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Darren Millar AM
Chair, Public Accounts Committee
National Assembly for Wales
Cardiff Bay
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09 December 2014

Dear Darren,

Follow up from PAC Meeting 09/12/2014

I wanted to write thank you for inviting me to give evidence this morning. As we touched upon the issue of a duty of candour towards the end of the meeting, I thought it might be helpful to let you and the Committee know that I am supportive of the Safe Nurse Staffing Levels (Wales) Bill that has been introduced by Kirsty Williams as reporting on staffing levels would be one of the 12 key things that I made reference to this morning. I have advised Kirsty, the Royal College of Nursing, the Health Minister and the Chair of the Health and Social Care Committee of this and will provide a more detailed briefing and rationale behind my support at an appropriate time to support debate in the Senedd.

I am also writing to confirm that in the New Year I will send you the key outcomes I expect to see reported on and reflected in key documents. In the interim, I thought it might be helpful to share with you, as there seems a clear read across to your current Inquiry, the fundamental questions I believe sit at the door of the Welsh Government to answer and which have, in no small part, guided my own work (Annex 1). These are in the public domain as they were attached to a briefing I circulated following the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Kind regards

Sarah Rochira

Sarah Rochira
Older People's Commissioner for Wales

Annex 1: Key issues for Wales (Taken from briefing document on the Mid Staffordshire NHS Foundation Trust Public Inquiry issued in December 2013)

- How does the NHS in Wales define effective and safe care, not just from a clinical perspective, but from the perspective of an older person?

- Are the mechanisms that we have in place to evaluate the quality of care sufficiently robust and evidence based to enable their findings to be used as an evaluation tool?

- Can staff within the NHS in Wales raise concerns effectively and where they do, is robust action being taken to address poor care or mistreatment?

- Are the mechanisms we have to gauge patient views of their treatment robust and do we use patient experiences effectively to drive continuous improvements?

- Is scrutiny of the quality of care undertaken by Health Boards robust and effective and is appropriate action taken and reviewed where failures take place.

- Is there sufficient openness and transparency with the public about what the health boards are getting right and, more importantly, what is going wrong?

- Does the Welsh Government effectively put the safety and quality of patient care at the front of its requirements of the NHS and is the way that the Welsh Government scrutinises performance of the NHS in relation to patient safety and quality of care sufficiently robust and evidence based.