Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

How Good is the NHS in Wales?

All Wales Findings of a Review of Progress against Healthcare Standards for Wales 1 April 2006 – 31 March 2007

November 2007

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Executive Summary

In May 2005 the Welsh Assembly Government published *Healthcare Standards for Wales,* setting set out a common framework of healthcare standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings. The standards are focused on improving the patient experience and placing patients at the centre of the way in which services are planned and delivered providing a basis for continuous improvement.

During 2007 NHS organisations have been required to self-assess their progress in delivering the highest level of performance against each of the 32 standards and to submit their assessments to Healthcare Inspectorate Wales by the end of June 2007 for testing and validation. Section 2 of this report provides full details of the assessment process adopted and the methodology used to test and validate self-assessments.

On the whole, submissions were of a good standard with responses clearly set out and adequately evidenced and most organisations assessed themselves realistically.

The focus on improving the quality and safety of healthcare commissioned and provided by NHS Wales has never been greater and the information gathered as part of the assessment process has enabled us to develop an overview of NHS Wales that has highlighted both good and not so good practice and shone a light on areas where further work and improvement is needed.

In this report we have used the information we have collected to address the issues that we know are of key importance to patients, service users, carers, the public and NHS staff, and provide answers to the following questions:

- *How well does the NHS engage with patients, service users, their carers and relatives and the public?* ; *Are patients, service users, their carers and relatives and the public provided with the information they need to make informed choices?*

- *Are Welsh healthcare premises fit for purpose? Are healthcare environments clean? Is the risk of healthcare associated infections minimised?*
- *How safe is the NHS in Wales?*
- *Are patients and staff treated with dignity and respect?; Is patient confidentiality maintained?; Where appropriate is informed consent obtained?*
- *Is care good, properly planned and co-ordinated across agencies and in line with national guidelines?*
- *Are the emergency healthcare needs of the Welsh population being met?*
- *Is care provided by appropriately skilled individuals?*
- *Is the food good, readily available and appropriate assistance given when needed?*
- *Is the planning and provision of healthcare in Wales based upon good quality information?*
- *How well is the NHS in Wales governed?*
- *Are NHS staff in Wales valued?*
- *How successful is the NHS in Wales in keeping people healthy?*

We will be working with the Welsh Assembly Government's Department of Health and Social Services to ensure that the general cross-cutting themes highlighted in this report are addressed on an all-Wales basis. In addition every NHS organisation in Wales has developed and is required to publish an Improvement Plan to address the areas highlighted as requiring improvement. These plans will be agreed by the Regional Offices of the Welsh Assembly Government's Department of Health and Social Services, who will monitor implementation as part of the performance management arrangements in place for NHS Wales.

The themes arising from this year's assessment will also inform a new programme of thematic reviews that will be carried out over the next year.

Finally, in recognition of the high level of importance that we as an Inspectorate place on dignity, respect and cleanliness issues we will be continuing our unannounced spot-checks of NHS provider organisations over the coming months.

1. Introduction and Context

1.1. This report sets out the key themes and findings arising from Healthcare Inspectorate Wales' analysis and testing of the self-assessments submitted by Welsh NHS organisations setting out their performance against the *Healthcare Standards for Wales* for 2006-07.

The Standards

1.2. The Welsh Assembly Government published *Healthcare Standards for Wales* in May 2005 and they came into effect on 1 June 2005. They set out a common framework of healthcare standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings.

1.3. First and foremost, the Healthcare Standards are designed to deliver the improved levels of care and treatment the people of Wales have a right to reasonably expect and hence provide a base upon which healthcare organisations can build and achieve the new and more challenging expectations for patient care set out in the Welsh Assembly Government's 10-year strategy, *'Designed for Life'.* All healthcare organisations[1] in Wales are required to take the standards into account when providing healthcare and commissioning healthcare services, irrespective of the setting.

1.4. *Healthcare Standards for Wales* sets out 32 standards under four domains. Each of the domains are derived from core values that should underpin both the commissioning and delivery of healthcare services, and each standard within a domain describes the values that the domain represents.

[1] Healthcare organisations are defined as Welsh NHS bodies, independent contractors and other organisations and individuals including the independent and voluntary sectors, which provide or commission healthcare for individual patients, service users and the public.

- The first domain *'Patient Experience'* sets out:

Standards to support the provision of healthcare in partnership with patients, service users, their carers and relatives and the public will be based on plans and decisions that respect diverse needs and preferences. Services will be user friendly and patient centred. Healthcare will be provided in environments that promote patient and staff wellbeing and respect for individual patients' needs and preferences in that they will be designed for the effective and safe delivery of treatment and care and are well maintained and cleaned to optimise health outcomes for patients.

- The second domain *'Clinical Outcomes'* establishes that:

Healthcare decisions and services will be based on what appropriately assessed research evidence has shown will provide an effective outcome for patients and service users taking account of their individual needs and preferences. Patients and service users will receive services as promptly as possible, and will not experience unreasonable delay at any stage of service delivery or of their care pathway.

- The third domain *'Healthcare Governance'* makes it clear that:

Providers and commissioners of healthcare will have in place systems that support both managerial and clinical leadership and accountability centred around patient and service user needs and preferences. Working practices will be in place to enable probity, quality assurance, quality improvement and patient safety to be the central components of all routines, processes and activities.

- The fourth domain *'Public Health'* states that:

Healthcare organisations will collaborate with relevant organisations and local communities to ensure the design and delivery of programmes and services to promote, protect and improve health, and which will tackle health inequalities and help people to live healthy and independent lives.

The 32 standards are set out at Annex 1.

Ensuring Compliance

1.5. As of April 2007, NHS healthcare organisations in Wales are required to undertake self-assessments against the healthcare standards and make an annual public declaration of how they have performed.

1.6. Organisations are required to formally submit their declaration and self-assessment returns to Healthcare Inspectorate Wales who are responsible for taking the lead in co-ordinating the testing and validation of returns, using a risk-based analysis, against a range of data sources. The process adopted by Healthcare Inspectorate Wales to test and validate the 2006-2007 submissions is set out in the following section.

1.7. From April 2008 onwards, compliance against the healthcare standards will also be used to inform organisations' Statements of Internal Control and Annual Reports.

2. The 2006-2007 Assessment Process

The Methodology

2.1 The 2006-07 assessment process included local self-assessment; testing and validation; corroboration with other regulatory and audit bodies and site visits.

Local self assessment

Activity	Date
Release of web based self-assessment tool to NHS bodies in Wales	**1 April**
NHS bodies submit completed self-assessment and evidence to HIW	**30 June**

Testing and validation

Activity	Date
Desk top analysis of responses and supporting evidence by peer and lay reviewers	**July**
Moderation Meetings	**August**

Corroboration with other regulators

Activity	Date
Healthcare Summits	**August**

Site visit

Activity	Date
Day 1 **Patient and Staff Focus groups**	**September**
Day 2 – Trusts Only **Observational visits to A&E; Outpatients and Elderly care Wards** **Completion of patient and staff Questionnaire**	

The Self Assessment

2.2. 2006-2007 has been a developmental year during which a new process of assessments is being developed and tried. The emphasis has been on developing an assessment process that firmly places responsibility for adherence with the *Healthcare Standards for Wales* on the Boards of healthcare organisations and supports the governance agenda. The process is a key step to ensuring healthcare organisations are held to account for the standard of services they provide and that patients and public are better informed of the performance of their healthcare providers and commissioners and more importantly the standards they should expect.

2.3. In consultation with healthcare organisations and other key partners Healthcare Inspectorate Wales has developed a self-assessment process that tests performance against the *Healthcare Standards* at three distinct levels:

- *Corporate* – how well do Boards do their job in relation to ensuring compliance with the Standards?
- *Operational/Clinical Outcomes* – how is compliance with the standards ensured at service/ward level?
- *User Experience*[2] – what is user experience like and is it improving?

2.4. Criteria and assessment questions have been set for each standard and developed into a web based assessment tool that allows for the on-line completion of self-assessments and the upload of documentary evidence to support the answers given against each question. The questions are supported by guides that provide useful guidance on the requirements of each of the 32 standards.

2.5. Organisations have been required to assess their progress in delivering the highest level of performance against each of the 32 standards using a maturity matrix. The maturity matrix allows for the assessment of performance at the corporate, operational and user experience levels as being at one of five maturity levels:

- Aware
- Responding
- Developing
- Practising
- Leading

Definitions of each of these maturity levels are provided at Annex 2.

2.6. Being a developmental year, NHS organisations have had to meet some tight timescales and were required to submit their completed self-assessment to HIW by 30 June 2007, three months after the assessment tool was released. The deadline was met by all NHS Trusts in Wales and 21 of the 22 Local Health Boards; the remaining LHB (Powys) submitted its return within a week of the deadline. NHS Direct and Healthcare Commission Wales (HCW) also made self-assessment submissions, however, HCW's was received late but again within a week of the deadline. We would like to acknowledge the great amount of work, effort and commitment demonstrated by NHS organisations to ensure deadlines have been met.

2.7. A list of the organisations that submitted a self-assessment can be found at Annex 3.

Testing and Validation

2.8. Healthcare Inspectorate Wales has tested and validated the self-assessment submissions from every NHS organisations, and this has involved a number of stages:

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[2] In the context of the Healthcare Standards assessment process the term 'user' is used to denote patients, service users, carers and staff.

- *Stage 1* – Desktop validation of the self-assessment by a team of peer and lay reviewers. This stage involved checking whether the questions supporting each criteria had been appropriately answered, testing that the answer was supported by sufficient and relevant evidence and evaluating whether the answer fitted the maturity score awarded by the organisation.

- *Stage 2* – Moderation meetings were held throughout August to compare and contrast responses and maturity markings by organisation and by standard. This stage of the process was key to ensuring the consistency and standardisation of scores.
- *Stage 3* – Site visits to organisations to test important aspects of the patient/user experience.

The Site Visit

2.9. The site visit was one stage of the validation and testing of the self-assessments submitted and as stated above focused on the testing of key aspects of the user experience. The visits to NHS organisations took place during September 2007.

2.10. Patient and staff focus groups were held in every LHB and NHS Trust. In addition, Trust site visits included observations undertaken in Accident and Emergency (A&E) departments, outpatient departments and elderly care wards. In addition, Criminal Records Bureau (CRB), training and appraisal checks were undertaken for staff on duty in the above departments/wards on the day of our visit. A detailed work programme for these visits can be found on the HIW website www.hiw.org.uk.

Healthcare Summits

2.11. In August, Healthcare Inspectorate Wales co-ordinated and facilitated three regional meetings, 'Healthcare Summits', bringing together review and audit bodies so that information and knowledge could be shared and fed into the Healthcare Standards assessment corroboration process. These Summits are a key step in the

move to greater sharing of information across review organisations and the development of joint audit and assurance plans.

3. Overview of NHS Wales

3.1 The National Health Service (NHS) was established on 5 July 1948 with the aim of ensuring "*the establishment of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness*" (1946 NHS Act).

3.2 Since 1948, the NHS has seen many changes both in the delivery of healthcare services and in the ways in which those services are structured and organised. Today the NHS in Wales comprises 36 statutory NHS bodies and provides four levels of care:

- *Primary Care* – which is provided through family doctors, opticians, dentists, pharmacists and other healthcare professionals.
- *Secondary Care* – which is more specialist care provided through hospitals and ambulance services.
- *Tertiary Care* - provided through specialist hospitals treating particular types of illness such as cancer.
- *Community Care* - provided by the NHS in partnership with local social services to help vulnerable people, such as the elderly or people with disabilities, live in their own homes rather than in institutions.

3.3 In addition, the NHS provides specialist services that support medical diagnosis and treatment and disease prevention, such as screening services.

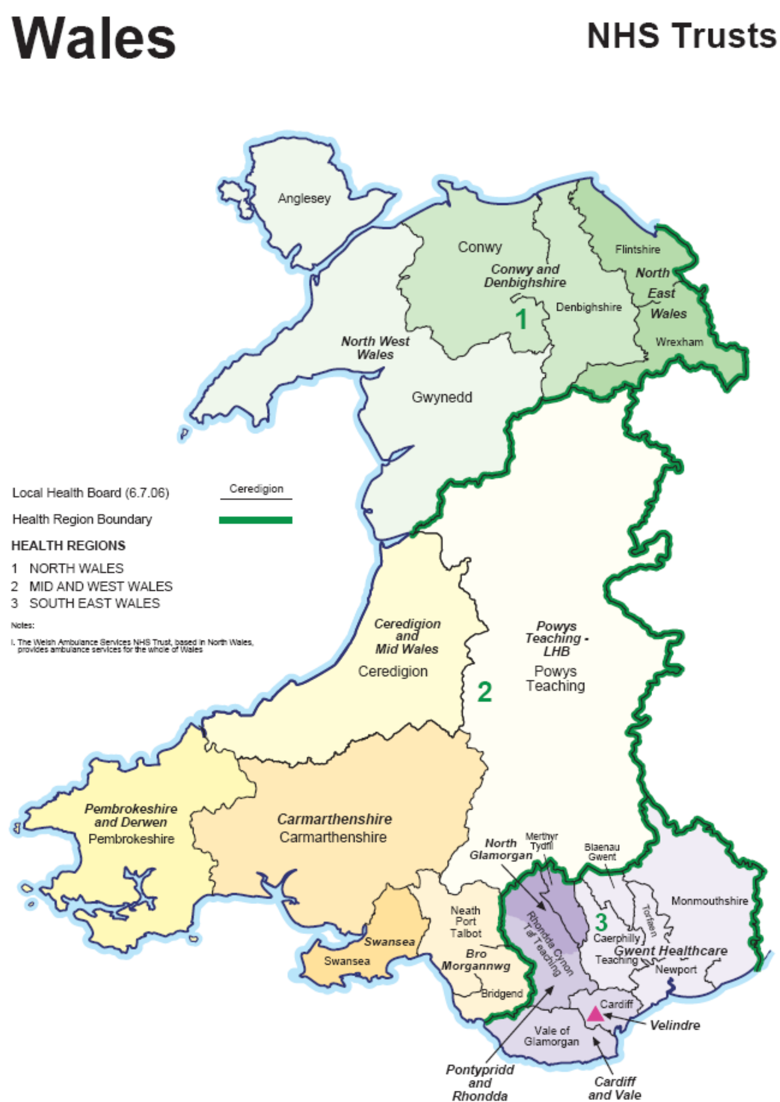
Primary and Community Care Providers

3.4 The first point of contact for most people with a health issue is with primary care services. This includes doctors, dentists, nurses, health visitors, pharmacists and opticians. Many of these staff are not directly employed by the NHS but are remunerated from NHS funds and are hence independent contractors. Primary care services are provided in surgeries, health centres and on the high street.

3.5 As at 30 September 2006, there were 1,882 General Practitioners (GPs) in Wales, 1,122 dentists, and approximately 600 opticians. Other health carers working in the community include health visitors, midwives, community nurses, physiotherapists, occupational and speech therapists.

Secondary and Tertiary Care Providers

3.6 There are 14 NHS Trusts in Wales, including the Welsh Ambulance Services NHS Trust.



3.7 Hospital services are provided within NHS Trusts. Most patients attend a hospital as a result of a referral from their GP or through Accident and Emergency Departments where access does not require a referral.

3.8 Hospitals across Wales provide a range of services and most people in Wales have access to a District General Hospital (DGH) that provides services on an outpatient, inpatient and day case basis. Specialised services such as cardiac surgery and burns and plastics services are provided in a limited number of hospitals. Most hospitals provide both elective and emergency care.

Welsh Ambulance Services Trust and NHS Direct

3.9 The Welsh Ambulances Services NHS Trust provides the following services across Wales:

- Emergency Medical Services.
- Patient Transport Services –pre-planned transport for patients to and from the various hospitals and treatment centres across Wales.
- Wales Air Ambulance Service – this service was launched in 2001 and relies on voluntary donations. The service, based in Swansea, runs dedicated air ambulances responding to emergency calls across Wales.

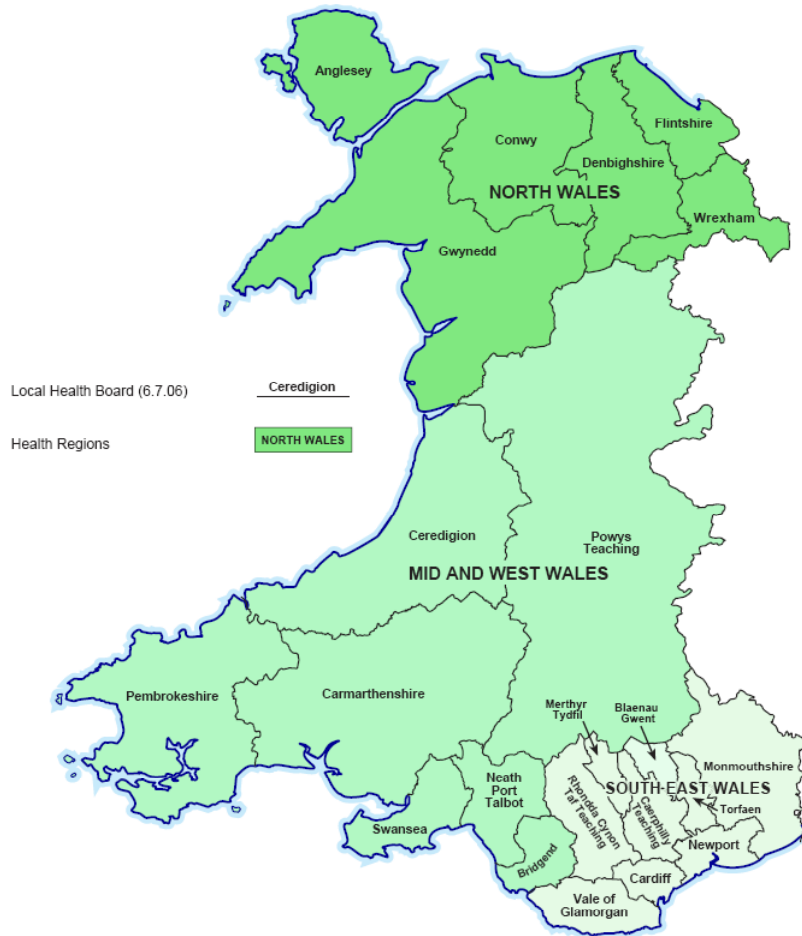
3.10 NHS Direct provides a 24 hour, nurse led, bilingual telephone helpline service providing information and advice about health, illness and health services. As of April 2007, it has been hosted by the Welsh Ambulance Services Trust.

Commissioning Organisations

3.11 There are 21 Local Health Boards and one unified healthcare board, each of which is co-terminous with local government unitary authorities. The main roles of LHBs are ensuring good corporate and clinical governance; securing and providing primary and community care health services; securing secondary care services; improving the health of communities; partnership; public engagement; provision of services.

Wales

Local Health Boards & Health Regions



3.12 The Specialist Health Services Commissioning body (Health Commission Wales) is an “arms length” agency that provides advice and guidance on the commissioning of specialised secondary and regional services. It also provides dedicated guidance, support and facilitation in relation to acute services commissioning.

4. How Did NHS Organisations Approach the Process?

4.1. As stated earlier, 2006-07 has been a developmental year and NHS organisations have had to meet some tight time-scales. A great amount of work, effort and commitment has been demonstrated by NHS organisations to ensure deadlines have been met.

4.2. Many organisations have seen the process as an opportunity to scrutinise their performance and assess the impact they are having in relation to improving the standards and quality of healthcare services in Wales. Others have not made the connection between the Healthcare Standards for Wales and their own internal governance and assurance processes, and have viewed the exercise as being a bureaucratic process that is additional to their day to day responsibilities.

4.3. Organisations where governance arrangements are better developed have invested resources and time to embed the Healthcare Standards assessment process into their governance and internal assurance mechanisms. They have ensured Board engagement by allocating a Board level lead for each of the 32 standards. Some organisations have engaged their own internal auditors in the process of validation and the evidencing of their self-assessment prior to submission to HIW. These organisations, particularly Board members, have been positive in their feedback on the process and while recognising that further refining and development is needed have welcomed the direction of travel.

4.4. On the whole, submissions were of a good standard with responses being clearly set out and adequately evidenced. Most organisations assessed themselves realistically and closely followed the wording of the maturity matrix when making their assessment of maturity level. However, some organisations consistently over-marked themselves and it was clear that they had not checked their responses against the requirements set out in the maturity matrix.

4.5. Generally, organisations had difficulty evidencing the User Experience level questions and found it difficult to demonstrate the impact that their work or specific

initiatives have had on patients, service users and carers. The lack of benchmarking and evaluation was a consistent theme, and continuous improvement was very poorly evidenced. Where evidence was provided it related to pockets of good practice and improvement rather than practice that was consistent across the organisation and all services.

4.6. The clarity of some of the questions was an issue, and the level of evidence supplied by organisations varied. We will be refining the questions and providing further guidance on the level and type of evidence required over the coming months.

5. Findings

5.1 For ease of reference, the key themes and findings arising from our analysis and testing of the self-assessments submitted by NHS organisations are set out below under the four domains of the Healthcare Standards and against key questions that we know to be of importance to patients, service users, carers and the public of Wales. The related standards have been highlighted against each question.

5.2 A summary of each of the organisations assessed is listed at Annex 3 and the level of maturity is provided at Annex 4. The full individual reports for each organisations can be accessed via our website www.hiw.org.uk.

Patient Experience & Clinical Outcomes

How well does the NHS engage with patients, service users, their carers and relatives and the Public?
[Related Standards: 1 &15]

Engagement in Service Development

Most NHS organisations in Wales have public and patient involvement strategies and processes in place. Many boards of NHS organisations are engaged in this process and have identified non executive board leads for this area of work.

The importance of true stakeholder engagement and involvement cannot be underestimated particularly when developing solutions to meet local needs or taking forward service changes. We found that consultation and involvement are often confused. While there are some excellent examples of true involvement and engagement, in the majority of cases we were provided with examples of consultation only.

As a result, many organisations had difficulty demonstrating how their engagement activities had led to service improvements, and we found little evidence of imaginative approaches to engagement, particularly with regard to hard to reach groups.

Too often, NHS organisations rely solely on formal patient representatives. Community Health Councils provide a statutory and independent voice in health services throughout Wales, and are a very valuable source of feedback. However, they cannot possibly represent the full range of public and patient views, and services therefore need to develop a wider range of ways of engaging and involving stakeholders.

Since the current NHS structure was introduced in Wales in 2003, there have been significant changes in the demography of the Country, requiring different approaches to public engagement. For example, many parts of Wales have seen changes to their immigrant population impacting on both healthcare needs and service provision. NHS organisations in Wales have struggled to develop proactive approaches to engagement to enable them to capture the views of the whole population they serve.

Local Health Boards have a key role in ensuring that the health needs of their population are met and public engagement should be at the heart of all their activities. However, our discussions with public and patients demonstrated a lack of understanding about the role of Local Health Boards. We recognise the challenges Local Health Boards face in this area and their commitment to taking the patient and public involvement agenda forward, however, more work needs to be done to increase public understanding of the work of Local Health Boards, much of which could be co-ordinated at a national level.

Encouraging and responding to feedback

Encouraging feedback, whether it be compliments or complaints, and responding in an appropriate and timely way is of fundamental importance to any organisation, but in particular to NHS organisations where any failure in the care system can have a high impact on the outcome for patients and their families. NHS Wales is developing, and over the last few years there has been a drive towards greater openness and transparency in addressing issues raised by patients and the public.

Some organisations have started to develop comprehensive approaches to encourage feedback on the services and care they provide in order that they can

learn from their successes as well as those aspects of service care and provision which were less positive. These approaches, which include the adoption of patient liaison services and compliment card systems enable less formal feedback and a timely resolution of issues which often negate the need for formal complaints. These organisations were able to demonstrate clear improvements in patient satisfaction.

However, many organisations still rely solely on their formal complaints processes and have not developed less formal methods of obtaining feedback on patient and public views. Some patients we spoke to raised concerns about using the formal complaints process, particularly whilst still in hospital or suffering from long term conditions, as they knew that they had to interact with the service again and felt that any complaint may impact on their future care. This was of particular relevance to older, more vulnerable patients and some people from minority ethnic groups. It is important therefore that NHS organisations create an environment within which all patients feel encouraged and supported to raise issues, and that these are addressed in a timely manner which demonstrates that their feedback is both appreciated and acted upon.

Are patients, service users, their carers and relatives and the public provided with the information they need to make informed choices?
[Related Standards: 6 & 7]

The provision of timely information is key to the empowerment of patients and service users to equip them to make choices about how they manage their own health, the services they access and the care provided to them.

We found considerable disparity across Wales with regard to the availability and usefulness of information. On the one hand, some of the larger organisations have arrangements in place that include patient information teams, whose role it is to work with clinical staff and service users to develop useful information sources on services, care and treatments. These have interpreter services available to ensure support for people from minority ethnic groups accessing accessing healthcare.

Others have been less proactive in identifying the communication needs of their population and developing information services to meet their needs. Many of these organisations rely on family members to provide interpretation, and have limited information available to meet the needs of service users and carers.

Although most organisations have contracts with 'Language Line' for the provision of translation services, this is sometimes not utilised on a timely basis, or is not suitable to meet more complex needs. Many organisations have hearing loops, but there is a lack of support mechanisms for their use, and issues relating to sensory disabilities such as deafness can often lead to appointment delays and the cancellation and rebooking of appointments because adequate support mechanisms are not in place.

NHS organisations in Wales rely too heavily on the Internet to distribute information within their communities, and many patients that we spoke to do not have access to such facilities. Easy read materials were available in some, but not all organisations, and some departments use picture books to aid communication with individuals with learning disabilities. However, this was not consistent and often staff had not been trained to use these aids.

Many LHBs and Trusts are working together to take forward the Expert Patient and Chronic Condition Management Programmes, designed to support patients with a long-term condition to develop expertise in self-care. Very positive feedback was received from both patients and NHS staff in relation to this initiative and it was felt that those involved developed true insight into their condition and felt better equipped to make informed decisions around their healthcare.

Care planning is important in terms of deciding the pathway of care for an individual, and this is particularly important for those individuals with a long term or mental health condition. We identified a mixed picture in terms of the quality of care planning across Wales, and there was in particular a lack of evidence of patient and carer involvement in the development of their care plans.

The 'Unified Assessment Process' is one particular approach to care planning where an individual requires both health and social care support. Again, the picture across Wales is variable, and we consider that sometimes the processes adopted to develop both a unified assessment and care plan are too formal and can drown out the patient's voice.

Are Welsh healthcare premises fit for purpose?
[Related Standard: 4]

We found some excellent examples of healthcare premises that have been purpose built to meet modern healthcare needs. However, some of the NHS estate is ageing and these premises are not designed to meet patients' rightful expectation for privacy and dignity. Such environments also make cleaning difficult.

Some organisations still have mixed sex bays and wards. This was particularly apparent in medical assessment units and some mental health facilities. Day rooms on wards are often used as discharge lounges or to store equipment as storage facilities are lacking.

Some of the smaller Accident and Emergency (A&E) Units have difficulty ensuring separate areas are available for children. This means that often they have to pass through major trauma areas which can clearly be upsetting. Suitable facilities are important to help families cope with stressful and upsetting trauma situations. However, we found that relative rooms in A&E are often either not available or inappropriate.

Car parking is a major issue for many Trusts both in terms of availability and charging for both the public and staff. Many of the patients we spoke to told us of concerns when attending outpatients and A&E departments that their vehicles would be clamped or that they would not have access to money to pay car parking charges particularly in emergency situations. Additionally, these patients mobility is often limited and sufficient parking close to the departments is just not available.

Disability Discrimination Act (DDA) audits have been undertaken across NHS premises in Wales and action plans are in place to ensure identified issues are addressed.

Where new healthcare premises are being developed, issues such as infection control are being addressed through building design and this is a major step forward.

Are healthcare environments clean?
[Related Standard: 5]

Some NHS Trusts in Wales feel that they have inadequate domestic cleaning hours, and ward managers consider that they should have direct responsibility for cleaning services on their wards. Generally good cleaning is inhibited in many areas, as they are unnecessarily untidy and cluttered due to poor housekeeping, for example, problems with storage space has led to mattresses being stored in bathrooms and communal areas. Some of the improvements that need to be put in place are simple and inexpensive. However by far the biggest challenge is to ensure that all staff, patients and visitors think hygiene and cleanliness while in a hospital.

A number of organisations have started to split the duties of domestic staff in relation to cleaning and the provision of food to patients. This is working well, helping to give a greater ownership of cleaning duties as well as freeing up more time to enable staff to help patients who need assistance to eat.

We found that while clinical and ward areas were generally clean, there were problems with public areas, particularly concourses, general corridors and stairwells. Public toilets in some hospitals are not clean. Also, the outside areas of many hospitals do not give the impression of cleanliness due to the level of litter. Patients and visitors also need to take ownership of this.

A number of patients and the public we spoke to raised concerns about the level of cleanliness within primary care practices. To date, we have not undertaken checks of these organisations, but we will over time be extending our rolling programme of spot checks to include primary care premises to address these concerns.

More information on this area is available within our report on *Infection Control - Findings and Themes,* which can be accessed, on our website www.hiw.org.uk.

Is the risk of healthcare associated infections minimised?
[Related Standard: 5]

Concern about healthcare associated infections is widespread. Symptoms can vary and the impact in some cases is severe. Some infections can be avoided, and so in September 2004 the Welsh Assembly Government launched *Healthcare Associated*

Infections - A Strategy for Hospitals in Wales. The Strategy aims to support the reduction of HCAIs in Wales and highlights the need for all hospital staff to take personal responsibility for infection control.

Nearly 2,500 people in Wales contracted *Clostridium difficile* (*C. difficile*) associated diarrhoea while in hospital in the year leading up to 30 June 2006.[3] However, the prevalence of *C. difficile* in Wales is half of that in England.

Welsh hospitals also experience significant problems arising from viruses that cause diarrhoea and vomiting. In 2006, there were 225 outbreaks of infection reported in Welsh hospitals, of which 194 were diarrhoeal illness outbreaks due to norovirus or other viral causes, compared with 18 outbreaks of diarrhoeal illness due to the bacterium *C. difficile*.

There is evidence of a high level of commitment and enthusiasm among specialist infection control staff within Trusts even though they are often small in number. There is also evidence of innovative ideas for the development of infection control procedures and the wider training of staff within Trusts. Infection control is included within the mandatory training programmes of most of the organisations we visited and infection control audit tools are in place. However, we consider that a review of the numbers of specialist infection control staff is needed, and organisations need to ensure that staffing and ward pressures do not prevent the release of staff for mandatory training.

Hand decontamination facilities were found to be universally poor in the cleaning storage rooms and in some hospitals separate hand wash sinks are not always available in ward utility rooms. Hand wipes are not available as the norm for bed bound patients to use before meals, and we found there to be inconsistent uniform policies across NHS Wales in relation to the wearing of uniforms whilst off duty.

Members of the public and patients are concerned about the risk of cross infection from uniforms and so staff should be discouraged from wearing their uniforms while off duty.

[3] National Public Health Service for Wales, All Wales Mandatory Clostridium difficile Surveillance, 01/07/05 – 30/06/06, September 2006.

All areas visited were implementing the Cleanyourhands Campaign Hygiene Programme. Patients and the public need to play their part in ensuring infection control is minimised by ensuring they use the alcohol gel that is available at the entrance to wards and at bedsides and that they challenge staff, whatever their grade or profession, who are not following good hand hygiene practices.

How safe is the NHS in Wales?
[Related Standards: 14, 16, 17, & 19]

As part of the Healthcare Standards review, we looked at arrangements in place relating to health and safety legislation, risk assessment and management, incident reporting and adult and child protection.

All NHS organisations in Wales demonstrated an awareness of their responsibilities in terms of health and safety legislation and risk management, and have put arrangements in place to raise staff awareness of these issues to ensure compliance with their requirements. What was less evident is how well these are embedded and operating in practice across the organisations and what difference they are making. Many organisations were able to provide us with examples of review and audit work carried out against these requirements, but the impact and resulting improvement from these actions was often not demonstrated. Staff sometimes see these processes as over bureaucratic administrative tasks that distract them from their day to day work rather than informing organisational behaviour and decision making.

NHS boards in Wales have a key role to play in moving the agenda forward and embedding an ethos of risk management at all levels of decision making within their organisation and the wider health community.

In 2006-07 the number of in-patient (including speciality) cases in Wales was 501,900 and the number of new outpatient attendances was 776,000. The number of new accident and emergency cases rose to 942,000. 1.7 million patient journeys were made by ambulance, and 12% of these were emergency cases. 17% of adults in Wales reported visiting the family doctor, 76% their dentist, 46% an optician and 80% a pharmacist. One woman in four reported contact with a health visitor, district nurse or community nurse compared to one in eight men.

Given this volume of activity across Wales, it is inevitable that incidents will occur, and for this reason, reporting mechanisms have been put in place across the NHS in Wales so that organisations can identify the level of incidents occurring, investigate the reasons for this, and take action to reduce the chance of similar incidents occurring again.

We found that the effectiveness of these arrangements across Wales is being hampered for a variety of reasons. For example, processes for recording and investigating incidents are thought to be over burdensome and time consuming and therefore often only limited information is recorded. Medical staff sometimes assume that nursing staff will complete the process on their behalf. In some organisations, there is also a lack of clarity around what incidents should be reported.

To become a truly learning public service, the NHS in Wales needs to continue to build a culture of openness and transparency, which, although apparent in many NHS organisations, is not yet universal. As a result, lessons learned from incidents are not being fed back to those involved or consistently shared across the NHS as a whole.

In March 2007 we published a report of our review of child protection arrangements across the NHS in Wales, and these matters, together with protection of vulnerable adults (POVA) arrangements were again followed up as part of the Healthcare Standards for Wales assessment process.

In general, we found there to be good practice in relation to safeguarding and child protection arrangements. However, NHS staff were less alert to the risks faced by vulnerable adults, with consideration of these issues often only occurring following an incident. As part of our visits to A&E, outpatients and elderly care departments, we reviewed child protection and POVA training and Criminal Records Bureau (CRB) checking arrangements and found that generally inadequate POVA training had been provided to these front line staff and also that in some cases CRB checks had not been carried out.

We will be following these issues up as part of our forthcoming work programme.

Are patients and staff treated with dignity and respect?
[Related Standards: 8]

NHS staff in Wales are committed to ensuring that all patients are treated with dignity and respect, and are making great efforts to achieve these often in difficult circumstances. We have raised issues elsewhere in this report around the suitability of premises and the use of mixed sex bays and wards which clearly impact upon patient dignity. Maintaining privacy is a big issue for those patients we spoke to, and many of them felt that the use of curtains in wards to provide a level of privacy was wholly inadequate. NHS staff must be sensitive to patients' sense of vulnerability in this kind of environment and protect patient privacy as far as possible.

We were also told of some instances where patients were kept in bed because this was easier for staff. However, these were isolated instances, and we are addressing these with the individual organisations concerned.

Respecting patients as individuals, which includes matters such as how they are addressed and spoken to, is key to the patient experience. It is often easy to assume that people are happy to be addressed in familiar terms without checking first. NHS organisations need to ensure that their staff take the time to check with patients their preferences.

We found excellent examples of good practice in some NHS organisations around understanding and addressing matters of respect and dignity linked to culture. For example, one Trust has worked with the local Muslim community to undertake an Operating Theatre 'walk through' exercise with elders so that standards of dress are maintained for patients undergoing medical procedures.

The review we have undertaken of child protection arrangements across NHS Wales highlighted that while facilities for children were found to be good in the main, adolescents are generally placed in adult wards. Only three Trusts in Wales have dedicated adolescent in patient facilities, and particular issues were identified in relation to adolescents with mental health problems. A lack of suitable facilities such as this impacts on both the dignity and safety of these patients.

NHS staff have an equal right to be treated with dignity and respect, and most organisations recognise the importance of this and clearly set out their expectations

and actions in the event that staff are not treated in this way. The staff we spoke to did not raise any concerns in this area. However, instances of violence against staff do sometimes occur, and the NHS in Wales has a zero tolerance policy. The Health and Safety Executive has undertaken a lot of work in this area, and in conjunction with the Welsh Assembly Government has launched the All Wales NHS Violence and Aggression Training Passport and Information Scheme.

Is patient confidentiality maintained?
[Related Standards 8, 26]

All NHS organisations in Wales have taken appropriate steps to preserve patient confidentiality. However, we did identify some issues relating to the practice of leaving patient notes unattended and accessible at staff workstations and reception areas. In addition, some patients were concerned that their care and treatment is discussed openly on wards and in A & E departments without seeking the patients permission beforehand. The display of patient information on whiteboards is an issue in some organisations.

Where appropriate, is informed consent obtained?
[Related Standards: 8, 26]

It is important that patients and carers maintain control over what happens to them in relation to their treatment and care. NHS organisations are required to obtain informed consent for procedures and treatments in line with All Wales consent guidance. In most organisations, both patients and staff we spoke to were satisfied that informed consent was obtained where appropriate. We identified some concern in one Trust however, where we identified that appropriate consent was not always obtained for invasive medical or investigative procedures. Action is being taken to address this.

Local Health Boards need to ensure that appropriate consent procedures are in place and operating within primary care.

Is care good, properly planned and co-ordinated across agencies and in line with national guidelines?
[Related Standards: 12, 24 & 29]

In May 2005 the Welsh Assembly Government released *Designed for Life*, its strategy for the future of health and social care in Wales. This strategy accepted the

view that the way in which health and social care services were provided in Wales was not sustainable, and that considerable change was needed *'probably in every hospital, GP practice and Social Services Department'*. A key aim of the Strategy is to provide quality services to people within their own homes, or as close to their own home as possible.

One of the steps towards delivering the strategy has been to improve the timeliness of secondary care provision. As at 31 March 2007, only three people in Wales were waiting over eight months for admission to hospitals as an in patient or day case. No patients were waiting over 12 months for a first outpatient appointment, no patients were waiting over four months for cataract surgery and the number of people waiting more than six months for a first cardiology appointment was 30.

These figures demonstrate a huge improvement in access times for key secondary care services. However, there are concerns amongst clinicians that national waiting times rather than clinical need is driving clinical priorities.

Local Health Boards and Health Commission Wales are responsible for commissioning services that meet identified local needs within this national framework. However, we identified key issues and problems with the current commissioning arrangements. Many Local Health Boards are simply contracting rather than commissioning services, and have Long Term Agreements in place, which are based on historical needs rather than a current assessment of the health needs of their local population. Furthermore, their size and capacity limits their influence on larger service providers.

There are additional complexities around the commissioning of specialist services, and quite often confusion around where responsibility lies for funding and monitoring the quality of services designed to meet patients care needs. The needs of the individual patient are often lost within such a confused commissioning environment.

Partnership working to ensure seamless services for the patient is improving and developing. Examples include:

- the development of Integrated Care Pathways, designed to map out the patient journey across all health and social care agencies for key diseases and illnesses;
- the Unified Assessment Process where health and social care workers collaborate to develop a complete assessment of an individuals health and social care needs;
- closer links between healthcare needs and other services that affect health and wellbeing and a persons ability to be cared for at home, e.g. housing, transport, leisure facilities, etc. However, some Trusts have very little input or ownership of local Health, Social Care and Well-Being Strategies.

Whilst these actions are leading to some improvement, there is still an over reliance on secondary care, and more work is needed to shift the balance to primary and community provision.

The NHS in Wales is committed to the provision of safe and effective healthcare services, and to achieve this conforms to National Institute of Health and Clinical Excellence (NICE) technology appraisals and interventional procedures and the recommendations of the "All Wales Medical Strategy Group". Healthcare is also based upon nationally agreed best practice and guidelines, as defined in National Service Frameworks, NICE clinical guidelines, national plans and agreed national guidance on service delivery.

With such a plethora of clinical standards and guidelines, NHS organisations often have difficulty prioritising and keeping up to date with the latest advice. Where prioritisation is taking place, this is frequently carried out at an operational level, with little engagement by or involvement of NHS Boards.

Are the emergency healthcare needs of the Welsh population being met?
[Related Standard: 3]

The Service and Financial Framework for the NHS in Wales for 2006-07 included a target that stated that 95% of all new patients (including paediatrics) were to spend less than four hours in a major A & E Department from arrival until admission,

transfer or discharge and no-one should wait longer than eight hours for admission, transfer or discharge.

In March 2007 no Trust had met the target for both the four and eight hour waiting times. However, two Trusts had met the four-hour target. In respect of major A & E Departments, 88.8% of patients spent less than four hours from arrival until admission, transfer or discharge, and 98% of patients spent less than eight hours from arrival until admission, transfer or discharge. Figures for all hospital emergency care facilities show 91.1% of patients spent less than four hours from arrival until admission, transfer or discharge, and 98.4% of patients spent less than eight hours from arrival until admission, transfer or discharge.

We undertook visits to every major A&E Department across Wales and found that most people were satisfied with the treatment and information that they were given. However, many A&E Departments were not informing patients of the length of time they could expect to wait, and whilst many had electronic timers in place, they were not being used.

Many parts of Wales have introduced out of hours services to help take the pressure off A&E Departments, and also have minor injury units are in place. However, many are being under utilised and increasingly people are turning up to A&E Departments with symptoms and ailments that would be better treated by non-emergency facilities. In particular, the growing number of immigrant communities is having an impact, as many are not registered with a GP and hence just go to A&E.

In terms of ambulance services in Wales, for the period 1 January to 31 March 2007 there were just under 76,000 emergency calls. 56.2% of first responses to immediately life threatening emergency (Category A) calls arrived within eight minutes, 61.7% within nine minutes, and 71% within 10 minutes. The target for all Category A calls is for a response (first responder or ambulance) within eight minutes.

The Welsh Ambulance Service Trust was subject to a review by the Auditor General for Wales and Healthcare Inspectorate Wales in 2006. These reports can be accessed via our website.

Is care provided by appropriately skilled individuals?
[Related Standards: 11, 21 & 22]

As at 30 September 2006 the provisional whole-time equivalent of all staff directly employed by the NHS in Wales was 70,620. The nursing, midwifery and health visiting group is the largest staff group accounting for 40% (27,901) of all staff. 5,332 medical and dental staff are employed.

As part of the Healthcare Standards self-assessment process organisations were required to set out how they ensured all staff employed by them are appropriately trained and how they ensure that skills are updated taking into account changes in practices and the introduction of new medical interventions and treatments.

We found that all organisations undertake the necessary pre-employment checks, which includes the confirmation of registration with the appropriate professional body. Many organisations undertake annual checks to ensure that registrations have been updated but this practice was not universal.

Not all organisations had clinical supervision processes in place and while all had appraisal processes in place, we identified issues in relation to the consistent application of these. A number of staff we spoke to had not had an appraisal in the last two years and highlighted some difficulties in relation to accessing Continuing Professional Development because of problems getting cover for them to attend training and development opportunities.

Is the food good, readily available and appropriate assistance given where needed?
[Related Standard: 9]

In recognition of the importance of good diet and nutrition to the quick recovery of patients many Trusts across Wales have invested considerable time and resources to improving the quality and choice of food available to patients. However, quality and choice is not consistent across all NHS organisations.

Protected meal times have been introduced on many wards, which ensures that patients are not interrupted at meal times by doctors' ward rounds or diagnostic procedures or visitors. However, we found that in some cases this has been applied too rigorously, for example, speech and language therapists who need to review the

swallowing reflexes of some patients have not being allowed on the wards at meal times.

In addition, some Trusts have introduced a colour coded tray system, which easily identifies those patients who need assistance to help them to eat. Again, these practices are not consistent across all organisations. A number of patients told us that they had observed some patients struggling at meal times as the required assistance was not available to them, and they were concerned that staffing on wards did not allow for this.

Dieticians are attached to some wards and provide individual advice on what patients should and should not eat, which we consider to be good practice. We also found good instances of innovative approaches to encourage patients to eat. For example, patients who have difficulties swallowing are often put off by pureed food. Recognising this, some Trusts have invested in the provision of reconstituted food designed to replicate standard meals but which on eating are easily swallowed.

We found that 24-hour access to food was limited, although most wards are able to provide snacks such as toast, bread and spreads. For those patients with specific dietary or cultural needs, choice is even more limited, albeit some Trusts are tackling this, for example by introducing menus for specific ethnic groups.

The majority of Local Health Boards, as part of their self assessment, indicated that they considered Standard 9, which relates to the provision of food, to be only appropriate to provider organisations. As a healthcare inspectorate, such a response gives us concern because commissioners should be ensuring that provider organisations have the arrangements in place to meet the dietary and nutritional needs of their patient population. LHBs are commissioning patient services and episodes of care, a part of which may be a specific clinical procedure, but they should also be looking to ensure that the whole patient experience is a good one.

Is the planning and provision of healthcare in Wales based upon good quality information?
[Related Standards: 25 & 26]

High level health, social care and well being strategies have been developed on a health community basis across Wales to respond to the identified needs of the local

population. These appear to be based upon well-developed information provided by the National Public Health Service amongst others.

The NHS in Wales produces a large amount of data about the provision of both secondary and primary care services, but this is often not utilised or available to those who need it in a form and at the right time to enable informed decision making in key areas such as commissioning services.

Projects such as *Informing Healthcare* have been designed to address these issues and help bring about a better integration of healthcare information and we will consider progress as part of our ongoing assessments against the Healthcare Standards.

At individual patient care level, we found that the quality of record keeping is variable, with some records not always available on a timely basis, and an over reliance on junior medical staff to complete the records. This is consistent with the findings from our earlier review of *Child Protection Arrangements across NHS Wales*, where we identified that the amalgamation of children's paper records had not occurred, and Trusts were found to be still working from many different sets of notes. 24-hour access to all previous case notes was not available. In addition, issues in relation to the quality of patient clinical record keeping was highlighted within our *Special Assurance Review of the Welsh Ambulance Services NHS Trust* reported in January 2007.

Healthcare governance

How well is the NHS in Wales governed?
[Related Standards 13, 27, 28]

The NHS in Wales has a complex governance structure, made up of 36 independent statutory bodies each with its own Board and sub committees, operating within a formal framework of standing orders and standing financial instructions. NHS Chairs are Ministerial appointments and formally accountable to the Minister for Health and Social Services, whilst Chief Executive Officers are appointed directly by the Board of the organisation and are accountable formally both to the Board for the

organisations performance and the Director of the NHS in Wales as Accounting Officer.

We found there to be inherent problems within this structure, in particular in relation to LHBs. The size and composition of these Boards are designed to ensure stakeholder engagement at a local level. Whilst they have been successful in achieving this engagement and commitment locally, there are significant challenges in ensuring corporacy and managing conflicts of interest. Some individual Board members are unclear of their roles and responsibilities in terms of bringing a perspective rather than being a representative, and within the Boards as a whole there is considerable variation in terms of knowledge, experience and understanding.

Keeping Boards of this size focused on their responsibilities for both setting the strategic direction and holding the executive to account for its delivery is very difficult, with the decision making process sometimes unclear and unwieldy and insufficient challenge and scrutiny. This often results in an over reliance on the Executive team to both set and deliver the Agenda. This is also true of some of the larger trusts particularly in relation to assurance mechanisms.

Historically, NHS Boards have focused heavily on financial performance, sometimes at the expense of the quality and level of service provision. This arose in response to the market driven approach and ethos that was a feature of the 1990s and it has been very difficult to change organisational cultures and hence move away from this. A clinical governance focus and related structures were introduced to address this imbalance in the late 1990s and while this was the right response and has led to an improved organisational focus on quality and clinical care, for those less mature organisations this has also resulted in a segregation of the overall governance agenda, making it difficult for Boards to properly understand and balance their responsibilities to design and deliver quality services within a responsible financial framework.

The size and structure of Local Health Boards does not support their commissioning role. One way in which the NHS in Wales is moving to address this is through the introduction of Regional Commissioning Units, designed to rebalance the commissioner provider relationship. It is too early to assess the impact of this.

Are NHS staff in Wales valued?
[Related Standards: 20, 22, 23 & 32]

LHB staff consistently told us that they felt valued and were given opportunities to develop themselves and influence organisational and service development. The picture was less consistent however within Trusts. On the one hand, some organisations have introduced mechanisms to demonstrate recognition and appreciation for the contributions made by individual staff members such as the 'Somebody Loves You Award Scheme' which is presented to a member of staff who has been recommended by a patient or relative as being particularly helpful or caring. However, within these larger organisations, although formal Human Resource systems, including those for training and development are in place, we identified inconsistency in their application. For example, in some organisations clinicians are left to take forward their own development and there is a lack of co-ordination and monitoring of clinical professional development and a lack of organisational responsibility for the provision of peer support.

The level to which staff felt valued varied depending on their perceived position within the organisation. In some organisations, there was a clear hierarchy of staff groupings, and staff felt unable to challenge practices. For example, some cleaning staff told us that they did not feel able to challenge clinical staff in relation to their handwashing practices. Some allied health professional groups also told us that they felt they had a lot more to contribute in terms of the design and delivery of services but that their organisations did not recognise the importance of their contribution.

Such a culture undermines the development of cross professional team working and the fundamental behaviours that lead to organisational success.

Public health

How successful is the NHS in Wales in keeping people healthy? [Related Standards: 18, 30, & 31]

The various aspects of the public health agenda and the role of the National Public Health Service are reflected throughout this report. The one aspect that has not been covered so far is whether the NHS in Wales is equipped to deal with major incidents and emergencies.

As part of their self-assessments against the Healthcare standards, every NHS organisation in Wales has been required to both describe and assess its emergency response arrangements. These arrangements are designed to cover events such as the outbreak of pandemic flu, emergency evacuation procedures in response to incidents such as gas escape or chemical spillage, etc. The results show that not only are arrangements in place, but they are tested regularly on a local and national basis, in partnership with, for example, the Local Authority, Police, Fire Service and other agencies.

6. Next Steps

6.1. Every NHS organisation in Wales is required to publish a Healthcare Standards Improvement Plan by 30 November 2007. These plans will be agreed by the Regional Offices of the Welsh Assembly Government's Department of Health and Social Services, who will monitor implementation as part of the performance management arrangements in place for NHS Wales.

6.2. Over the coming months we will be working with stakeholders to refine and improve the assessment tool for the future and to align the Healthcare Standards self-assessment process with the annual financial cycle. In addition from April 2008 all independent healthcare providers will also be required to assess themselves against the Healthcare Standards for Wales.

6.3. Healthcare Inspectorate Wales has already began working with audit and regulatory bodies in Wales to develop a review programme for NHS Wales that is based around the key issues raised by the Healthcare Standards assessment process. Further, in recognition of the high level of importance that we as an Inspectorate place on dignity, respect and cleanliness issues we will be continuing our unannounced spot-checks of NHS provider organisations over the coming months.

Annex 1

Healthcare Standards for Wales

Patient Experience

Standard 1
The views of patients, service users, their carers and relatives and the public are sought and taken into account in the design, planning, delivery, review and improvement of health care services and their integration with social care services.

Standard 2
The planning and delivery of healthcare:

- *a. reflects the experiences, views and preferences of patients and service users;*
- *b. reflects the health needs of the population served;*
- *c. is based on nationally agreed evidence and best practice; and*
- *d. ensures equity of access to services.*

Standard 3
Patients with emergency health needs access appropriate care promptly and within national time-scales set annually by the Welsh Assembly Government.

Standard 4
Healthcare premises are well-designed and appropriate in order to:

- *a. promote patient and staff well-being;*
- *b. respect different patients' needs, privacy and confidentiality;*
- *c. have regard for the safety of patients, users and staff; and*
- *d. provide a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.*

Standard 5
Healthcare services are provided in environments, which

- *a. are well maintained and kept at acceptable national levels of cleanliness;*
- *b. minimise the risk of healthcare associated infections to patients, staff and visitors, achieving year on year reductions in incidence; and*
- *c. emphasise high standards of hygiene and reflect best practice initiatives.*

Standard 6
Healthcare organisations, in recognising different language, communication, physical and cultural needs:

- *a. make information available and accessible to patients, service users, their carers and relatives and the public on their services;*
- *b. provide patients and service users with timely information on their condition; the care and treatment they will receive as well as after-care and support arrangements; and*

c. *provide patients and service users with opportunities to discuss and agree options relating to their care.*

Standard 7

Patients and service users, including those with long-term conditions, are encouraged to contribute to their care plan and are provided with opportunities and resources to develop competence in self-care.

Standard 8

Healthcare organisations ensure that:

a. *staff treat patients, service users, their relatives and carers with dignity and respect;*
b. *staff themselves are treated with dignity and respect for their differences;*
c. *informed consent is obtained appropriately for all contacts with patients and service users and for the use of confidential patient information; and*
d. *patient information is treated confidentially, except where authorised by legislation to the contrary.*

Standard 9

Where food is provided there are systems in place to ensure that:

a. *patients and service users are provided with a choice of food which is prepared safely and provides a balanced diet; and*
b. *patients and service users' individual nutritional, personal, cultural and clinical dietary requirements are met, including any necessary help with feeding and having access to food 24 hours a day.*

Standard 10

Healthcare organisations ensure that people accessing healthcare are not unfairly discriminated against on the grounds of age, gender, disability, ethnicity, race, religion, or sexual orientation.

Clinical Outcomes

Standard 11

Healthcare organisations ensure that:

a. *clinical care and treatments are delivered by healthcare professionals who make clinical decisions based on evidence based practice;*
b. *clinical care and treatments are carried out under appropriate clinical supervision and leadership;*
c. *clinicians continuously update skills and techniques relevant to their clinical work including peer reviews; and*
d. *clinicians participate in regular audit and review of clinical services.*

Standard 12
Healthcare organisations ensure that patients and service users are provided with effective treatment and care that:

a. *conforms to the National Institute for Clinical Excellence (NICE) technology appraisals and interventional procedures, and the recommendations of the All Wales Medicines Strategy Group (AWMSG);*
b. *is based on nationally agreed best practice and guidelines, as defined in National Service Frameworks, NICE clinical guidelines, national plans and agreed national guidance on service delivery;*
c. *takes account of patients' physical, social, cultural and psychological needs and preferences; and*
d. *is integrated to provide a seamless service across all organisations that need to be involved, including social care organisations.*

Standard 13
Healthcare organisations, which either lead or participate in research, have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

Healthcare Governance

Standard 14
Healthcare organisations continuously and systematically review and improve all aspects of their activities that directly affect the safety and health of patients, service users, staff and the public. They will not only comply with legislation, but apply best practice in assessing and managing risk.

Standard 15
Healthcare organisations, recognising different language and communication needs, ensure that patients, service users, relatives and carers:

a. *can provide feedback on their experiences and the quality of services;*
b. *have their complaints looked at promptly and thoroughly in accordance with complaints procedures;*
c. *are given information about complaints advocacy support provided by Community Health Councils in Wales; and*
d. *receive assurance that organisations act on any concerns and make appropriate changes to ensure improvements in service delivery.*

Standard 16

Healthcare organisations have systems in place:

- a. *to identify and learn from all patient safety incidents and other reportable incidents;*
- b. *to report incidents to the National Patient Safety Agency's (NPSA) National Reporting and Learning System and other bodies in line with existing guidance;*
- c. *to demonstrate improvements in practice based on shared local and national experience and information derived from the analysis of incidents; and*
- d. *to ensure that patient safety notices, alerts and other communications concerning safety are acted upon within required time-scales.*

Standard 17

Healthcare organisations comply with national child protection and vulnerable adult guidance within their own activities and in their dealings with other organisations.

Standard 18

Healthcare organisations have planned and prepared, and where required practised, an organised response to incidents and emergency situations, which could affect the provision of normal services.

Standard 19

Healthcare organisations ensure that:

- a. *all risks associated with the acquisition and use of medical devices are minimised;*
- b. *all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed;*
- c. *quality, safety and security issues of medicines are managed; and*
- d. *the prevention, segregation, handling, transport and disposal of waste are managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.*

Standard 20

Healthcare organisations work to enhance patient care and to continuously improve staff satisfaction by providing best practice in human resources management.

Standard 21

Healthcare organisations:

- a. *undertake all necessary employment checks and ensure that all employed or contracted professionally qualified staff are registered with the relevant bodies;*
- b. *require that all employed professionals abide by their published codes of professional practice and conduct; and*
- c. *address where appropriate under-representation of minority groups.*

Standard 22
Healthcare organisations ensure that staff:
- *a.* *are appropriately recruited, trained and qualified for the work they undertake;*
- *b.* *participate in induction and mandatory training programmes; and*
- *c.* *participate in continuing professional and occupational development.*

Standard 23
Healthcare organisations ensure that staff are supported by:
- *a.* *processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management; and*
- *b.* *organisational and personal development programmes which recognise the contribution and value of staff.*

Standard 24
Healthcare organisations work together with social care and other partners to meet the health needs of their population by:
- *a.* *having an appropriately constituted workforce with appropriate skill mix across the community; and*
- *b.* *ensuring the continuous improvement of services through better ways of working.*

Standard 25
Healthcare organisations use effective information systems and integrated information technology to support and enhance patient care, and in commissioning and planning services.

Standard 26
Healthcare organisations have effective records management processes in place to ensure that:
- *a.* *from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required; and*
- *b.* *patient confidentiality is maintained.*

Standard 27
Governance arrangements representing best practice are in place which:
- *a.* *apply the principles of sound clinical and corporate governance;*
- *b.* *ensure sound financial management and accountability in the use of resources;*
- *c.* *actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;*
- *d.* *include systematic risk assessment and risk management; and*
- *e.* *are integrated across all health communities and clinical networks.*

Standard 28

Healthcare organisations:

- a. *ensure that the principles of clinical governance underpin the work of every team and every clinical service;*
- b. *have a cycle of continuous quality improvement, including clinical audit; and*
- c. *ensure effective clinical and managerial leadership and accountability.*

Public Health

Standard 29

Healthcare organisations promote, protect and demonstrably improve the health of the community served and reduce health inequalities by:

- a. *collaborating and working in partnership with local authorities and other agencies in the development, implementation and evaluation of health, social care and well being strategies; and*
- b. *ensuring that needs assessment and sound public health advice informs their policies and practices.*

Standard 30

Healthcare organisations:

- a. *have systematic and managed disease prevention and health promotion programmes, which include staff, which meet the requirements of the National Service Frameworks, national plans and health promotion and prevention priorities; and*
- b. *take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services, and the commissioning and provision of services.*

Standard 31

Healthcare organisations:

- a. *have plans in place to mobilise resources to protect the public in the event of significant infectious disease outbreaks and other health emergencies;*
- b. *identify and act upon significant public health problems and health inequality issues, with Local Health Boards taking the leading role;*
- c. *implement effective programmes to improve health and reduce health inequalities; and protect their populations from identified current and new hazards to health; and*
- d. *encourage and support individuals to recognise their own responsibilities in maintaining their health and well being.*

Standard 32

Healthcare organisations achieve the Corporate Health Standard, the national quality mark for workplace health, moving to a higher level on reassessment.

Annex 2

Maturity Level Definitions

	Aware	Responding	Developing	Practising	Leading
Corporate	The Board is aware of the issues to be addressed but are unable to demonstrate decisions/ actions to address them.	The Board recognises the key issues and has identified options that are prioritised, although there is no evidence of strategic direction.	The Board is taking steps to address the key issues through the development of strategic plans with evidence of good practice across the organisation.	The strategic agenda is being progressed and monitored by the Board with significant evidence of continuous improvement across the organisation.	The Board is leading the strategic agenda through the implementation of innovative practice that is shared across and beyond the organisation to others, enabling realisation of long term sustainability.
Operational	There is awareness of the issues to be addressed, but no approaches have been developed to address them.	There is recognition of the key issues to be addressed and there is a range of options identified to address them.	Steps are being taken to address the key issues with evidence of practical application across the organisation.	There are well-developed plans being implemented throughout the organisation that address the key issues with evidence of evaluation and benchmarking leading to continuous improvement.	There is evidence of innovative practice, which is being shared across and beyond the organisation to others. They are further developing their approaches to ensure long term sustainable improvement.
User Experience	The individual(s) experience is generally poor and no approaches have been developed within the service to address them.	The individual(s) experience is generally not good although approaches have been developed within the service to address them.	The individual(s) experience is improving in many areas, although this is not yet consistent across the organisation.	The individual(s) experience is generally good across all areas.	The individual(s) experience is generally excellent and the service can demonstrate clear evidence of good practice, which can be shared.

Annex 3

Organisations that Submitted a Self-Assessment

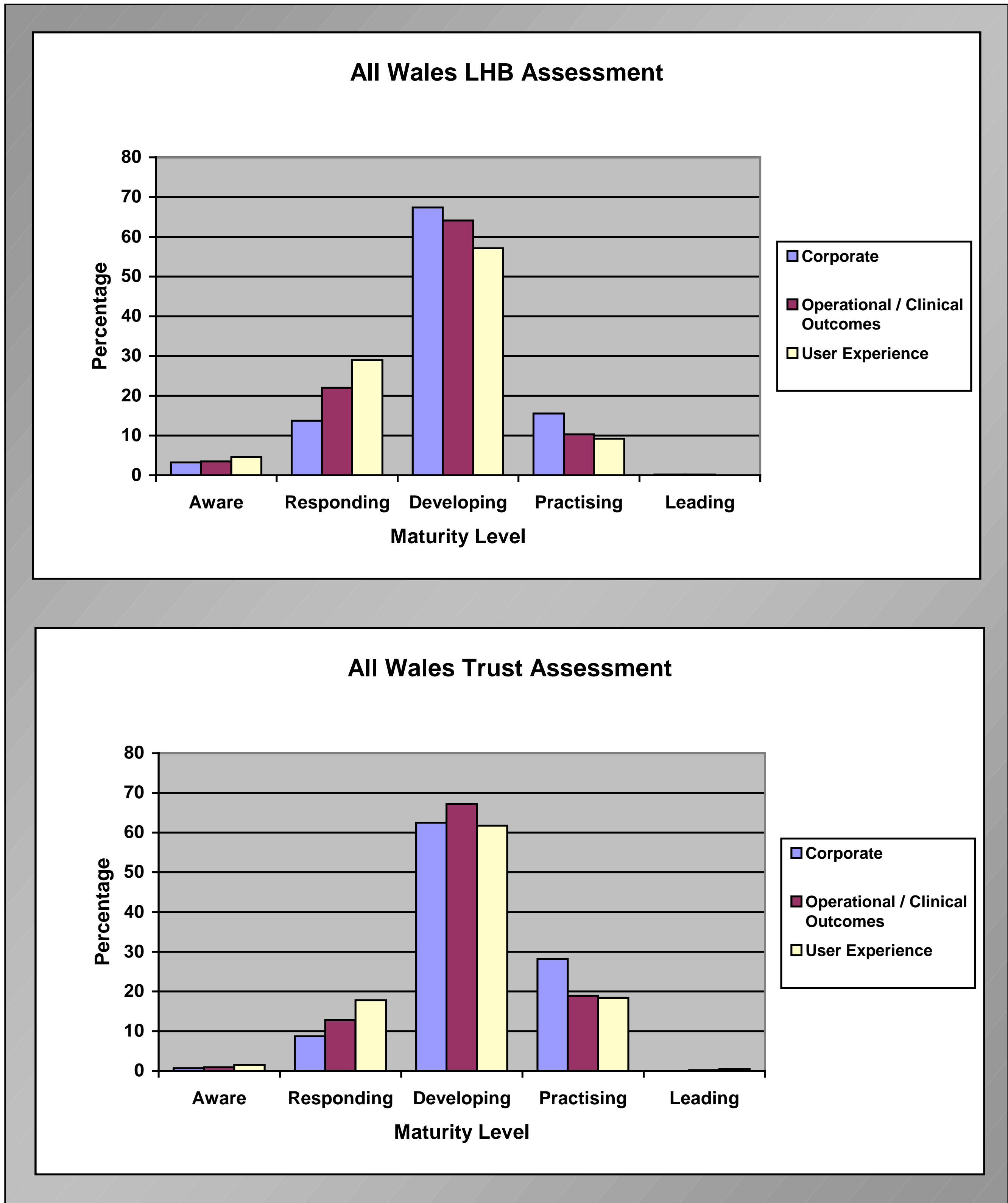
Local Health Boards
Anglesey Local Health Board
Blaenau Gwent Local Health Board
Bridgend Local Health Board
Caerphilly Local Health Board
Cardiff Local Health Board
Carmarthenshire Local Health Board
Ceredigion Local Health Board
Conwy Local Health Board
Denbighshire Local Health Board
Flintshire Local Health Board
Gwynedd Local Health Board
Merthyr Tydfil Local Health Board
Monmouthshire Local Health Board
Neath Port Talbot Local Health Board
Newport Local Health Board
Pembrokeshire Local Health Board
Powys Local Health Board
Rhondda Cynon Taff Local Health Board
Swansea Local Health Board
Torfaen Local Health Board
Vale of Glamorgan Local Health Board
Wrexham Local Health Board

NHS Trusts
Bro Morgannwg NHS Trust
Cardiff and Vale NHS Trust
Carmarthenshire NHS Trust
Ceredigion & Mid Wales NHS Trust
Conwy & Denbighshire NHS Trust
Gwent Healthcare NHS Trust
North East Wales NHS Trust
North Glamorgan NHS Trust
North West Wales NHS Trust
Pembrokeshire and Derwen NHS Trust
Pontypridd & Rhondda NHS Trust
Swansea NHS Trust
Velindre NHS Trust
Welsh Ambulance Services NHS Trust

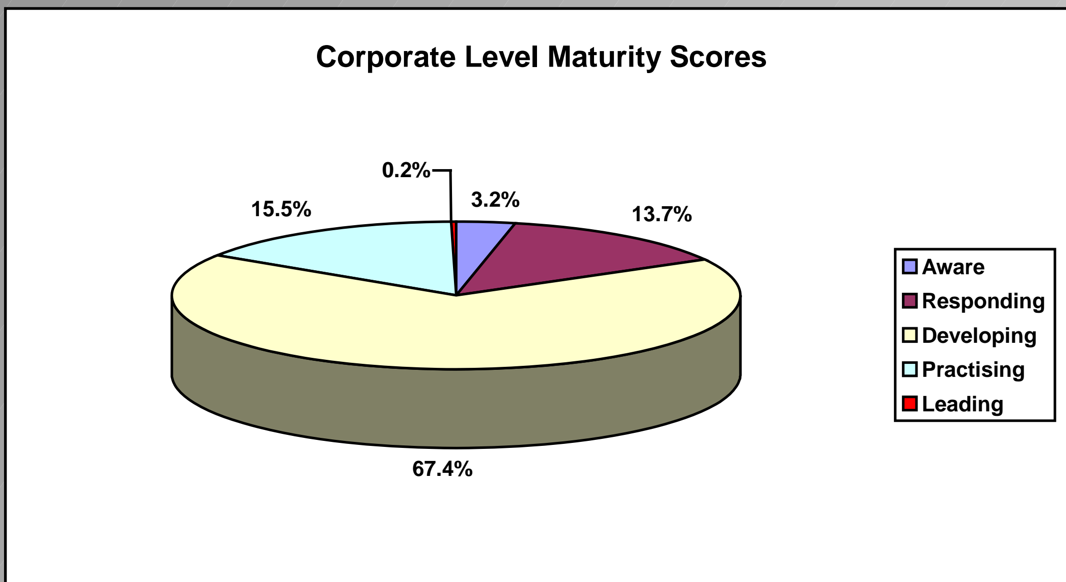
Specialist Commissioning Body
Health Commission Wales

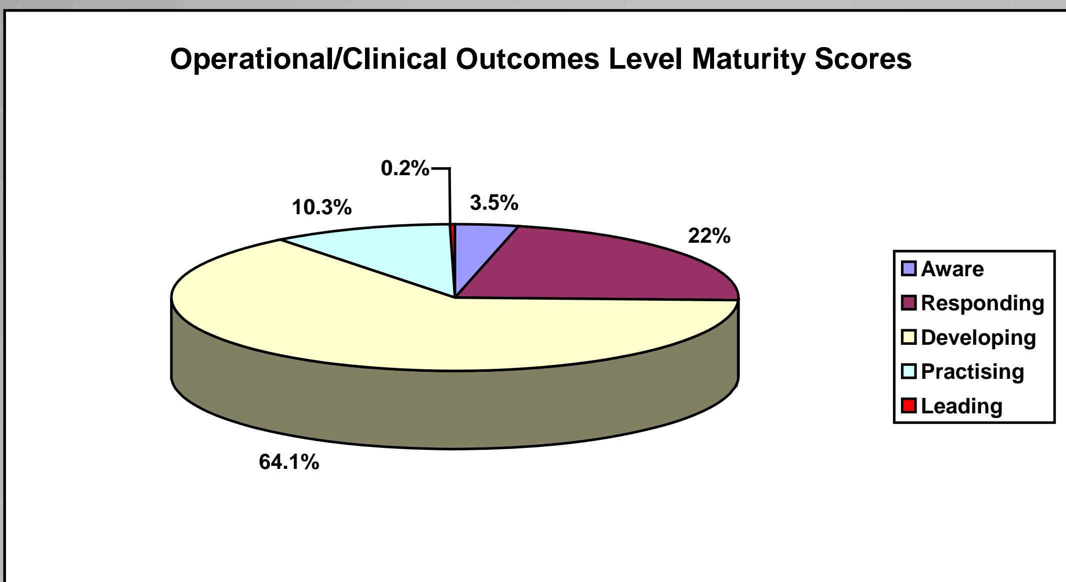
Summary of All Wales Maturity by Corporate, Operational/Clinical Outcomes and User Experience Levels

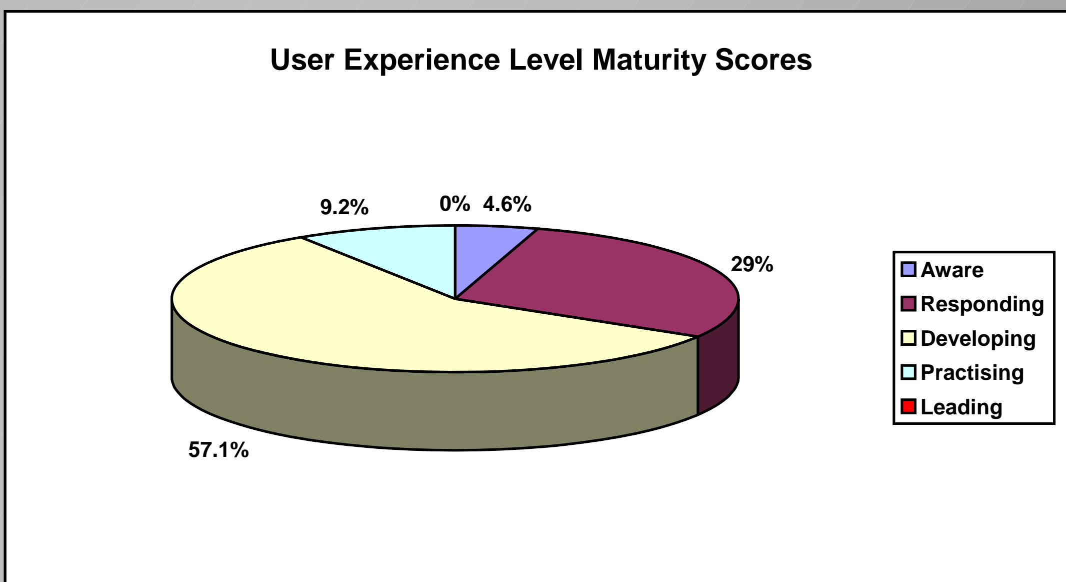
The charts below display the assessments that HIW gave to both LHB's and Trusts at Corporate, Operational/Clinical Outcomes and User Experience levels.



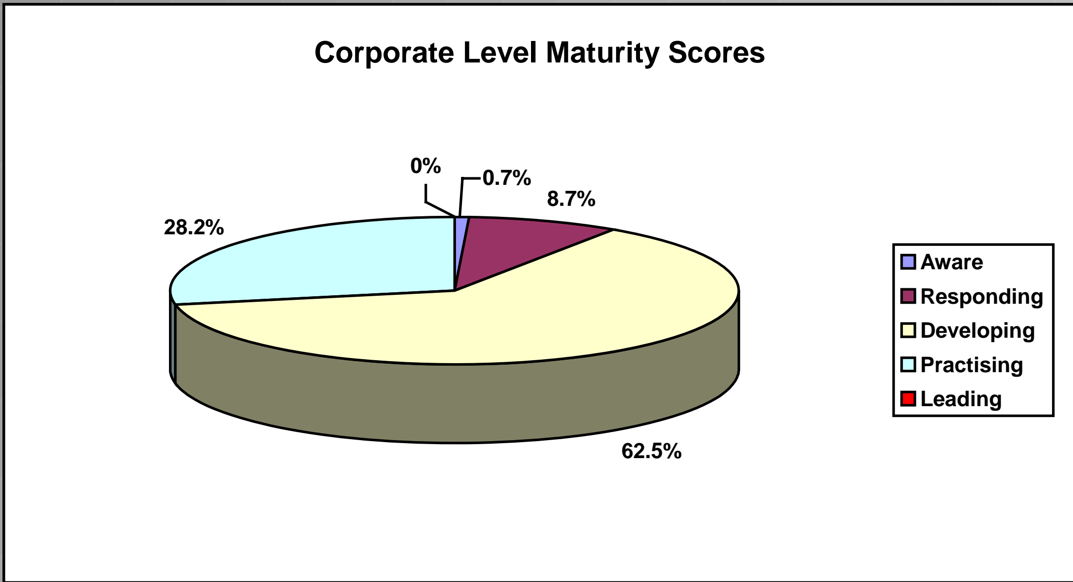
The charts below display a breakdown of assessments that HIW gave to LHB's at each individual level.

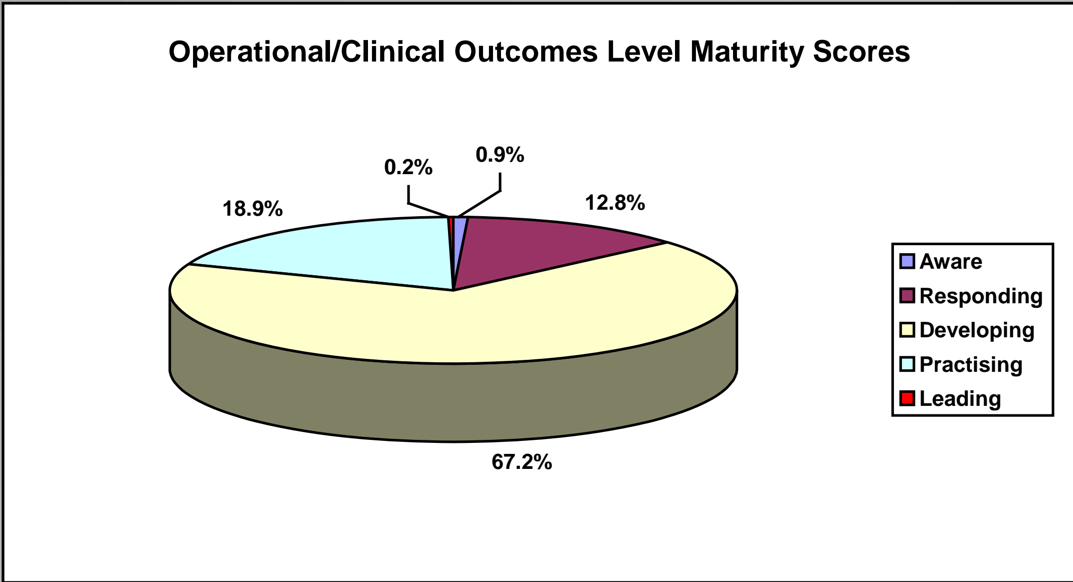


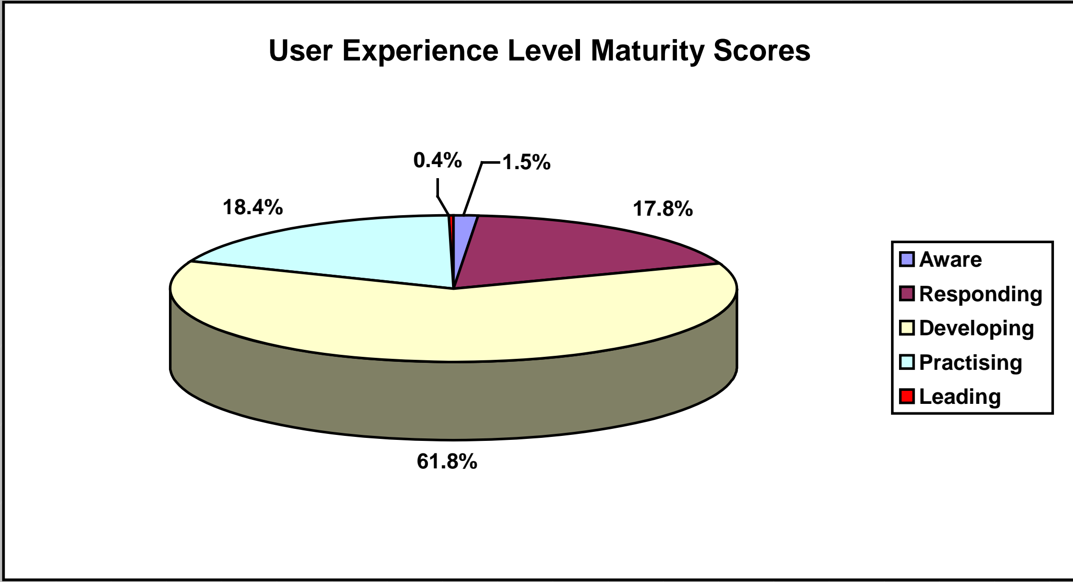




The charts below display a breakdown of assessments that HIW gave to Trusts at each individual level.







Annex 5

Glossary of Key Terms

All Wales Medicines Strategy Group – provides advice to the Minister for Health and Social Services on strategic medicines management and prescribing.

balanced scorecard - a management system providing a model within which an organisation can clarify its vision and strategy and translate them into action. It supports continuous improvement in organisational performance.

Caldicott Guardian – a senior clinician in each NHS organisation who is responsible for implementation of aspects of the Caldicott report, which reviewed the protection and use of patient information.

care pathway – a defined set of treatment and care steps designed to meet the particular needs of each patient.

clinical audit – evaluation and measurement by health professionals of how far they are meeting standards that have been set for their service.

clinical governance – a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

clinical networks – a group of services which work together across organisational boundaries to provide better patient care.

clinical outcome – the impact effect of a treatment on the health or wellbeing of an individual.

Community Health Council (CHC) – not-for-profit, community-based health promotion, advocacy and policy organisations. CHCs were established in 1992 and were set up to strengthen community participation in defining state and local policy that impacts healthcare access and quality. CHCs represent the public interest in the NHS and have a statutory right to be consulted in health changes in their area.

Criminal Records Bureau (CRB) – an executive agency set up to help organisations make safer recruitment decisions by providing wider access to criminal record information. The CRB helps employers in the public, private and voluntary sectors identify candidates who may be unsuitable for certain work, especially that involving contact with children or other vulnerable members of society.

data protection – a requirement upon public bodies and others to act responsibly in managing personal data. Such responsibilities are covered by the Data Protection Act 1984 and the Computer Misuse Act 1990, designed to safeguard data held in individuals.

Designed for Life – sets out a vision for the future of health services in Wales and has a 10 year strategy in place for achieving it. The strategy includes three strategic

frameworks, each lasting about three years. These include: Framework 1 (2005-2008) Redesigning Health Care; Framework 2 (2008-2011) Delivering Higher Standards and; Framework 3 (2011-2014) World Class Services.

Healthcare Standards – a common framework of healthcare standards published in May 2005 by the Welsh Assembly Government to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings

infection control – a set of procedures to prevent the spread of infection, which will include, for example, washing of hands, use of sterile equipment, etc.

Local Health Boards (LHBs) – statutory bodies responsible for implementing strategies to improve the health of the local population, securing and providing primary and community healthcare services and securing secondary care services.

National Health Service (NHS) Trusts – self-governing bodies within the NHS, which provides healthcare services. Trusts employ a full range of healthcare professionals including doctors, nurses, dieticians, physiotherapists, etc. Acute trusts provide medical and surgical services usually in hospitals. Community trusts provide local health services, usually in the community, e.g. district nurses, chiropodists, etc. Combined trusts provide both community and acute trust services under one management.

National Institute for Health and Clinical Excellence (NICE) – a special health authority producing guidance for the NHS and patients on medicines, medical equipment and clinical procedures.

National Patient Safety Agency (NPSA) – a special health authority created in July 2001 to co-ordinate the efforts of the entire country to report, and more importantly to learn from mistakes and problems that affect patient safety.

National Public Health Service for Wales (NPHS) - delivers a full range of public health services seeking to: improve the health and wellbeing of the people of Wales and reduce inequalities in health; protect against existing, new and emerging diseases and health threats and; contribute to improvement in health and social care services.

National Service Framework (NSF) – guidelines for the health service on how to manage and treat specific types of disease and illness.

Patient and Public Involvement (PPI) – strategy designed to ensure that the views and opinions of patients, service users, carers and the public are taken into account when planning and delivering services.

Royal College of Nursing (RCN) Clinical Leadership Programme – a programme allowing nurses protected time to observe care and delivery of services, and interview patients about delivery of care. Designed to enable nurses to develop and refine their leadership capabilities, improve team and organisational skills and centre on the needs of patients.

Statements of Internal Control – a statement on the NHS body's overall arrangements for gaining assurance on the effective management of the principle risks within the organisation.

Trust Board – a group of people who are by statute responsible for major strategy and policy decisions in each NHS Trust. Typically comprises a lay chairman, five lay members, the Trust Chief Executive and Executive Directors.

Welsh Risk Pool (WRP) - a mutual self-assurance scheme for all health bodies in Wales. It also supports patient and staff safety by encouraging and supporting good risk management performance and assessment by measuring against set standards.