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Learning from Trusted to Care



ONE YEAR ON

Foreword by Dr Ruth Hussey and Professor Jean White

Over the last twelve months the Steering Group has considered the Trusted to Care Report and its recommendations, as well as the learning from the unannounced spot checks visits. The Steering Group was keen to ensure the work taken forward to address the issues raised was on an all Wales basis to make sure whole system change was achieved.

Much good work has been achieved but we must now maintain this momentum and drive further improvements to ensure the very best care is provided to all our frail and older people, when ever that care is required and where ever it is being provided. The Steering Group is making some recommendations to ensure this happens.

Learning from Trusted to Care – one year on

Report from the Steering Group





Background

The Minister for Health and Social Services commissioned a review into the care being provided for older people at the Princess of Wales and Neath Port Talbot Hospitals towards the end of 2013. This followed significant concerns raised with the Minister about poor standards of care in the two hospitals. Professor June Andrews, director of Dementia Services Development Centre at the University of Stirling and Mark Butler, director of the People Organisation undertook this review between December 2013 and April 2014. The Minister published their report¹ in full on 13 May 2014, and made clear this was a report for the whole of Wales.

The Trusted to Care report raised a number of concerns about the quality of care and patient safety on some of the wards in the two hospitals and about some clinical and managerial processes at Abertawe Bro Morgannwg University Health Board (ABMUHB). A total of 18 recommendations were made of which 14 were directed to ABMUHB and four to Welsh Government.

An All-Wales Response

When publishing the report the Minister made it clear that he expected every organisation within NHS Wales to respond and learn from it. He wrote to all NHS organisations to consider the report's recommendations and gave them four weeks to identify any improvements needed and to ensure systemic concerns about care were not present elsewhere in Wales. Their responses have been published² on their individual websites. In addition the Minister ordered a programme of unannounced independent spot checks to be carried out on medical wards in acute hospitals caring for older people. These spot checks were to test standards of care in four key areas identified within Trusted to Care, as particular areas of concern:

-  **The use of sedation**
-  **Giving patients their medication**
-  **Continence care (toileting)**
-  **Hydration (drinking)**

¹ <http://gov.wales/topics/health/publications/health/reports/care/?lang=en>

² <http://gov.wales/topics/health/publications/health/reports/care/?lang=en>

The findings from these spot checks have been published³ on the Welsh Government website.

Since then a further programme of unannounced spot checks to older people's mental health wards⁴ have been undertaken. The findings have been published and work is underway to take forward the learning. This has been reported separately. It was particularly important to look at this care environment in light of the serious failures in care that emerged at the Tawel Fan Unit in north Wales. See link:

These spot check programmes have provided valuable learning for the way in which care is provided to older people to meet their clinical and well-being needs. Much of the work of the steering group has focused on taking forward that learning at a system level.

Trusted to Care Steering Group

The Trusted to Care Steering Group was established by the Minister to give direction and drive implementation of the review's recommendations, as well as the findings from the spot check programme to ensure Wales-wide learning and improvement. Jointly chaired by the chief medical officer and chief nursing officer, the terms of reference for the Steering Group are at appendix 1.

The Trusted to Care steering group met nine times from July 2014 to June 2015. The minutes of each meeting are published⁵. This report summarises the work of the group, the actions taken to date and highlights some areas for further action on an all-Wales basis.

It should be noted that whilst the group maintained an overview of the actions being taken by ABMUHB in response to their specific organisations, separate quarterly meetings took place between Welsh Government and the Health Board as part of delivery monitoring arrangements. This report does not therefore deal with those 14 recommendations. It is for the independent follow-up review to assess and determine whether sufficient progress has been achieved.

The Steering Group's approach

The starting point for the work was the recommendations directed at Welsh Government, whilst at the same time considering the wider findings emerging from the unannounced spot check programme which were then underway.

³ <http://gov.wales/topics/health/nhswales/spot-checks/?lang=en>

⁴ <http://gov.wales/docs/dhss/publications/150618reporten.pdf>

⁵ <http://gov.wales/topics/health/nhswales/spot-checks/?lang=en>

The Group was mindful of other work in train which was clearly linked to the matters that needed to be considered. The Keith Evans review of concerns (complaints) handling within NHS Wales –‘Using the gift of complaints’, is a particular example. Sharing learning in an integrated way is a fundamental requirement within the NHS but also between the NHS and Social Care. We were therefore keen to ensure that our work could be shared more widely, informing the work being undertaken in other forums such as the Care Homes Steering Group. The Group members were also mindful of the *Flynn Review* which was published as the work was drawing to an end.

To gain a more detailed understanding of the issues that were emerging the Group spoke to or sought advice from a range of people during the course of its work. This included hearing directly from NHS frontline staff, the Older People’s Commissioner for Wales and Professor Baroness Finlay of Llandaff, professor in palliative medicine. Through these discussions some important themes developed. This helped direct the work of the steering group to ensure a focus on pursuing a small number of key actions which we considered had the potential to achieve whole system change and sustainable improvement. Throughout its work the Group has been particularly struck by the need to remove unnecessary barriers and complexity to make it easier for staff to do their very best for their patients.

The following sections describe what has been achieved.

Progress against the Welsh Government Recommendations

Recommendation 15 - *The Welsh Government should commission a strategic campaign to increase public and professional understanding that regular hydration and feeding are as important as hand-cleaning in promoting well-being for older people in hospital.*

‘Water Keeps You Well’ was launched on a phased basis on 26 June 2015 and will have full roll out across Wales in January 2016.

Hydration was highlighted as a major area of concern in the *Trusted to Care* report. Subsequent discussions with Professor Andrews and evidence gained from the spot checks enabled the focus of the campaign to be determined. 1000 Lives Improvement was commissioned to take forward its development:

The campaign builds on existing work underway at Prince Charles Hospital within Cwm Taf University Health Board. Their ‘Drink a Drop’ initiative was praised as good practice identified during the spot check process.

Water Keeps You Well campaign:

- is directed at patients' families and NHS staff, in addition to patients themselves
- stresses the importance of liquids generally - in the form of hot drinks, fruit, soup, milk, sugar-free soft drinks as well as drinking water.
- has a focus on changing the behaviours of patients, their visitors and staff. The behaviour change department at Bangor University is supporting this aspect of the work, whilst Cardiff University Business School will support the evaluation of the campaign.
- has been piloted in a small number of hospitals during the summer and over the coming months will be rolled out to all hospitals in Wales in the first instance, with a view to then extending it to further settings, including care homes.

Recommendation 16 – *The Welsh Government should review the effectiveness of health scrutiny and quality reporting processes relating to the care of frail older people.*

The new Health and Care Standards published in April 2015 will form the basis of a consistent reporting and scrutiny process

This was a culmination of an extensive consultative process to update the previous standards framework and align with the fundamental standards of care into one overarching framework. The standards provide a framework on the way health services should be organised, managed and delivered on a day-to-day basis – to improve the quality and safety of healthcare services, identifying strengths and highlighting areas for improvement. A number of standards are especially relevant to assessing the care of frail and older people.

The Health and Care Standards will continue to be used by Healthcare Inspectorate Wales to underpin their inspections and reviews. Health services are however expected to understand and actively assure themselves of how well they meet these standards on an on-going basis.

The standards align with the seven themes identified in the NHS Outcomes and Delivery Framework issued in April 2015, which were developed through engagement with patients, clinicians and stakeholders. These domains include safe, effective, dignified and individual care against which all organisations are expected to report progress against openly and transparently through their public board meetings and committees. Increasingly these measures are focused on outcomes for patients and citizens rather than measuring processes. There is also a significant focus on assessing and reporting on how patients considered their care experience.

Recommendation 17 – *The Welsh Government should commission ABMU to develop a model dashboard and guidance for Board assessment of frail and elderly care for adoption across NHS Wales by the end of 2014.*

ABMUHB developed a model dashboard and submitted this for the steering group's consideration on 30 September 2014.

In light of the development of the new health and care standards framework we agreed it was not appropriate to issue this for Wales-wide adoption by the end of 2014. However it is being used to influence a new approach to monitoring and reporting on care standards as described above. Building on the dashboard developed by ABMU work is concluding to agree a consistent set of core measures across the relevant domains by which all Boards will be expected to report as a minimum in a consistently timely way. It is important that these standards are embedded consistently across Wales and they are used to provide a clear, consistent and comparable reporting process which can be easily understood by anyone wishing to assess the quality of care being provided any where in Wales. The work has also been informed by the expectations set out by the Older People's Commissioner for Wales through the feedback that she has provided to all NHS organisations in response to their 2013/14 annual quality statements

Taken together these 2 recommendations provide an opportunity to ensure a consistent and transparent approach by all NHS organisations in providing assurance about the quality of care provided across all services.

There is now an expectation to see strong board engagement and ownership of these quality standards as well as seeing evidence that they use such metrics to inform their quality assurance role

The Green Paper on quality and governance published in July 2015 provides a further opportunity to engage on further improvements.

Recommendation 18 – *The Welsh Government should institute a further independent review of provision for older people within a year of the date of this report.*

A follow up review was undertaken during July and August 2015 by Professor June Andrews and Mark Butler, the authors of the original report. The findings of this follow up review are being published along side this report.

Further Actions and Improvements: building on the findings from the spot checks

The initial spot checks proved to be both a valuable source of assurance about the care of elderly patients in hospital as well as a valuable source of learning from which the NHS has made further improvements. For these reasons the programme of spot checks was extended to mental health wards caring for older people where a further 22 wards were visited.

Quality Checks Toolkit

The approach developed for the spot checks was innovative and centred on using clinical judgement to assess the actual care being received by individuals at the time of the visit. It provided an opportunity to speak to patients and their families about their care and also for discussions with staff. It enabled the reviewers to identify what was working well and where improvements were needed. If any serious concerns were found they were addressed immediately. The process was well received and a commitment was made to share the methodology so that organisations themselves could adopt the approach, either alongside or instead of similar review processes that were already in place.

This work has been taken forward by 1000 Lives Improvement. The Quality Checks toolkit builds on the original approach and is aimed at multi professional teams in any care setting to assess and assure the quality of care being provided and identify areas where improvements are needed. This approach is well suited to peer review, offering further opportunities for individual and team development and a vehicle for sharing good practice. NHS organisations have also agreed to share their individual toolkits and approaches to further develop the toolkit and supporting approaches to identify best practice across Wales, enabling a consistent approach to be adopted.

Recommendation 1

All NHS organisations should contribute to the further development of, and incorporate the use of, the Quality Checks toolkit and peer review into their quality improvement and assurance systems

Medicine Management Improvements

Medicine administration, recording and management were one of the themes of the *Trusted to Care* report and a recurring theme from the spot check visits. The Steering Group agreed that this was an area where considerable focus was required. A working group chaired by the chief pharmaceutical officer was set up to look at all aspects of medicine administration, recording, review and storage (MARRS) which needed to be addressed.

The important outcomes from this work have resulted in:

- the development of an all Wales MARRS policy to provide an overarching framework for health boards and trusts responsible for developing the underpinning procedures. This requires each health board and trust to ensure:
 - processes and guidance are in place to guarantee MARRS processes are safe
 - all healthcare professions involved in the administration of medicines have received appropriate education, have been assessed as competent and work within the limitations of their competence. This competence must be re-assessed as part of the annual appraisal process.
 - any medication-related incidents that occur in the MARRS processes are recorded and reported in line with the local incident policy and procedure. The health board or trust must determine and communicate their chosen process of escalation of such incidents. The cause of errors should be investigated to enable learning from the incident, therefore minimising the risk of a similar error happening in the future.

- an associated e-learning education package for all staff involved in MARRS which is now in use across all health boards and trusts. In collaboration with Learning@NHSWales this will be migrated to an e-platform by January 2016.

- a patient safety notice issued to the NHS setting out requirements to be met to ensure the safe and secure storage of medicines in refrigerators.

- a further patient safety notice on the storage of medicines in cupboards on hospital wards and in clinics is being finalised and will issue shortly.

- a literature search was undertaken on the effectiveness of the use of tabards and red zones in reducing the number of staff interruptions when undertaking medication rounds. The evidence review was inconclusive regarding the impact on reducing distractions and the consequential effect on medication administration errors. The review's conclusion concurred with the findings in an article published during this time⁶. Evidence from the spot checks found an inconsistent use of red tabards and also mixed views on whether they helped or hindered during medicine rounds. In light of the literature findings the use of tabards alone was therefore not supported. However, the group is impressed with the work being undertaken in Hywel Dda UHB in introducing a whole system, red zone, approach (including the use of tabards) to improve the safety of administering medicines. The project was shortlisted in this

⁶ <http://qualitysafety.bmj.com/content/23/5.toc>

year's NHS Awards. As this becomes embedded and evaluated the findings will be considered by the MARRS group to determine if this approach should be adopted across Wales.

- A framework has been developed which standardises the involvement of healthcare support workers (HCSW) in the processes involved in medicines management. Practice had been found to be variable across Wales during the spot checks. The framework will ensure only appropriately trained HCSWs, with the right knowledge and skills, can provide support with medication and its related tasks. This will ensure practice is robust, safe and of equitable standard across Wales. Planned roll out across Wales will begin in October 2015.

Longer term improvements in medicines management

The Steering Group believes that establishment of a single electronic computerised system for the medicines management process must be the way forward. It considers this would hugely benefit the management of medicines in terms of stock control, support for medicines management and improving patient safety. It would provide a database for the management of formularies, a single link to patient details, improve the sharing of patient medicines information within and across health boards and within primary care teams, and also improve the management of information on medicines used at the patient level including prescribing errors, administration errors and any missed doses.

NHS Wales Informatics Service (NWIS) is developing a business case to begin implementation of a Wales-wide hospital pharmacy and e-prescribing system in 2016-17

Recommendation 2

The Steering Group strongly supports the implementation of electronic systems for medicines management and administration and advises that a business case should be completed as soon as possible.

Training and support for pharmacists and clinicians

In July 2014 all registered pharmacists and technicians working in the managed sector, which includes hospital, health board and Public Health Wales employed pharmacists, were invited to complete an online e-learning resource on professionalism and attend a facilitated "learn in the workplace" session on raising concerns – over 90% completed the online resource and 98% attended one of 83 face to face meetings. A modified programme of workshops was rolled out for community pharmacists in summer 2015, targeting pharmacies that provide services to care homes.

Welsh Government has funded 15 care homes and their supplying pharmacy to install a digital system that tracks, records and audits the supply of a medicine from the pharmacy to the time it is administered to a patient. This will be a powerful resource to monitor the use in care homes of medicines of concern which includes sedatives and antimicrobials. An evaluation of the system is underway and will determine whether the technology should be routinely installed in care homes as part of a medicines safety specification.

The All Wales Medicines Strategy Group (AWMSG) published *Polypharmacy: guidance for prescribing*⁷ in July 2014 to provide support to clinicians, pharmacists and nurses in prescribing and medicines management in the elderly.

The Welsh Medicines Resource Centre published a case study on the use of sedative medicines in older people⁸ in April 2015 followed by a bulletin on the same topic in June 2015 to address specific concerns about the prescribing of sedatives. Over 500 general practitioners completed the online case study.

Dementia care

Many of the recommendations that fell to ABMUHB related to training staff in caring for people with dementia. However addressing the challenges posed by dementia is a societal issue and has ramifications for all staff working in public facing services. Welsh Government took the first step to standardise education and awareness raising by issuing advice to the NHS that requires at least 50% of those NHS staff who have day to day contact with patients having an appropriate level of training by April 2016. This guidance was not specific in what different staff groups or staff working in different services should receive as a minimum and at present this is left to provider organisations to determine locally. Across NHS Wales various types of training and awareness raising information is available on which the organisations draw.

Recommendation 3

To ensure consistency the Steering Group recommends that a framework should be developed setting out the requirements for different levels of training required for different staff groups and for staff working in different service areas.

Working towards an electronic patient information system

It was clear from the spot check findings and reinforced from the discussions we had with frontline staff, especially nursing staff, that the issues around the recording of

⁷ <http://www.awmsg.org/docs/awmsg/medman/Polypharmacy%20-%20Guidance%20for%20Prescribing%20in%20Frail%20Adults.pdf>

⁸ <http://www.wemerec.org/Documents/Bulletins/SedativeBulletinOnline.pdf>

paper based patient information needed to be tackled - with a shift to electronic systems.

The findings from the spot check visits raised a number of recurring issues relating to nursing record keeping and the Trusted to Care Steering Group recognised this as an area for improvement. NWIS was therefore asked to lead work to modernise nursing record keeping ensuring it is fit for purpose, reducing the amount and duplication of documentation being completed by the NHS. This is a large scale project which requires a phased approach with the aim of improving the quality management of patient care, as well as improving the administrative time spent by NHS staff. In the first phase:

- current documentation has been reviewed and a set of core nursing documents have been produced - these include admission, assessment and risk assessment, care planning and discharge
- the review has followed the patient journey from unscheduled care through to the ward, out into the community, including linking with social care, and back for readmission.
- the project is also establishing a governance process to approve, list and monitor national nursing documents.
- best practice will be agreed and shared across Wales.
- any documents which are surplus to requirements will be removed from the system.
- a small pilot project will be undertaken on the electronic method to be used to capture a set of defined nursing information at the point of delivery, which will be evaluated to make recommendations for next steps.

Recommendation 4

This work should be taken forward with strong clinical engagement and overseen by the National Information Management Board (NIMB).

Improving the environment for frail older people

As a result of the spot checks the Group identified common issues presenting in potential barriers and difficulties for staff in providing consistently good care as a result of environmental factors and ward surroundings.

Welsh Government has responded by publishing guidance to the NHS⁹ which provides assistance in new build proposals and routine refurbishment of ward environments to support optimum delivery of care and the delivery of dementia friendly environments

⁹ <http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf>

NHS organisations must follow minimum standards which include giving consideration to such things as:-

- signposting - large clear picture signage for toilets, dining rooms and bathing facilities etc
 - large script for directions to specific locations within the hospital; consider picture signage
- floors should be designed to be 'non shiny / non reflective' and one colour to prevent fear of mobilisation as well as causing problems for those people with visual impairments
- clock faces should be large and ideally have day and date on the clock too
- for dementia and older persons units memory frames / boxes should be available by single rooms to help people orientate themselves and find their rooms easily

The guidance is already being implemented by all health boards and Velindre NHS Trust. The group was also struck at how much timely attention to maintenance matters, in contributing to good quality patient care.

Some of the additional discretionary capital allocations made available by the Welsh Government in 2015/16 is being used to address the issues raised around infrastructure during the spot check visits. Examples include:-

Abertawe Bro Morgannwg University Health Board has made improvements to Ward 20 at the Princess of Wales Hospital to renew the nurse call system and new lighting issues, with plans to replace furniture, create wet rooms in place of baths and replace floors.

Aneurin Bevan University Health Board has funded a range of improvements including shower, toilet and sanitary improvements; clinical hand basin replacements; sluice room upgrades; kitchen upgrades and flooring improvements to clinical areas across the district general hospital sites.

Betsi Cadwaladr University Health Board has purchased alarm / nurse call systems for two community hospital sites.

Cardiff and Vale University Health Board has improved bathroom / toilet flooring at its Iorwerth Jones unit, painted and decorated the communal areas including corridors and day rooms. The ward bathroom refurbishment programme has re-started at the University Hospital of Wales to address, privacy and dignity, disability and sight impairment. Further funding has been identified to continue the bathroom refurbishment programme.

Hywel Dda University Health Board has made funding available for the refurbishment of Bryngolau Ward at Prince Phillip Hospital.

Powys training Health Board has funded work on the Larches Mental Health Resource Centre at Ystradgynlais Hospital. A programme of work is being developed to improve signage for toilet doors, toilet door colour and toilet seat and grab rails to be a contrasting colour across the site.

Cwm Taf University Health Board is making funding available to address concerns on safety and access to pharmacy cabinets as well as addressing specific issues at two wards at Royal Glamorgan Hospital relating to general storage of equipment and consumables.

Velindre NHS Trust has progressed well against the recommendations including installing digital locks in key areas such as treatment rooms, installing security control maglocks in key areas of the site, installation of drug dispensers, various fridges have been installed to maintain fluids at required temperatures and a CD cupboard relocated as recommended in the report.

Recommendation 5

Health boards must ensure their refurbishment programmes continue in line with the guidance issued and fully address the spot check findings for their respective organisations. Progress must be monitored and reported by Boards

Leading by example and working together

Good leadership has a positive impact on individual teams and as a consequence on the services being provided. This was the clear message received through the spot check visits and from our frontline reviewers. Effective team working has been shown to produce the best outcomes for patients. Examples were shared demonstrating innovative roles being introduced to meet changing service need, as well as frustrations where individuals felt that policies were impacting on day to day service delivery e.g. the staff recruitment process and elements of the all Wales sickness policy.

We heard some evidence that when changes were made to working systems and practices, sometimes the practical impacts meant that staff adopted 'work arounds' as the changes were difficult to make. It is important that staff are fully engaged in designing changes and indeed have a central role in continuous quality improvement. All changes need to be appraised to ensure there are no unintended

consequences for example the introduction of protected mealtimes which in some cases has resulted in families and carers not being on wards at mealtimes to help their loved ones eat. All organisations need to review such examples and ensure that the original intent of initiatives such as these are being met, providing the best outcomes for patients and staff have a responsibility to strive for quality improvement.

These issues can only be addressed through strong local leadership and good team working.

Board responsibility

The responsibility of board members has formed part of regular discussions at Steering Group meetings. The board has a duty to ensure it is fully aware of required outcomes and must take a view on how well those outcomes have been achieved. Board members must be able to provide assurance that patients are cared for and their needs are met. Where this assurance cannot be provided the Board must be clear on what is and what is not acceptable.

Strong leadership is fundamental and the Welsh Government recognises the need for effective board level leadership which is transparent and inclusive. It is important that boards take ownership so that staff have the confidence and belief that when issues are raised with senior management they will be taken seriously and will be dealt with competently. The Steering Group felt strongly that all board members must play a full and active part in the leadership of the health board.

Adequate training must be provided for board members including, non-executive and independent members to ensure they understand the expectations being placed upon them, and the high level of scrutiny and challenge which must be expected at that level. Boards must also ensure they engage fully with the populations they provide services for.

The Steering Group welcomes the work in hand to refresh the induction and training programme for independent board members who have a key role in ensuring effective board level scrutiny and that executives are held to account. The Steering group also heard that Academi Wales are working on an update of the Good Governance Guide for Boards and they continue to work with individual boards and trusts on board learning and development activity.

Values and behaviours

Good leadership is required at all levels within the NHS, clinical, managerial and executive to support a safe environment for patients where quality care is at the forefront. This requires a focus on culture and behaviour at all levels and the sharing of best practice across organisations.

The Steering Group was made aware of the values and behaviour framework developed by ABMUHB through engagement with patients and staff, and how this is being embedded into everyday practice and management process within the Health Board. This is a means through good leadership to ensure values are at the heart of ABMU's culture. This work is welcomed as it advances the overarching common principles for the NHS in Wales, developed in partnership between Welsh Government, NHS Employers and Staff representatives. These principles will replace the extant NHS Wales values published in 2009 and complement the work underway in all health boards and trusts to finalise and/or refresh their local values statements. The Steering Group endorsed this important development.

The importance of families and volunteers

Volunteers and the important role they can play as part of the wider team has been recognised as a common theme with many excellent examples of the added value they bring. As with other examples cited there is a real opportunity to share good practice across Wales. Schemes such as the Care Home Ask and Talk Service¹⁰ (CHAAAT), which utilises the NHS Retirement Fellowship, running in Gwent with Aneurin Bevan Health Board is a good example where older people living in care homes are able to share their experiences.

Our prudent healthcare¹¹ approach reinforces the importance of public and health professionals working together, placing the patient at the very centre of everything we do. There are many examples where this approach is being taken forward across Wales, where the principles of prudent healthcare underpin the services being provided. Llanelli¹² provides a good example where adult social services are being transformed, where those providing and using the service are empowered to make changes which benefit the service user/patient.

The prudent health and care plan being developed will highlight the change that is needed to make prudent healthcare happen. In addition, the Academy for Medical Royal Colleges, with Public Health Wales is formulating a Choosing Wisely¹³ Wales initiative, which seeks to address over treatment and overtreatment, by involving patients much more in designing and deciding upon their own health and care.

Prudent healthcare seeks to ensure that health and care is designed to better meet the needs of frail and older people.

¹⁰ https://www.youtube.com/watch?v=OKiQU8-S_8l&feature=youtu.be

¹¹ <http://www.prudenthealthcare.org.uk/>

¹² <http://www.prudenthealthcare.org.uk/wp-content/uploads/2014/09/Transforming-adult-social-care-Llanelli.pdf>

¹³ http://www.aomrc.org.uk/doc_download/9830-choosing-wisely.html

Recommendation 6

All organisations should embed a co-productive¹⁴ approach, working closely with individuals, families, carers and volunteers to ensure the right support, in the right place, is provided using the skills that best meet the level of need, following an evidence-based approach.

Conclusion

The Steering Group is pleased to report on the progress and improvements made across Wales in response to Trusted to Care. Group members recognised at an early stage there were recurring themes emerging from the findings of the spot check visits. These themes fell into three key areas where the Group felt action was required at an all Wales level – assurance, learning and improvement; infrastructure (environment, information and information technology) and leadership and team working. Significant work has taken place over the last twelve months focussing on these areas, as demonstrated in this report. Much has been achieved but the momentum must be maintained.

The work overseen by the Steering Group aims to ensure patients and their carers are full partners in doing what is right for individuals and which very much fits with the principles of prudent healthcare. With this in mind the NHS is expected to maintain the momentum of improvements already seen resulting from the spot check learning and the all Wales work. Where additional work is required to support this further the Steering Group has made a small number of recommendations (summarised in appendix 2).

¹⁴ <http://www.prudenthealthcare.org.uk/coproduction/>

Trusted to Care Steering Group

Terms of Reference and Membership

1. The Task Force Group on the Trusted to Care Report has been established to give direction and drive implementation of the recommendations for improving quality and patient safety of older people across all Health Boards/Velindre Trust in Wales, but primarily within Abertawe Bro Morgannwg University Health Board area. The group will also oversee the implementation of the recommendations ascribed to Welsh Government.
2. Specific responsibilities include:-
 - overseeing the implementation of all recommendations to ensure they are met in full.
 - ensuring action is taken to address the four main areas where elderly patient care was compromised. This will be in the context of spot checks overseen by Sir Ian Carruthers and Professor June Andrews:
 - in giving patients their medication;
 - in ensuring patients are kept hydrated;
 - in the over-use of night- time sedation; and
 - in basic continence care.
 - providing regular progress updates to the Minister for Health and Social Services and assurances that the quality and safety of care being provided meets the required standards.
 - developing innovative proposals to bring about cultural and behavioural changes to ways of working and communication and information sharing within the NHS and with service users and the public.
 - overseeing the implementation of relevant aspects of the Keith Evans review of concerns and complaints handling within the NHS.
3. The Group will meet monthly, but will be expected to work virtually outside of the meetings to ensure oversight is maintained and progress is achieved within timescales. Professional and expert advice will be drawn from a wider Reference Group.
4. Members of the Steering Group are:
 - Ruth Hussey – Joint Chair

- Jean White – Joint Chair
- Albert Heaney
- Bernadette Fuge
- Nick Budd
- Chris Jones
- Sarah Watkins
- Roger Walker

In attendance will be:

- Jan Davies
- Jan Firby (secretariat support)
- Mandy Stone (secretariat support)

Depending on agenda priorities others may be required to attend specific meetings.

5. The Group is expected to operate until at least June 2015.

Summary of Steering Group Recommendations

Recommendation 1

All NHS organisations should contribute to the further development of, and incorporate the use of, the Quality Checks toolkit and peer review into their quality improvement and assurance systems.

Recommendation 2

The Steering Group strongly supports the implementation of electronic systems for medicines management and administration and advises that a business case should be completed as soon as possible.

Recommendation 3

To ensure consistency the Steering Group recommends that a framework should be developed setting out the requirements for different levels of training required for different staff groups and for staff working in different service areas.

Recommendation 4

This work should be taken forward with strong clinical engagement and overseen by the National Information Management Board (NIMB).

Recommendation 5

Health boards must ensure their refurbishment programmes continue in line with the guidance issued and fully address the spot check findings for their respective organisations. Progress must be monitored and reported by Boards

Recommendation 6

All organisations should embed a [co-productive](#) approach, working closely with individuals, families, carers and volunteers to ensure the right support, in the right place, is provided using the skills that best meet the level of need, following an evidence-based approach.