeks the views of the public and patients and will continue to seek opportunities for doing this. The National Institute for Clinical Excellence is developing a framework for a Citizens Council which will ensure representative public involvement in the process of developing standards. We must ensure that all NHS organisations recognise the value and importance of learning from patients' experiences. |
| 159 | The processes for involving patients and the public in organisations in the NHS must be transparent and open to scrutiny: the annual report of every organisation in the NHS should include a section setting out how the public has been involved, and the effect of that involvement. | Accepted: Improving Health in Wales commits NHS Trusts and Local Health Groups to publish annual plans which include patients' views and action taken as a result. A mechanism for monitoring this process is being developed by the Assembly. |
| 160 | The public's involvement in the NHS should particularly be focused on the development and planning of healthcare services and on the operation and delivery of healthcare services, including the regulation of safety and quality, the competence of healthcare professionals, and the protection of vulnerable groups. | Accepted: We are committed to involving patients at every level in the development of services and of their delivery. A mechanism for monitoring this process is being developed. |

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| 161 | Proposals to establish Patients' Forums and Patients' Councils must allow for the involvement of the wider public and not be limited only to patients or to patients' groups. They must be seen as an addition to the process of involving patients and the public in the activities of the NHS, rather than as a substitute for it. | Accepted in principle: We are committed to the principle of transparency and openness. Improving Health in Wales commits NHS Trusts and Local Health Groups to publish annual plans which set out proposals for involving the public and patients in the development of healthcare services and the process for doing this will be monitored and evaluated by the National Assembly. The Assembly is also piloting a number of pathfinder projects to test out new ways of providing patient support and advocacy for patients and their families. |
| 162 | The mechanisms for the involvement of the public in the NHS should be routinely evaluated. These mechanisms should draw on the evidence of what works. | Accepted: Improving Health in Wales commits NHS organisations to incorporate a range of public involvement mechanisms into their health service planning and reviews exercises. This process will be supported by guidance from the Assembly. |
| 163 | The process of public involvement must be properly supported, through for example, the provision of training and guidance. | Accepted: We are committed to providing training and guidance for front-line staff and NHS managers to embed effective public involvement principles. We will shortly be piloting a number of pathfinder projects across Wales where patient support staff will be employed to develop more effective ways of public involvement and to provide training and guidance to front line staff. |
| 164 | Financial resources must be made available to enable members of the public to become involved in NHS organisations: this should include provision for payments to cover, for example, the costs of childcare, or loss of earnings. | Accepted: The issue of financial resources and support costs will be considered by the Assembly within the budget planning cycle, should this be required to support the process of public involvement. |
| 165 | The involvement of the public, particularly of patients, should not be limited to the representatives of patients' groups, or to those representing the interests of patients with a particular illness or condition: the NHS Modernisation Agency should advise the NHS on how to achieve the widest possible involvement of patients and the public in the NHS at local level. | Accepted: To underpin the Assembly's commitment to supporting public involvement, we have produced a resource guide for the NHS, sign-posting best practice in public involvement. This highlights the need for effective communication with patients at all levels and emphasises the importance of achieving the widest possible public input into decisions concerning the day to day running of the NHS. |
| 166 | Primary care trusts (and groups), given their capacity to influence the quality of care in hospitals, must involve patients and the public, for example through each PCG/T's Patient and Advocacy Liaison Service. They must make efforts systematically to gather views and feedback from patients. They must pay particular attention to involving their local community in decision-making about the commissioning of hospital services. | Accepted: The Assembly supports the principle of PALS but proposes a different structure, which includes the provision of patient support managers in local health groups and complaints advocates in community health councils. Funding for the initial pathfinder projects will be provided by the Assembly. If successful, there are proposals to extend patient support and advocacy services across Wales based in NHS trusts, local health groups and community health councils. |

The care of children

Responsibility for children's services

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| 167 | A National Director for Children's Healthcare Services should be appointed to promote improvements in healthcare services provided for children. | Accepted: There will be a new post of National Children's Director for Wales. |
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| 168 | Consideration should be given to the creation of an office of Children's Commissioner in England, with the role of promoting the rights of children in all areas of public policy and seeking improvements to the ways in which the needs of children are met. Healthcare would be one of the areas covered by such a commissioner. Were such an office to be created, we would see it as being in addition to, rather than in place of, our other recommendations about the need to improve the quality of leadership in children's healthcare services. | The question of whether to appoint a Children's Commissioner for England is a matter for the UK Government. Wales already has a Children's Commissioner and I chair a Cabinet Sub-Committee on Children and Young People. |
| 169 | The Cabinet Committee on Children and Young People's Services should specifically include in its remit matters to do with healthcare and health services for children and young people. | |
| 170 | Each health authority and each primary care group or primary care trust should designate a senior member of staff who should have responsibility for commissioning children's healthcare services locally. | <p>Accepted:</p> <p>Some health authorities currently have a designated member of staff for commissioning of children's services. For the future I expect all local health boards to have a senior member of staff designated for this purpose.</p> |
| 171 | All trusts which provide services for children as well as adults, should have a designated executive member of the board whose responsibility it is to ensure that the interests of children are protected and that they are cared for in a paediatric environment by paediatrically trained staff. | <p>Accepted in principle:</p> <p>On 20th September, I announced the development of a Children's National Service Framework for Wales. I would expect this to be considered as part of that development.</p> |

| Setting standards for children's healthcare services | | |
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| 172 | The proposed National Service Framework (NSF) for children's healthcare services must be agreed and implemented as a matter of urgency. | <p>Accepted in principle:</p> <p>On 20th September, I announced the development of a Children's National Service Framework for Wales. I would expect this to be considered as part of that development.</p> |
| 173 | The NSF should include a programme for the establishment of standards in all areas of children's acute hospital and healthcare services. | |
| 174 | The NSF should set obligatory standards which must be observed, as well as standards to which children's services should aspire over time. | |
| 175 | The NSF should include incentives for the improvement of children's healthcare services, with particular help being given to those trusts most in need. | |
| 176 | The NSF must include plans for the regular publication of information about the quality and performance of children's healthcare services at national level, at the level of individual trusts, and of individual consultant units. | |
| Planning the future of children's services | | |
| 177 | There must be much greater integration of primary, community, acute and specialist healthcare for children. The NSF should include strategic guidance to health authorities and trusts so that services in the future are better integrated and organised around the needs of children and their families. | <p>Accepted in principle:</p> <p>The proposed Children's Hospital in Cardiff will fulfil this recommendation.</p> <p>On 20th September, I announced the development of a Children's National Service Framework for Wales. I would expect the NSF to consider all of these issues as part of a whole systems approach to care.</p> |
| 178 | Children's acute hospital services should ideally be located in a children's hospital, which should be physically as close as possible to an acute general hospital. This should be the preferred model for the future. | |
| 179 | In the case of existing free-standing children's hospitals, particular attention must be given to ensuring that, through good management and organisation of care, children have access when needed to (a) facilities which may not routinely be found in a children's hospital and (b) specialists, the appointment of whom in a children's hospital could not be justified given the infrequent call on their services. | |
| 180 | Consideration should be given to piloting the introduction of a system whereby children's hospitals take over the running of the children's acute and community services throughout a geographical area, building on the example of the Philadelphia Children's Hospital in the USA. | <p>Accepted in principle:</p> <p>See answer to recommendations 177-179.</p> |

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| 181 | Specialist services for children should be organised so as to provide the best available staff and facilities, thus providing the best possible opportunity for good outcomes. Advice should be sought from experts on the appropriate number of patients to be treated to achieve good outcomes. In planning and organising specialist services, the requirements of quality and safety should prevail over considerations of ease of access. | Accepted: The Specialised Health Service Commission for Wales (SHSCW) is undertaking a comprehensive review of tertiary children's services available to children resident in Wales. The review will result in a strategy and commissioning plan for the provision of a full range of services in an equitable and accessible way to the children of Wales. The review will take account of the BRI recommendations and will be completed by 2002, with an initial report going to the SHSCW board in January 2002. |
| 182 | Where specialist services for children are concentrated in a small number of trusts spread throughout England, these trusts should establish Family Support Funds to help families to meet the costs arising from travelling and staying away from home. The Funds should be administered flexibly and should not be limited to those on income support or with low incomes. | For consideration: The hospital travel costs scheme was set up to ensure that no patients needing hospital treatment would be denied that treatment because they were unable to afford the cost of travel to hospital. The Welsh Assembly Government recognises the importance of parental visits to the well being of sick children in hospital, it is also sensitive to the need for the NHS to devote as much as possible of its funding to direct patient care. The SHSCW review of Children's Tertiary Services will need to consider this recommendation. |
| 183 | After completion of a pilot exercise, all trusts which provide acute hospital services for children should be subject to a process of validation to ensure that they have appropriate child-and family-centred policies, staff, and facilities to provide a good standard of care for children. Trusts which are not so validated should not, save in emergencies, provide acute hospital services for children. | Accepted in principle: The development of the NSF will consider how standards will be set and monitored. |
| The staffing of children's healthcare services | | |
| 184 | Children should always (save in exceptional circumstances, such as emergencies) be cared for in a paediatric environment, and always by healthcare professionals who hold a recognised qualification in caring for children. This is especially so in relation to paediatric intensive care. | Accepted: We accept that children should be cared for in an environment appropriate to their age and their physical and psychological development and this will be considered further in the development of the NSF. The Assembly has consulted on standards for paediatric intensive care and the final standards will publish later this year. |
| 185 | The 1991 standards for the numbers of paediatrically qualified nurses required at any given time should serve as the minimum standard and should apply where children are treated (save in emergencies). The standards should be reviewed as a matter of urgency to take account of changing patterns in the provision of acute healthcare services. | Accepted in principle: On 20 th September, I announced the development of a Children's National Service Framework for Wales. I would expect this to be considered as part of that development. We are investing in the development of paediatrically qualified nurses and in paediatric resuscitation techniques over the next few years. |
| 186 | All surgeons who operate on children, including those who also operate on adults, must undergo training in the care of children and obtain a recognised professional qualification in the care of children. As matter of priority, the GMC, the body responsible for the revalidation of doctors, should agree with the Royal College of Surgeons of England the appropriate number and range of procedures which surgeons who operate on children must undertake in order to retain their validation. This will have consequences for the way in which general surgery for children is organised. | Accepted in principle: Proposals for the revalidation of doctors is broadly supported - detail to be agreed between the General Medical Council and the Royal College of Surgeons. |
| Communication between healthcare professionals, children and their parents or carers | | |

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| 187 | Parents should ordinarily be recognised as experts in the care of their children, and when their children are in need of healthcare, parents should ordinarily be fully involved in that care. | <p>Accepted:</p> <p>On 20th September, I announced the development of a Children's National Service Framework for Wales. I would expect the NSF to consider all of these issues.</p> |
| 188 | Parents of very young children have particular knowledge of their child. This knowledge must be valued and taken into account in the process of caring for the child, unless there is good reason to do otherwise. | |
| 189 | Children's questions about their care must be answered truthfully and clearly. | |
| 190 | Healthcare professionals intending to care for children should be trained in the particular skills necessary to communicate with parents and with children. | <p>Accepted:</p> <p>We agree that those caring for children should require appropriate specialist training.</p> <p>In most cases, the staff involved in the care of children choose an elective at some stage in their pre-registration studies. It is at this point that training in the necessary communication skills should take place. For other staff, training should be available at a post-registration level which covers the issue of communication skills.</p> <p>Provision of such training at undergraduate level will be discussed with Higher Education Institutions with a view to ensuring this meets the needs of both children and parents, as far as possible.</p> |
| 191 | Healthcare professionals should be honest and truthful with parents in discussing their child's condition, possible treatment and the possible outcome. | <p>Accepted:</p> <p>On 20th September, I announced the development of a Children's National Service Framework for Wales. I would expect this to be considered as part of that development.</p> |

Healthcare services and treatment for children with congenital heart disease

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| 192 | National standards should be developed, as a matter of priority, for all aspects of the care and treatment of children with congenital heart disease (CHD). The standards should address diagnosis, surgical and other treatments, and continuing care. They should include standards for primary and social care, as well as for hospital care. The standards should also address the needs of those with CHD who grow into adulthood. | <p>For consideration :</p> <p>We cannot look at these recommendations in isolation, they need to be considered alongside other work., for example the National Paediatric and Congenital Cardiac Service (PCCS) Review Group which was established in March 2001.</p> <p>In addition, the NSF for children's services will propose generic standards on the care of children in hospital, and the integration of such care with primary and social care.</p> |
| 193 | With regard to paediatric cardiac surgery, the standards should stipulate the minimum number of procedures which must be performed in a hospital over a given period of time in order to have the best opportunity of achieving good outcomes for children. PCS must not be undertaken in hospitals which do not meet the minimum number of procedures. Considerations of ease of access to a hospital should not be taken into account in determining whether PCS should be undertaken at that hospital. | <p>For consideration:</p> <p>The National Paediatric Cardiac Services Review Group will make recommendations on many of these issues which will inform the development of Children's services in Wales.</p> |
| 194 | With regard to those surgeons who undertake paediatric cardiac surgery, although not stipulating the number of operating sessions sufficient to maintain competence, it may be that four sessions a week should be the minimum number required. Agreement on this should be reached as a matter of urgency after appropriate consultation. | <p><i>For consideration :</i></p> |

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| 195 | <p>With regard to the very particular circumstances of open-heart surgery on very young children (including neo-nates and infants), we stipulate that the following standard should apply unless, within six months of the publication of this Report, this standard is varied by the DoH having taken the advice of relevant experts: there must, in any unit providing open-heart surgery on very young children, be two surgeons trained in paediatric surgery who must each undertake between 40 and 50 open-heart operations a year.</p> | |
| 196 | <p>The national standards should stipulate that children with CHD who undergo any form of interventional procedure must be cared for in a paediatric environment. This means that all healthcare professionals who care for these children must be trained and qualified in paediatric care. It also means that children must be cared for in a setting with facilities and equipment designed for children. There must also be access on the same site as where any surgery is performed to a paediatric intensive care unit, supported by trained intensivists.</p> | |
| 197 | <p>Surgical services for children with very rare congenital heart conditions, such as Truncus Arteriosus, or involving procedures undertaken very rarely, should only be performed in a maximum of two units, validated as such on the advice of experts. Such arrangements should be subject to periodic review.</p> | <p><i>See 194</i></p> |
| 198 | <p>An investigation should be conducted as a matter of urgency to ensure that PCS is not currently being carried out where the low volume of patients or other factors make it unsafe to perform such surgery.</p> | <p>Accepted: A thorough review is underway.</p> |

Background to the Kennedy Report

1. The Kennedy Report was published on 18 July. The Inquiry, chaired by Professor Ian Kennedy, was asked to look at children's heart surgery at the Bristol Royal Infirmary between 1984 and 1995 and to draw wider lessons for the health service as a whole.
2. In examining events at the Bristol Royal Infirmary between 1984 and 1995 the Report describes 'a tragedy born of high hopes and ambitions'. Between 1991 and 1995 the Report makes clear that between 30 and 35 more children, aged under one year, died after open heart surgery in Bristol than was typical of similar heart units elsewhere in England. This was not due to differences in the severity of the cases. While mortality rates fell throughout the rest of the country this did not happen in Bristol.
3. The Report exposes considerable flaws in the systems, culture and management arrangements in place at the time; and highlights a culture where little account was taken of the views and concerns of parents, there was a shortfall in clinical audit practices, management actively discouraged open discussion and resolution of concerns raised by staff and early warnings were brushed to one side.
4. The recommendations are wide ranging and many will require a fundamental cultural shift.
5. The Report concludes that there was a tragic combination of key clinicians failing to reflect on their practice (the senior staff concerned got things wrong not least because they assumed that in time things were bound to come right); senior management failing to grasp the seriousness of what was going wrong; and people in a range of capacities failing to act. It was left to a whistleblower, an anaesthetist in the hospital, Dr Stephen Bolsin, to trigger the chain of events, which led eventually in 1996 to the suspension of children's heart surgery.
6. The Report makes 198 wide ranging and challenging recommendations about the organisation and culture of the NHS to ensure that if implemented a tragedy such as Bristol cannot happen elsewhere.
7. The Kennedy Report places the patient at the centre of its view of how the health service should be organised and the recommendations flow from the guiding principle that the patient should be entitled to expect:
 - Respect and honesty;
 - Care in a setting which is well led;
 - Competent healthcare professionals;
 - Care which is safe;
 - Care of an appropriate standard; and
 - Inclusion and Involvement in the NHS, both as patients and members of the public.
8. The recommendations are a considered attempt to shift the culture of the NHS to one where it can be acknowledged that medicine is not a perfect science and that even the best people can make mistakes. It describes a future culture where appropriate systems and relationships are in place to provide a safe framework within which clinical care can be provided to a high and recognised standard; outcomes can be monitored and evaluated; staff are well regulated, trained and supported for the tasks expected of them; error is minimised but when it does occur lessons are learnt and shared; and above all where patients are genuine partners in the decision making process.

BRISTOL ROYAL INFIRMARY: TEMPLATE FOR RESPONSES

| No | Recommendation | Action to date | Future Action proposed | By whom &date |
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| 1. | In a patient-centred healthcare service patients must be involved, wherever possible, in decisions about their treatment and care. | | | |
| 2. | The education and training of all healthcare professionals should be imbued with the idea of partnership between the healthcare professional and the patient. | | | |
| 3. | The notion of partnership between the healthcare professional and the patient, whereby the patient and the professional meet as equals with different expertise, must be adopted by healthcare professionals in all parts of the NHS, including healthcare professionals in hospitals. | | | |
| 4. | Information about treatment and care should be given in a variety of forms, be given in stages and be reinforced over time. | | | |
| 5. | Information should be tailored to the needs, circumstances and wishes of the individual | | | |
| 6. | Information should be based on the current available evidence and include a summary of the evidence and data, in a form which is comprehensible to patients | | | |
| 7. | Various modes of conveying information, whether leaflets, tapes, videos or CDs, should be regularly updated, and developed and piloted with the help of patients. | | | |
| 9. | The public should receive guidance on those sources of information about health and healthcare on the Internet which are reliable and of good quality: a kitemarking system should be developed. | | | |
| 10. | Tape-recording facilities should be provided by the NHS to enable patients, should they so wish, to make a tape recording of a discussion with a healthcare professional when a diagnosis, course of treatment, or prognosis is being discussed. | | | |

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| 11. | Patients should always be given the opportunity and time to ask questions about what they are told, to seek clarification and to ask for more information. It must be the responsibility of employers in the NHS to ensure that the working arrangements of healthcare professionals allow for this, not least that they have the necessary time. | | | |
| 12. | Patients must be given such information as enables them to participate in their care. | | | |
| 13. | Before embarking on any procedure, patients should be given an explanation of what is going to happen and, after the procedure, should have the opportunity to review what has happened. | | | |
| 14. | Patients should be supported in dealing with the additional anxiety sometimes created by greater knowledge | | | |
| 15. | Patients should be told that they may have another person of their choosing present when receiving information about a diagnosis or a procedure. | | | |
| 16. | Patients should be given the sense of freedom to indicate when they do not want any (or more) information: this requires skill and understanding from healthcare professionals | | | |
| 19. | Healthcare professionals responsible for the care of any particular patient must communicate effectively with each other. The aim must be to avoid giving the patient conflicting advice and information. | | | |
| 20. | The provision of counselling and support should be regarded as an integral part of a patient's care. All hospital trusts should have a well-developed system and a well-trained group of professionals whose task it is to provide this type of support and to make links to the various other forms of support (such as that provided by voluntary or social services) which patients may need. | | | |
| 21. | Every trust should have a professional bereavement service. (We also reiterate what was recommended in the Inquiry's Interim Report: 'Recommendation 13: As hospitals develop websites, a domain should be created concerned with bereavement in which all the relevant information concerning post-mortems can be set out in an appropriate manner.') | | | |
| 28. | Patients must be given the opportunity to pass on views on the service which they have received: all parts of the NHS should | | | |

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| | routinely seek and act on feedback from patients as to their views of the service. In addition, formal, systematic structured surveys of patients' experience of their care (not merely satisfaction surveys) should be routinely conducted across the NHS and the results made public. | | | |
| 29. | NHS trusts and primary care trusts must have systems which ensure that patients know where and to whom to go when they need further information or explanation. | | | |
| 31. | Trusts and primary care trusts must have systems for publishing periodic reports on patients' views and suggestions, including information about the action taken in the light of them. | | | |
| 33. | A duty of candour, meaning a duty to tell a patient if adverse events have occurred, must be recognised as owed by all those working in the NHS to patients. | | | |
| 34. | When things go wrong, patients are entitled to receive an acknowledgement, an explanation and an apology | | | |
| 35. | There should be a clear system, in the form of a 'one-stop shop' in every trust, for addressing the concerns of a patient about the care provided by, or the conduct of, a healthcare professional. | | | |
| 36. | Complaints should be dealt with swiftly and thoroughly, keeping the patient (and carer) informed. There should be a strong independent element, not part of the trust's management or board, in any body considering serious complaints which require formal investigation. An independent advocacy service should be established to assist patients (and carers). | | | |
| 92. | Where clinicians hold managerial roles which extend beyond their immediate clinical practice, sufficient protected time in the form of allocated sessions must be made available for them to carry out that managerial role. | | | |
| 93. | Any clinician, before appointment to a managerial role, must demonstrate the managerial competence to undertake what is required in that role: training and support should be made available by trusts and primary care trusts. | | | |
| 94. | Clinicians should not be required or expected to hold managerial roles on bases other than competence for the job. For example, seniority or being next in turn are not appropriate criteria for the appointment of clinicians to managerial roles. | | | |

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| 99. | Any clinician carrying out any clinical procedure for the first time must be directly supervised by colleagues who have the necessary skill, competence and experience until such time as the relevant degree of expertise has been acquired. | | | |
| 102. | Patients are always entitled to know the extent to which a procedure which they are about to undergo is innovative or experimental. They are also entitled to be informed about the experience of the clinician who is to carry out the procedure | | | |
| 143. | The process of clinical audit, which is now widely practised within trusts, should be at the core of a system of local monitoring of performance. Clinical audit should be multidisciplinary | | | |
| 144. | Clinical audit must be fully supported by trusts. They should ensure that healthcare professionals have access to the necessary time, facilities, advice and expertise in order to conduct audit effectively. All trusts should have a central clinical audit office which co-ordinates audit activity, provides advice and support for the audit process, and brings together the results of audit for the trust as a whole. | | | |
| 149. | Steps should be taken nationally and locally to build the confidence of clinicians in the data recorded in the Patient Administration Systems in trusts (which is subsequently aggregated nationally to form the Hospital Episode Statistics). Such steps should include the establishment by trusts of closer working arrangements between clinicians and clinical coding staff. | | | |
| 151. | Systems for clinical audit and for monitoring performance rely on accurate and complete data. Competent staff, trained in clinical coding, and supported in their work are required: the status, training and professional qualifications of clinical coding staff should be improved. | | | |
| 155. | Patients and the public must be able to obtain information as to the relative performance of the trust and the services and consultant units within the trust | | | |
| 156. | As part of their Annual Reports trust boards should be required to report on the extent of their compliance with the national clinical standards. These reports should be made public and be made available | | | |

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| | to CHI. | | | |
| 157. | The involvement of the public in the NHS must be embedded in its structures: the perspectives of patients and of the public must be heard and taken into account wherever decisions affecting the provision of healthcare are made. | | | |
| 159. | The processes for involving patients and the public in organisations in the NHS must be transparent and open to scrutiny: the annual report of every organisation in the NHS should include a section setting out how the public has been involved, and the effect of that involvement | | | |
| 160. | The public's involvement in the NHS should particularly be focused on the development and planning of healthcare services and on the operation and delivery of healthcare services, including the regulation of safety and quality, the competence of healthcare professionals, and the protection of vulnerable groups. | | | |
| 161. | Proposals to establish Patients' Forums and Patients' Councils must allow for the involvement of the wider public and not be limited only to patients or to patients' groups. They must be seen as an addition to the process of involving patients and the public in the activities of the NHS, rather than as a substitute for it. | | | |
| 162. | The mechanisms for the involvement of the public in the NHS should be routinely evaluated. These mechanisms should draw on the evidence of what works. | | | |
| 163. | The process of public involvement must be properly supported, through for example, the provision of training and guidance. | | | |
| 170. | Each health authority and each primary care group or primary care trust should designate a senior member of staff who should have responsibility for commissioning children's healthcare services locally. | | | |
| 171. | All trusts which provide services for children as well as adults, should have a designated executive member of the board whose responsibility it is to ensure that the interests of children are protected and that they are cared for in a paediatric environment by paediatrically trained staff. | | | |
| 181. | Specialist services for children should be organised so as to provide the best available staff and facilities, thus providing the best possible opportunity for good outcomes. Advice should be sought from | | | |

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| | experts on the appropriate number of patients to be treated to achieve good outcomes. In planning and organising specialist services, the requirements of quality and safety should prevail over considerations of ease of access. | | | |
| 187. | Parents should ordinarily be recognised as experts in the care of their children, and when their children are in need of healthcare, parents should ordinarily be fully involved in that care. | | | |
| 188. | Parents of very young children have particular knowledge of their child. This knowledge must be valued and taken into account in the process of caring for the child, unless there is good reason to do otherwise. | | | |
| 189. | Children's questions about their care must be answered truthfully and clearly. | | | |
| 190. | Healthcare professionals intending to care for children should be trained in the particular skills necessary to communicate with parents and with children. | | | |
| 191. | Healthcare professionals intending to care for children should be trained in the particular skills necessary to communicate with parents and with children. | | | |