Chapter 3

Health care quality in Wales

Less than two decades after devolution, the Welsh health system remains a relatively young one; many of the institutions and mechanisms needed to promote high quality care are in place, but now a further push is needed to move towards a more mature, robust quality architecture. In many respects, "quality" is at the heart of the Welsh health system; this chapter describes Wales' already-rich health care quality architecture. The ambition for an excellent, patient-centred health system, promoting quality, access and equity is clearly there in Wales, but now tangible practical steps are needed to make the necessary changes. This chapter makes a series of recommendations to support Wales in strengthening quality assurance and quality improvement. Assessment and recommendations are made across health system domains – from the role of accreditation and standards, to patient voice and professional training. Cutting across these domains, the priority should now be for Wales should be looking to increase accountability for delivering good quality and improving quality, and trying to establish some more concrete levers for positive system change.

Continuously improving the quality of care is a deeply established and widely shared commitment in the Welsh health system, NHS Wales. This report assesses the governance model, institutions and policies in place to assure, monitor and improve health care quality in Wales. Comparisons with quality monitoring and improvement activities in other OECD health systems are drawn and, based upon these, the strengths and weaknesses in Wales' quality architecture are identified. Where weaknesses are identified, recommendations for strengthening arrangements in Wales are proposed, drawing on successful examples from other OECD countries.

Analyses that quantify quality and outcomes in the Welsh NHS are available elsewhere (for example the Health Foundation and the Nuffield Trust, 2014). This report does not seek to replicate these quantitative assessments. Instead, the report's primary aim is to help policy makers, clinicians and patients answer the question "How can the governance model, institutions and policies that make up Wales' quality architecture evolve to deliver ever better health care"? The chapter opens with a brief description of how health care in Wales is planned, financed and delivered, focusing on the role of Health Boards, and the Prudent Healthcare agenda. Section 3.2 then examines separate elements of the quality architecture (such as use of inspection or professional licensing, authorisation of medical devices and pharmaceuticals, audits and peer review, etc.) in detail, in a format that follows other volumes in the OECD's Health Care Quality Review series. An assessment of how the system is meeting the challenges it faces, and a series of recommendations to help Wales improve, are made throughout, and brought together in a conclusion and recommendations box at the end of the chapter.

3.1. The planning, financing and delivery of health care in Wales

The Welsh National Health System provides publically funded health care for Wales' 3 million population. While also a relatively young system – a devolved health system was established in Wales in 1999 – most of the core functions of the health system are devolved as part of NHS Wales, with only some more limited functions remaining at a UK level. Wales has chosen to abolish the purchaser-provider split and does not accept that competition is the best driver for quality improvement. NHS Wales is therefore referred to as a "planned" system, based on unified decision making and integration of service delivery, and a systematic planning cycle. The Welsh Government has overall responsibility for planning of the system, while local Health Boards, trusts and local authorities also have established management and planning mechanisms. Recent health policy in Wales has emphasised the importance of "Prudent Healthcare"; the Prudent Healthcare agenda now needs to be backed up by a detailed roadmap – an Implementation Action Plan – containing a clearer vision for what services will look like.

Population characteristics in Wales

Located on the Western Coast of Great Britain, Wales has a population of just over 3 million people, mostly concentrated in the south of the country and along the northern coast, with a largely rural centre. Some 19% of the population is Welsh speaking, with some communities particularly in the north and west of Wales speaking Welsh as a first language. NHS Wales is the only system in the United Kingdom which endeavors to provide services in two languages, England and Welsh, in line with the patient's wishes.

Wales is the most economically disadvantaged of the four UK nations, with a Gross Value Added in 2012 of GBP 15 696, compared to England GBP 21 349, Scotland GBP 20 571, and Northern Ireland GBP 16 531 (Office of National Statistics, 2012). The lower income per head in Wales likely impacts upon population health and wellbeing, and demand for health services. Wales has a higher dependency ratio than the other UK nations – with more children and retired persons –, and also has a greater number of adults under retirement age with a disability (National Audit Office, 2012). Based on these indicators, as well as other determinants such as rate of drinking, smoking and obesity, a review of the UK nations by the National Audit Office (2012) estimated that relative health need per person in Wales is higher than in England and Scotland (1.07 compared to 0.91 and 0.98 respectively), and slightly lower than in Northern Ireland (1.11).

A devolved health system in Wales was established in 1999 with primary legislative powers passed to the Welsh National Assembly in 2006

The Welsh National Health System (NHS) provides publically funded health care for all of Wales' population of 3 million, which is around 5% of the total population of the United Kingdom. Originally part of the health system for England and Wales, with the National Health Service Act 1946, powers over NHS Wales were passed to the Secretary of State for Wales in 1969. Devolution of responsibility for NHS Wales followed in 1999, following a national referendum, some 50 years after the establishment of the devolved systems in Scotland and Northern Ireland. This Act established the National Assembly for Wales as a corporate body with an executive government and a legislating body, and passed the governance of the NHS in Wales from the UK Parliament to the Welsh Government and the Welsh Minister for Health and Social Services. A subsequent Government of Wales Act 2006 provided the Welsh National Assembly with primary legislative powers in a number of areas including health. The National Assembly for Wales is a democratically elected body that represents the interests of Wales and its people, makes laws for Wales, and holds the

Welsh Government to account, and is responsible for areas such as health, education, language and culture, and public services. The UK Government retains responsibility for UK-wide areas such as tax, defence, foreign policy, social security and welfare benefits. Wales' voice in the UK Government is represented by the Secretary of State for Wales in the Wales Office. There are also certain situations in which the Welsh Government works collaboratively with the UK Government on legislation that affects Wales but which is passed by the Westminster Parliament.

While most of the core functions of the health system are devolved as part of NHS Wales, some areas of health and health services are not devolved, including the following: abortion; human genetics, human fertilisation, human embryology, surrogacy arrangements; xenotransplantation; regulation of health professionals (including persons dispensing hearing aids); poisons; misuse of and dealing in drugs; human medicines and medicinal products, including authorisations for use and regulation of prices; standards for, and testing of, biological substances (that is, substances the purity or potency of which cannot be adequately tested by chemical means); vaccine damage payments; and welfare foods. International mattes, such as relationships with the WHO and the OECD, are also a non-devolved matter. Wales also principally draws on the clinical guidelines developed by the National Institute for Health and Care Excellence (NICE), with some established collaboration around pharmaceuticals and medical devices (see Chapter 1 on England).

The bulk of funding for the NHS Wales comes as part of a block grant from Treasury in the United Kingdom

Funding for NHS Wales comes as part of a block grant for the Welsh Government from the Treasury in the United Kingdom. In 2014-15 a grant of GBP 15.1 billion was made to the Welsh Government, of which GBP 6.4 billion was allocated to Health and Social Services, representing 42% of the expenditure of the devolved responsibilities of the Welsh Government (Welsh Government, 2014a). The block grant from the UK Government to Wales is made based on the population allocations covered by the Barnett formula (which is also used to calculate grants to the other devolved nations). The adequacy of this funding calculation has been called into question, notably in the 2010 report "Fairness and accountability: a new funding settlement for Wales" (Welsh Government, 2010). This report suggested that Wales is at present underfunded relative to its needs, and that the funding of devolved activities in Wales has fallen below what Wales would receive if funding was allocated based on the same formulae used to allocate resources to comparable functions in England. The block grant allocation made based on the Barnett Formula to Wales makes up between 50-60% of public spending in Wales, with the remaining per cent

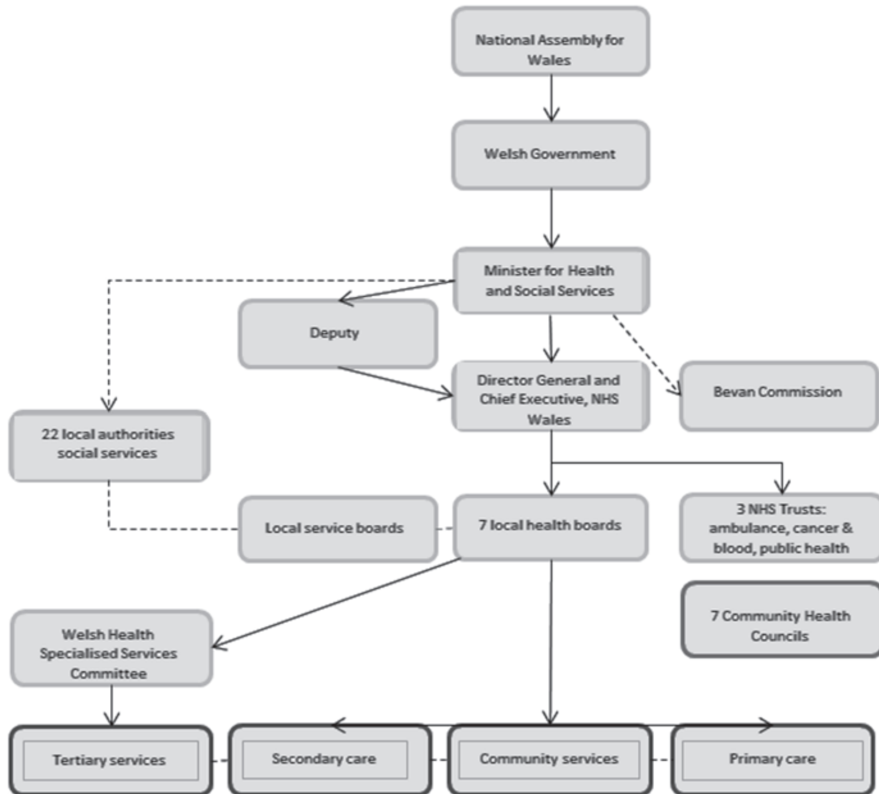
of public spending made up in the most part from social security benefits and tax credits (The Health Foundation and Nuffield Trust, 2014).

Wales has chosen to abolish the purchaser-provider split and focuses on careful planning mechanisms

Wales has chosen to abolish the purchaser-provider split and does not accept that competition is the best driver for quality improvement. NHS Wales is therefore referred to as a "planned" system, based on unified decision making and integration of service delivery, and a systematic medium term (three year) planning cycle, set out in the NHS Wales Planning Framework (Welsh Government, 2013), and the NHS Wales (Finance) Act 2014. The system focusses on clearly defined planning roles and responsibilities and clear and integrated national priority setting, while allowing sufficient freedom within arrangements for organisations to respond to local health needs. There is a high level of scrutiny around plans, from government, management, clinical staff, patients and the public, and strong relationship between the planning system and quality, delivery, and performance monitoring arrangements. The Welsh Government has overall responsibility for planning of the system, while local Health Boards, trusts and local authorities also have established mechanisms for setting out how resources (financial, workforce and infrastructure) will be deployed to yield maximum benefit in order to address areas of population health need and improve health outcomes, improve the quality of care, and ensure best value from resources.

NHS Wales is led by the Minister for Health and Social Services in the Welsh National Assembly, and the Director General for Health and Social Services and NHS Wales Chief Executive, and organised and governed through seven local Health Boards and three NHS Trusts (Welsh Ambulance Services NHS Trust, Public Health Wales, and the Velindre NHS Trust for non-surgical cancer care and the blood service). Health Boards in Wales are responsible for assessing the needs of their population as a whole, and for ensuring services are provided that meet those needs. Wales' 22 local authorities, with locally elected politicians, are responsible for local government including social services. They are statutorily required to work with the NHS and non-statutory partners using a variety of joint arrangements such as local strategic partnerships. Groups of local authorities have coterminous boundaries with Health Board (Figure 3.1).

Figure 3.1. Structure of health services in Wales



Source: Adapted from Longley, M. et al. (2012), *United Kingdom (Wales): Health System Review. Health Systems in Transition*, Vol. 14, No. 11, pp. 1-–84, and based on submission from the Welsh Government.

Five years after their establishment Health Boards are showing less local innovation and fewer radical approaches to system change and quality improvements than would be expected

Health Boards, which were created in 2009, plan and commission all services for their local area, with the exception of some of the more highly specialised services covered by the NHS Trusts and the Welsh Specialist Services Committee. Understanding of the role that Health Boards should play has been improving in Wales, and they have moved from an amalgamation of hospitals and commissioners to more cohesive organisations, better connected with local authorities and the needs of the population. Efforts have been made to push the Health Boards towards assuming a planning approach more closely attuned to demand for health services, and anticipating demand ahead of time.

A central part of this has been the expectation that all Health Boards complete Integrated Medium Term Plans, which set out projected Health Board activities for the following three years. The intention of the Integrated Medium Term Plans is that Health Boards, once their plans are approved by the Minister, are given more year-on-year flexibility in their activities, whilst being held to account on the basis of the plans they have put forward. Only a few Health Board plans have to-date been approved by the Minister, and the Health Boards that have not had Integrated Medium Term Plans approved work toward a one year plan and have less flexibility and closer supervision going forward. The Minister and NHS Wales provide a Planning Framework which gives guidance on what Health Board plans will be assessed against.

The introduction of a three-year systematic planning cycle with the IMTPs, as a step forward from yearly budget cycles and a focus on annual targets, seems like a positive one. A move to give Health Boards greater flexibility and independence could also be expected to foster better connectivity with local needs, as well as innovative local approaches to planning and delivering care. Having been established in 2009, Health Boards have now had five years in which to mature, and begin to demonstrate their central importance to the Welsh NHS. Given their close proximity to local population needs, and the apparent desire that they be driving local change, a far greater degree of local innovation and more radical approaches to system change and quality improvements could well be expected from Health Boards by now.

However, there are signs that Health Boards are not at this point fulfilling their full potential, and it may be now be appropriate for the partnership between the Welsh Government and Health Boards to be revisited. While central governing authorities in Wales have taken a deliberate step back to encourage some more local autonomy, it may be that at present Health Boards do not have sufficient institutional and technical capabilities and capacities to drive meaningful change, and a stronger central guiding hand may be needed. To maximise the potential of Health Boards as local planners, purchasers and providers the centre may have to step back in and play a more supportive – and prescriptive – role.

There are some signs of evolving relationships between the Health Boards and the Welsh Government and other central authorities. With the introduction of the Integrated Medium Term Plans Wales has taken a step in the right direction, but more work is needed to get the balance between local freedom, innovation and sensitivity to population needs, and core standards that should be centrally driven, right. Similarly, the introduction of an Escalation and Integration Framework in 2014 seems to be an appropriate development. The framework is used as a tool for greater co-ordinated action between the Welsh Government, Healthcare

Inspectorate Wales, and the Auditor General for Wales, and as a robust tool for quality assurance and intervention by the Welsh Government in case of crisis or serious concerns about quality.

In Wales, though, work is still needed at both ends of the spectrum – in terms of setting expectations of Health Boards, and supporting Health Boards to meet and exceed expectations, and foster local innovation. More can be done to set, and publicise, core minimum expectations of all local Health Boards. While the NHS Wales Planning Framework seems a useful step towards clarifying planning expectations, there still seems to be scope for the government to be more prescriptive about exactly what is expected – in terms of financing and budget allocation, performance and efficiency, and quality achievement and improvement – from Health Boards and the providers they oversee. The Welsh Government is already beginning to explore some of these issues for the health system as a whole, and for Health Boards, in the consultation document (Green Paper) "Our Health, Our Health Service" (Welsh Government, 2015a), and with the Integrated Medium Term Plans. More also needs to be done to support Health Boards as they try to deliver meaningful, and more significant, system change, with a focus on good collaboration between the Welsh Government and the Health Boards, building technical, managerial and leadership capacity in Health Boards, and sharing of experiences and expertise across Health Boards and system-wide. Other OECD countries also struggle with the balance between national standards (and control), and local freedom and innovation, and some offer lessons that Wales could learn from (Box 3.1).

Box 3.1. Getting the balance between local freedom and central standards right: Examples from Denmark, Italy and Norway

In **Italy,** 21 regions and autonomous provinces are responsible for the planning and delivery of health services, and the main way in which the government's steering role and regional government's delivery role is expressed in the Patto per la salute (Pact for health), a three-year plan that is agreed jointly between central and regional governments. Backing up this central direction-setting, which is not dissimilar to Wales Integrated Medium Term Plans for Health Boards, is AGENAS, the *Agenzia Nazionale per i Servizi Sanitari Regionali* (National Agency for Regional Health Services) which is supports regions in developing knowledge and capacity, and also oversees the National Outcomes Programme (*Programma Nazionale Esiti* – PNE). This Programme is a national initiative that monitors129 health care indicators (input, process and outcomes) across hospitals and municipalities in Italy. Results across the indicators, which are at present mostly covering hospital settings, are (depending on the indicator) published at a national, regional, and hospital level. The OECD (2014) has recommended that Italy look to expand further the responsibilities and capacities of the national authorities whose role is to support the R&AP, notably AGENAS, but this supportive institution, and national indicator platform, are already interesting ways of pushing both local performance and quality standards, and fostering innovation.

Box 3.1. Getting the balance between local freedom and central standards right: Examples from Denmark, Italy and Norway *(cont.)*

Denmark also offers a model of considerable interest, with the *Danske Regioner*, or association of Danish regions. In Denmark national legislation increasingly sets out requirements on topics such as waiting times, safety of pharmaceuticals and adverse event reporting, and then more detailed regulation is carried out through the agreement between the national level, the regions, and the municipalities. Quality targets are an increasing feature of these agreements. The agreement on the regional budget for 2013, for example, stipulates a 10% decrease in hospital standardised mortality rate and a 20% decrease in adverse events for the next three years. Although these agreements are not legally binding, they are considered to be an important mechanism to govern the Danish health care system, whilst leaving sufficient room for regional and local adaptations according to needs.

In **Norway** the *Kommunesektorens organisasjon*, the Norwegian Association of Local and Regional Authorities, is a national interest association for all 428 Norwegian municipalities, 19 counties, and public enterprises KS have regular contacts with central authorities to advocate for the interest of its members, and negotiate agreements with the government. The 2012-15 agreement, for example, aims at promoting quality initiatives in the primary health care services. The agreement puts great emphasis on patient participation, prevention, rehabilitation and the use of new technologies. KS actively communicates with the members, disseminates information and facilitates the exchange of experience. The regular consultations between the central government and the Norwegian Association of Local and Regional Authorities also focus on financial issues depending on the duties and responsibilities of local authorities.

Source: OECD (2013), *OECD Reviews of Health Care Quality: Denmark 2013 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264191136-en; OECD (2014), *OECD Reviews of Health Care Quality: Norway 2014 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264208605-en, OECD (2014), *OECD Reviews of Health Care Quality: Italy 2014: Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264225428-en.

What is clear in these international examples is how important collaboration between local authorities is, and how effective support for local bodies – from the centre, from each other, from a third organisation, or a mix – is key. More also needs to be done to support Health Boards as they try to deliver meaningful, and more significant, system change, with a focus on good collaboration between the Welsh Government and the Health Boards, building technical, managerial and leadership capacity in Health Boards, and sharing of experiences and expertise across Health Boards and system-wide. Some ways of doing this in Wales might include:

- Mentoring partnerships between Health Boards, where more successful and experienced Boards can support those that may be struggling.

- Mentoring partnerships and experience exchanges between top managers across boards, the Welsh Government, and organisations from across the United Kingdom.
- Learning trips and exchanges with other countries where local innovation and leadership is well established.
- Staff exchanges and secondments between Health Boards, and between Health Boards and the Welsh Government.

The Prudent Healthcare agenda should now be backed-up by an Implementation Action Plan

Recent health policy in Wales has emphasised the importance of "Prudent Healthcare", with 2014 announced by the Minister for Health and Social Services as the "Year of Prudent Healthcare". Prudent Healthcare is described as being "healthcare that fits the needs and circumstances of patients and actively avoids wasteful care that is not to the patients benefit", a vision outlined in a written statement on 14 July 2014 to the Welsh Government. The Prudent Healthcare agenda focuses on harm reduction, appropriateness of care – notably the minimum appropriate intervention and care setting, and that for instance no patient should be seen routinely by a consultant when their needs could be appropriately dealt with by an advanced nurse practitioner –, a push for professional excellence, promotion of equity and criteria of clinical need, and a remodeling of the relationship between user and provider on the basis of co-production, including the encouragement of a "prudent patient", using NHS resources wisely. Prudent Healthcare can be seen as a way of balancing quality, and the constraints of austerity – it is the bargain of co-production at an individual and population level where patients and the NHS each make a contribution to improve health and wellbeing. All these principles are underlined by a commitment to rebalance the health care system by strengthening primary and community-based care.

The Prudent Healthcare agenda now needs to be backed up by a detailed roadmap – an Implementation Action Plan – containing a clearer vision for what services will look like, and should look like, in Wales in the next decade. This Implementation Action Plan should be a blueprint for the transformations that are expected in NHS Wales in the next 5-10 years, and should be made up of measurable, time-bound and deliverable changes. As a starting point, this chapter gives a series of recommendations that could well be reflected in such an Action Plan.

Health Boards could be pushed to align funding with the goals of Prudent Healthcare

Financial flows in Wales, including to Health Boards, could be better leveraged. Considering the central importance given to shifting care away from hospital settings and towards primary and community care, more could be done both in terms of incentives and levers for this shift, designing and fostering innovative service and organisational models. Though far from the only lever, funding flows have a significant influence on the shape of health systems and services, and could be exploited more in Wales. Some targeted funding has been put in place for 2015-16: GBP 30 million of hypothecated funding to develop primary care services across Wales, and GBP 20 million to take forward projects funded by the Intermediate Care Fund this year that have proven to be effective across community and acute environments, linking out-of-hospital care and social care to strengthen the resilience of the unscheduled care system. Pushing beyond this, Wales could consider commitments or concrete ambitions such as setting an expectation that a certain percentage of Health Board spending be shifted out of hospitals and secondary care and towards primary care in the next 5-10 years, or pushing for minimum investment levels from Health Board financial planning in primary and community care.

Other OECD countries are also grappling with the particular challenge of shifting care away from hospital and specialist settings and towards primary and community care, and many have developed strategies and objectives around making this happen. Fewer countries have backed such strategies with concrete action and effective levers. In Norway, though, the 2012 "Coordination Reform" has the overriding aim of directing more investment towards primary care in order to curb the growth of expenditure in hospitals and strengthening integration between care levels, introduced a vision for change but also substantial economic and organisational changes that went alongside (OECD, 2014a). In particular, the reform relies on a percentage of co-financing of hospital care by municipalities (which has since been repealed), and a financial penalty for municipalities for any delay in discharge for a patient in the event that the municipality is unable to provide appropriate community care. At the same time, Norway started building up a network of intermediate care facilities ("Distriktsmedisinsk senter" or "Sykestue" in Norwegian), which have a key responsibility for caring for patients upon discharge from hospital. These units are service models for integrated care, financed jointly by hospitals and municipalities, for patients who no longer need acute hospital care but are not yet well enough to return home. The careful way in which Norway backed up strategic vision with incentives, financial levers, and organisational and

service change is surely very interesting for Wales, even if the detail of the mechanisms to encourage change in Wales will inevitably differ.

Wales could be more ambitious in fostering new models of care delivery and organisation

A central objective of the Prudent Healthcare agenda is to shift more care away from hospitals and towards primary and community settings. Wales is, like many other OECD countries, trying to get the bulk of care and patient contacts taking place away from acute care settings. Given significant challenges of aging populations and a growing burden of chronic disease, a robust and high quality primary care sector is needed to effectively manage patients in the community. The Prudent Healthcare website identifies a number of more concrete ways that Prudent Healthcare could be implemented in primary care, including a greater focus on prevention, "prudent prescribing", and better engagement with patients and encouraging self-care and shared decision making (Lewis, Focusing primary care services on people by applying Prudent Healthcare).

Wales could, though, be more ambitious in fostering new models of care delivery and organisation, particularly given that innovation is identified as a driving force for Prudent Healthcare. This need not be a case of totally transforming governance structures, or system-wide reform, but rather supporting experimentation with care models, and matching a strategic ambition for system change, with system change on the ground. The Primary Care clusters that have been established in Wales seem to be a good move towards developing a more effective and more engaged primary care sector (see Box 3.2).

The Primary Care Clusters have potential to be an important resource in Wales, especially if the balance between cluster autonomy and incentives for innovation and action is got right. The extra funding that is being made available for the Primary Care Clusters could, for instance, be used to incentivise innovation and new ways of working. primary care clusters could be given the opportunity to bid for small grants to fund pilot projects – perhaps in collaboration with other institutions in Wales, or working across clusters – which they have identified as having potentially positive impact for their patients. Successful experiences could then be scaled-up with leadership from the Welsh Government, and/or collaboration with other Primary Care Clusters.

Box 3.2. Primary Care Clusters in Wales

In Wales and in the UK general practitioners (GPs) operate through local practices, providing general medical services as independent practitioners who then contract with the NHS. To promote collaboration between general practices at the level of 25 000 to 50 000 populations, Health Boards have also established a total of 64 primary care "clusters", initially of GP practices, which cover all the localities in Wales. As part of these clusters GPs meet regularly, under a "cluster lead", to discuss and reflect on local health needs and priorities using health records from their surgeries, to identify general practice service improvement by linking elements of the individual practice development plans, to work with other partners to improve the co-ordination of care and the integration of health and social care and to reduce inequalities.

Primary Care Clusters can be a way for GPs to reflect on their own quality of care, particularly given the requirement that practices review all of their case notes, and audit all of their patient deaths. Primary Care Clusters can also take forward recommendations to Health Boards and other service partners, and change approaches within practices. For instance, in Monmouthshire South a complaint from a family member regarding the behaviour of practice staff towards a patient with dementia, that was discussed as part of the cluster, led to the establishment of a "dementia champion" in that practice. The next step is for Health Boards to use cluster action plans as a vehicle for making more rapid and wide scale progress. Cluster action plans will highlight priority areas, such as the rising prevalence of diabetes, and focus on developing solutions e.g. nurse specialist support in the community. Cluster leads are also encouraged to engage voluntary sector organisations to inform proposals for service redesign. It is anticipated that locally agreed dashboards will be used to ensure accountability through professionally led governance arrangements.

The Welsh Government is using the national GP contract and Quality and Outcomes Framework to further strengthen collaboration within clusters, tasked with producing cluster action plans by the end of September 2014 (British Medical Association, 2014). These plans informed the round of Health Board three year Integrated Medium Terms Plans in January 2015.

The Minister for Health and Social services has recently made GBP 6 million available to the 64 Primary Care Clusters across Wales, to enable them to build infrastructure and put leadership and governance arrangements in place. These resources are directed to the clusters through the parent Health Board. This is part of GBP 40 million new funding for primary care announced by the Minister in 2015, of which GBP 30 million will be informed by the three-year Integrated Medium Term Plans established by Health Boards. GBP 4 million will be used to fund new innovative models of working within a primary care programme. It is expected that primary care clusters will inform the use of this new funding.

All Health Boards should have a primary care professional on their board

Health Boards are reported as actively engaging with GPs and primary care staff, and the development of primary care clusters is another avenue

for primary care views to feed back into governance structures, but more could be done to promote the voice of primary care. Given the expectation that NHS Wales should gradually re-orientate towards the primary care sector, it is surprising that Health Boards are not expected to always have a primary care professional on the board. At present, officer members of Health Boards consist of the following: a chief officer; a medical officer; a finance officer; a nurse officer; and an officer who has responsibility for the provision of primary, community and mental health services.

Wales has begun grappling with this issue, especially through a recently published consultation document (Green Paper) entitled "Our Health, Our Health Service" (Welsh Government, 2015a) which asks whether the right governance arrangements are in place on Health Boards, including whether the Health Board size and membership are correct. As part of this exercise, and also as part of considering the role of Health Boards more generally, the Welsh Government should seriously consider introducing a requirement that Health Boards have a primary care professional (for instance, a GP or primary care nurse) on their general board.

The value of high level, consistent primary care practitioner involvement is important for at least two reasons. First, primary care practitioners, for example GPs, will have a clear idea of local health needs and weaknesses in service delivery, and as such are well placed to inform Health Board planning. Having a GP or equivalent on the Health Board is a further lever to ensure that these perspectives are heard, and most importantly reflected in planning and action. Second, primary care practitioners will feel the impact of decisions made by Health Boards, for instance with regards to changing hospital services or processes around referral, admission and discharge, or unscheduled care. Given that Health Board decisions can have a potentially significant impact on primary care practice, it is right that they be well represented from the beginning of discussions around service change.

3.2. Governance of health care quality monitoring and improvement

Wales has a rich quality monitoring and improvement architecture, including a range of key health care policies and legislation, the successful 1000 Lives campaign, and periodic external reviews. Some common quality improvement levers are either unrealistic in Wales – notably meaningful patient choice of provider is more difficult in a small system like Wales – or Wales has chosen a different path, notably the abolition the purchaser-provider split. In light of this, robust measurement of performance, open comparison of results, and visible accountability for Health Boards should be ensured.

Much of the legal framework for quality was set out previously on an "England and Wales" basis but Wales is now articulating its own quality strategies and action plans

A range of key health care policies, as encapsulated in policy documents and recent and future legislation, underpin the Welsh approach to the quality of care. Just prior to devolution, Quality Care and Clinical Excellence was published by the Welsh Office in 1998 (Welsh Office, 1998), which introduced clinical governance for all NHS organisations in Wales and provided a framework quality and standards. The key components of the clinical governance framework included clinical audit, evidence-based practice and processes for monitoring clinical care using information and record keeping systems, as well as policies for managing risk and lines of responsibility and accountability for the overall quality of clinical care. The Health Act 1999 (Department of Health, The Health Act, 1999) introduced a statutory duty of quality within NHS trusts, with Chief Executives being held responsible, on behalf of their boards, for assuring the quality of their services.

Since devolution, a number of documents and frameworks addressing quality of care have been published. These include: the Health and Social Care (Community Health and Standards) Act 2003 which set out an overarching duty of quality for health bodies; the Healthcare Standards for Wales Framework 2005, after which health bodies were to demonstrate progress against the standards through an annual assessment; and the Healthcare Quality Improvement Plan (QUIP) 2006 which set out to strengthen the focus on quality in the Welsh NHS.

Most recently, "Doing Well, Doing Better, Standards for Health Services in Wales" (2010) sets out the core standards for the NHS, revising the Healthcare Standards Framework with the aim of better reflecting the new integrated NHS structures in Wales and the prevention agenda. A further update to this framework was issued in April 2015. In 2011 the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 set out the statutory basis for the handling of concerns and complaints in the NHS, and was later complemented by the Framework for Assuring Service User Experience. The Putting Things Right system of "do it once, do it well" was then launched with a view to dealing with complaints effectively and being able to demonstrate clearly that lessons had been learned. In 2012, Achieving Excellence: the Quality Delivery Plan for the NHS in Wales set the double goal of ensuring continuous quality improvement through inspiring all staff and managers to take responsibility for improving the quality of care they provide. This was supported by the 1000 Lives quality improvement programme.

Future legislation is planned in terms of a Public Health Bill (Welsh Government, 2013a) and a Well-being of Future Generations Act (Welsh Government, 2014a), which will impact on the quality of efforts to improve health in the widest sense. The Well-being of Future Generations Act is particularly interesting, and unique, in its approach to strengthening governance arrangements for improving the well-being of Wales and ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The Act aims to improve well-being in line with the principle of sustainable development. Wales has also introduced new social services legislation which will help drive integrated and preventative services (Social Services and Wellbeing Act, 2014).

The 1000 Lives campaign has been a successful way of fostering a culture of quality improvement

Between 2008 and 2010 NHS Wales Health Boards and trusts took part in the 1000 Lives campaign, a two-year quality improvement initiative which sought to save 1 000 lives, and prevent 50 000 episodes of harm in the NHS. The initiative was adapted from a successful campaign run in America by the Institute for Healthcare Improvement. At the end of the campaign in 2010 these goals were deemed to have been reached, with an End of Campaign Report (NHS Wales, 2010) estimating that 1 199 additional lives had been saved by NHS staff in Wales between April 2008 and April 2010. Given this success, and the momentum the campaign built, 1000 Lives was extended into the 1000 Lives Plus national programme to further improve the quality of Welsh health care and embed the methodology used by the campaign into new areas.

One of the dimensions judged to be a strength of the 1000 Lives campaigns has been the focus on patient experience and putting the patient at the centre of care. In June 2013, the 1000 Lives improvement team published a White paper on "The Listening Organisation – Ensuring care is patient centred in NHS Wales". The paper explains how listening to patients and understanding what it feels like to experience care is a key way for NHS Wales can improve its services. Patient stories have been promoted by the team as an effective and powerful way of making sure that the patient's voice is heard and that improvement of services is centred on the needs of the patient. A number of patient-driven care resources have been developed. Patient stories are now regularly shared at board level and have had a significant impact at a senior executive and non-executive level as they make an abstract problem "real".

External reviews are a common part of the Welsh quality architecture

Wales has seen a number of high profile investigations and reviews of the health system, in England and in Wales, which have had an impact on the quality of care architecture and – often – been a source of external pressure and scrutiny for the health system. One of the most significant policy statements has been "Delivering Safe Care, Compassionate Care" (Welsh Government, 2013b) which was published in 2013 as the response of the Welsh Government to the Francis Report in England, which followed the Mid Staffordshire NHS Foundation Trust Public Inquiry (for further details see also Chapter 1 on England). Amongst the changes following this report were the introduction of an all-Wales Quality Statement from 2014, a revision of the NHS Wales Fundamentals of Care Standards (aligning them within the new Health and Care Standards framework from April 2015), and a commitment to improve the complaints procedures (for discussion of complaints, see Section 3.8). A Green paper on quality and governance, *Our Health, Our Health Service*, was published on 6 July 2015.

A number of other reviews in Wales have been undertaken at the request of the Welsh Government. Amongst them, the 2014 Andrews Report "Trusted to Care" (Andrews and Butler, 2014), an independent review of two hospitals within one Health Board, which was prompted by complaints to the Minister about care standards in one of the hospitals. The report made a series of recommendations on quality and patient safety, and identified areas for concern – for instance medicine management and storage, and concern about care for frail older people. Some changes have followed the report, for instance the introduction of ministerially commissioned "spot checks" in acute hospitals. Another external review, assessing the work of Healthcare Inspectorate Wales (HIW) (Marks, 2014) was published in late 2014. The commissioning of this report, again by the Minister, followed a report by the Health and Social Care Committee of the National Assembly for Wales (HSCC) which highlighted a number of shortcomings of HIW.

While there is a clear value to external scrutiny of the health system, and careful reflection on broad areas of delivery is sometimes called for, there is danger of over-reliance on ad-hoc reports in response to moments of crisis or concern. The main focus of quality improvement strategies and architecture should be, first, on ensuring that appropriate mechanisms for identifying shortcomings early are in place and fit for purpose. These include comprehensive data systems and quality indicators which are regularly reviewed, public reporting of performance, benchmarking of providers, an effective inspection and assurance function for services, and a robust patient feedback and complaints system. Second, systematic quality

improvement initiatives need to be in place throughout the system, including shared learning and best practice dissemination, incentives for innovation, public and patient involvement, and professional development. This chapter covers most of these areas in further detail.

Robust measurement of performance and visible accountability for Health Boards must be ensured

Wales has chosen to abolish the purchaser-provider split, and also does not accept that competition is the best driver for quality improvement. The Welsh model is more one of unified planning and integration of service delivery at local level, based on a responsibility for Health Boards to assess and meet the needs of their local population. In addition, Wales has not followed other OECD countries – including England – in prioritising patient choice of provider. While a patient may request to be seen at a particular hospital, Welsh patients do not have a statutory right to choice (unlike in England). Patients are offered care based on their constituency, and based on the organisation judged best placed to provide the care needed.

In a small country such as Wales, where there are limited numbers of specialist services and acute hospitals, a statutory guarantee of patient choice may well be too difficult to deliver. Similarly, in a small system such as Wales abolition of the provider-purchaser split may well be more efficient and possibly save transaction costs, and the Welsh Government should be able to maintain a close working relationship with all provider-purchasers. Nonetheless, patient choice and the provider-purchaser split are in many countries important levers for quality assurance and quality improvement. For instance, where competition for patients exists, and prices are fixed, providers have to compete on parameters other than prices, including on quality (Kumar et al., 2014).

Given that Wales cannot use patient choice or the provider-purchaser split to drive quality improvement, efforts must be made to ensure that all other quality levers are working effectively. In the absence of patient choice, the patient voice must be well represented (see Section 3.8). In the absence of the provider-purchaser split, robust measurement of performance, open comparison of results, and visible accountability for Health Boards must be ensured, and open comparison of results, and visible accountability for Health Boards must be ensured. The Quality Statements are a step towards this, but a core data portal which brings together all Health Board data from across Wales, in as close to real-time as possible, is a further step to consider.

3.3. Professional training and certification

Professional regulation and licensing of all health professionals is currently not a devolved matter, and is dealt with on a UK basis. Meanwhile, Wales takes the lead for continuing professional development and revalidation processes. Wales has already started to use health workforce contracts to align staff expectations with health care goals. Scope remains for Wales to develop a more ambitious and forward looking workforce plan.

Professional certification is on a UK basis while Wales assumes responsibility for medical appraisal for revalidation

Professional regulation and licensing of all health professionals is currently not a devolved matter, and is dealt with on a UK basis (see Chapter 1 on England). The relevant bodies for Medicine, Nursing, Dentistry, Pharmacists, Allied Health Professions, Biomedical and Clinical Scientists, all recognise the importance of close collaborative working with Welsh Government, with regular communication and recognition of the implications of UK level regulation for devolved administrations. While regulation of health professionals is a non-devolved area, education and training is devolved to Wales. The interdependence between these two areas of policy brings some challenges for Wales. The increasing divergence of the health systems across the United Kingdom will inevitably result in different approaches being adopted in these areas and arrangements which provide Wales with the greatest degree of flexibility will be required to address issues that arise in Wales across the full range of professions.

There have been a number of reviews into the education and training of specific professional groups, including the Shape of Training Review and the English Trusted to Care Review. These all have implications for both the professional regulatory and educational frameworks across the United Kingdom as well as in Wales.

In Wales the Health Professional Education Investment Review has recently been concluded, and the report was published on 14th April 2015 for a six-week period of stakeholder engagement which ended on 25th May 2015. The main focus of the report was to consider whether the arrangements currently in place to support the GBP 350 million investment made in health professional education and training each year in Wales represent the best arrangements for Wales. In particular, the review has considered whether Welsh Government obtains value for money and a secure supply of staff for the NHS and wider care settings.

Wales has responsibility for organising processes for annual medical appraisals, linked to five-yearly revalidation (see also Chapter 1 on

England). Wales has commissioned a single web based software platform – the MARS platform – which is available for use by all doctors in Wales (Wales Deanery and Welsh Government, 2014). The MARS platform can also be accessed by the responsible officer for each organisation, who in turn recommends revalidation to the General Medical Council.

The Wales Deanery has a School of Postgraduate Medical and Dental Education, which plays an important role in continual professional development. The General Medical Council undertakes a National Training Survey each year and produces a summary report for Wales. This provides important, if indirect, feedback on services and patients safety. The Welsh Government also has a range of policies and supporting guidance to improve the performance of already registered nurses and midwives, and non-registered Healthcare Support Workers. This includes the Framework for Advance Nursing, Midwifery, and Allied Healthcare Professional Practice in Wales, which is seen as a core standard-setting document for this growing group of professionals, and the only one in the United Kingdom.

The development of a skills and development framework for health care support workers, currently a non-regulated staff group, is under development, and an increasingly modular approach is being taken towards nurse education and development. A focus on extended skills sets for professional staff groups is also a key feature of the "Prudent Healthcare" approach adopted in Wales.

Adequate, effective and innovative staffing aligned with strategic objectives for NHS Wales should be a priority

Wales does have slightly different contracts for the four independent contractor professions who provide General Medical Services, General Dental Services, Community Pharmacy and Community Optometry. These contracts give Welsh authorities more traction in encouraging engagement of professionals with particular population needs in Wales. The Welsh Government and Health Boards should be attentive to using these levers to align professional activities and competencies with the direction of travel for NHS Wales. Notably, given the strategic direction set by the Welsh Government, the role of GPs (under the General Medical Services contract) and community pharmacy would be expected to be central important. Encouragingly, Wales has already started to use the GPs' contract to push for quality improvement, for example as part of the Primary Care Clusters (see Section 3.1).

Aligning staffing for NHS Wales with the Prudent Healthcare agenda – which focuses on the most appropriate care provided by the most appropriate professional, and a shift of services towards primary and

community care – will be central to the success of the strategy. This is already recognised by the Welsh Government, who state as part of reflection on "Making prudent healthcare happen", that "the NHS Wales workforce is both a key enabler and driver for change and must be integral to all planning and investment decisions if the opportunities to improve care are to be realized" (Griffith and Middlemiss, Shaping a workforce to serve the people of Wales). This paper identifies a number of possible routes for helping align NHS workforce planning with Prudent Healthcare, for instance 24-hour GP practices in emergency hospital departments; new roles, such as community link workers supporting people experiencing poverty or hard-to-reach groups; and consultants working beyond traditional boundaries in delivering care outside of hospitals. A primary care workforce plan was published in July 2015 (Welsh Government, 2015d). This plan considers the developments that are needed within the primary care workforce, including to align the workforce with the Prudent Healthcare agenda, going forward to 2018. This plan seems to be a step in the right direction, including action points such as the need to put into place more robust workforce planning mechanisms, involving stakeholders including GP clusters, Health Boards and the Welsh Government.

Responsibility for workforce planning is at the level of Health Boards, which means that the expiration of the Welsh workforce strategy – Delivering a Five-Year Service, Workforce and Financial Strategic framework for NHS Wales – in 2016 should present further opportunity for careful and ambitious central planning around workforce development in Wales. To help deliver a more ambitious and forward-looking approach to workforce planning Wales needs to develop more empirical capacity for workforce modelling, based on anticipated population and health needs, and based on the way that the system is expected to change. Then, based on insights from the empirical workforce modelling, Wales could start to experiment with new ways of organising the health workforce in Wales. The focus should be on piloting innovative staffing models, and new care pathways, which then have the potential to be scaled-up if they are found to be successful. The OECD paper "Health Workforce Planning in OECD Countries: A Review of 26 Projection Models from 18 Countries" (Ono, Lafortune and Schoenstein, 2013) should offer a wealth of examples of approaches from other OECD countries, which Wales could draw on. This process could help move the Prudent Healthcare agenda on from strategy setting, to establishing practical consequences for staffing numbers, staff training, and staffing models and organisation.

3.4. Inspection and accreditation of health care facilities

Inspections by Health Inspectorate Wales and accountability against the Health and Care Standards framework are the main tools Wales has to assure quality in health care facilities. To strengthen these approaches, and/or to add to them, Wales could look to international trends in inspection and accreditation.

Healthcare Inspectorate Wales reviews all health services

Health services are reviewed against a range of published standards, policies, guidance and regulations by Healthcare Inspectorate Wales. Healthcare Inspectorate Wales core role is to "review and inspect NHS and independent health care organisations in Wales and provide independent assurance for patients, the public, the Welsh Government and health care providers, that services are safe and of good quality". HIW operates as an "arm's length body" (i.e. it is operationally independent) which carries out its functions on behalf of Welsh Ministers. Although part of the Welsh Government, protocols have been established which safeguard its operational autonomy. Health Boards self-assess against the standards framework for health services in Wales, which HIW is responsible for reviewing. HIW also produces, amongst other types of inspections and reviews, Healthcare Inspectorate Wales Dignity and Essential Care Inspection (DECI) reports as a result of inspections.

The Welsh Government recently commissioned an independent review of HIW, which was published in late 2014 (Marks, 2014). This review suggested that HIW's scope to date has been too narrow – focusing on standards at individual wards and health bodies – and too reactive – undertaking special reviews of services only in response to particular concerns or incidents. The review recommended that HIW take a broader scope to contribute to achieving system-wide improvements, settings its own programme of peer and thematic reviews.

Traditionally, HIW has not looked at the primary care sector, although a review of GP services is to be undertaken in 2015, and a limited programme of primary care inspections and thematic review to commence from 2016. This expansion of coverage seems a welcome development. Healthcare Inspectorate Wales is also undertaking inspections of dental practices.

A standards framework underpins Wales' quality of care architecture

Wales' Health and Care Standards framework was introduced in April 2015, bringing together the two previous sets of standards, the "Fundamentals of Care", Guidance for Health and Social Care Staff, and the

Healthcare Standards for Health Services in Wales (Welsh Government, 2015b). The Health and Care Standards framework underpins the quality of care architecture, and it is against this framework that providers and staff are held to account. The standards fall across seven themes – staff and resources, individual care, staying healthy, safe care, effective care, dignified care, timely care – under which one or more standards are set out (see Box 3.3 for a number of examples).

International trends in accreditation may offer lessons for Wales

Approaches to accreditation in OECD countries show significant diversity, with significant differences in terms of coverage, methods (application of criteria, whether accreditation is mandatory or voluntary), objectives (minimum standards or improvement) and frequency. A few trends do stand out. First, there has been a move towards increasingly consistent methods, for example with national authorities increasingly developing a single, consistent method for system-wide application. The second trend is toward a greater reach of facilities; accreditation is increasingly applied to the private hospitals, to primary care, to laboratory and diagnostic facilities and other organisations involved in providing health care. The third is toward a greater sophistication, including a much broader set of dimensions including customer focus and organisational factors such as managerial competence. The latter two of these trends are worth keeping in mind for Wales, especially given the ongoing evolutions in both the role of HIW and the development of core standards.

Another trend for Wales to look at is the way that a few organisations within OECD health systems are looking to overcome traditional organisational boundaries and better reflect the patient pathway in accreditation and inspection activities (Box 3.4). For HIW to follow some of these approaches as part of their expanded approach to thematic reviews, for example, could be of great interest. Such an approach would consider all elements of the patient pathway (primary care, acute care and social care), and might eventually lead to standards – or guidance – developed around measurable dimensions such as timeliness, information exchange and patient involvement in their care.

Box 3.3. Health and Care Standards framework

Under the Health and Care Standards framework there are seven themes, all of which are turned towards delivering person-centred care. The framework also explicitly acknowledges "the principles of co-production and Prudent Healthcare". In terms of this focus, co-production of care is seen as a key part of the Prudent Healthcare agenda, wherein patients both take action to protect and promote their own health, and work alongside health professionals in establishing the most appropriate care. For instance, one theme is "Staying Healthy" and is directed in significant part towards patients' responsibilities. Other standards, for example around Safe Care, are more squarely directed at health care professionals.

Each standard is also set out in terms of what it should mean – when the standard is met – for individuals using the NHS in Wales, for example for the standard of "Timely Care", this should mean that:

- (I) have easy and timely access to primary care services.
- To ensure the best possible outcome, (my) condition is diagnosed early and treated in accordance with clinical need.

Health and care standards framework, selected examples

Staying healthy	
Standard 1.1. Health promotion, protection and improvement	People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.
Criteria	
People know and understand what care, support and opportunities are available, locally, regionally and nationally, including community support and support for people from protected groups.	
People are supported to engage, participate and feel valued in society.	
People are supported to be healthy, safe, and happy, and to lead an active life.	
Children have a good, healthy, safe and nurturing start in life.	
Carers of individuals who are unable to manage their own health and wellbeing are supported.	
People are supported to make decisions about their health behaviour and wellbeing which impact on their health and the health and wellbeing of their children.	
Breast feeding is promoted and supported.	
Smoking cessation and smoke free environments are promoted and supported.	
People are supported to avoid harm to their health and wellbeing by making healthy choices and accepting opportunities to prevent ill health.	
There is active promotion of healthy and safe workplaces and communities.	
There is active promotion of the health and well-being of staff.	
Systems, resources and plans are in place to identify and act upon significant public health issues so as to prevent and control communicable diseases and provide immunization programmes; with effective programmes to screen and detect disease.	
Needs assessment and public health advice informs service planning, policies and practices.	
Health services have systems and processes in place that play their part in reducing inequalities and protect and improve the health and wellbeing of their local population.	
Relationships and allocations of responsibilities between the various organisations with public health responsibilities are clear and acted upon.	

Box 3.3. Health and Care Standards framework *(cont.)*

Health and care standards framework, selected examples *(cont.)*

Safe care	
Standard 2.2. Preventing pressure and tissue damage	People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.
Criteria	
People are assessed for risk of pressure and tissue damage and if considered at risk, they receive further assessment and a plan of care is developed and implemented.	
People are made aware of the risks of pressure and tissue damage and shown ways of preventing them. They and those caring for them are encouraged and advised on appropriate care procedures, including nutritional advice.	
Appropriate beds, chairs and other equipment are made available to reduce the risks of pressure and tissue damage and specialist preventative equipment such as special mattresses and cushions are also available if necessary. All equipment is clean and properly maintained.	
Correct moving techniques are encouraged, including regular turning and appropriate self-care, helping people to avoid pressure and tissue damage, increasing their well-being, independence and dignity.	
Risk assessments are in place to identify if a person is at risk, their skin is checked at least once daily, and preferably when their personal hygiene is attended to.	
Timely care	
Standard 5.1. Timely access	All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.
Criteria	
People's health outcomes are monitored in order to ensure they receive care in a timely way.	
All aspects of care are provided, including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with national timescales, pathways and best practice.	
Conditions are diagnosed early and treated in accordance with clinical need.	
Accessible information and support is given to ensure people are actively involved in decisions about their care.	
There is compliance with the NHS Outcomes and Delivery framework relating to timely care outcomes.	

Source: Welsh Government (2015), *Health and Care Standards*, http://www.gov.wales.

Box 3.4. Inspection and accreditation of patient pathways

Accreditation the integrated bundle of services needed by particular patient groups remains uncommon in OECD health systems. In Germany, disease management programmes offered by health insurance agencies must be accredited by the Federal Insurance Office, and a similar arrangement exists in the Netherlands (see, for example, van Doorn et al., 2014).

In the United States, independent non-profit organisations, with well-established reputations, such as Joint Commission International and the National Committee for Quality Assurance are increasingly offering this type of accreditation. The JCI's Clinical Care Program Certification (CCPC) programme evaluates the acute or chronic disease management provided by hospitals, ambulatory care, home care, and long term care centers. Examples of programmes include acute myocardial infarction, heart failure, stroke, asthma, chronic obstructive pulmonary disease, pain management, palliative care, low back pain, chronic depression, and HIV/AIDS. Areas evaluated include patient safety, support for self-management amongst patients and caregivers, clinical outcomes, and programme leadership and management.

The NCQA assesses programmes of care for people with asthma, diabetes, chronic obstructive pulmonary disease, heart failure and ischemic vascular disease. Standardised performance measures, which include preventive care aspect such as tobacco use, influenza vaccination and pneumococcal vaccination, are assessed against its Standards and Guidelines for the Accreditation and Certification of Disease Management.

Source: www.jointcommissioninternational.org and www.ncqa.org; Van Doorn, A. et al. (2014), "Effect of Accreditation on the Quality of Chronic Disease Management: A Comparative Observational Study", *BMC Family Practice* 2014, Vol. 15, No. 179, http://dx.doi.org/10.1186/s12875-014-0179-4.

3.5. Authorisation of medical devices and pharmaceuticals

UK level regulations derived from EU Directives on medical devices and pharmaceuticals provide the first layer of authorisation in Wales. In addition, the All Wales Medicines Strategy Group works with NICE around assuring timely and cost-effective provision of medicines. The Surgical Materials Testing Laboratory (SMTL) at Princess of Wales Hospital, Bridgend works to quality assure medical devices for the Welsh NHS and to provide technical advice, and helps to provide a quality and cost control dimension to surgical materials procurement.

Much of the basic regulation of medical devices and pharmaceuticals is based on EU and UK regulation and legislation, while Welsh initiatives add a further layer of quality assurance

The current legislative basis for the quality and assurance of medical devices derives from EU Directives, which have been into four sets of UK regulations which apply across the United Kingdom. In 2003, the

UK Government established the Medicines and Healthcare Products Regulatory Agency (MHRA) as an executive agency of the Department of Health (DOH) to enforce the regulations relating to the safety of medicines and medical devices in the United Kingdom. The Welsh Government works closely with the MHRA, and MHRA's alerts to NHS Wales through the Welsh Government's Public Health Alert System. The Welsh Government's serious incident reporting process acts as an assurance that issues relating to devices are reported promptly to the agency by the NHS organisations. The MHRA also provides the Welsh Government periodically with advice on specific questions and issues about medical devices raised by members of the public and the Welsh Government responds to MHRA's medical device related consultations. Pharmaceutical hazard alerts produced by the MHRA are disseminated electronically to appropriate professional groups across Wales both within and outside normal working hours.

The All Wales Medicines Strategy Group (AWMSG) works with the National Institute for Health and Care Excellence (NICE) (see Chapter 1 on England), to ensure timely and safe access to new, cost effective, medicines and treatment. AWMSG brings together NHS clinicians, pharmacists, health care professionals, academics, health economists, industry representatives and patient advocates. AWMSG, acting in a strategic and advisory capacity, is an authoritative and expert channel through which consensus can be reached on the use of medicines within both primary and secondary care. Established in 2002 AWMSG has always undertaken appraisals in public to improve transparency. Many other bodies, including NICE, have subsequently studied the AWMSG process and moved towards adopting this approach.

Two advisory subgroups report to AWMSG and provide expert advice; the New Medicines Group (NMG) and the All Wales Prescribing and Advisory Group (AWPAG). AWMSG and its subgroups are supported by the All Wales Therapeutics and Toxicology Centre (AWTTC) which provides the secretariat, pharmaceutical assessment and health economics resources. The work of AWTTC consists of health technology appraisals, medicines management prescribing, medicines safety, education, toxicology and prescribing analysis. The All Wales Prescribing Advisory Group (AWPAG) address a range of issues relating to the cost, quality and safety of prescribing and each year review and determines the national prescriber indicators. Performance against these indicators is monitored at national, Health Board and cluster level. To stimulate understanding and awareness of adverse drug reactions and the reporting of these events on Yellow Cards to the MHRA, the number of reports submitted at Health Board and cluster level is being monitored as a national indicator to address a ten-year decline in reporting.

The Welsh Government currently works with NICE under an agreement covered by Section 83 of the Government of Wales Act 2006. In May 2012, a memorandum of understanding was agreed which formally sets out a collaboration between NICE and AWMSG. The aim is to join up the strategic planning, development and delivery of advice in Wales, avoiding duplication or conflict of work, yet complementing and supporting the work of AWMSG. Welsh Government mandates the implementation of both AWSMG and NICE technology appraisals by NHS Wales bodies. NICE advice supersedes advice from AWMSG when this becomes available. Processes to adopt advice from NICE on highly specialised technologies are in place, and similarly, technologies fast tracked through the MHRA early access scheme, will be adopted.

Wales' Surgical Materials Testing Laboratory is an interesting model for other OECD countries

Comparable to the work of NICE and the AWMSG, except applied to surgical materials, the Surgical Materials Testing Laboratory (SMTL) at Princess of Wales Hospital, Bridgend works to quality assure medical devices for the Welsh NHS and to provide technical advice. Funded by the Welsh Government, through the Welsh Health Specialised Services Committee (WHSSC), the laboratory gives advice on appropriate selection of standards and application of test methods, assesses data submissions from manufacturers to support all Wales contracts, including product testing to European and international standards, and clinicians' requirements, and investigates defects and incidents on behalf of NHS Wales, and with liaison with the MHRA.

What is particularly interesting about the work of the SMTL is how it feeds into procurement in Wales (led by the Welsh procurement service, NHS Wales Shared Services Partnership Procurement Services (NWSSPPS). Findings by the SMTL help make evidence-based decisions about which medical devices are fit for purpose, and which are most cost-effective. For example, SMTL will test gloves to ensure that they are fit for purpose, and that they comply with the European Standard (EN 455) specified during procurement. Defect and incident investigations enable NWSSPPS and SMTL to focus their efforts on medical devices which have a track record of causing clinical incidents within Wales. Then, if multiple gloves from different manufacturers are found to be fit for purpose, the final choice can be based on cost, in the knowledge that a shortlist of effective and safe products has already established based on careful testing and evidence review.

SMTL are also starting a Usability (Human Factors) assessment service for medical devices to ensure clinical acceptability, appropriate product handling, and patient safety. An example of this is the contract for single use tonsillectomy instruments. Single use devices from a UK-wide contract had led to an increase in post-operative bleeding rates from 0.6% with reusable instruments to 1.6% with single use (Tompkinson et al., 2005a). SMTL, Procurement and Clinicians were tasked by the Welsh Government to audit suppliers and test instruments (Tompkinson et al., 2005b), and the subsequent highly specified devices led to a drop in post-operative bleeds down to 0.6%. In addition to the testing programme, the Welsh Government funded a surveillance programme to monitor clinician, instrument and patient incidents related to tonsillectomy. This effectively demonstrated that the quality of instruments procured by Wales has resulted in better health outcomes for patients undergoing tonsillectomy than with the original single-use instruments.

3.6. Audits, peer review and performance reporting

Wales has been using audits and peer review processes in an interesting and quite sophisticated way to drive quality improvement in some areas of health care delivery. A large number of national audits and eight outcome reviews are co-ordinated by Welsh Government and contribute to an overarching view of performance and benchmarking with other UK organisations. Peer Review processes in cancer have led to micro-level attention to clinical processes and broader learning for the system, and could be extended. Backing up these improvement tools, Wales has a core performance framework – the NHS Outcomes and Delivery Framework – which is used to hold Health Boards and NHS Trusts to account.

Wales has a core performance framework against which NHS organisations are held to account

The NHS Outcomes and Delivery Framework (Welsh Government, 2014b; Welsh Government, 2015c) is used to hold NHS organisations – essentially Health Boards and NHS Trusts – to account against a set of measures, last revised for the 2013/14 framework, and still in use into 2015/16. Developed following a series of feedback events with stakeholder organisations, citizens and clinicians, the framework has seven identified quality "domains", which are the same as those used in the new standards framework (Staying healthy, Safe care, Effective care, Dignified care, Timely care, Individual care, Our staff and resources). At present, the standards used for previous frameworks have been kept, and these are still being used to measure performance. For example, for the need and

prevention domain, there are three standards, covering influenza vaccines, vaccines for children under 4, and smoking cessation, which are checked weekly, quarterly, and quarterly respectively. For experience and access, one of the three standards covers scheduled care acute access times (assessed monthly), under which: 95% of patients will be waiting less than 26 weeks for treatment with a maximum wait of 36 weeks; percentage of procedures cancelled on more than one occasion by the hospital with less than 8-days notice that are subsequently carried out within 14 days or at the patient's earliest convenience. Alongside the new NHS Outcomes and Delivery Framework a new set of clinically focused outcomes indicators are being developed, which will replace the current standards in due course. Reflecting the direction suggested during stakeholder interaction, clinical outcomes measures will focus in particular on the following areas: the ambulance service and A&E; total emergency pathways for fractured neck or femur, stroke and cardiac (heart attack); ophthalmology outpatient waiting times for both new cases and follow-ups based on clinical need and; cancer pathway (Welsh Government, 2015c).

Accountability against the NHS Outcomes and Delivery Framework is through Quality and Delivery Meetings (QDM) between the Welsh Government and all NHS Health Boards and Trusts, covering achievement of standards and delivery requirements. QDMs are informed by the outputs of the quality and safety assurance group, a regular meeting of Welsh Government officials, which considers a wide range of data and "soft" intelligence on organisations. These outputs are in turn matched with performance data at the integrated delivery board, and this determines the content of QDM discussions. Additionally, these meetings will periodically review other key areas, highlighted through other external bodies' reports such as Community Health Council, HIW and outstanding Welsh Audit Office national audit recommendations. The frequency of these meetings is determined by the status of the organisations' Integrated Medium Term Plan (IMTP). For Health Boards where a three year plan has been approved, accountability meetings will be held on a three-monthly basis. For Health Boards where three year plans are yet to be approved, bi-monthly meetings will be held. Frequency will also be determined by the escalation level of delivery determined through the Welsh Government's internal review process, which may point to a need for higher levels of scrutiny on certain aspects of quality, even where a plan has been agreed. Periodic themed meetings may also take place to explore progress against each theme throughout the year.

Following a poor outcome from a QDM – where there is a failure to deliver on one or more of the targets – an escalation plan for action is in place. The response is centred upon increased monitoring by and support

from the Welsh Government and relevant agencies. In extreme cases – Continued failure to improve performance or failure to engage with the national process – the issue is elevated to regular reporting established between CEO NHS Wales and Health Board Chief Executives, and the possible introduction of "special measure" arrangements, a review of executive and board effectiveness, and potentially removal of appropriate funding schemes. This process is supported tripartite Escalation and Intervention arrangements bringing together Welsh Government, HIW and the WAO. This enhanced and transparent approach to escalation and intervention was introduced in April 2014, when the framework was published. This process is intended to give a more rounded and fully informed assessment of all potential issues and concerns from across all regulators (Welsh Government, 2014c).

The Escalation and Intervention framework has four levels: routine arrangements (normal business), enhanced monitoring, targeted intervention and special measures. Following the publication of the framework, the Betsi Cadwaladr University Health Board was placed at the second level of escalation – enhanced monitoring – in November 2014. In June 2015, serious concerns about quality and performance within the Health Board led to a decision by the Minister for Health and Social Care, on the basis of advice from the three regulators (Welsh Government, HIW and Wales Audit Office), to move the Health Board into special measures. Special measures may entail the suspension or removal of powers and duties from individual members or all members of the Health Board's board, and also means that Welsh Ministers can also direct a Health Board to undertake certain steps with regards to its functions. Neither of the external review bodies – HIW or the Wales Audit Office – undertakes intervention actions themselves. The Special Measures intervention, as part of the Escalation and Intervention Framework, seems an important quality assurance measure in instances of real quality failings. Clearly a difficult process for patients and staff using and working in a Trust or hospital, the Special Measures intervention demands sensitive handling, with upmost priority given to patient safety, and quality improvement.

Audits are used to benchmark quality and inform planning

Audits of NHS Wales and its organisations and clinical domains are used to give surveillance over quality of care, and inform planning. A total of 33 national audits and eight outcome reviews are co-ordinated by Welsh Government and contribute to an overarching view of performance and benchmarking with other UK organisations (some national audit data are comparable across the UK nations).

The national clinical audit programme began across England and Wales in 1996, were reviewed in 2006, and have been overseen by Healthcare Quality Improvement Partnership (HQIP) since 2008 on behalf of England and Wales. HQIP is led by a consortium of the Academy of Royal Colleges, the Royal College of Nursing and National Voices, and the outputs of audits should feedback to clinical staff, as well as informing policy, strategy and service planning, with audits based on widely agreed standards. For Wales, part of the benefit of HQIP lies in the comparison across a larger pool of hospitals, given the inclusion of England also. Wales has set up a National Clinical Audit & Outcome Review Advisory Committee to improve participation and performance in agreed national audits. The committee is seeking to ensure that there is a Welsh representative on the steering Committee of all the national audits to ensure that a Welsh perspective is taken into account in the ongoing development of each audit. Wales is also moving to a position where there is a local champion for every audit in every Health Board. The Committee sends out regular e-bulletins to develop awareness and encourage participation. The audits are published on the Welsh Government e-governance website and are being gradually put onto the "My Local Health Service" website in a form easily accessible by the public. There are aims to publish the participation rates for each Health Board/hospital as a mechanism for further driving up engagement.

In Wales, the audit findings have been very influential in developing National strategies for improving services and linked to the National improvement process developed by 1000 Lives who are working with individual organisations to encourage and support change and service improvement (see Section 3.2), and for each of the National Implementation Groups working on Delivery Plans. Wales also has "Mortality Case Note Reviews", which are undertaken for all deaths in hospital in Wales. The review is a two-step process, starting with a general (universal) assessment, and followed by a full root cause analysis as a second stage.

Encouragingly, some broad lessons for NHS Wales have been emerging from the various audit processes, and there are some reports of these lessons being fed back into organisation and delivery. For instance, examples of early themes for learning coming out of the Mortality Case Note Reviews are around end of life care, recognition of sepsis, medical record keeping and anticoagulation practice. Welsh Government has appointed a National Clinical Lead for this process to consider how variations in the process can be reduced and a consistent approach taken across the country. A standardised approach to the categorisation of harm is now being applied to this process so quantitative data can be presented in addition to the local learning for improvement. This process will facilitate the implementation of the independent medical examiners role in due course. In terms of lessons

from the national audits and outcome studies, findings should be being fed into Clinical Delivery Plans. For instance, clinical audit for diabetes care observed high levels of admissions, and insulin management errors, which fed back into shaping the Clinical Delivery Plan. The audit process should then be able to track whether there have been improvements in care and outcomes.

Some focused peer review processes have been successful ways of identifying weaknesses and improving quality, and could be extended

A number of peer review processes focusing on clinical practice have been started in Wales, notably for cancer, and appear to be effectively identifying weaknesses and in some cases changing practice. Peer Review was launched in Wales in 2012, following a 2011 recommendation by the Welsh Government that a Peer Review process for cancer services be started, to be led by Healthcare Inspectorate Wales (HIW), working in partnership with the Cancer Networks in North and South Wales. The Peer Review processes – reviews for cancer have been carried out or are ongoing for lung, upper gastro intestinal, urology, lower gastro intestinal, head and neck and gynecology, as well as for palliative and end of life care – focuses on the measures required to improve both the quality and safety, and demonstrate and share of cancer services within the revised structures of NHS Wales. The networks leading the Peer Review (South Wales Cancer Network, North Wales Cancer Network, and the Palliative Care Implementation Board) plan each Peer Review, co-ordinate self-assessment, training and documentation within each Health Board, and then report on the Peer Review visit and process within each Health Board.

Completed peer reviews have led to a report, and an action plan, corresponding to the review domain which are published on the Health Inspectorate Wales website. The Peer Review process appears to have been very effective at identifying concrete concerns in clinical practice, and appears well-received by clinicians. For instance, for the lung cancer Peer Review identified specific shortcomings and challenges related to particular wards and units – such as staffing shortages, too low treatment capacity, non-attainment of treatment pathways – along with concrete recommended action, resource implications, responsible person(s) and a target achievement date. Such activities have a clear focus on supporting and improving quality delivered by each team, and each clinician, for each patient.

This micro-level attention to clinical processes and learning from them should be praised, and Wales might look at the feasibility first of making such peer review processes more widespread, and second, trying to find

effective ways of integrating lessons from peer review into standard clinical practice. A new wave of peer reviews could, for example, make recommendations on the application of the principles and tools of Prudent Healthcare in organisations across NHS Wales. An approach like this would help generate concrete ideas for implementation, and also make action around Prudent Healthcare more "real" and everybody's concern.

3.7. Development, use and reporting of quality indicators

A good range of health system information, including on quality, is systematically collected in Wales. This information feeds into a number of reports are published or produced for internal use. A particularly promising initiative is the Secure Anonymised Information Linkage Databank (SAIL), which brings together a wide array of routinely collected data on health, well-being and services, which can then be used for research and evaluation. There is still space for wales to strengthen the collection, use and reporting of quality indicators, including through reporting health system data in a more user-friendly format, and participating in UK-wide benchmarking of indicators.

Wales is ahead on securely linking individuals' health and social care data, and is actively using some quality indicators

Wales has some good ways in which data is made easily accessible, which should help its usability for the health system. Amongst the information that is collected systematically in Wales is the following:

- NHS waiting times
- NHS beds and their use
- Delayed transfers of care
- Ambulance service
- NHS complaints
- Quality and Outcomes Framework Statistics on primary care (see Chapter 1 on England)
- All Wales perinatal survey
- Welsh Healthcare Associated Infection Programme
- Antimicrobial resistance programme
- Specialist heart surgery in the United Kingdom.

Much of this data is pulled together and available on the website of the Welsh Government, gov.wales/statistics-and-research/, often in the form of regular summary reports. The datasets for a number of indicators, mostly process indicators with some performance indicators (waiting times, transfer of care delays) are available on the Welsh statistics website, statswales.wales.gov.uk.

In terms of quality indicators specifically, a number of reports are published or produced for internal use. One of these is the Welsh Government Quality Dashboard, which is based on qualitative and quantitative data, and is used internally within the Welsh Government Produced monthly for each Health Board and Trust in Wales, the dashboard presents an overview of priorities and pressure points on a single A3 page. Data include serious untoward incidents (SUIs), never events, patient safety alerts compliance, health care acquired infection (HCAI), pressure ulcer incidence, mortality, timeliness /access indicators as well as narrative on and all-Wales or organisation specific quality issues, notably commentary on serious incidents such as never events or avoidable deaths (for instance suicide, death from HCAI).

Quality Statements are another way that quality indicators are drawn together, and are produced by Health Boards and Trusts to report to their boards on quality and quality indicators in line with health care standards prescribed by the Welsh Government. The Health Board/Trust Annual Quality Reports are summarised by the Welsh Government in a National Annual Quality Statement. This Statement, first published for the year 2014, is focused on patients and consumers, and offers easily understandable information on the implementation of programmes (for instance weight-loss short courses, "Eating For Life"), and efforts being undertaken to improve quality within the NHS (e.g. Health Board and Trust involvement in tackling sepsis; figures on reductions of deaths from MRSA). As well as serving as a summary of quality and quality improvement activities, the Statement has a clear focus on patient education about health service activities and, indirectly, has a value in encouraging better self-care (e.g. awareness of prevention of infection by good hand hygiene, information about smoking, obesity and lifestyle change).

National Delivery Plans for particular clinical areas, for instance diabetes or cancer, use a number of indicators as assurance measures for the plan, for example hospital stays for diabetic patients, or percentage of people with a diabetes related limb amputation. A range of information, including on indicators related to quality for instance "never events", hospital mortality, and mortality post-surgery, are published by Health Board on the My Local Health and Social Care website.

For emergency care a dashboard of indicators has been created by the Unscheduled Care Board, in conjunction with the Welsh Government. The "Integrated Unscheduled Care Dashboard" contains a large number of indicators that are updated with a frequency ranging from every ten minutes to every day. Information shown includes ambulance activity, any bottlenecks from admission to discharge, or patients over 85 using accident and emergency (A&E) department care. In Wales, this tool has been reported as useful in supporting national discussions regarding the management of Unscheduled Care.

SAIL should be seen as a highly valuable resource, and an example for other countries to follow

A particularly promising initiative is the Secure Anonymised Information Linkage Databank (SAIL), which brings together a wide array of routinely collected data on health, well-being and services, which can then be used for research and evaluation. Using anonymised data, SAIL enables detailed research studies considering broad dimensions of health care, including the impact of health policy on population health and outcome, cost-benefit assessments of new treatments, the impact of changing service design on different populations, socio-determinants of health, and the consequences of demographic change, amongst others. SAIL appears to be an international leader in overcoming the technical and political obstacles and successfully allowing individuals' data to be brought together and studied as a composite picture of health service needs, activities and outcomes.

A large number of the reports and studies that have come out of using the SAIL database are published online (www.saildatabank.com). SAIL should be seen as a highly valuable resource, and an example for other countries, but also for Wales in showing the great value of linking and exploiting available data and using it to reflect on health system performance and quality. Recognising the value of SAIL, the Welsh Government should look for ways to fully exploit the technical resources and insights that SAIL offers; the valuable intelligence that SAIL can offer should be central to NHS Wales' strategy planning and policy impact assessment.

Wales should bring together available data into a more user-friendly format

While Wales is already using some health system data, and quality information, to help system management and quality improvement, more could be done. One further step that Wales could take is to bring together available data into a more user-friendly format. The Integrated Unscheduled Care Dashboard is a positive step towards more proactive use of data – making information available in real time, and promoting a usable format for

NHS Wales professionals – and a good base to build on. Other OECD countries, such as Portugal, Denmark (see Chapter 3 on Scotland) and Sweden (see Chapter 1 on England) have developed more extensive information dashboards, and have managed to promote more information and knowledge based planning across their health systems (Box 3.5).

Box 3.5. A comprehensive health information infrastructure: Lessons from Portugal

Portugal has a very extensive information infrastructure which – relatively exceptionally – spans almost all levels of care. Data sources include setting-specific information structures, and disease-specific registers and data sources. Furthermore, this data is also regularly used to drive quality improvements. Part of the utility of Portugal's data is thanks to its accessibility; three main Portals bring together a significant bulk of available health data.

Much of Portugal's rich data infrastructure is thanks to the use of electronic patient records and unique patient identifiers. These records go towards creating the Portuguese Health Data Platform (PDS), which consists of a Patient Portal (Portal Do Utente, launched May 2012), a Professional Portal (Portal Do Professional, launched June 2012), an Institutional Portal (Portal Institucional, under testing) and an International Portal (Portal Internacional, piloted June 2013). The different portals hold different information, to be used in different ways. For instance, the Professional Portal provides health professionals with patient clinical data and records stored from different institutions and central repositories. The Institutional Portal, when operational, should provide statistics from anonymised clinical data to central institutions.

Eventually, PDS is intended to be a platform linking together data from across the health system. Already good progress has been made in making several data sets available in one place. Prescriptions, a chronic kidney disease register, a surgical safety checklist, and birth reports are all, for example, included in PDS. Long-term care, an oft-neglected area of data collection, is also included in PDS using the RNCCI database

The PDS database consists of several application modules that allow the recording of: medical, nursing, and social service evaluations; assessment by other professionals (rehabilitation medicine, physiotherapy, psychology, occupational therapy, etc.); IAI, a bio-psychosocial evaluation method; pressure ulcer risk evaluation and recording; falls risk evaluation; health care associated infections; pain evaluation; discharge abstracts; diabetes assessment; adverse drug reaction notification; and acute exacerbations.

There are also some mandatory minimal datasets:

- For hospital discharge teams (EGA) and primary care referral teams (CS): medical, nursing and social evaluations; evaluation of physical autonomy; pressure ulcers; pain evaluation.
- For integrated home care teams (ECCI), and for inpatient facilities: the same for hospital discharge teams upon admission, during care and on discharge. In addition the recording of falls, diabetes, pressure ulcers risk, and an individual intervention plan.

Source: OECD (2015), *OECD Reviews of Health Care Quality: Portugal 2015 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264225985-en.

As Wales builds its eHealth Strategy, work on which is underway, citizen access to health information should be a priority. Welsh citizens access their own health information, which should eventually be portable across the health system, in a usable, intuitive and straightforward format. For this priority area Portugal's experiences their Patient Portal (Portal Do Utente) may hold lessons for Wales.

While comparability issues will always exist, the four UK nations have much to gain from benchmarking across a core set of agreed common indicators

National and international benchmarking against indicators of quality of care, and outcome indicators, can be an effective way of identifying issues, promoting reflection, and driving improvement. The OECD has been collecting internationally comparable information on health care quality since 2001, and now nearly 15 years later collects over 30 indicators, many of which are reported on by most if not all OECD countries. Internationally comparable indicators such as these help countries benchmark their performance across a range of domains, and OECD includes collection on primary and acute care, mental health care, cancer care, patient safety, responsiveness and patient experiences, and cardiovascular disease and diabetes. Internationally comparable indicators can point to areas in which countries are falling short, as well as areas where they're having particular success. In both cases further reflection with regard to the drivers of the indicators reported is called for – the OECD Health Care Quality Review series seeks to do just that – to understand where improvements and changes need to be made, or to secure and potentially share successful approaches. In some cases, differences in performance can be explained in part by differences in measurement by countries, or comparability problems. Often, though, variations in performance on indicators can be the start of fruitful reflection over the strengths and weaknesses in various areas of the system, quality of care, and outcomes.

In the United Kingdom, the four countries are in a fairly unique position of having, relatively speaking, similar populations, health system structures, and delivery models. Benchmarking of indicators between the four countries should be a valuable way for each country to gain insights into what is going well and less well in each nation. Particularly if benchmarking exercises are backed up with discussions and sharing of experiences and best practice, a core set of comparable indicators collected across all four countries could be a very valuable learning resource. Comparison across countries in the United Kingdom, and benchmarking, is undertaken and possible to a certain extent. A recent report by the Health Foundation and the Nuffield Trust (2014) was able to make some important comparisons across the four

nations, pulling together comparable data across areas such as life expectancy, expenditure, some indicators of staffing, some indicators of rates of procedures, waiting times, a limited number of outcome and quality measures (for instance Survival after renal replacement therapy), rates of screening, vaccination and immunisation, and patient satisfaction. This data wasn't systematically available in a comparable way, or systematically benchmarked, but was rather put together by the Health Foundation and the Nuffield Trust. Some benchmarking between regions, or hospital trusts, across the UK countries also takes place.

Nonetheless, political tensions and technical challenges mean that there is a much more limited set of useful comparable data available for the UK nations than would be expected. Indeed, the Health Foundation and the Nuffield Trust (2014) four nations report states that despite the indicators that they were able to put together "there is an increasingly limited set of comparable data on the four health systems of the UK". This same report makes a strong recommendation that a more comparable and wider range of comparative performance data be collected to both enable cross-border learning and for the impacts of divergent policies to be assessed, pointing to a minimal set of data that is currently collected and should be collected with a definition that renders it is comparable across the four countries covering expenditure, staff, hospital activity, hospital waiting times, ambulance services, and satisfaction.

3.8. Patient and public involvement in improving health care quality

Patient and public involvement in improving Welsh health care quality is promoted through regular consultation on the direction and planning of the health system, through prioritising user experience, and through a number of established routes for patient complaints. There is potential for Community Health Councils to play a valuable role in reflecting the patient voice, but some attention to the scope of their activities and remit is needed.

There are a number of avenues through which Welsh patients and public engage with NHS Wales

Regular consultation with the Welsh public on the direction and planning of the Welsh health system is seen as a priority, and there are a number of avenues through which this happens. Consultation can happen through Welsh Ministers. Health Boards and NHS Trusts also hold annual general meetings in public, and consultations around changes to services. Efforts are made to share information about health system performance, for instance Health Board and NHS Trust Quality Statements are made public via the "My Local Health Service" website. The My Local Health Service

website gives a large amount of information broken down by Health Board, by hospital, and by GP practice. For example, information on "Safe Care" includes mortality from common medical emergencies, health care acquired infection, mortality following surgery, and serious incident reporting. The National Service User Experience Group (NSUE) works with the Welsh Government to provide advice and recommendations on ensuring that robust and valid service user feedback is sought and used.

Service user experience is also a stated priority in Wales. The 2013 Framework for Assuring Service User Experience is based on three domains of patient experience: first and lasting impressions; receiving care in a safe, supportive, healing environment; and understanding and involvement in care. Particular attention is given to collecting patient experience feedback. Following the publication of the framework, a set of core patient experience questions, to be used across all care settings, were issued to NHS Wales. The questions use the framework's three domains to ensure a consistent approach to determining patient experience across Wales. All NHS organisations are expected to use the core questions to complement their patient feedback method, and regular monitoring suggests an overall improvement in the quality of the data provided.

Established routes for patient complaints exist in Wales

There are established routes for patient complaints and feedback in Wales, notably through the Public Service Ombudsman, to whom patients can direct complaints if they are not satisfied with the response from the Health Board. The Ombudsman publishes an annual report summarising the cases considered and any lessons that should be learned by health or social services. Complaints can also be directed through the advocacy service provided through Community Health Councils.

A clear effort has been made in Wales to use patient concerns and complaints to help improve quality of care. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 [Welsh Government, The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations, 2011] drew on powers in the NHS (Wales) Redress Measure 2008. The regulations set out the statutory basis for the handling of concerns and complaints in the NHS. The Putting Things Right system of "do it once, do it well" was then launched with a view to dealing with complaints effectively and being able to demonstrate clearly that lessons had been learned. In 2014 a report, "Using the Gift of Complaints – A Review of Concerns (Complaints) Handling in NHS Wales", was published (Evans, 2014). The review examines how concerns are handled in NHS Wales and made over

100 recommendations, and following the review a number of reflection groups have been established – supported by a public engagement reference group – which will report to the National Quality and Safety Forum in due course.

Community Health Councils should focus their activities on reflecting the patient voice

Community Health Councils (CHCs) are a key feature in the architecture of Wales, with a clear role to engage with and ensure that the patient voice is heard. Community Health Councils, which are made up of members of the public and have a role representing patients and collecting patient's views, and scrutinising NHS services. There is a CHC for each of the seven Health Boards, which are brought together under a Board of Community Health Councils (CHC Board). The Welsh Government has recently made changes to the Regulations which govern Community Health Councils in Wales, principally to strengthen the leadership role of the CHC Board to allow them to set standards for the way in which CHCs carry out their functions. This includes how they interact with other bodies such as Healthcare Inspectorate Wales and the provision of an effective and responsive advocacy service.

The potential for Community Health Councils to engage with the local community, and advocate for patients around their concerns seems clear. The value added of some of the other CHC functions, notably inspections and on-site scrutiny of health care, is less clear. It would seem more effective for the CHCs to focus their activities on reflecting the patient voice, and engaging with other scrutiny bodies in Wales – notably Healthcare Inspectorate Wales – to make sure that patient concerns are heard and followed through. With comprehensive representation and advocacy of patient views, for which the CHCs have an important role to play, public scrutiny of NHS Wales can still be appropriately maintained.

3.9. Use of financial incentives to improve quality

Wales has introduced some financial incentives to improve quality, including by using the pay-for-performance scheme the Quality and Outcomes Framework to establish a three-year cluster network development programme in primary care. Additionally Wales has given Health Boards more management and financial responsibility, and more freedom to manage their own resources, under certain conditions.

Financing of the health system is mostly centrally planned, although Health Boards now have more management responsibility

The NHS in Wales is funded almost entirely through direct financial allocations from the Welsh Government. In addition to Welsh Government funding, NHS organisations receive a relatively small amount of income for treating patients from outside Wales, private patients, and for non-clinical services such as catering. Approximately 85% of the Welsh Government's health budget flows as a single funding stream to the seven health boards. Funding is allocated to boards, in part calculated on a per-head population basis, to enable them to provide and commission services to meet the health needs of their population. Per capita funding is weighted to reflect relative health needs, and in 2014-15 ranged from GBP 1 621 per head for Cardiff and Vale University Health Board to GBP 1 926 per head for Cwm Taf University Health Board, reflecting differences in the demography and socio-economic structures of the populations.

The recently introduced (2014-15) Integrated Medium Term Planning approach for Health Boards and NHS Trusts is underpinned by a new financial duty on Health Boards, as set out in the NHS Finance (Wales) Act 2014, which enables them to manage their resources over the three-year planning period, rather than the previous requirement to break even each and every year. The Act requires each Health Board and NHS Trust to prepare a plan which sets out its strategy for complying with the financial duty while improving the health of the people for whom it is responsible, and the provision of health care to such people.

The Welsh Government's planning framework sets out the detailed requirements for Health Boards to undertake an assessment of their population's health needs and then develop service responses to meet those needs. The plans are expected to include service, quality, workforce, revenue and capital investment plans that are fully aligned. The additional financial flexibility to manage resources over a three-year period should provide boards with an opportunity to better invest in new service models, particularly enhancing primary and community care services, with the expectation of resource savings in the latter years of the plan, for example through a reduced burden on expensive hospital care. The three year financial flexibility is also intended to avoid the unplanned, and often clinically ineffective, increased expenditure to utilise surplus funds or cuts just to balance the books at end of the year.

Health Boards and NHS Trusts are still in a process of adapting to the new planning framework and its revised financial duty. As part of the IMTPs maturing, attention should be given to how well Health Boards are assuming their new financial responsibilities, and how fully they are taking

advantage of the increased flexibility they are given, for example by investing in new service models. It may be that Health Boards need – at least initially – more intensive guidance and support. This may be a balance between more direction over investments and financial flows – for instance a push towards a certain percentage of investment in primary and community care – and support and sharing of best practice, for instance sharing of successful investment models from Wales, as well as from elsewhere in the United Kingdom.

Financial incentives have been directed towards primary care

Financial incentives to promote quality are also in place for general practitioners, throughout the Quality and Outcomes Framework, as they are in England and Scotland. Wales has made some changes to the use of the QOF, notably reducing the scale of points in the clinical domain, and finally removing clinical points in the QOF for 2015/16. This decision was taken because it was felt that indicators either had consistently high levels of performance achieved (for example heart disease area), and/or quality improvement work was ongoing or continuing through National Audit processes (e.g. chronic kidney disease). This step was also part of a desire to emphasise professional clinical judgment, and the use of best practice guidelines, and move away from more prescriptive approaches to clinical management.

Since 2013/14, Wales has used QOF to develop a three-year cluster network development programme. This domain, which is unique to Wales, has a strong focus on strengthening GP-led multi-disciplinary team working and strengthening collaborative with working with both community and social services. In addition, the cluster network development programme delivers quality improvement through work in three general practice national priority areas; the prevention and early diagnosis of cancer; improving end of life care; and minimising the harms of polypharmacy (see also Section 3.1).

3.10. Patient safety initiatives

Wales has a comprehensive approach to patient safety, combining reporting and monitoring, incident follow-up, targeted programmes, and strategic planning to address and prevent areas for concern. Reporting and monitoring of adverse events is well established, with incidents collected centrally, and learning opportunities promoted. Government strategy and guidance has been used to shape action around health care associated infection, complemented by the 1000 Lives programme. Wales is also taking several steps to monitor and tackle antimicrobial resistance.

Mechanisms are in place to promote adverse event reporting and follow-up

Each Health Board and NHS Trust in Wales has a system of collecting adverse events using an electronic DATIX system. This allows central analysis of patterns of adverse events. Patient safety incident reports are submitted to the National Reporting and Learning System (NRLS) and the data is used to develop guidance and tools to help improve patient safety at a local level. A number of practical toolkits and guidance documents are available to help NHS managers and health care staff to implement patient safety initiatives. Guidelines have been developed that support staff learning from patient safety incidents and support approaches to preventing such incidents happening again. This information is provided on a Patient Safety Wales website (NHS Wales, 2014). The Welsh Government monitors adverse events on a regular basis, including Never Events, which are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. An updated list of 25 core Never Events was produced in 2013/14and annually the Welsh Government publishes a report on the never events that have been reported Work is also under way to strengthen reporting of adverse events by primary care.

Some complaints and patient safety incidents are reportable to the Welsh Government, with intelligence gained from investigation of such incidents shared with NHS through the issues of notices and alerts as appropriate. Work is underway to review the Welsh patient safety incident system, and review what is reportable, as well as the internal Welsh Government process to monitor and share incidents and learning with policy leads. Healthcare Inspectorate for Wales is also sighted on all patient safety incidents as part of their intelligence arrangements to monitor NHS organisations. The Coroner and the Public Services Ombudsman for Wales also share their reports with Welsh Government, and the Welsh Government shares these reports with the relevant policy lead for the area. The Coroner has a legal power and duty to write a report following an inquest if it appears that there is a risk of other deaths occurring in similar circumstances. This is known as a “report under regulation 28”, as the power is derived from regulation 28 of the Coroners (Inquests) Regulations 2013. The reports are sent to individuals and organisations that are in a position to take action to reduce any risks that have been identified. They then must reply within 56 days to say what action they plan to take.

The Welsh Government has an agreement with NHS England to ensure continued reporting to the NRLS by Welsh Organisations. Learning from this process results in the development of safety solutions/alerts which is regularly issued to the NHS. Alerts cover a wide range of topics, from

vaccines to patient identification. An internal Welsh Government process has been produced to issue such advice to NHS Wales, working with colleagues responsible for this function in NHS England alerts. The various alerts are considered in conjunction with Welsh data and any other available information and where necessary an alert or notice will be issued to the NHS in Wales. The aim of the advice is to help ensure the safety of patients and is issued directly to NHS organisations in Wales. The National Reporting and Learning System collate and summarise incidents that are reported via a national online reporting mechanism. The information gathered is provided on their website. An example of summary data from this source is provided below. In addition the Welsh Government has recently started to publish data specifically on Serious Incidents reported to Welsh Government on My Local Health Service website (Table 3.1).

Table 3.1. Reported patient safety incidents for the financial year 2013-14 by Health Board

Health Board	Number of incidents occurring	Rate per 10 000 population	Degree of harm				
			None	Low	Moderate	Severe	Death
BETSI CADWALADR	6 238	92.44	4 501	1 178	513	37	9
HYWEL DDA	3 564	94.96	2 401	698	464	1	0
ABERTAWE BRO MORGANNWG	5 278	103.48	4 901	289	86	0	2
CARDIFF AND VALE	6 946	150.97	4 594	2 105	155	92	0
CWM TAF	4 224	146.46	2 765	1 044	412	2	1
ANEURIN BEVAN	6 259	110.98	3 873	1 547	828	10	1
POWYS	736	54.74	304	236	182	12	2
Welsh Health Boards	33 245		23 339	7 097	2 640	154	15

Source: Organisation Patient Safety Incident Reports – data workbooks April 2014, available at: www.nrls.npsa.nhs.uk/resources/?entryid45=135255, accessed 1 Sept 2014.

Reducing health care associated infections is an important target

Health care-associated infections (HCAIs) are defined as infections that occur as a result of contact with the health care system in its widest sense – from care provided in the home, to general practice, nursing home care and care in acute hospitals. Wales has a strategy for dealing with these infections – *Healthcare Associated Infections – A strategy for hospitals in Wales* (Welsh Government, 2004) published in 2004 and subsequently *Healthcare Associated Infections – A community strategy for Wales* (Welsh Government, 2007). The latter strategy highlighted the need for: "all staff to understand the impact of infection and infection control practices to enable them to discharge their personal responsibilities to patients, other staff, visitors and themselves". Later, in 2011, a framework of action for health care organisations in Wales – *Commitment to Purpose: Eliminating*

preventable Healthcare Associated Infections – was issued, which sets out expectations of all health care organisations in Wales as regards HCAIs.

Health Boards and Trusts are responsible for delivering safe and effective care and for taking all steps to avoid preventable HCAIs and to minimise the risk of antimicrobial resistance developing or increasing. National evidence-based guidelines for preventing HCAIs are set out in the June 2014 *Code of Practice for infection prevention and control*. This sets out the minimum necessary IPC arrangements and standards that NHS organisations are expected to meet to ensure that patients are cared for in an environment in which the risk of HCAIs is kept as low as possible. It reinforces and codifies existing expectations of NHS organisations.

Since July 2013, as part of the Welsh Government's commitment to openness, the results from the mandatory national surveillance programme for *C.difficile*, *Meticillin-resistant Staphylococcus aureus* (MRSA) and *Meticillin-sensitive Staphylococcus aureus* (MSSA) have been presented in a more transparent and meaningful way for the public. Every Health Board/Trust publishes information about these infections monthly on their websites. They are also published nationally by the Welsh Government on the *My Local Health Service* website. The information provided includes the number and rates of the three HCAIs per 100 000 population, and per 1 000 District General Hospital admissions. Better access to information is both informing the public and helping to drive up standards across the NHS in Wales. Wales has a national Outbreak Plan that provides a framework for the management of outbreak situations. This has a specific section for dealing with outbreaks of infections in hospital settings.

Public Health Wales provides information, targeted data analysis and advice to Welsh Government, and surveillance of HCAIs. A range of national surveillance programmes are managed by Public Health Wales to ensure the independent provision of accurate indicators related to infection control. The mandatory national surveillance programme includes surveillance of *C.difficile infections*, *Staphylococcus aureus* (Meticillin resistant and sensitive) bacteraemias; Top Ten bacteraemias; Caesarean section surgical site infections; orthopaedic surgical site infections; ventilator associated pneumonia; and central venous catheter infections in critical care. The data is made publically available and is monitored closely by Welsh Government. A new national target was introduced in June 2014, requiring NHS Wales to collectively reduce the rate of *C.difficile* infections and MRSA bacteraemias by at least 50% between 1 April 2014 and 30 September 2015 (18-month period) compared to the 2012-13 rates. To achieve the national target, each of the six major Health Boards are required to reduce the rates to no more than: 31 per 100 000 population for *C.difficile* cases (compared to the 2012-13 rate of 63 per 100 000 population), and 2.6

per 100 000 population for MRSA bacteraemias (compared to the 2012-13 rate of 5 per 100 000 population). Based on estimated associated costs (including treatment and increased length of stay) a reduction of 100 cases would equate to approximate savings for NHS Wales in the order of GBP 1 million for *C.difficile* (GBP 10 000 per case) and GBP 0.70 million for MRSA bacteraemias (GBP 7 000 per case).

The *1000 Lives Improvement Programme* also engages with the challenge of reducing recognises the complex and diverse challenges involved in tackling HCAIs, and has chosen most recently to focus specifically on infections related to invasive devices, notably urinary catheters and peripheral vascular cannulae. Best practice relating to invasive devices is being highlighted in the STOP Campaign. The campaign uses a wide range of communication methods and resources to encourage every member of staff to consider the way in which they use invasive devices, change their practice and stop infection.

Wales is taking steps to monitor and tackle antimicrobial resistance

The Welsh Government supports the UK Five Year Antimicrobial Resistance Strategy, 2013-2018, published in September 2013. This Strategy was developed collaboratively with the UK health departments and the bodies that will be responsible for delivering the work. Public Health Wales is developing a draft Antimicrobal Resistance Delivery Plan which outlines the proposed Welsh response to this call for action, and which will be published in Spring 2015.

Health Boards and trusts have worked closely with Public Health Wales, the All Wales Medicines Strategy Group, professional bodies and higher education providers on a range of AM stewardship activities. Activities include monitoring prescribing patterns and usage, development of audit tools, and provision of educational material for health professionals and the public. Health Boards and Trusts actively promote antimicrobial stewardship by supporting and empowering an Antimicrobial Management Team (AMT). At least twice a year Public Health Wales hosts an all Wales Antimicrobial Stewardship Forum in the interests of shared learning and promoting best practice. Public Health Wales has recently developed a series of Health Check reports designed to support individual Health Boards. They will be repeated every six months summarising local prescribing and resistance data, drawing comparisons with national data and presenting the surveillance data in a format that can be used by Health Boards to support local and focused action.

3.11. Conclusions

Less than two decades after devolution, the Welsh health system remains a relatively young one; many of the institutions and mechanisms needed to promote high quality care are in place, but now a further push is needed to move towards a more mature, robust quality architecture. In many respects, "quality" is at the heart of the Welsh health system: the importance of high quality and patient-centred care is given a high-level priority; strategy documents are ambitious and appropriately orientated; commitment by staff and the public to the values of NHS Wales seems strong. Concrete action across a number of domains is now needed.

Wales should be looking to increase accountability for delivering good quality and improving quality, and trying to establish some more concrete levers for positive system change. This is a process that has already been started, with the introduction of the Integrated Medium Term Plans, and the Escalation and Intervention Framework, both of which add a layer of accountability and assurance overseen by the Welsh Government. There is still room for further progress, though. To do this the Welsh Government will likely have to become more prescriptive about what is expected from some bodies and organisations – notably Health Boards – while encouraging and incentivising innovation – for example from primary care clusters. This may mean, for example, setting out clearer roadmaps for acting on the Prudent Healthcare agenda, and/or a stronger push to support shifting care towards primary care settings. In the absence of patient choice, patient voice also needs to be amplified as an important quality assurance check. A richer, better exploited information infrastructure would also function as a quality assurance check, especially if confidence in the indicators could be fostered, and a driver for positive change. Well-used data – by policy makers, managers, medical staff, patients and the public – can bring a wealth of information about what is and isn't working in a system, and can support effective decision making at all system levels.

The ambition for an excellent, patient-centred health system, promoting quality, access and equity is there in Wales, but now tangible practical steps are needed to make the necessary changes. One next step may be that the Welsh Government, in consultation with key stakeholders, establish a menu of precise, measurable actions, to be applied in a time-bound way, to create momentum in NHS Wales. Further reflection would be needed do decide what steps are needed to deliver change that is right for Wales, but an action plan for improvement is now what is needed to back up Wales' strategic ambition for the health system.

Policy recommendations for Wales

To ensure high quality health care at every encounter and continuously improving care across the system, Wales should:

1. Secure accountability, drive standards, and promote innovation

- Continue developing the partnership between Health Boards and the Welsh Government:
  - to drive meaningful improvement a stronger central guiding hand may be needed, with more prescriptive demands made of Health Boards – in terms of financing and budget allocation, performance and efficiency, and quality achievement and improvement – and how they are expected to contribute towards the growth of NHS Wales;
  - Health Boards, alongside rigorous standards and expectations, should be given sufficient technical, managerial and leadership support, and efforts undertaken to build capacity and knowledge, for example through sharing of experiences and expertise across Health Boards and system-wide, learning trips and exchanges, mentorship systems, and education and development opportunities;
- Ensure open comparison of results, and visible accountability for all Health Board;
- Back up the Prudent Healthcare agenda with an Implementation Action Plan: a menu concrete, measurable, time-bound set of changes to bring tangible results to the Prudent Healthcare objectives;
- Develop an ambitious workforce strategy, which includes planning, piloting and evaluating innovative staffing models.

2. Put primary care front and centre as a force for dynamic system change

- Consider way of supporting and growing Primary Care Clusters and their activities, encouraging the primary care sector to reflect on their own performance and contribution to NHS Wales;
- Foster new models of care delivery and organisation for primary care, incentivising innovation and new ways of working, using small grants for Primary Care Clusters to back pilot programmes;
- Create a formal role for a primary health care professional on all Health Boards – a board seat reserved for a GP on every Board;

3. Make Wales a data-driven system

- Much more could be made of available information to help inform clinical decision making, and pulling together all available information on a single platform or portal – as has been done in Denmark, Portugal and Sweden – would be a good starting point;

Policy recommendations for Wales *(cont.)*

- Work to establish a set of key health data and quality indicators for all UK health systems, collected using agreed common definitions, to facilitate quality and performance benchmarking;
- Capitalise on the state-of-the-art SAIL programme exploiting available linked data and using it to reflect on health system performance and quality.

4. Do more to promote the patient voice

- In the absence of patient choice, patient voice is key: more can be done in Wales to collect patient experiences and views;
- Promote platforms for patient feedback, notably through re-focusing activities of Community Health Councils, and improving avenues for feedback and complaints online;
- Prioritise making electronic patient records accessible, and usable, by patients.

References

Andrews, J. and M. Butler (2014), “Trusted to Care: An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board”, gov.wales/docs/dhss/publications/140512trustedtocareen.pdf.

Commission on Funding and Finance for Wales, wales.gov.uk/icffw/home/report/firstreport/?lang=en.

Department of Health (1999), “The Health Act”, http://www.legislation.gov.uk/ukpga/1999/8/section/60.

Evans, K. (2014), “Review of Concerns (Complaints) handling within NHS Wales – Using the Gift of Complaints”, Welsh Government, Cardiff.

Griffith and Middlemiss, “Shaping a Workforce to Serve the People of Wales”, www.prudenthealthcare.org.uk/workforce.

Halm, E.A., C. Lee and M. Chassin (2002), “Is Volume Related to Outcome in Health Care? A Systematic Review and Methodoligic Critique of the Literature”, *American College of Physicians-American Society of Internal Medicine*, Vol. 137, No. 6.

The Health Foundation and Nuffield Trust (2014), “The Four Health Systems of the United Kingdom: How Do They Compare?”, www.nuffieldtrust.org.uk/compare-uk-health.

Holtham, G. (2009), “Funding Devolved Government in Wales: Barnett & beyond”.

Independent Institute of Fiscal Studies (2015), “Health Spending Protected by More in England, But Social Services Spending Protected More in Wales”, www.ifs.org.uk/publications/7591, accessed 15.04.2015.

Kumar, A. et al. (2014), “Pricing and Competition in Specialist Medical Services: An Overview for South Africa”, *OECD Health Working Papers*, No. 70, OECD Publishing, Paris, http://dx.doi.org/10.1787/5jz2lpxcrhd5-en.

Lewis, S. (2014), “Focusing Primary Care Services on People by Applying Prudent Healthcare”, http://www.prudenthealthcare.org.uk/primarycare/.

Longley, M. et al. (2012), “United Kingdom (Wales): Health System Review. Health Systems in Transition”, Vol. 14, No. 11, pp. 1—84.

Marks, R. (2014), “Healthcare Inspectorate Wales The Way Ahead: To Become an Inspection and Improvement Body”, gov.wales/docs/dhss/publications/140107reporten.pdf.

National Audit Office (2012), “Healthcare across the UK: A Comparison of the NHS in England, Scotland, Wales and Northern Ireland”.

OECD (2015), *OECD Reviews of Health Care Quality: Portugal 2015 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264225985-en.

OECD (2014a), *OECD Reviews of Health Care Quality: Italy 2014: Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264225428-en.

OECD (2014b), *OECD Reviews of Health Care Quality: Norway 2014 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264208605-en.

OECD (2013a), *OECD Reviews of Health Care Quality: Denmark 2013 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264191136-en.

OECD (2013b), *OECD Reviews of Health Care Quality: Sweden 2013 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204799-en.

Office of National Statistics (2012), “Regional Gross Value Added (income approach)”, Retrieved from http://www.ons.gov.uk/ons/dcp171778_291684.pdf.

Ono, T., G. Lafortune and M. Schoenstein (2013), “Health Workforce Planning in OECD Countries: A Review of 26 Projection Models from 18 Countries”, *OECD Health Working Papers*, No. 62, OECD Publishing, Paris, http://dx.doi.org/10.1787/5k44t787zcwb-en.

Organisation Patient Safety Incident Reports – data workbooks April 2014, www.nrls.npsa.nhs.uk/resources/?entryid45=135255, accessed 1 Sept 2014.

Tomkinson, A. et al. (2005a), "Instrumentation and Patient Characteristics That Influence Postoperative Haemorrhage Rates Following Tonsil and Adenoid Surgery", *Clinical Otolaryngology*, Vol. 30, No. 4, pp. 338-346, August.

Tomkinson, A. et al. (2005b), "A Laboratory and Clinical Evaluation of Single-use Instruments for Tonsil and Adenoid Surgery", *Clinical Otolaryngol*ogy, Vol. 30, No. 2, pp. 135-142, April.

Van Doorn, A. et al. (2014), "Effect of Accreditation on the Quality of Chronic Disease Management: A Comparative Observational Study", *BMC Family Practice*, Vol. 15, No. 179, http://dx.doi.org/10.1186/s12875-014-0179-4.

Wales Deanery and Welsh Government (2014), "Medical Appraisal & Revalidation System for Wales", Retrieved from https://medical.marswales.org/.

Welsh Government (2015a), "Our Health, Our Health Service: Green Paper Consultation Document", gov.wales/docs/dhss/consultation/.

Welsh Government (2015b), "Health and Care Standards", www.gov.wales.

Welsh Government (2015c), "NHS Outcomes Framework 2015-2016", www.gov.wales.

Welsh Government (2015d), "A Planned Primary Care Workforce for Wales", http://gov.wales/docs/dhss/publications/150717reporten.pdf.

Welsh Government (2014a), "Final Budget 2014-15".

Welsh Government (2014b), "Well-being of Future Generations Bill", Retrieved from http://wales.gov.uk/topics/sustainabledevelopment/future-generations-bill/?lang=en.

Welsh Government (2014c), "NHS Delivery Framework", Retrieved from http://wales.gov.uk/topics/health/publications/health/strategies/framework/?lang=en.

Welsh Government (2013a), "The NHS Wales Planning Framework", Welsh Government, Cardiff.

Welsh Government (2013b), "Public Health White Paper", Retrieved from http://wales.gov.uk/consultations/healthsocialcare/white-paper/?lang=en.

Welsh Government (2013c), "Delivering Safe Care, Compassionate Care", Retrieved from http://wales.gov.uk/topics/health/publications/health/reports/safecare/?lang=en.

Welsh Government (2010), “Fairness and Accountability: A New Funding Settlement for Wales”.

Welsh Government (2004), “Healthcare Associated Infections – A Strategy for Hospitals in Wales”, Welsh Government, Cardiff.

Welsh Office (1998), *Quality Care and Clinical Excellence*, Welsh Office, Cardiff.

Websites used

gov.wales/statistics-and-research/

/mylocalhealthservice.wales.gov.uk/#/en

www.saildatabank.com

www.jointcommissioninternational.org

www.ncqa.org.

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