
Annual Quality Statement 2012-2013

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Statement from Chief Executive and Chairman

Everyone who works in the health board is here, first and foremost, to serve the public and we all have a part to play in driving up standards. We must always put patients and patient safety at the heart of our decision making and we are immensely proud of our staff who each and every day work hard to deliver safe and compassionate care.

This is our first annual quality statement and in this report we have drawn together examples of the work we have been doing to improve the quality and safety of patient care.

During the year we worked to transform the way we provide safe, sustainable and quality health services. “Healthcare in North Wales is Changing” was the programme of work on which we engaged and consulted the public. The plans were subject to intense scrutiny and many people and communities across North Wales got involved in the debate. A further programme of work is now underway to transform acute hospital services so that they are fit for the future.

The Francis Report (February 2013) which looked at failings in the quality of care at Mid Staffordshire NHS Trust also contained important lessons for the NHS. We need to make certain that we are listening to patients and staff as well as checking our systems so that we can focus on the areas for improvement that are important to those we care for.

A critical safety issue which developed during the first few months of 2013 was an outbreak of *Clostridium difficile* infection in one of our hospitals which highlighted that more could and should be done to improve the safety of patients. As a result we have brought in experts to help us identify ways to improve.

In June 2013 a public report undertaken by Health Care Inspectorate Wales and the Wales Audit Office highlighted significant failings in the governance and management arrangements of the Health Board, which in turn may be compromising our ability to adequately identify problems which may arise in the quality and safety of patient care. We recognise and accept these findings and are already working to tackle all the issues raised in the report.

The Health Board is committed to responding to the challenges we face as we continue to work together to deliver the best possible care for the communities we serve.

To our knowledge we declare that the information within this document is a true and accurate reflection of the quality of care provided by the Betsi Cadwaladr University Health Board (The Health Board).

Introduction

This is the Health Board's first Annual Quality Statement. It brings together a summary of how the organisation has been working over the past year to improve the quality of all the services it plans and provides.

This report gives us opportunity to:

- review how well we are doing
- identify good practice that we can share and spread more widely
- identify areas for further improvement
- track our progress, year on year.

The information contained within this document draws on a range of different data sources including the Health Boards self-assessment against the Standards for Health Services in Wales set by the Welsh Government

What is the health board responsible for and how is it organised?

The Health Board is responsible for the provision of a full range of primary, community, mental health and acute hospital services for a population of about 678,000 people across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham).

The Health Board is responsible for the operation of three acute hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Wrexham Maelor Hospital) along with a network of community hospitals, health centres, clinics, mental health units and community team bases.

The Health Board also coordinates the work of 115 GP practices (as at August 2013) and NHS services provided by North Wales dentists, opticians and pharmacies.

To help health, social care and community services to work together effectively to support residents, NHS services outside of hospitals have been organised into 14 'localities'.

The localities are as follows:

- Anglesey
- Arfon, Dwyfor, Meirionnydd
- Conwy West , Conwy East
- North Denbighshire, Central/South Denbighshire
- North West Flintshire, South Flintshire and North East Flintshire.
- West & North Wrexham, Wrexham Town, South Wrexham

Clinical services are organised into clinical programme groups (CPGs) led by senior clinical staff who are accountable for the quality and delivery of services. The Board has discussed the need to build upon the strengths of this clinical leadership model. In the next twelve months there will be changes to the way services are organised

and managed so that we can tackle the current challenges to improve governance and operational delivery.

Some changes have already been made. There is now a single lead on the Health Board for quality and safety within the organisation. This is the Executive Director of Nursing, Midwifery and Patient Services. She is supported by the Medical Director and the Director of Therapies and Health Sciences.

Throughout the year the first item at every Board meeting has been, and will continue to be, an item about improving patient safety and often an individual patient story. This helps the Board to learn from patients experiences and remain focussed on quality and safety throughout its discussions and decision making.

The Quality and Safety Committee of the Board has been working to develop better reporting of quality and safety indicators. This has driven more open reporting including the publication of mortality data and each CPG reporting directly to the Committee helps to reduce the gap from “board to ward.”

Meeting Standards

This section provides a summary of how well we are meeting standards in hospitals and in the community, including primary care. It also provides information about our staff and some of our achievements against key indicators of quality.

Standards set out what is expected to ensure that we are doing the right thing, in the right place with the right staff. Standards drive the way we work and practice day in and day out, so that we can provide the safest, highest quality and most efficient services and care for the people of North Wales.

Some assurances that we are meeting standards come from checks we have done within the organisation such as a self-assessment against the Standards for Health Services set by Welsh Government and Clinical Audits.

Other assurances about how well we are doing or what more needs to be done come from external bodies and organisations such as the Wales Audit Office, Healthcare Inspectorate Wales, Royal Colleges and Medicines Healthcare Regulatory Agency.

Standards for Health Services

There are 26 standards against which the Health Board monitors quality and safety. These came from a national framework called [Doing Well, Doing Better – Standards for Health Services in Wales](#).

The Standards are reviewed at all levels within the Health Board. This helps the Health Board to identify where there is good practice and where there is room for improvement. The review of standards at a corporate level (covering policies and processes and systems) are led by Board members and help the organisation to check that patients are receiving safe care. All standards are looked at within a 12 month period and the latest corporate self-assessment scores for all 26 standards can be found at appendix 1.

Below is the outcome of the assessment scores for the key corporate standards the Health Board is required to report on.

These assessments were concluded in January 2013

	Last Year's Score	This Year's Score
Governance and Accountability	4	4 ↔
Participating in Quality Improvement Activities	3	3 ↔
Safe and Clinically Effective Practice	3	3 ↔
Managing Risk and Health and Safety	3	3 ↔
Dealing with Concerns and Managing Incidents	3	3 ↔

The Scores in the table above are based on the following matrix:

1	2	3	4	5
Identified as something we must address urgently	Identified as something we need to do and plans are being developed for this	We are doing this but have identified a number of gaps and need to review existing plans	This has been built into our normal practice. We are making progress in this area	We have been doing this for some time, have continuously improved and shared learning

With regard to the key standards, the Audit Committee has requested a further review on elements of the Safe and Clinically Effective Practice and the Dealing with Concerns and Managing Incidents standards in order to gain further assurance that the issues are being addressed against expected progress.

In addition to the above, the organisation reviews progress against the standards with the Clinical Programme Groups. Progress against the CPGs standards is reported on a quarterly basis to the Quality and Safety Committee and any CPGs not making sufficient progress are highlighted. Scores for the CPGs will differ from the Corporate Standards as they focus on how policies and systems are working in all of their areas.

The self-assessment against the above Standards and the Governance and Accountability module are reported in the Annual Accounts for 2012/2013 as part of the [Health Boards Governance Statement](#).

Our processes have highlighted key areas for improvement across some of our standards and these are detailed in the looking forward section (Page 52).

Clinical Audit and Effectiveness

Clinical Effectiveness is an overarching term that can be described simply as ‘doing the right things, at the right time to the right patient’. The Health Board supports a culture of clinical effectiveness through a number of ways such as encouraging staff to question what they do, to review patient outcomes, to make changes or suggestions to improve practice and therefore lead to improvements in patient care and patient experience. In addition, the implementation of evidence based practice (such as research findings) is essential in underpinning and supporting the delivery of safe and effective patient care.

Clinical Audit is a means of identifying whether care meets agreed standards which may be set either nationally or locally. It is an opportunity for health care staff to reflect on clinical practice to support and encourage improvements and deliver better quality treatment and care outcomes for patients.

In addition to local clinical audit, in 2012 the Welsh Government published [The national clinical audit and outcome review plan for 2012/13](#). The results of clinical audit and outcome reviews are one of the core mechanisms for assessing the quality of Welsh healthcare services and confirming how they compare against the best services provided elsewhere.

To develop and maintain the Health Board as a learning organisation it is essential that Health Board staff have the opportunities to contribute to robust and regular clinical audit to measure the quality of its services against consistently improving standards.

The Health Board has undertaken some “organisation wide” clinical audit projects which have been prioritised following concerns expressed by patients and their families. These include Consent, Record Keeping, the Deteriorating Patient and Discharge Planning. Initial audits were undertaken in 2012 and are being re-audited during 2013. Findings from these audits are received by the Clinical Audit Group and reported to the Clinical Effectiveness Sub Committee on behalf of the Quality and Safety Committee. In future, to strengthen governance arrangements greater detail on the findings from national and corporate clinical audit will be shared more comprehensively directly through the Quality and Safety Committee.

Each CPG has also produced a Clinical Audit Programme which incorporates their local priorities.

The following are examples of changes in practice as a result of clinical audit activity:

Audit of Orthoptic Stroke Service: As a result of this audit, the Orthoptic Department have initiated joint assessments with other members of the stroke team combining skills for the benefit of the patient.

Wait or Waste: Specialist Input in the Acute Medical Unit: This audit highlighted the importance of timely specialist input to maintain quality of care and patient flow.

National Audit of Dementia: this has resulted in the development of a multi-professional care pathway for patients who have dementia and are admitted to an acute general ward.

Nasogastric Tube (NG) Placement: As a result of the audit a NG Tube training programme has been established, a protocol has been agreed and disseminated, and a coded report to be used by Radiologists to define tube position and safe use.

Internal Audit

Internal audit is an independent assurance function within the Health Board. An internal audit risk-based plan is agreed each year and is monitored by the Audit Committee. Last year 29 separate reviews were undertaken which received assurance ranging from high, significant, limited and in one case no assurance. This case related to Enhanced Residential Care for a patient with Learning Disabilities

where it was identified that the patient was not receiving the care which had been planned.

The review relating to implementing lessons learnt from complaints received limited assurance where documentation maintained by Clinical Programme Groups did not adequately record lessons learnt and any subsequent changes in practice/process.

The review relating to statutory and mandatory training also received limited assurance where mandatory training attendance, as defined by the Health Board, was below its expected target.

The review relating to Health and Safety received limited assurance as the Health Board does not adequately prioritise all aspects of Health and Safety and the governance arrangements below Board level lack rigour.

All reviews have an agreed management action plan with identified timescales for the actions to be completed. Progress against the timescales are reported to and monitored by the Audit Committee.

The Head of Internal Audit provides an overriding opinion on the adequacy of the Health Board's systems of internal control, within an annual report, which is reported to the Audit Committee – the opinion provided was that of limited assurance.

Fundamentals of Care (FOC)

Fundamentals of Care refer to the following standards which are audited using an on-line tool. It looks at the experience of randomly selected patients. It helps to identify trends and enables the Ward Sister/Charge nurse and teams to identify areas of good practice and opportunities for improvement demonstrated by local action plans.

The standards are:

- Communication and Information
- Respecting People and Relationships
- Ensuring Safety
- Promoting Independence
- Sleep, Rest and Activity
- Ensuring Comfort, Alleviating Pain
- Personal Hygiene, Appearance and Foot Care
- Eating and Drinking
- Oral Health and Hygiene
- Toilet Needs
- Preventing Pressure Sores/Ulcers

The three **highest** scoring standards from the patient/user perspective are consistent with last year's audit.

FOC Standard	User Experience Score
Standard 1: Communication and Information	96%
Standard 7: Ensuring Comfort and Alleviating Pain	98%
Standard 8: Personal Hygiene and Foot Care	97%

The three **lowest** scores from the user perspective were also the same as in the previous year's audit and all three standards have seen a decrease in score by 1% to 2%.

FOC Standard	User Experience Score
Standard 6: Sleep Rest and Activity	90%
Standard 10: Oral Health and Hygiene	87%
Standard 12: Preventing pressure ulcers	91%

Work to improve these areas at Ward level is taking place through the Transforming Care programme.

The annual report was received and considered by the Improving Service User Experience Sub Committee on behalf of the Quality and Safety Committee in June 2013.

Care Metrics

Care metrics are part of the Fundamentals of Care. They are an "on line" audit tool which enables the clinical areas to capture data in real time. This helps frontline teams to take ownership and improve patient experience.

Currently 143 clinical areas which comprise of all inpatient wards (both acute and community setting), Critical Care units, Emergency Departments, General Outpatient Departments per DGH and day units from all Clinical Programme Groups within the Health Board, self-report data into the Care Metrics Module, which populates the All Wales Nursing and Midwifery Dashboard.

The current National Care Metric indicators are:

1. Percentage compliance with Hand hygiene (Live)
2. Healthcare acquired pressure ulcers (Live)
3. Nutrition score completed and appropriate action taken (Live)
4. Complaints regarding nursing care (under review - All Wales level)

The value of care metrics is acknowledged by the Francis Report (2013) and we will continue to integrate these indicators into the Quality and Safety report of the Board.

It is noted that there are currently no care metrics for Primary Care within this national audit tool.

Summary of external reviews and investigations reported in 2012/13

As a statutory public body, we are subject to a robust programme of external assessment, inspection and review. This is to make sure that we meet our statutory

and legislative duties, identify areas for improvement and ensure our internal systems and procedures are fit for purpose.

This section provides a summary of the findings of external reviews and investigations specific to the health board reported in 2012/13.

Healthcare Inspectorate Wales (HIW)

Healthcare Inspectorate Wales Unannounced Hospital Cleanliness & Dignity and Essential Care Spot-check December 2011 (Ysbyty Glan Clwyd)

Health Inspectorate Wales undertake a regular rolling programme of unannounced Hospital Cleanliness & Dignity and Essential Care Spot-checks in Health Organisations across Wales. On the 14th and 15th December 2011 HIW attended Ysbyty Glan Clwyd, visiting 6 wards and the report was received in May 2012.

Staff were generally observed to be providing a good standard of care in a sensitive manner. Matrons across the Health Board have now carried out 70 peer reviews and are using a similar approach of observational study to identify good practice and address concerns.

Healthcare Inspectorate Wales – IR(ME)R Review

During November 2012, HIW undertook an Inspection at Wrexham Maelor Hospital in accordance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The objective of the inspection was to make an assessment of the Radiography Department's compliance with IR(ME)R for diagnostic imaging.

As a result of the inspection, HIW provided assurance that the Radiology Department at Wrexham Maelor Hospital and, more generally, the Health Board is broadly compliant with IR(ME)R.

Healthcare Inspectorate Wales Independent Review of Patient Care at Ysbyty Glan Clwyd

In 2011 Healthcare Inspectorate Wales (HIW) was invited by the Chief Executive of the Health Board to undertake an independent review of care provided at Ysbyty Glan Clwyd.

This arose in part in response to a Public Services Ombudsman for Wales report that had raised serious concerns about care at Ysbyty Glan Clwyd.

The Independent Review commenced February 2012 and the Health Board received the report in December 2012. It highlighted that Ysbyty Glan Clwyd was working to capacity, with committed staff who were working under intense pressure. Staff were observed to be professional in their dealings with patients and care was being delivered in a way that was compassionate and maintained patients' dignity. However, more work still needed to be done to ensure that the highest standards of patient care were reached at the Hospital.

A hospital site manager has been put in place to improve the flow of patients through the hospital and new arrangements for discharge planning are helping to ease pressures.

Healthcare Inspectorate Wales – Independent External Review of Quality and Safety arrangements at Betsi Cadwaladr University Health Board.

HIW undertook a review of the clinical governance arrangements that the Health Board had put in place to ensure the quality and safety of patient care. Preliminary work was commenced in November 2012 and the emerging findings have been fed into a joint review undertaken by WAO and HIW into the effectiveness of the Board's governance arrangements which was published in June 2013.

Joint WAO and HIW Review – Review of governance arrangements at Betsi Cadwaladr University Health Board

In March 2013 WAO and HIW agreed that they would undertake a joint review to look at the corporate, clinical and financial arrangements of the Board and assess if these were appropriate, operating effectively and were sufficient to ensure the quality, safety and sustainability of services for the population served by the Health Board.

The report identified a number of significant failings with the Board's management and governance systems which the Board has recognised and accepted. Urgent action is underway to address these matters in full.

Wales Audit Office (WAO)

Structured Assessment

WAO reviewed and reported, on Year Three of the Structured Assessment. The Structured Assessment looks at whether or not the Health Board has proper arrangements to ensure good governance.

The assessment highlighted the precarious financial position of the Health Board and that actions were being taken to plan and manage finances in a sound and sustainable manner.

It recognised that governance arrangements continued to evolve but further action was urgently needed in some key areas including, strategy and planning, embedding clinical leadership and strengthening management information.

Transforming Unscheduled Care and Chronic Conditions Management

The Wales Audit Office undertook a review, which was carried out between January 2012 and April 2012, of the key interrelated areas of Chronic Conditions Management and Unscheduled Care.

The report received by the Health Board in December 2012 concluded that unscheduled care services remained under pressure while chronic condition services were still fragmented and underdeveloped.

An action plan has been developed to monitor improvements.

Use of Locums

WAO undertook a review during 2012-13 and the Health Board received the report in March 2013. The report concluded that whilst the Health Board is using locum doctors to maintain service delivery, the current approach represents poor value for

money, presents some risk to the quality of services and does not address the situation in a strategic way.

The key actions now being progressed include working with the Deaneries to develop shared training programmes and improve the recruitment of trainees and developing an acute care network across North Wales.

Procurement of Consultancy Services Local Feedback and All Wales Report

The report was received by the Health Board in February 2013 and identified three recommendations relating to formal documentation for appointments, contract monitoring arrangements and post contract evaluation.

These important issues are now being addressed to ensure that the Health Board has all the appropriate systems and processes in place.

Infection Control

Review of Governance Arrangements, Structures and Systems for the Preventions and Control of Healthcare Associated Infections

In May we asked Professor Brian Duerden, Emeritus Professor of Medical Microbiology at Cardiff University, to carry out a thorough, independent, expert review of our infection control arrangements.

We did this because we were concerned that our systems to monitor and manage infection control issues were not operating consistently and effectively and that this had meant we were slow to identify an outbreak of *Clostridium Difficile* at Glan Clwyd Hospital.

The Health Board has put in place an improvement plan to ensure that this situation does not happen again.

Welsh Risk Pool

The Welsh Risk Pool is the indemnifying body for the NHS in Wales. The Welsh Risk Pool monitors the standards of care we provide in three 'high risk' clinical areas. The scores for 2012/2013 are shown below. The Board has been able to gain assurance from this process that in these high risk clinical areas the underpinning systems and policies are in place and are being used in practice. All three areas have now produced an action plan in response to areas for improvement and these are monitored by the Risk Management Sub Committee.

Standard / Clinical Area No	Title	Evidence Criteria Score	
		2012	2013
CA1	Maternity	96%	96%
CA2	Operating Department Services (theatres)	89%	94%
CA3	Emergency Department Services (A&E)	96%	97%

Clinical Data standards

Clinical data is captured by interpreting the diagnosis and treatment recorded in the patient's case notes, and coding this on the patient administration system according to international standards. This allows the health service to identify the numbers of patients it has treated, the conditions they needed care for and the types of treatment provided.

As well as enabling us to measure activity, this provides a valuable source of data for measuring health trends, predicting future needs, planning services and also for clinical audit and research. The Board won a National award for data quality in 2013.

Based on the CHKS Data Quality index, for the 12 months to February 2013, the Health Board performed as follows:

- 81.4 against an all Wales peer of 52.1
- 81.4 against an external peer of 89.6 (specific English Trusts)



The team receiving their award from the Managing Director of CHKS

Assuring the delivery of quality services in Primary Care

General Medical Practices

A 3 year rolling programme of quality assurance visits to all North Wales GP practices has been in place since January 2011.

GP Practices			
Number of GP practices in North Wales (as at 1 st April 2012)	119		
	West 38	Centre 36	East 45

Number of GP practices visited to date using new standard system	West 20	Centre 17	East 22
2011 – visits commenced Jan '11	10	10	10
2012/13 (up to Jan 13)	10	7	12
Number of GP practices remaining to be visited between January and December 2013	65		
	West 18	Centre 19	East 23

In addition to the rolling programme of visits, practices are requested to complete the All Wales Clinical Governance Practice Self Assessment Tool (CGPSAT) on an annual basis.

The CGPSAT is designed to encourage general practices to reflect and assess the systems they have in place in order to facilitate the delivery of safe and effective clinical practice.

When compared to other Health Boards, as at February 2013, North Wales practices have the highest number of assessments completed and in progress.

More information can be obtained from:

[GP Self Assessment Tool](#)

In GP practices the Health Board measure key indicators of the quality of care by using a nationally agreed framework (Quality and Outcomes Framework (QOF)).

GP Practices across North Wales achieved high scores which indicate that the care that they are providing is safe and appropriate. The Health Board provides prescribing support through pharmacists and pharmacy technicians to all GP practices across the Health Board to ensure patients are getting the most from their medicines.

The Health Board also provides professional support and advice to practice nurses and assists GP practices in addressing any issues of concern in relation to these roles.

Support is also offered with the professional development of nurses working within nursing homes across North Wales.

The implementation of the Gold Standard Framework (GSF) in primary care, for palliative care supported by Macmillan Cancer has helped local teams to provide high quality care at the end of life.

Borras Park Surgery, Wrexham is the first GP practice in Wales to receive the 'Going for Gold' Primary Care Accreditation, and will receive a quality hallmark award for palliative care in their practice.



The team are presented with their award from a representative of the Gold Standards Framework Centre

Community Pharmacy

Community Pharmacy also has a risk based quality assurance programme. An all Wales Community Pharmacy Practice self assessment was developed and approved by Community Pharmacy Wales during 2012 and practices have been requested to complete this. The tool will be used as a baseline on which to review practices prior to commencing a revised visiting programme in 2013.

There have been a reduced number of practice visits since May 2012 due to capacity of appropriate staff to undertake the visits. 32 visits have taken place up to February 2013 (10 in the West, 4 in the Centre and 18 in the East). In order to meet the Pharmacy Quality Assurance programme specification, 28 pharmacies needed to be visited by March 2013 (62 pharmacies remain to be visited over the next 3 years).

General Dental Practice

There is a robust framework in place for the professional review of standards within General Dental Services. This is supported by Public Health Wales, and includes an annual Quality Assurance Self-Assessment. Processes are also in place for monitoring compliance with contractual quality specifications which includes visits to practices and follow up of concerns.

Dental Practices are subject to mid-year and end of year contract reviews which may involve a visit if appropriate.

Optometrists

There is no standardised quality assurance programme for optometry. Practices seeking accreditation for the Welsh Eye Care Scheme are assessed by Cardiff University.

The Board receives an annual Primary Care Improvement Report. The current report for the period April 2012 – Feb 13 can be found at: [Primary Care Improvement Report](#) and was considered at the April 2013 Board meeting. The report identifies that there is more work to be done to measure quality outcomes in Primary Care and lists the priorities for action.

The Workforce

Further information on staff views can be found in the staff survey section on Page 47.

We seek to ensure quality of care through recruiting, retaining and developing a workforce with the right skills and in the right numbers. Our approach is through:

- Workforce planning to identify future needs
- Effective recruitment strategies and practices including the necessary pre-recruitment checks
- Rostering of staff based on safe staffing numbers
- Core mandatory training
- Appraisals
- Personal development
- Healthy workforce

Workforce Profile

The table below shows the head count of our workforce at the beginning of the year and at the end of the year. The figures show that the largest single staff group for the Health Board are nurses and midwives.

Staff in Post by Staff Group	Assignment Count as at 1 st April 2012 ¹	Assignment Count as at 31 st March 2013 ²
Add Prof Scientific and Technical	752	717
Additional Clinical Services	3055	3222
Administrative and Clerical	3009	2813
Allied Health Professionals	1013	980
Estates and Ancillary	1622	1540
Healthcare Scientists	285	234
Medical and Dental	1253	1265
Nursing and Midwifery Registered	5685	5760
Students	12	8
Total	16686	16539

¹ Assignment Count is the number of posts held by staff employed as some staff have more than one post with the Health Board.

² The April 2012 figures include Shared Service staff who were transferred to another Healthcare Body on the 1st June 2012

Key Challenges – Recruitment Difficulties

We continue to face difficult recruitment challenges across a number of staff groups but particularly concerning is recruitment to our medical workforce which has been the subject of debate at a local level through a variety of medical committees.

Medical & Dental Workforce

The ability of the Health Board to recruit and retain its Medical Workforce is affected by both national and local issues.

The Health Board has taken a number of actions to ease the problem with the recruitment of medical staff including:

- Continuing to work with the Wales Postgraduate Deanery to ensure that its reconfiguration plans do not disadvantage North Wales and lead to improved recruitment
- Recruitment campaigns
- Support for Bangor University in bidding for funding to sustain the academic and organisational component of the North Wales Clinical School
- Clinical Engagement in the development of service reviews
- Development of new models of service delivery
- Curriculum redesign (C21 Project) being undertaken by Cardiff University.

Non-Medical Workforce

Recruitment difficulties have also been identified in other staff groups such as Allied Health Professionals which has been particularly challenging in Occupational Therapy (Paediatrics and Learning Disabilities) and Speech and Language Therapy (bilingual Welsh-English speakers). This provides an indicator of where we need to look at alternative staffing skill mix and innovative ways to deliver our services differently to ensure appropriate care for our patients.

Developing New, Changed and Extended Roles

Using a competency based approach we are working to ensure that our future workforce is flexible and adaptable in a changing care environment. A key development in a number of services is that of Advanced Practitioner. This is a growth area particularly within Nursing and Midwifery and Allied Health Professions where these roles have been identified as part of the workforce solution to our Medical and Dental recruitment issues.

Education Commissioning

Within NHS Wales planning work is undertaken to identify future graduate recruitment needs within the following professional staff groups: Doctors, Dentists, Nurses, Midwives, Allied Health Professionals, Healthcare Scientists, Psychologists and Pharmacists. The numbers have been considered in the context of our workforce strategies, future staffing retirements/turnover and, known future service delivery models as well as our financial constraints.

Medical Appraisal and Revalidation

In January 2013, the Medical Appraisal and Revalidation System for NHS Wales, overseen by the General Medical Council commenced within the Health Board. Medical Appraisal is a regular review of past achievements with constructive planning of future progress. It is not a performance assessment, but a positive tool for skills and knowledge development.

Personal Appraisal and Development Reviews

Annual appraisals are required for all non-medical staff. In the staff survey only 35% of staff reported as having an appraisal in the last year. This level of appraisal is poor and the Health Board has set improvement targets.

Statutory and Mandatory Training

All our staff are required to attend statutory and mandatory training. Compliance levels are recorded and reported to the Workforce and Organisational Development Committee of the Board. These show that significant improvement is required to ensure satisfactory levels are reached.

Sickness Absence

Sickness absence rates within our workforce are a key indicator which is reported to the Board at each of its meetings. The National target is 4.55%, our performance between June 2012 and May 2013 was 5.17%. We are working to reduce sickness rates and have invested in a Confidential Advice Relating to Employees (CARE) service to support staff and manage sickness absence.

Nursing and Midwifery Staffing Levels

Ensuring appropriate nurse staffing levels and skill mix within our wards and departments is vital to the delivery of safe, high quality, compassionate care. This is a key indicator within the Health Board Nursing and Midwifery Quality Assurance Framework and considerable work has been undertaken in the last three years to meet national guidelines. This has included in-depth scrutiny of rosters and review of budgets across wards and departments to meet agreed guidelines. The Health Board are now Birth Rate plus compliant and will be undertaking the Welsh Government three yearly Birth Rate Plus re-assessment in July 2013. These findings will be reported to the Health Board in October/November this year.

On an all Wales basis, work to inform the setting of minimum nurse staffing levels within acute wards has progressed over the last 12 months as commissioned by the Chief Nursing Officer (CNO) for Wales. This has resulted in the CNO "Guiding Principles to Support Safe Nurse Staffing Levels on Acute Hospital Wards and Health Boards". These must be put in place by April 2014. Full compliance with the guidelines remains a challenge for the Health Board in some areas. The Health Board is awaiting final confirmation of the additional funding allocation for nurse staffing following the recent announcement by the Health Minister of £10 million extra funding for nurse staffing in Wales. The situation on the wards and in the community is being closely monitored, with senior nursing teams scrutinising the planned rotas on a daily basis to ensure wards and departments are clinically safe to meet patient need.

Staffing levels need to take into account patient acuity and dependency. The CNO has commissioned the development of a number of acuity and dependency tools across Wales. These will be used in acute wards, community and mental health services. The Health Board is involved in this national work and is trialling the electronic version of these tools on a number of acute wards across.

Quality triggers

Quality triggers help form a routine part of quality monitoring for the Health Board and act as an early warning system to identify services that might give cause for concern.

The Quality and Safety Committee of the Board has looked at evidence from other organisations as to what makes a good quality and safety report. It has been working to integrate all the key information in a single report so that in future we will be better able to answer the question “How safe are our services”?

These quality triggers have been included within a wider quality and safety report which the Quality and Safety Committee of the Health Board have been monitoring.

Here are some of the key quality triggers the Health Board have been monitoring:

- Mortality figures, both the unadjusted and risk-adjusted figures
- Complication rates following surgery
- Infection Control rates
- Incident Reporting Rates
- Patient and Service User Experience
- Concerns and Complaints
- Staff Survey Responses

These indicators are some of the rates which have been scrutinised in depth, and in detail in the monthly Quality & Safety report. This is helping the Health Board to focus on key risks and areas for improvement.

Waiting Times from Referral to Treatment

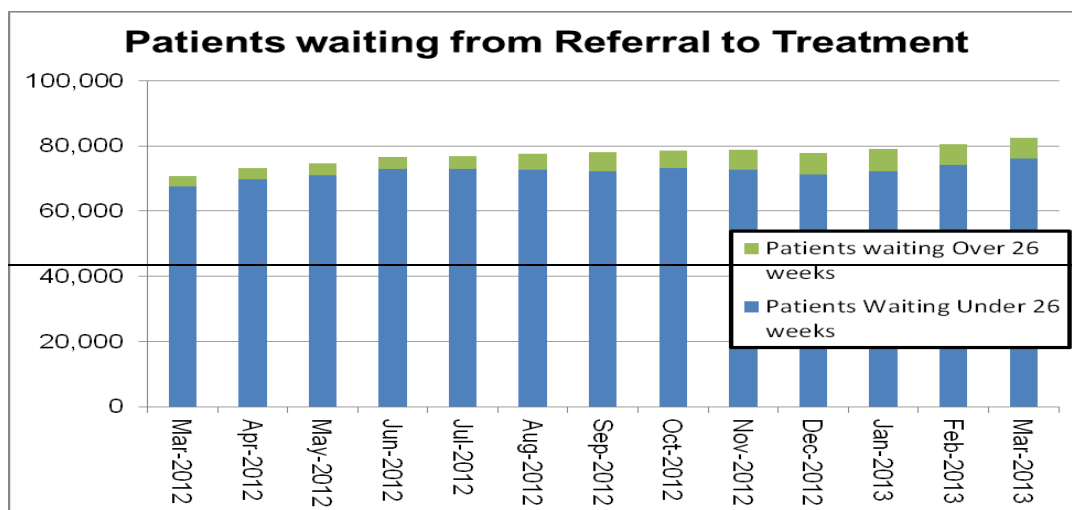
This is the total time waited from referral by a GP or other medical practitioner for hospital treatment in the NHS in Wales and includes time spent waiting for outpatient appointments, diagnostic tests, therapy services and inpatient or day-case admissions. The two targets for Wales are:

- 95% of patients to be treated within 26 weeks
- No patient should wait longer than 36 weeks

The Health Board's performance at the end of the year was:

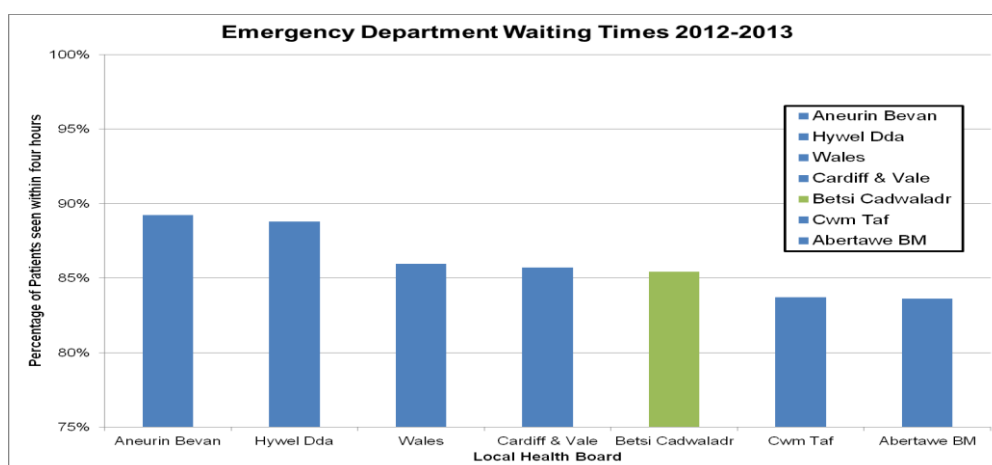
- 92.15% of patients waiting less than 26 weeks
- 958 patients waiting more than 36 weeks

This is disappointing and arose because we were unable to commission additional planned elective surgery in the final quarter of the year, together with the pressures on bed capacity leading to the cancellation of some operations, as a result of the demands on emergency care. This is an area where we are determined to improve our performance and reduce waiting times for patients.



Accident and Emergency Department

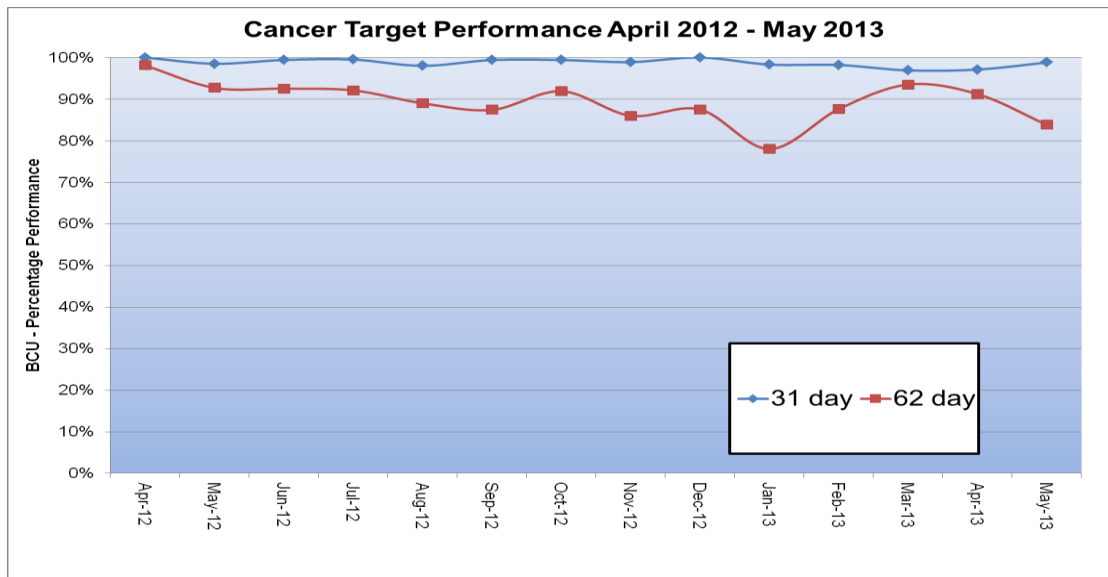
Patients should wait no longer than four hours until they are treated, transferred or admitted to hospital. During the last year 85% of patients who attended Accident and Emergency Departments were seen within 4 hours, compared to a Welsh average of 86%.



Waiting Times for Suspected and Diagnosed Cancer Patients

Patients who are suspected as having cancer require treatment within 62 days. For those patients who are not suspected as having cancer, but go on to be diagnosed with cancer are treated within a 31 day standard.

The following chart shows performance against the two standards. Performance has worsened through the year and despite showing a recovery since January, it has fallen back.



We continue to review individual breach reports for any treatment not delivered within the timescales of waiting time standards. Our review of breaches reveals no systemic issues in our management pathways, although further improvements are always possible. Where we do record numbers of breaches in the cancer targets, this is mostly due to capacity limitations within our hospitals. To address these shortfalls we have taken several actions such as prioritising the treatment of cancer patients for surgery and extended working hours in the radiotherapy department.

There are also some further opportunities to improve waits for diagnostics. We are working across all departments to ensure that any late referrals are managed quickly through hospital systems. This will improve opportunities for departments to work together to rectify problems in the patient pathway.

Providing high quality safe services and improving outcomes

This section explains what we are doing to improve the health of the people of North Wales through good public health as well as the provision of high quality safe services. It also describes the 1000 Lives Plus programme of work underway to improve patient safety and reduce avoidable harm.

The Health Board is committed to improving the health and wellbeing of citizens through good public health as well as safe and effective treatment.

To achieve this requires sustained and long term change to account for the advances in medicine, new technologies and a population that is ageing and living much longer. This means working with patients', partners and the wider public on:

- prevention, self-management and home-based services, recognising the important role carers play in helping maintain independence at home
- integrated health and social care centres, partnerships and teams
- hospital clusters, networks and regionally based services
- planned specialisation and consolidation of care into centres of excellence

Local Population Health Priorities

Whilst, in general, the health and well-being status of the North Wales population is relatively favourable compared to many parts of Wales, the benefits of better health and well-being are unevenly distributed among the population.

The Health Board's own response to improving population health is set out in the [Local Public Health Strategic Framework \(LPHSF\)](#)

The Health Board decided to focus on a small number of the key areas: Tobacco, Alcohol, Obesity, Early Years, Immunisation and Workplace Health and the section which follows highlights some of the key achievements we have made.

Tobacco

The North Wales population can access free smoking cessation support from Stop Smoking Wales Services or local pharmacists. A higher number of smokers in North Wales currently access help from their pharmacy compared to Stop Smoking Wales. The Board has also focussed attention on smoking cessation support for pregnant women and patients who are going to have surgery. Action to educate and prevent children from starting to smoke is also a key part of work with schools, Local Authority and other partners.

Alcohol

Front line health and social care workers have been trained to give brief advice about alcohol consumption. This is shown to be effective. A national alcohol awareness toolkit has also been developed in North Wales and training has been targeted in Primary Care.

Obesity

Work on obesity has focused on healthy and safe weight during pregnancy, community weight management and physical activity. There have been a number of training events to help staff develop key skills and confidence. There have also been some innovative schemes including one to support pregnant women and a scheme in Flintshire for overweight women who are trying for a pregnancy.

Immunisation

Immunisations uptake rates continue to increase. Target levels which will give population level immunity have been achieved in a large number of the scheduled immunisation programmes. In those programmes where target levels have not been achieved uptake is among the highest in Wales for the majority of programmes.

Immunisation schedule	Target*	Wales average*	Health Board achievement *
5 in 1 vaccine by 1 year of age	95%	96.5%	96.8%
1 dose of MMR by 2 years of age	95%	94.6%	95.8%
4 in 1 preschool booster by 5 years of age	95%	91.3%	93.1%
2 doses of MMR by 5 years of age	95%	89.6%	92.0%
2 doses of MMR by 16 years of age	95%	82.6%	90.3%
Human Papilloma Virus (HPV) 3 doses by 14 years of age	90%	86.6%	87.7%
Seasonal Influenza**			
Age 65+	75%	67.7%	70.0%
At risk under 65	75%	49.7%	52.1%
Pregnant women	75%	43.6%	53.0%
NHS staff – Overall uptake Staff with direct patient contact	50%	35.5%	35.9% 41.1% (medical/dental) 35.6% (nursing/midwifery)

Vaccine Uptake by Local Authority - Childhood Programme*

Local Authority Area	5 in 1 by 1 year of age	1 dose MMR by 2 years	4 in 1 preschool booster	2 doses MMR by 5 years	2 doses MMR by 16 years	HPV 3 doses by 14 years
	Target 95%	Target 95%	Target 95%	Target 95%	Target 95%	Target 90%
Anglesey	97.6%	95.2%	92.1%	91.0%	90.0%	84.9%
Conwy	96.1%	94.3%	90.6%	90.2%	91.8%	88.0%
Denbighshire	95.5%	96.0%	91.1%	90.6%	87.7%	86.7%
Flintshire	97.1%	96.2%	94.4%	93.0%	90.8%	89.6%
Gwynedd	97.0%	95.0%	93.5%	91.8%	90.3%	86.4%
Wrexham	97.1%	97.1%	94.7%	93.8%	90.5%	88.7%

Vaccine Uptake by Local Authority – Seasonal Influenza**

Local Authority Area	Influenza - Age 65+	Influenza - at risk under 65	Influenza - pregnant women
	Target 75%	Target 75%	Target 75%
Anglesey	68.8%	53.1%	47%
Conwy	69.9%	50.0%	53%
Denbighshire	68.4%	48.8%	56%
Flintshire	71.7%	54.4%	58%
Gwynedd	67.4%	48.3%	51%
Wrexham	73.1%	56.3%	51%

* Source: Vaccine Uptake in Children in Wales COVER Annual Report 2013
[http://nww2.nphs.wales.nhs.uk:8080/VaccinationsImmunisationProgsDocs.nsf/\(\\$All\)/5BEB94EE63907A9880257B950037FC4E/\\$File/COVER20122013.pdf?OpenElement](http://nww2.nphs.wales.nhs.uk:8080/VaccinationsImmunisationProgsDocs.nsf/($All)/5BEB94EE63907A9880257B950037FC4E/$File/COVER20122013.pdf?OpenElement)

** Source: Seasonal Influenza vaccine uptake in Wales – 2012/13
<http://howis.wales.nhs.uk/sites3/page.cfm?orgid=474&pid=21303>

Workplace Health

The Health Board secured Gold standard of the Corporate Health Standard in 2012. This is an externally assessed quality award and is a way of helping and supporting the Health Board to develop policies and procedures that improve the health and well-being of staff. We recognise that a healthy workforce means a healthy organisation.

Screening Programmes

The Health Board works in partnership with Public Health Wales to deliver national screening programmes.

In North Wales, over 140,000 eligible women (76.6%) had cervical screening in the last reported year; the majority of these tests were carried out in GP practices. 73.9% of eligible women in North Wales had breast screening and 50.6% of eligible men and women had bowel screening in the last test year. 99.7% of eligible babies were screened for significant hearing loss.

Measles

At the end of 2012 and the early months of 2013, the Health Board in partnership with Public Health Wales, successfully managed an outbreak of measles in the Porthmadog and Lleyn Peninsula area of North Wales. Lessons learnt from the outbreak resulted in additional actions being taken to further strengthen the resilience of the population against measles, mumps and rubella outbreaks. In March 2013, a Public Health Emergency was declared in Wales as a consequence of a large measles outbreak in South Wales. The Health Board took immediate and assertive action to prevent spread of the disease within and across North Wales.

Working with primary care and our partners in Local Authorities, we developed and implemented additional response plans to offer parents the opportunity to have their unprotected children immunised. To complement existing programmes we also rapidly put in place a range of interventions including a school based immunisation programme for children aged between 10 and 18 years.

Although there were a small number of isolated cases of measles in North Wales there was no major outbreak as a consequence of the actions taken. Levels of uptake of MMR are now at their highest level in all age groups, however we have not yet reached the 95% target for two doses of vaccine and the Health Board is continuing with actions to sustain and increase the level of uptake across North Wales.

Environmental Protection

Following concerns raised by local communities in Flintshire, a detailed, two year investigation (which included extensive community engagement) into the Hanson Cement works, Padeswood, was concluded in July 2012.

The investigation's main finding was that no evidence was found that emissions from Hanson Cement have resulted in harm to physical health. The investigation also found no persistent evidence of increased ill-health in the population living near the site, compared with those living elsewhere in Wales or North Wales.

Progress during the year

The Health Board has also made progress in a number of key service areas:

- Improved outcomes in [stroke](#), [cancer](#) and cardiovascular disease
- Home treatment and crisis resolution for Mental Health
- Palliative Care Strategy for North Wales, in partnership with local hospices and other partners
- Significant improvement in reducing the Caesarean section infection rate
- More productive operating theatres
- Availability of senior medical staff in A&E
- Starting to build a new Emergency Quarter in Glan Clwyd
- Electronic GP referral system
- Electronic summary of Individuals health records available to the GP Out of Hours service
- Enhanced care at home (ECH) being rolled out across North Wales so that more patients can be cared for at home
- A partnership approach to injury prevention
- Appointment of a Consultant Nurse in Dementia
- Community pharmacies in South Gwynedd offering cognitive behavioural therapy

Challenges during the year

Providing high quality safe services and improving outcomes for patients has been challenging this year. These challenges have been associated with minimising the impact of long term health conditions and shifting the balance of resources to help people and communities look after themselves better. We have also been working to make sure that people are only admitted to hospital when this is really the best option. This is against a backdrop of financial pressures and the need to reconfigure services.

The Health Board reviewed its key risks regularly during the year and identified the following for action:

- Infection prevention and control
- Responding to and learning from complaints and incidents (concerns)
- Providing better information about the quality of services
- Delivering clinically safe and affordable services
- Creating a climate that always puts the patient first
- Effective financial planning
- Delivering planned care within a reasonable time
- Responding to emergency care demand
- Recruiting medical staff
- Ensuring staff have the right skills

The complete risk register can be found here: [Corporate Risk Register](#)

Mortality Reviews

The statistics on mortality are useful indicators; however, as part of our continual drive for improvement the Health Board has been undertaking a programme of mortality reviews. Mortality reviews are meetings where senior doctors, nurses, pharmacists, managers and other health professionals review a patient's care after they have died. This mortality review allows health staff to achieve a real understanding of the quality of care the patient received.

The reviews have helped identify key areas for improvement such as;

- better documentation
- improved communication between patients, family/carers and healthcare professionals
- increased awareness and use of the National Early Warning Score to recognise deteriorating patients quickly

Risk Adjusted Mortality Index (RAMI)

Since 2010, all Health Boards in Wales have been required to set targets for the reduction of avoidable mortality and harm. The Health Board has undertaken this work through a series of initiatives which include (i) reviewing the clinical pathway for patients who die whilst in hospital care (ii) using intelligent measures such as the Risk Adjusted Mortality Index (RAMI) score (see link below).

[Risk Adjusted Mortality Index](#)

Infection Control and Prevention

During the first few months of 2013 there was a notable increase in the number of patients with *Clostridium Difficile* infection at Glan Clwyd Hospital. The Chief Medical Officer for Wales requested that Public Health Wales assist and support the Health Board and ensure all necessary action was being taken to control the outbreak at the hospital. Public Health Wales concluded that although the Health Boards response to the outbreak was effective more could be done to provide a safe environment for patients. ([Public Health Report](#)) They recommended that the Board review its infection control governance procedures. An Independent Expert was brought in to lead this review which identifies ways in which the Board can improve and drive down rates of *Clostridium Difficile* and other hospital acquired infections. It also helps the Health Board to identify opportunities to strengthen the governance and management arrangements for infection prevention and control. [A copy of the report can be found here.](#)

1000 Lives Plus



1000 Lives plus, launched in April 2010, is a five year programme to improve patient safety and reduce avoidable harm, waste and variation across NHS Wales. The programme has three key areas;

- a) Improving leadership for Quality
- b) Maintenance programme areas
- c) Mini-collaboratives

The Health Board are engaged in a number of mini-collaboratives that aim to reduce harm.

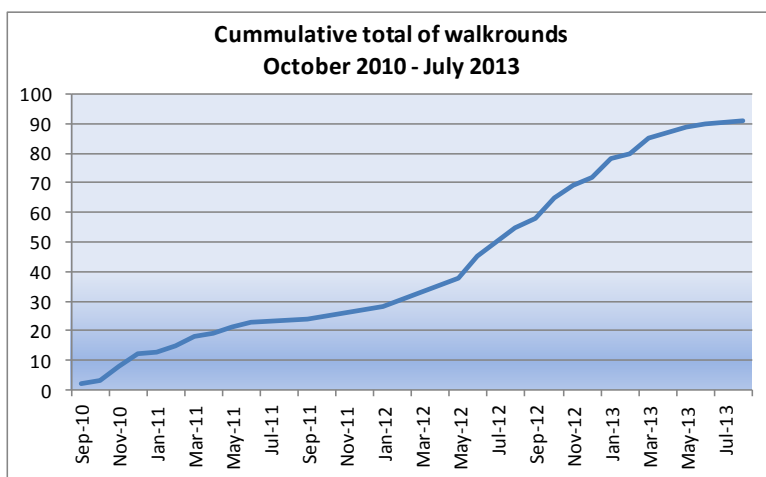


Leading The Way

A leadership walk around is a visit to the department or area by a senior leader within the organisation together with an independent member of the Board. This allows patient safety issues to be highlighted and fed back to the Board, as well as giving senior leaders the opportunity to learn more from staff about the actions they have taken to improve patient safety in clinical areas.

Between October 2010 and July 2013 the Patient Safety Leadership Walkround™ team have undertaken 91 visits across the Health Board. These have included visits to hospital wards, pharmacy, theatres and community sites. A number of themes have emerged with the top three issues being raised categorised as;

- Workforce
- Estates
- Equipment availability



Scheduled Walkrounds now include revisits to areas to discuss progress on issues raised.

Surgical Care

Enhanced Recovery is an evidence-based model of care that is designed to optimise all aspects of the patient's care pathway, from pre-operative assessment through to discharge and beyond. It aims to create a fitter and more educated patient before their surgery, who will then recover faster from major surgery. This gives an explicit focus on a package of care which includes less invasive surgical techniques, appropriate anaesthetic and pain relief and the early management of fluids and diet, which accelerates a patient's mobility after their operation.



Reducing complications during surgery.

The system of care for surgical patients can be improved and experts have identified a small number of interventions to reduce the number of infections after surgery, as well as introducing the World Health Organisation (WHO) Surgical Checklist.

Although compliance with completing the checklist is good we still have more to do to reach and sustain the goal of achieving 95%.

Medical Care

A significant success has been the rollout of a programme to respond to patients whose health deteriorates rapidly. The programme details a series of interventions which take place from admission to discharge. This includes the use of the NHS National Early Warning Score (NEWS).



Improving the health of patients with heart conditions

The Health Board is also participating in a number of programmes to improve the health of patients with diseases affecting the heart. These include the Heart Failure collaborative, the Acute Coronary Syndrome collaborative (covering all myocardial infarctions (heart attacks) and unstable angina).

Improving care for patients who have had a stroke

The Health Board uses a series of health interventions to provide specialist stroke services using evidence based care approach. The interventions which have been proven to have the highest impact on outcome following stroke have been grouped together so that they are performed in the same timeframe or by a particular group of clinicians. Performance against the interventions has consistently improved during the year.

Improving the ward environment

Several initiatives are in place to reduce patients acquiring pressure sores whilst in hospital, improving mouthcare during their stay, reducing the numbers of patients with hospital acquired thrombosis, which is a type of blood clot, improving nutrition and care through 'intentional rounding' to assess patients.

Improving patient/user experience

This section sets out how the Health Board has been listening to the experience of patients, service users and carers and describes how we have used this information to improve our services.

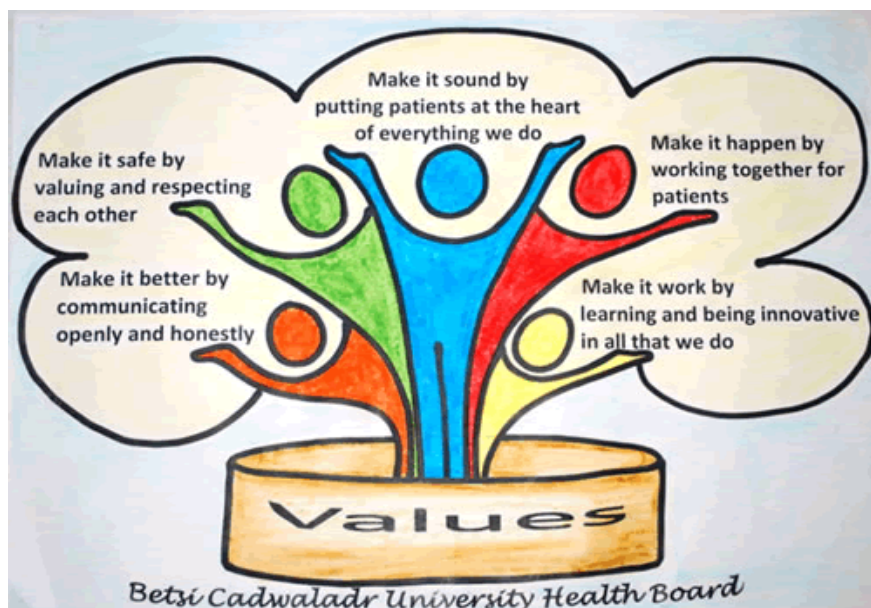
Feedback comes from individual patients and carers as well as from surveys, audits, patient stories, focus groups

Involving patients in their own healthcare decisions

The Health Board has taken a strategic approach to ensure patients are at the centre of all decisions about their care. There are a number of initiatives that have been introduced to ensure that this philosophy is embedded in the day to day work of the organisation. This patient centred approach is underpinned by the Health Board Values.

Values

The Health Board Values which were developed following extensive engagement with staff and volunteers, lay the foundation for patient centred care.



The Values help us to define and develop our culture – what we do and how we do it and will help us to develop a shared way of behaving that is patient centred.

To support the highest quality of care at the front line, there is an organisational requirement for leaders to model the appropriate behaviours and to communicate these at every opportunity. The values are also promoted using the following initiatives:

- Staff orientation programme
- Staff Personal Development Review Documentation
- Staff Achievement Awards

The FREDA (Fairness, Respect, Equality, Dignity, Autonomy) Model

To further embed a person centred approach the “Freda” model has been developed based on the “Esther” Network” as outlined in Davies (2012).³ This is currently being rolled out across the organisation and greater detail will be provided in next years report about the difference this has made to patients.

Freda is a persona of a patient, based on a real patient’s story and her experience of healthcare in North Wales.

The Freda model encourages staff from all disciplines to question if the service is based around “Freda’s” best interests and gives them the authority to question “are we doing the right things”.

- What does Freda need/want?
- What is important for Freda when she gets sick?
- What is important for Freda when she comes back home from the hospital?

Dignity Pledge

Alongside the Health Board values and the Freda model there is a Dignity Pledge which clearly lays out to patients, service users and staff the standard of behaviour/care that is expected.

“Our pledge is to work with, and for patients, to provide dignified and compassionate care; that results in a positive patient and family experience”

The Health Board is committed to embedding the Human Rights values as part of our culture and this pledge is based on the FREDA principles of human rights.

Compliance with the Dignity Pledge is audited by lay volunteers. In a recent audit 347 patients were asked about the way staff communicated with them. The findings suggest that overall the patients were positive about the way in which staff communicated particularly with regard to patient involvement and understanding of their care. However, additional work is required to ensure patients are addressed appropriately and their preferred language is identified. These were the questions that patients were asked:

- Q1: Do staff acknowledge you and say hello?

Q2: Do staff always introduce themselves?

Q3: Do staff ask you what you would like to be called (i.e. Mr, Mrs, First Name)

Q4: Did staff ask you what your preferred language is?

Q5: Did staff tell you what they were going to do?

Q6: Did staff give you explanations about any intervention or treatment?

Q7: Did staff check you understand their explanations?

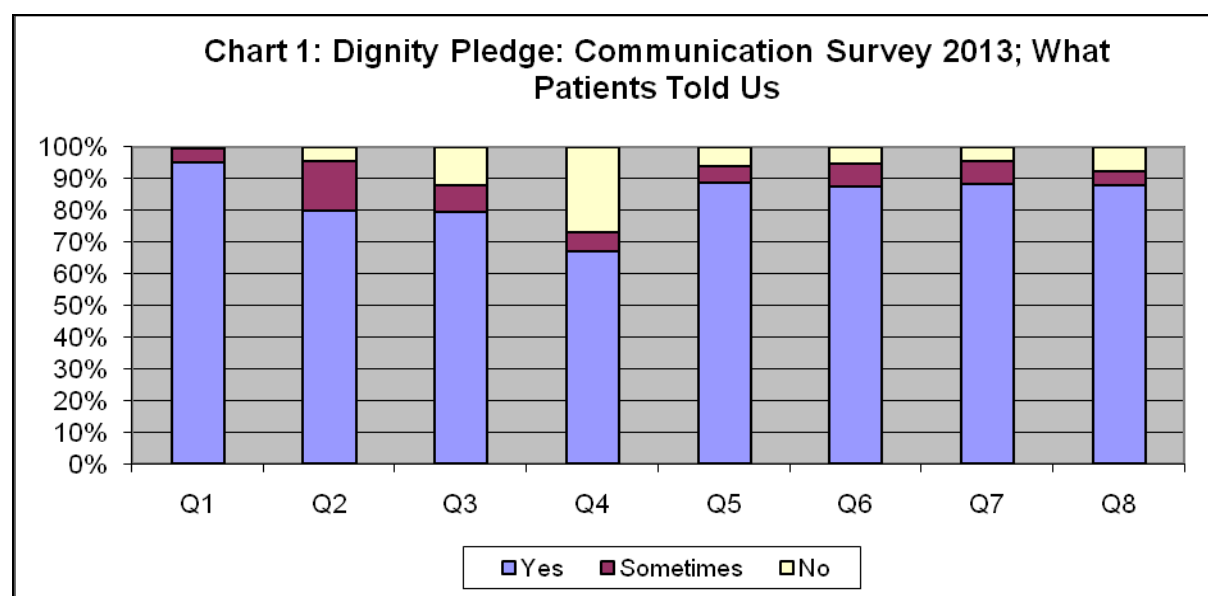
Q8: Did staff ask if there is anything else they can do before leaving you?

Chart 1 below, depicts the total results for the Health Board; the findings suggest that overall the Health Board scores positively against most questions, in particular the

³ Davies J, (2012) *Person Driven Care: A Study of the Esther Network in Sweden and the lessons that can be applied to enable NHS Wales to become a patient-centred healthcare system*. Improving Healthcare White Paper Series; No.7. 1000 Lives Plus

questions around the patients involvement and understanding of their care. The two areas where additional work is required are:

- Q3: Asking if patients wish to be addressed by their title or first name
- Q4: Asking what the patients preferred language is.



Engaging with the public

A programme of service reviews was progressed in 2012/13 driven by the need to improve quality and safety of services. [*"Healthcare in North Wales is Changing"*](#) brought together a number of proposals which were consulted upon in line with national guidance. The methods used have been accredited as good practice independently by the Consultation Institute.

The consultation included:

48 Public meetings over 16 days of more than 3,000 people

Open consultation questionnaire (on line and paper versions) widely distributed by the Health Board with responses from 1899 residents and organisations;

- Household survey of residents by post, 638 of 5,000 randomly selected households
- Eight focus groups with members of the public
- Engagement with the National Clinical Forum (NCF)
- Written submissions from stakeholders and
- Petitions

A number of changes were made to the proposals as a result of the consultation responses, including the location of one of the hospital hubs, and improved access to some services in more rural areas.

Stakeholders

The Health Board also listens and responds to patient and user feedback received via public stakeholders.

- The Boards draft 5 year plan was discussed with local community groups
- There are Bi annual meetings with Local Authorities across North Wales
- The Health Board engages on an ongoing basis with trade unions and across professional groups
- The Health Board has a well-established Stakeholder Reference Group and Health Professionals Forum
- Locality Stakeholder Groups have been established in each of the 14 Localities
- Work this year has been undertaken with the traveller community, black and ethnic minority groups and the homeless. Staff also attended the first North Wales Gay Pride event to gain people's views of health services
- With the help of partner organisations and carers, the Health Board has developed a Carers Information and Consultation Strategy for North Wales

Service User Experience

The Health Board has adopted a range of methods to gather information on service user experience including a large scale patient experience survey.

This is the second year that the Picker Inpatient Survey has been conducted at the Health Board. The Picker Institute Europe is a not-for-profit organisation that specialises in measuring patients' and service users' experiences. They provide robust, reliable and actionable feedback, and support the Health Board to use the data to drive improvement. The Picker Institute is commissioned to undertake the National Inpatient Survey in 69 NHS Trusts in England and this allows for benchmarking Health Board data with other service providers.

The survey was based on a sample of 1,913 in-patients who were discharged from one of the 3 acute hospitals during September 2012 (867- 45% responded). The survey asks 86 extensively researched questions on what patients say is important to them.

The [Survey Report](#) highlights some positive aspects of patient experience in that:

- 73% rated their care at 7+ out of 10
- 74% felt they were treated with respect and dignity
- 78% had confidence and trust in the doctor treating them
- 84% said there was always enough privacy when being examined and treated.
- 89% felt that the toilets and bathrooms were very/fairly clean.

There were 14 areas where the Health Board was significantly worse than the average (this is comparing the Health Board data against the 69 English Trusts who have undertaken the survey), these fall into the themes of:

- Planned admissions
- Mixed sexed accommodation
- Food (quality and choice)

- Communication (for example; staff not introducing themselves, lack of involvement of patients in discussions and availability of written information)
- Staffing levels
- Discharge arrangements
- Opportunities to give feedback on service
- Not receiving information explaining how to raise a concern

The benefits of commissioning Picker to conduct regular surveys for the Health Board are to gain historic comparisons of patient experience overtime. When comparing the 2013 results with the 2011 survey it is disappointing to note that there has been a significant decline in the in-patient experience at the Health Board in the following areas.

- Accident and Emergency (waiting time, lack of information and privacy)
- Waiting for a bed for planned admission
- Noise on Wards
- Availability of hand gel
- Assistance at meal times
- Time taken to answer a call bell
- Patient involvement with discharge arrangements
- Confidence and trust in doctors
- Dignity and respect
- Wanting to complain about care received

The Picker Institute will facilitate a workshop for a cross section of Health Board staff and service user representatives in September 2013 to review these results and develop an action plan to take forward the improvement work. The Health Board will monitor the improvement work closely by receiving regular reports and monitoring outcomes once improvements are made.

The Health Board also for the first time commissioned a Picker Out-Patient Survey. This was based on a sample of 1,978 patients who had attended for an out-patient appointment during March 2012 (48%- 952 patients responded). The survey highlighted some positive experiences:

- 93% of outpatients reported their care as very good to excellent
- 89% of outpatients felt that they were treated with dignity and respect
- 85% of outpatients reported that they were definitely given enough privacy when being examined or treated.
- 83% had confidence and trust in the doctor examining and treating them

Outpatients (Reported on in March 2013) advised us that

- They had to wait more than 5 months for an appointment
- They waited longer than they were told-or not told how long the wait would be
- They want to be kept informed of the reason for delays in outpatients.
- No one apologised for the delay in waiting time
- That they want to receive information from outpatients that is clear and concise.

- That hand-gel in outpatients should be clearly signed and regularly replenished.

An action planning workshop has taken place for the Outpatient Survey results, and the action plan is in place. Improvements have been made in providing information when clinics are delayed, volunteers have been recruited to support and inform patients of waiting times, hand gel placement and signage reviewed and adapted. The length of time to wait for the first appointment is still proving a challenge for the Health Board and this is being closely monitored by the Board.

Ongoing regular surveys (monthly) of the patient experience are also being implemented at the Health Board using the All Wales Patient Experience Questionnaire.

Monitoring visits undertaken by the Community Health Council 2012/13

Visiting NHS premises is one of the core functions and a statutory responsibility of the North Wales Community Health Council (CHC). This forms part of the quality monitoring programme of local health services on behalf of the public. This exercise provides essential information on the state and acceptability of the environment where services are delivered and provides the Health Board with information which supports the improvement of service delivery.

The Health Board's Corporate Governance and Communications Team co-ordinates the response process in respect of CHC Monitoring Reports.

Activity during 2012/13

Between 1 April 2012 and 31 March 2013 the North Wales CHC undertook the following inspection visits:

Secondary Care:

During 2012/13 the North Wales CHC undertook a pilot exercise to trial a new approach to secondary care monitoring visits. The pilot involved the use of different "themed" visits which concentrated on particular aspects of the patient experience. Visits were undertaken with a focus on four distinct themes:

- External Access (undertaken once a year only)
- Patient and People Care
- Internal Fabric and
- Equality of Access

A total of 129 hospital inspections were undertaken across North Wales as follows:

Hospital	Number of Visits
Ysbyty Wrexham Maelor	37
Ysbyty Glan Clwyd	24
Ysbyty Gwynedd	10
Mental Health Units (across North Wales)	21
Llandudno General Hospital	4

Abergele Hospital	7
Chirk Community Hospital	4
Penley Hospital	3
Deeside Community Hospital	4
Flint Community Hospital	4
Ysbyty Bryn Beryl	2
Ysbyty Penrhos Stanley	3
Blaenau Ffestiniog Memorial Hospital	2
Ysbyty Alltwen	2
Ysbyty Eryri	2

Some of the main themes emerging and actions taken from the visits were:

North Wales CHC Concern	Health Board Response
Inadequate car parking	This is continuously reviewed. Visiting times have been staggered on larger sites to accommodate visitors.
Lack of public transport	This is outside the control of the Health Board however discussions are held with the local authorities and transport providers.
Provision of day rooms	This is an issue on some sites due to lack of space.
Staffing	The lack of staffing was a regular issue. CPGs constantly review their staffing complement and ensure that adequate staffing levels and skill mix are available.
Linen	The lack of linen and nightwear was a common theme and has been raised with Hotel Services.
Decoration of Wards	The decoration of wards is routinely reviewed and there is an on-going programme of refurbishment/redecoration in place.
Signage / road marking	Where issues have been raised these have been addressed by the Estates Department where possible.
Lack of chairs with arms in waiting areas	This has been raised across a number of sites and is addressed locally.

North Wales CHC will continue to monitor performance on these issues.

Other issues such as cleanliness, quality and availability of food, staff not wearing ID badges were raised with staff on the spot.

In addition to issues raised during the CHC's visiting and monitoring programme, the CHC's Advocacy function has raised issues around privacy, dignity and ward cleanliness which the Health Board has responded to on a case by case basis.

Emergency Department Watch

In addition, visits were undertaken to the Emergency Departments across North Wales on 17 August and 24 November 2012. The focus of this “Emergency Department Watch” was the patient experience, with a particular focus on privacy, dignity and safety. The exercise involved both a report completed by members, based on their observations, and the distribution of a questionnaire to patients to return directly to the North Wales CHC.

The results were generally positive and patients felt that they had been treated in a dignified manner. There were two questions which received a significant number of negative responses however. These questions and the Health Board’s responses were:

Question	Health Board Response
“Were you asked what name you preferred to be called by?”	Staff priority is to ensure that the patient is properly assessed as soon as they enter the department. However, the Matron has reminded staff that this should be done when the patients are admitted either to cubicles (minors) or Trolleys (Majors).
“Were you kept informed of timings / delays at each stage?”	Reception clerks will receive training to update the screens in the reception area with length of expected wait. Triage nurses are asked to inform the patients of the expected length of wait although often this changes rapidly. The matrons will ensure this is discussed with all staff to ensure as timely as possible information is available.

Primary Care

In addition to secondary care, the CHC also undertake monitoring visits to GP practices and community pharmacies as part of a rolling programme. During the period of the report a total of 44 visits were undertaken (23 GP Practices, 21 Community Pharmacy) as follows:

Locality	GP Practice	Community Pharmacy
Wrexham	1	0
Flintshire	2	2
Denbighshire	1	9
Conwy	8	10
Gwynedd	8	0
Anglesey	3	0

Actions and recommendations arising from these reports are taken forward by the Health Board’s Primary Care Support Unit.

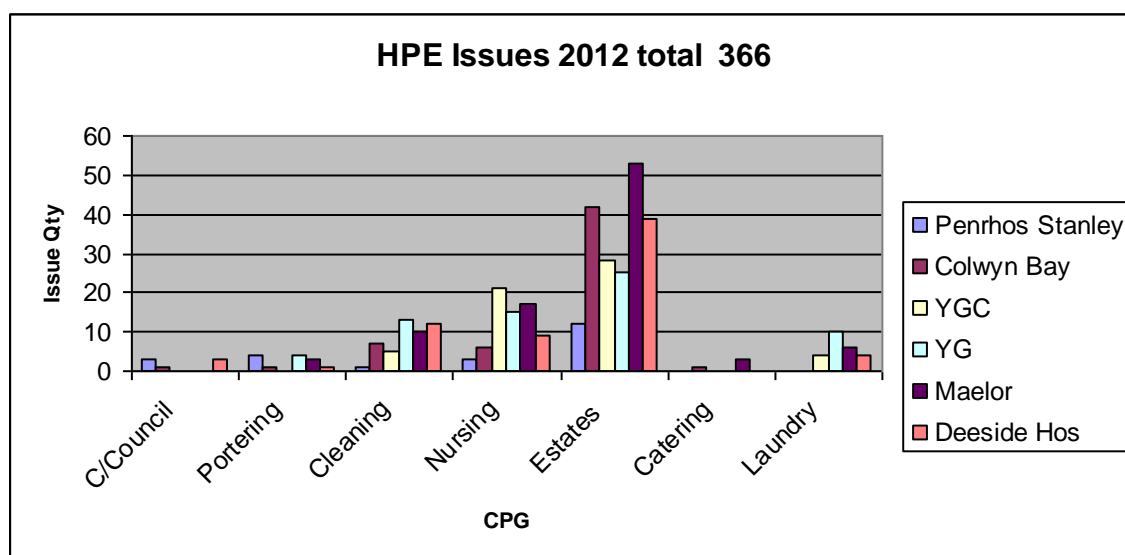
Hospital Patient Environment (HPE) Assessments

The Hospital Patient Environment (HPE) programme focuses on the patients' perspective, and supports other NHS Wales initiatives including:

- Fundamentals of Care
- Health and Social Care Guide
- Performance Improvement Framework and
- Signposts – A practical guide to public and patient involvement in Wales

The process involves the setting and verification of non-clinical national standards in hospitals.

The HPE visits were undertaken by North Wales CHC on behalf of the Welsh Government in Autumn 2012 across the 3 major acute hospital sites and 3 community hospitals (Ysbyty Penrhos Stanley, Deeside Hospital and Colwyn Bay Hospital) Details Results from the Audited Health Board locations can be found at: [HPE Report](#)



Across the Health Board there were concerns about sign posting and car parking. These matters are being reviewed by the Estates Department alongside other Estate issues.

Nursing issues identified related to information or understanding of patient needs and dignity.

Portering and Cleanliness issues across the organisation were attended to immediately or within a short time frame.

Concerns were also expressed about the lack of a regular programme for the external cleaning of windows.

Regular smaller scale surveys

Regular smaller scale surveys are also conducted. One of these has involved canvassing patients' views on dignity which then shaped the Health Board's Dignity Pledge. Another survey helped to inform the North Wales Carers Information and Consultation Strategy.

Comment Card Scheme

Service users told us that they would like to tell us about their suggestions or comments about the service they have received. Therefore the Health Board has designed, in conjunction with service users, a freepost and electronic comment card scheme. These cards allow for anonymous feedback to the organisation and act as an early warning system. A high proportion of the comments are compliments, however some identify areas for improvement, which in many instances can be quickly rectified, for example providing additional heating in outpatients during a refurbishment programme or improving signage.

Problems with car parking at Glan Clwyd were also a consistent theme. A car parking strategy has been developed for Glan Clwyd to address congestion and address safety issues.

Transforming care

Transforming Care is a quality improvement programme that aims to:

- increase the amount of time a registered nurse spends in delivering value added care to patients
- reduce adverse events which includes Health acquired pressure ulcers and falls
- Improve the patient and staff experience

The Health Board has introduced " *Intentional rounding*" in the ward areas. This means that nurses regularly check on patients and ensure their fundamental care needs are met. Seventy five inpatient wards (66% of inpatient wards) across the Health Board have this in place.

Patients have benefited already as a direct result:

- Reduction of Health Acquired Ulcers
- Improved structure and organisation of care delivery
- Reduced interruptions during medication rounds (ward activity follow data supports reduction in interruptions)
- Improved nutrition / hydration of patients
- Patients are ready for meals with less interruptions e.g. toilet needs
- Patients know they have protected time with staff "their time"
- An opportunity for staff to assess and evaluate the plan of care with their patient
- An opportunity for patients to be involved in their care and improved communication
- Opportunity for staff to "role model" regarding dignity, care and compassion to fellow healthcare professionals and patients
- Increased opportunity for staff to recognise deteriorating patients

The intentional rounding quality measurement tool has also been adapted for use within the Outpatient environment for the first time. Themes from the Picker Survey findings have been used to direct this development in Outpatients resulting in improved patient communication and experience during clinic delays, this initiative has re-emphasised the importance of keeping patients informed at all times.

Learning from patient stories

Patient Stories are about actively listening to, and learning from, patients', relatives, or carers' experience of health care.

Patient stories are utilised for training, raising staff awareness and sharing good practice. They inform the patient safety items received by the Board which are then cascaded through the organisation. Patient stories form part of the training for dignified care ambassadors. Patients and relatives are also offered the opportunity to attend and present their stories at Board Meetings, workshops, conferences and team meetings to share their experiences first hand with healthcare professionals.

Patients stories often allow for practical action to be taken to improve patient experience. Examples of this in 2012-13 include:

- Patient Safety Alert issued detailing best practice guidance when communicating with, or caring for someone who is deaf blind.
- Awareness of Sensory Loss module recommended as a compulsory module on Health Care Support Workers' training.
- Review of breastfeeding support on Children's Wards.
- Improved patient carer information about Home Enhanced Care Services
- Diaries at the bedside in Intensive Care Units.

Being a learning organisation

This section provides a summary of how the health board is working to learn from the experiences of patients and staff to improve services in the future.

Feedback from patients and their carers always provides an opportunity for learning. Sometimes things go wrong and at times we let our patients down.

The Health Board responds to concerns in line with the Putting Things Right Regulations. The aim is to 'investigate once, investigate well' ensuring that concerns are dealt with in the right way, the first time round. The Health Board is also required to produce a [Putting Things Right annual report](#).

In addition to the lessons learnt from concerns, staff are encouraged and supported to report incidents when things go wrong so that we can learn and improve. Incident reporting has increased year on year and in the Staff Survey, our staff have confirmed that they are happy to report incidents and feel fairly treated when things go wrong.

The Health Board has a new electronic system (Datix) for the reporting and management of incidents, complaints and claims and there has also been good progress rolling this system out.

Complaints

Staff try to address concerns raised by patients/service users and their carers/relatives as they arise. In 2012-13, the Health Board recorded 1701 concerns which were resolved 'on the spot'. However, some patients/service users, their carers/relatives choose to make a formal complaint. In 2012/13, 1597 complaints were received, an increase of 258 (19%) on the previous year.

The Health Board continues to strive to respond to complaints within the agreed timeframes. This is an area of significant challenge for the Health Board and we have failed to comply with the standard. The table below compares 2011-12 and 2012-13 performance.

No. of Complaints Received		Difference from previous year	Acknowledged within 2 working days		Responded to within 30 working days	
2011/12	2012/13	19% increase	2011/12	2012/13	2011/12	2012/13
1339	1597		89%	98%	32%	42%

The four main issues of concern are :

- aspects of clinical treatment
- appointment delays /cancellation
- written and oral communication
- attitude of staff

Public Service Ombudsman for Wales (PSOW)

Complainants are advised of their right to request an independent review by the Public Service Ombudsman for Wales (PSOW) if they are dissatisfied with the Health Boards response. There were 86 applications to the PSOW by complainants during 2012/13, which represents approximately 5.3% of the total number of complaints received within this period. This is a similar percentage to the previous year of 5.6%. The PSOW has noted that the complaints received and investigated by his office are lower than the health body average and that the majority of complaints received related to clinical treatment in hospital. He also commented positively on the number of quick fixes and voluntary settlements and the lower than average number of complaints upheld. However, it has been necessary for his office to issue one Public Health interest report.

Section 16 Public Reports

Public reports are issued under Section 16 of the Public Services Ombudsman (Wales) Act 2005 in cases where the PSOW believes that there are issues of public interest arising from an investigation. During this reporting period the Health Board has received one public report pertaining to a complaint about the care provided to a patient at Glan Clwyd Hospital in 2009 concerning a delay in diagnosis and treatment. Recommendations to review procedures, undertake further audit and training were accepted by the Health Board.

Coroners Rule 43 Reports

Within this reporting period the Health Board has received three Rule 43 reports following Coroner's inquests in relation to:

- The procedures used to share information
- Family liaison
- Information for patients and their family/carers following discharge after major abdominal surgery.

Action plans have been put in place to address these important issues.

Incidents

There has been a 3.2% increase in the number of incidents reported within the Health Board. The Health Board continues to encourage staff to report to promote an open culture so that we can learn and improve. In total 16,759 incidents were reported during 2012/13, 76% of these were patient safety incidents (12,788). The highest reported incidents across all three acute and community regions were 'slips, trips and falls'. Almost 80% of incidents reported were categorised as causing no or minor harm. The most serious incidents are also reported to Welsh Government who then monitor the Health Boards responses so that we can be assured that we are reducing the likelihood of similar occurrences in the futures. During the past year 2012/13 we have reported 136 serious incidents, an increase of 29% on last year. These incidents represent 1% of all reported clinical incidents.

The top 5 categories of incidents reported during 2012/2013 were:

- Suicide (actual or attempted) with 23% (31)
- Unexpected Death of a client open to Mental Health Services with 12% (16)
- Absent Without Leave patients with 7% (10)
- Unexpected death of patient receiving NHS treatment with 7% (10) and
- Unnecessary /duplication / wrong x-ray performed with 7% (10)

Some investigation outcomes identify that even though a death may well have been unexpected there were no care or service delivery problems identified.

Serious incidents are investigated using 'root cause analysis' methods to establish precisely why the incident occurred so recommendations can be made for changes to practice. This process reduces the risk of a similar incident occurring again.

Learning from incidents has resulted in:

- Reviews of clinical procedures and processes
- New equipment purchases
- Local alerts and national product recalls (Medical Devices).

Compensation Claims

During the reporting period a total of 289 new compensation claims were received, of which 220 have been identified as clinical negligence and 69 as personal injury. This represents an increase of 31% on the previous year. The re-occurring themes are: record keeping, communication, supervision, competence and training.

Organisational Learning from Patients Experience

The priority for the Health Board is to provide safe, high quality care and treatment to all its patients. To achieve this it is important that the organisation promotes a culture that recognises where mistakes have been made. Too often the failings are associated with recurrent themes across the NHS. It is therefore imperative the Health Board has an effective system to support organisational learning from both local and national recommendations.

The Quality and Safety Committee of the Board provide consideration and scrutiny of concerns. Clinical Programme Groups have local forums where complaints and incidents are reviewed.

Below are some examples of the actions the Health Board has taken in response to the concerns raised by patients:

Care & Treatment:

- Following an incident regarding the delay in transferring a patient from one acute hospital to another for specialist treatment a review of the transfer arrangements between hospitals has been undertaken and a new protocol drawn up.
- Following a complaint received regarding the unsuitability of the patient chairs for frail elderly patients arrangements were made to purchase smaller chairs with integrated high risk cushions for the Care of the Elderly wards.

- Following a number of incidents regarding the unintended exposure under IR(ME)R in the Radiology Department, the procedures for justification and patient ID checking have been amended to include the need to check the patient's imaging history for recent similar studies.

Staffing, Training & Supervision

- The process for engaging Locum doctors from agencies has been reviewed. Qualifications and references are checked before a Locum takes up his/her post. The Clinical Lead reviews locum CVs as to suitability prior to commencement of duty.

Information & Communication

- Patient information regarding discharge advice on 'when to seek medical advice after major abdominal surgery' has been developed for local use as well as stimulating the production of nationally available information by EIDO healthcare.
- A complaint from a patient having an unacceptable wait for a GP Out of Hours home visit highlighted the need for staff to be reminded to follow policy in relation to 'comfort calling' to ensure patients are kept informed whilst waiting for a doctor to visit.
- Following a complaint regarding the care of a patient undergoing chemotherapy when attending the A&E Department with a fever. The protocol between the Cancer Treatment Centre and the A&E Departments has been revised regarding communication.

Improving Policy & Procedures to ensure Best Practice:

- A Health Board wide Discharge policy has been developed and a number of drop in sessions have been held to launch the policy
- A Health Board wide consent audit has been undertaken
- A number of complaints received have also raised concerns regarding the lengthy nature of the 'complaints handling procedures'. In response to these the Health Board has undertaken a complete review of the procedure, streamlined the administrative processes as well as implementing a new web based risk management system.

Patient safety alerts

It is important that we also learn from mistakes and problems that have happened elsewhere. This work was coordinated by the National Patient Safety Agency (NPSA) until March 2012. They issued alerts and identified "never events"

During its period of operation the NPSA issued some 76 alerts and advice notices, with the last being issued in March 2012. Of the 76 issued, 70 relate to the following:

- **19 Patient Safety Alerts** - requires prompt action to address high risk safety problems and has a specific timeline for implementation

- **39 Rapid Response Reports** - providing an urgent warning to healthcare organisations of substantive risks which are new (or not well known).
- **12 Safer Practice Notices** – advises on the implementation of particular recommendations or solutions.

The Health Board provides the Welsh Government with quarterly performance updates in respect of its compliance status against the implementation of all applicable alerts and to date the following alerts are the subject to ongoing review by those Clinical Programme Groups to which the alert is applicable:

Patient Safety Alerts – 3 under review
Rapid Response Reports – 10 under review
Safer Practice Notice – 3 under review



The Health Board is currently working in partnership with the Welsh Governments All Wales Alerts Working Group to monitor progress against the open alerts. In so doing the Health Board takes the opportunity to learn from other Health Boards in respect of particular aspects of the implementation of the alerts and raise issues relating to problem areas requiring National solutions.

Never Events

A 'Never Event' is a serious, largely preventable patient safety incident that should not occur. During this reporting period, one 'never event' under the category of 'retained material post-surgery requiring re-operation' occurred and was reported to Welsh Government. The incident was fully investigated and improvements to clinical practices and procedures have been implemented.

Research and Innovation

The Health Board supports a broad range of health research providing patients with the opportunities to participate in clinical trials and studies. Partnership and collaborative working with Bangor and Glyndwr Universities provides opportunities for staff to develop and undertake research thereby developing local skills and innovative ways of delivering health care. The Health Board has a large number of active research staff who both lead and support research.

Discussions are taking place with Bangor University on the development of a Clinical Research facility to support new and emerging health research. This will provide opportunities to further develop and expand the existing research portfolio. In 2012/13 the Health Board hosted just under 400 active research projects which include trials involving drugs and interventions as well as projects looking at the way services are delivered or managed, and others seeking to explore patient's experiences of health care. These will also include projects undertaken by health care staff as part of their studies for higher academic qualifications reflecting the Health Board's commitment to staff development. During this period, the Health Board recruited over two thousand patients into studies providing opportunities for

patients to be involved in research which could lead to improved services for future patients of the NHS.

Staff Survey

During January and February 2013 all staff in NHS Wales were invited to take part in a [Staff Survey](#). This asked questions about how staff felt about working within their Health Board or Trust and their views on the quality of care delivered. Within the Health Board 28% of staff completed the survey. The results were received by the Health Board in May 2013 and presented to the May Board meeting and the Local Partnership Forum (comprising senior managers and Trade Union representatives). Our staff told us that they felt trusted to do their job, were treated with respect by colleagues and managers and had a strong commitment to deliver their best for service users. They felt satisfied with the quality of care they were able to deliver personally. They also said that they were encouraged to report errors, incidents and near misses as part of our commitment to patient safety. (see figure 1)

However there were also a number of issues where staff felt much more needed to be done: (see figure 2)

- Time and numbers of staff to deliver high quality care
- Healthcare under significant pressure to maintain quality-only 50% of staff felt that they would be confident that the Health Board would provide good quality care if a friend or relative needed treatment
- Concerns about other priorities calling into question the Health Board's continued commitment to make quality and safety the first priority
- Concerns about the senior management team's visibility and understanding of the pressures on staff
- Better communications with staff
- Lack of feedback to staff on how they are performing
- Staff not feeling they were fully involved in their teams to improve services for patients
- Poor communication and management of change

The Board felt that these were significant matters of importance and that changes needed to be made to show clear and lasting improvements for staff and patients. We have worked with staff and Trade Union partners over the summer of 2013 to respond to these areas of concern and make improvements. An action plan with recommendations will be presented to the September Board meeting.

Figure 1: Statements producing highest scores



Figure 2: Statements producing the lowest scores



Looking forward

To maintain and deliver high quality care in the face of considerable challenge the Board will keep their focus on quality and seek out best practice.

There are a number of significant issues raised within the Annual Quality Statement which the Board needs to attend to going forward in order to raise the quality, safety and standards of care provided to the patients and communities we serve.

Governance and Leadership

The review undertaken by HIW and WAO published in June 2013 highlighted a number of key areas where improved performance is required. This will help the Board to focus on the issues which need to change so that we can drive improvement in the quality and safety of care for patients. The improvement of the governance and leadership of quality and safety will be led by the Executive Director of Nursing, Midwifery and Patients Services supported by an external Medical Director appointed by Welsh Government. The programme of work will include a review of the Quality and Safety Committee and sub committee structure and will look to improve the reporting and escalation of information to the Board. This will include a review of the quality indicators the Health Board has in place and remapping which information goes to which committee. In addition, HIW will undertake specific monitoring actions alongside their routine inspection programme of healthcare settings. This will include development work with the Quality and Safety Committee to ensure it is better prepared to identify and address key patient safety risks. The work of the Board will be overseen by HIW and WAO so that all can gain assurance that the appropriate action is being taken within acceptable timescales to address these critical issues.

Welsh Government are providing support to ensure that the Board makes the necessary progress. Transitional arrangements have been put in place to ensure the Board has additional capacity and support in key areas including the senior leadership team.

Healthcare acquired Infection – including *Clostridium Difficile*

Patients deserve to be protected from all avoidable infections and we are determined to take focused action to reduce all healthcare acquired infections. The Executive Director of Nursing, Midwifery and Patient Services has lead responsibility for infection, prevention and control and she will ensure accurate and timely reporting to the Quality and Safety Committee and the Board via the Improving, Prevention and Control of Infection Sub Committee. The key issues for 2013/2014 will be:

- *Clostridium-Difficile* infection, including the continued management of the outbreak at Ysbyty Glan Clwyd.
- Reducing cases of MRSA (Methicillin-resistant *Staphylococcus aureus*) bacteraemia and MSSA (Methicillin-sensitive *staphylococcus aureus*)

The Health Board has already taken a number of steps to improve its systems for the [prevention and control of infection](#) supported and informed by Public Health Wales. An independent expert in infection prevention and control, Professor Brian Duerden has reviewed our procedures and has made recommendations for improvement which the Board is already acting on. His full [report](#) has been published and available via the Health Boards web site. The Health Board has put in place an improvement plan to ensure that this situation does not happen again. As part of this improvement plan the Health Board has appointed an external specialist nurse in infection control.

Risk Adjusted Mortality Index (RAMI)

Risk Adjusted Mortality Index (RAMI) rates are higher at the Health Board when compared to other organisations across the UK and are slightly higher than the Welsh average. RAMI is one measure of mortality used to look at rates of death in hospitals but is complex and needs care in interpretation. For example, differences in the way hospitals look after patients which are entirely safe and appropriate can cause higher or lower RAMI. However, the rate has increased in time in the west of North Wales and this is subject to a detailed and thorough investigation including a case note review which is taking place across all sites.

Risk Adjusted Mortality Index (2012 Model) rolling total to December 2012:

UK Average	Welsh Average	Health Board Average
100	104	107

This variation needs to be better understood so that the Board and the public can be assured that any action required can take place to improve the safety and standard of care provided. Information about RAMI and crude mortality will be reported at Board meetings and is available via our website so that we can monitor the progress and any improvement required.

Dealing with concerns and learning lessons

Concerns received from patients and their carers will routinely be reported to the Board and the quality and safety report will be available via our website.

Feedback continues to be an important area of learning for the Health Board and significant improvement is needed in the timeliness of responses provided to patients and evidencing that we have learnt lessons. In May 2013, the Board agreed that the Executive Director of Nursing, Midwifery and Patient Services will lead the management of concerns and oversee the implementation of the improvement plan. This not only focuses on satisfactory outcomes and prompt local resolution but also identifies recurring themes so that we can develop more robust arrangements to

make sure that as an organisation we learn and change for the better as a result of patient's experiences. This will be supported by a new Organisation Learning from Experience Policy which will be out to consultation with staff during the year.

During 2013-14 specific detailed reviews will continue to ensure that there is sustained improvement in the Hergest Unit in Ysbyty Gwynedd as well as in Mental Health Services across North Wales.

Staff will continue to be encouraged and supported to raise concerns in relation to patient safety and the arrangements for escalating concerns quickly to the appropriate level will be reviewed to ensure that the Board is aware and can address issues which may arise across sites and structures.

Listening to staff

The staff survey and the review undertaken jointly by HIW and WAO identifies that we need to do more to communicate effectively with staff. A comprehensive and coordinated communication strategy will be developed and implemented which will create new opportunities for staff to raise concerns so that we can focus on the quality and safety of patient care and create a positive work climate as well as building trust. This will include open forum meetings and an area of our intranet where colleagues can engage in sharing opinions and ideas about how to make things better.

We will be working to give staff a stronger voice and following the staff survey we will be working through open forums and task and finish groups to look at how we can improve quality and patient care.

Staffing Levels

The Health Board has recognised the recruitment difficulties it faces in certain parts of our medical workforce. In 2013-14 the Health Board will continue to progress a number of key actions to ease the problem including:

- Collaborative working with the Wales Deanery
- Recruitment campaigns
- Developing and reconfiguring services
- Working with Bangor University (North Wales Clinical School and clinical research facility)

Progress with this key challenge will be monitored by the Workforce and Organisation Development Committee and reported to the Board.

We will work to implement the Chief Nursing Officer for Wales guiding principles to support safe nurse staffing levels on acute hospital wards by April 2014. The findings of the three yearly birth rate plus re-assessment will also be reported to the Health Board in autumn 2013.

Standards for Health Services

Following a review of the Standards during the year at a corporate level, the following actions were identified for action during the year:

Standard 1 – Governance and Accountability

We will work to improve the Boards ability to govern effectively and in doing so build confidence in the quality and safety of services. A governance and leadership delivery team led by an external Chief Executive will work alongside the Board Executives, Clinicians and staff representatives to drive rapid improvement in the governance and leadership arrangements of the organisation. Their work will focus on six key areas which will help to ensure that the Board is able to evidence its commitment and actions to improving its governance and management arrangements.

- Board Development
- Strategy and Objective setting
- Management and leadership
- Quality and safety
- Services strategy
- Communications

These actions seek to address the issues identified in Standard 1 of the Standards for Health Services in Wales, the Governance and Accountability Module assessed by HIW and the findings of the joint review undertaken by HIW and WAO in relation to the Boards overview of governance arrangements. A detailed report on these actions can be found here: [Response to WAO and HIW review](#)

Standard 2 – Equality, Diversity and Human Rights

The Equality Impact Assessment process will be embedded across the organisation. The Health Board will continue to develop the role of Equality Lead in all areas.

Standard 7 – Safe and Clinically Effective Practice

The Health Board will ensure that all Clinical Programme Groups have common and consistent processes in place to monitor and record compliance against external guidelines.

In order to maximise Clinical Effectiveness, the Health Board's Clinical Effectiveness Sub Committee is reviewing existing processes that seek assurances from CPGs that patient care is safe and clinically effective. The review will provide each CPG with the opportunity to demonstrate this through a number of measures such as compliance against national guidance and standards, ensuring service changes are informed by patient concerns, how they act on findings from clinical audit and to identify concerns or barriers to progress. This will contribute to the delivery of the Health Board's strategy and aims, and support organisational learning.

Standard 10 – Dignity and Respect

We will roll out the Butterfly Scheme. This is an exciting new scheme for dementia care in general hospitals.

The Butterfly Scheme allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs.

Standard 11 – Safeguarding

There has been new guidance released with regard to Sexual Exploitation and Counter Terrorism. Training and awareness sessions will be undertaken to help staff to identify patients who may be at risk in these areas.

Standard 23 – Dealing with Concerns and Managing Incidents

The Executive Director of Nursing, Midwifery and Patient Services will lead the implementation of an improvement programme to ensure that lessons learnt and action taken are disseminated and spread to all areas of the organisation and concerns are dealt with in a more timely manner.

Standard 25 – Recruitment and Employment Practices

A clear plan of action has been agreed and will be implemented to ease the problems of recruitment in medical staffing.

Openness and Transparency

There is a range of ways in which the public access information about the quality and safety of our services. We will continue to work on the way in which information is shared so that it is clear, jargon free and accessible and will be regularly updated on our website so that it is easier to use. Key information will be provided in a range of accessible forms for those with disabilities and for those with different language needs.

Healthcare in North Wales is Changing

2013/14 will be one of the Health Board's most challenging years.

To make sure our services are safe and fit for the future we are using clinicians to generate solutions in the following areas:

Focus on Unscheduled Care	Focus on Planned Care
End of Life Care	Clinical Triage, Prioritisation & Thresholds
Chronic Conditions – Cardiac, Diabetes and Respiratory	Outpatients
Frail Elderly, Falls, Dementia	Improving Patient Flow through hospital Continuing Health Care

The challenge is to make demonstrable, significant improvements in health for all and in the delivery of safe, high quality healthcare.

Our plans will be predicated on the achievement of clear outcomes for patients. In the context of financial challenge and restructuring of services and the workforce, the Health Board must ensure that quality and safety remain at the core of its planning.

Services based on clinically proven national guidance will be prioritised with a focus on avoiding unsuccessful or unnecessary operations, tests or treatments.

Re-modelling services will form the heart of the change agenda and will be guided by clinical evidence, quality standards and performance.

Key acute hospital service developments will be in maternity and paediatrics, vascular, breast and general surgery; care for the elderly and emergency medicine. More work will be done to enhance primary care and community services to make sure as many services as possible, where safe to do so, are provided out of hospital and that services for vulnerable groups are co-ordinated and meet need.

1000 Lives Plus

The safety of patients and effectiveness of clinical care will continue to be improved through the 1000 Lives plus programmes, infection control, medication, dementia care and falls prevention programmes.

The Health Board is establishing a process for monitoring the actions from each walkround, measuring their success over time and scheduling revisits to areas where appropriate in 2013.

Francis Report

The Francis Report was published in February 2013. To date the Health Board have identified Executive and Programme leads for the report and a structure to support their work in the future. This includes a large stakeholder group which draws together a wide range of views and perspectives which will help to scrutinise and challenge the Health Boards response.

The report has already been considered for its immediate impact on the Health Board with various Executive leads being approached to respond to those recommendations specific to their role and responsibilities within the organisation.

It is envisaged that 2013/14 will be spent analysing the Health Boards status against the recommendations and advising on new or additional actions that best meet the requirements of the Francis Report. It is hoped that during the latter half of 2013/14 changes will be introduced across the Health Board that not only reflect the Francis Report but improve patient care independent of the report.

Conclusion

The Health Board has set out a range of actions that will be taken to ensure continuous improvement. The Boards response to the review of governance arrangements by HIW and WAO will drive improvement in the Board's effectiveness to deliver high quality care as well as its ability to recognise as early as possible when things have gone wrong so that action can be taken and lessons learnt. We will work hard to listen to those that use our services as well as listening to our staff

so that together we can learn from experience and deliver the quality of care that our communities deserve.

Throughout the Health Board staff are committed to providing the very best care for their patients even when working in challenging and pressurised circumstances. We will be working to ensure that care across the Health Board is safe and compassionate and patients remain at the centre of all we do.

Should you require any further information please contact:
info.bcu@wales.nhs.uk or

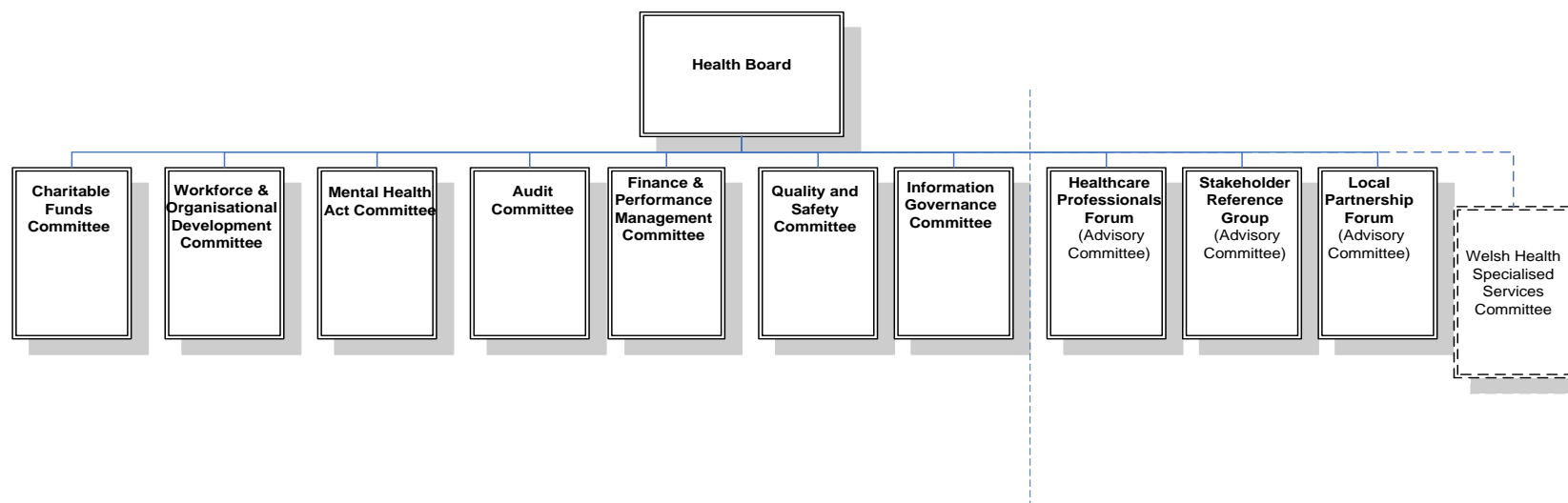
The Chief Executive's Office

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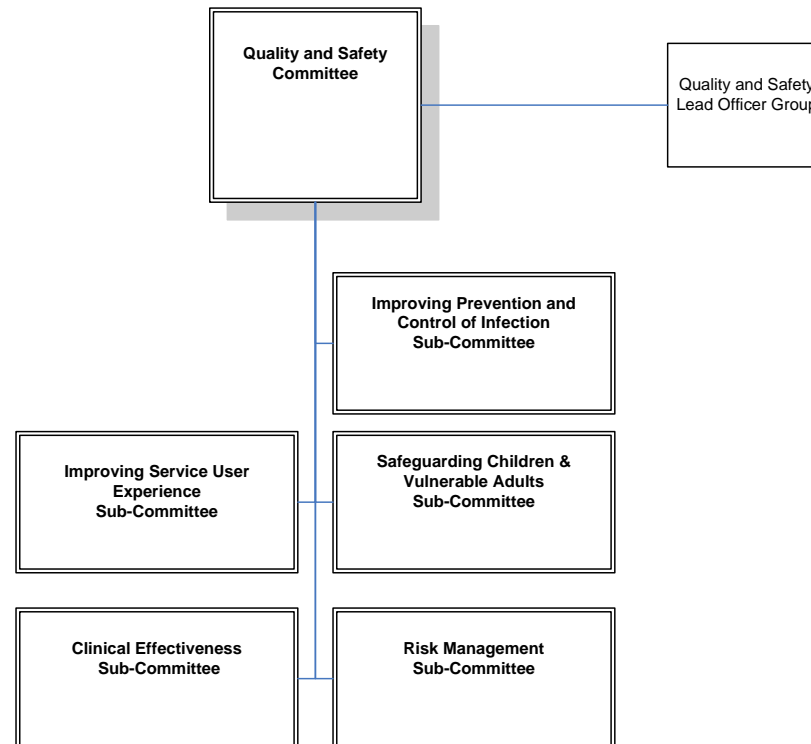
Appendix 1– Standards for Health Services

	Current Score
Standard 1 - Governance and Accountability	4
Standard 2 - Equality, Diversity and Human Rights	3
Standard 3 - Health Promotion	3
Standard 4 - Civil Contingencies	4
Standard 5 - Citizen Engagement and Feedback	3
Standard 6 - Participating in Quality Improvement Activities	3
Standard 7 - Safe and Clinically Effective Practice	3
Standard 8 - Care Planning and Provision	3
Standard 9 - Patient Information and Consent	3
Standard 10 - Dignity and Respect	3
Standard 11 - Safeguarding	4
Standard 12 - Environment	4
Standard 13 - Infection Control and Decontamination	4
Standard 14 - Nutrition	4
Standard 15 - Medicines Management	3
Standard 16 - Medical Devices and Equipment	4
Standard 17- Blood Management	4
Standard 18 - Communicating Effectively	3
Standard 19 - IM&T	3
Standard 20 - Records Management	3
Standard 21 - Research and Innovation	4
Standard 22 - Managing Risk and Health and Safety	3
Standard 23 - Dealing with Concerns and Managing incidents	3
Standard 24 - Workforce Planning	3
Standard 25 - Recruitment and Employment Practices	4
Standard 26 - Training and Organisational Development	3

Betsi Cadwaladr University Health Board - Committees



Betsi Cadwaladr University Health Board



Glossary

Acute	Acute care is a branch of secondary healthcare where a patient receives active but short term treatment for a severe injury or episode of illness, and urgent medical condition, or during recovery from surgery.
Advanced Practitioner	The RCN defines advanced nursing practice as a level of practice rather than a role or job title. Advanced nursing practice both builds on, and adds to, the set of competences common to all registered nurses.
All Wales Nursing and Midwifery Dashboard	The dashboard is a set of indicators and metrics to demonstrate the impact of the care provided on patient outcome.
Allied Health Professionals	There are various roles that come under the banner of the allied health professions (AHPs). These are: <ul style="list-style-type: none"> • arts therapists (art therapists, drama therapists and music therapists) • chiropodists/podiatrists • dieticians • occupational therapists • orthoptists • orthotists • paramedics • physiotherapists • prosthetists • radiographers • speech and language therapists
Birth Rate Plus	A workforce planning system which matches the needs of mothers with the right number of Midwives to provide one-to-one care in labour.
Board	Board is the term used in this document for the collective group of staff including Executives and Independent members that meeting monthly to make decisions on behalf of the Health Board.
Breach	The passing of the targeted date for a patient to be seen by a consultant to begin definitive therapy for cancer.
CHKS	CHKS is a leading provider of healthcare Intelligence and quality improvement services
Clinical Governance Practice Self Assessment Tool (CGPSAT)	This is a universal tool used across Wales for General Practices to monitor their Governance arrangements
Clinical Programme Group	Clinical Programme Groups (CPGs) are the way in which we have organised the range and complexity of clinical services across North Wales. Each of the eleven

	CPGs are led by a Chief of Staff who is a Clinically qualified practising professional, who takes responsibility for services and is supported by a team of clinicians and managers.
Concern	A “concern” means any complaint, notification of a patient safety incident or a claim for compensation
EIDO	EIDO Healthcare was established in June 2000 in response to the growing need in the UK healthcare sector for improvements to the informed consent process. They provide information to support patients to be properly informed so that they can share in the decision-making process.
“Esther” Network	The “Esther” Network is made up of caregivers, clinicians, patients and families who work to promote and improve the complex care in Höglandet.
Francis Report	The Francis Report was a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust.
Health Board	Betsi Cadwaladr University Local Health Board
Healthcare in North Wales is Changing	This was the title provided to the consultation events that were undertaken during the summer of 2012 with regard to the review of services
Healthcare Inspectorate Wales (HIW)	Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales
Indemnifying body	The Welsh Risk Pool indemnify the Health Board against damage caused by such things as fire, theft, and flooding, which are specified by the terms of the contract between the company and the insured. They also <i>compensate for loss or damage; to provide security for financial reimbursement to an individual in case of a specified loss incurred by the person.</i>
Intentional Rounding	To implement hourly nursing rounds, to check on patients and ensure their fundamental care needs are met
Localities	<p>Within Betsi Cadwaladr University Health Board, North Wales has been split into 14 ‘localities’. Localities have a population of between about 30,000 and 50,000 people. This is felt by the Welsh Government to be the ideal population size for health, social care and community services to work together effectively to support residents.</p> <p>Each locality has a multi-agency Locality Leadership Team which looks at how community based services can work together to respond to the needs of local residents with the overall aim of trying to keep people closer to home for longer and prevent, where</p>

	appropriate, unnecessary hospital admissions.
Local Partnership Forum (LPF)	This is the formal mechanism where the Health Board's Executive and Trade Union organisations work together to improve health services for the people of Wales
Locum	This is the phrase given to a person who temporarily fulfills the duties of another
Mini-collaboratives	These are a number of people with specialist skills and knowledge working together on identified projects regarding patient safety eg Falls.
National Patient Safety Agency (NPSA)	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
NEWS (National Early Warning Score)	This is national guidance that helps all organisations to recognise signs of a critically unwell patient in hospital
Optometry	Optometry is a health care profession concerned with the health of the eyes.
Orthoptic	Deals with the diagnosis and treatment of defective eye movement and coordination.
Out of Hours	The service which provides GP level care for patients between 6pm and 8am and at weekends.
Palliative Care	Care which gives relief from symptoms but does not cure diseases. It is often given to people who are terminally ill.
Patient Acuity	The measurement of the intensity of care required for a patient accomplished by a registered nurse.
Primary Care	The collective term for all services which are the first point of contact for the patient, for example the GP, Dentist, Pharmacist or Optician.
Risk Management	Clinical Risk Management concentrates on identifying and correcting risks associated with direct patient care, whilst non-clinical risk management is associated with all other Health Board activities.
Risk Register	The Risk Registers provides a means for managers to record risks in their areas of responsibility and the actions they are taking to minimise or eliminate those risks.
Root Cause Analysis	Root Cause analysis allows the Health Board to look deeper in to problems to find out why they are happening or have happened.
Rostering	A roster is a list of names of people involved with some organization or assignment. It can be a list of people and additional information, like the times when they are required to work
Secondary Care	Hospital or specialist care to which a patient is referred by their GP.

Stakeholders	Stakeholders in the term used to describe anyone who has an interest in the organisation.
Transforming Care	Transforming Care is a quality improvement programme that aims to reduce the time nursing staff spend on tasks that does not directly benefit the patients and engages and involves all health care professionals to make improvements
Wales Deanery	The Wales Deanery supports the education and training of trainees, hospital doctors, GPs and Dentists in Wales.
Welsh Audit Office (WAO)	The Wales Audit Office is the public service watchdog for Wales. Their aim is that the people of Wales know whether public money is being managed wisely, and public bodies in Wales understand how to improve outcomes.