

BRIDGEND LHB

H.I.W 06-07 Assessment Grid - Appendix A

Dec-06

1 Patient Experience				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 1.	Local equality arrangements are in place and are reflected in all aspects of commissioning.	<p>Corporate</p> <p>1. Is there an up-to-date Welsh Language Scheme agreed at Board level?</p> <p>2. Is there an up-to date Race Equality scheme agreed at Board level?</p> <p>3. Is there an up-to date Equality and Diversity scheme agreed at Board level?</p> <p>Operational</p> <p>4. How is progress and compliance with the above schemes monitored?</p> <p>5. What mechanisms and tools do you use to review and undertake equality and diversity impact assessments of new and existing services?</p> <p>6. How do you plan and design services that meet the needs of specific groups, including young people, older people and people with disabilities?</p> <p>7. How do you ensure primary care contractors are complying with equality and diversity legislation and guidance?</p> <p>Impact on Patient Care/Experience</p> <p>8. What developments have taken place during the last 12 months that address the needs of minority groups within your local community?</p>	<p>Yes, Welsh Language Scheme agreed by Board Oct 2004. Annual compliance report on Board agenda in Aug 05 and action plan on Board agenda in Oct 05.</p> <p>Yes, Race Equality Scheme was signed off by the Board in December 2005.</p> <p>Yes, Equality and Human Rights Action Plan was agreed by the Board April 2006</p> <p>Board are updated annually on progress against the action plans for the Schemes. On an ongoing basis throughout the year the lead officer for the Scheme action plans presents progress to the Executive Team of the LHB to ensure progress is monitored and Directors can take corrective action where necessary.</p> <p>The LHB has adopted the Centre for Equality and Human Rights Equality Impact Assessment tool to support all screening activity.</p> <p>Planning Team work in partnership with statutory and non-statutory partners, service users and carers to plan, commission and monitor service developments. Work co-ordinated through service/patient specific joint strategy planning teams (eg Children and Young People's Framework Partnership (CYFPF), Older Persons Strategy Planning Team (OPSPT), Learning Disabilities Joint Strategy Planning Team and Joint Mental Health Strategy Planning Team which all report to an executive Partnership Board (CEO and Member representation), supported by Joint Executive Team (CEO & Senior Officers). Regular reports to LHB Performance Management Committee and Board. Planning Teams meeting bimonthly/quarterly and are supported by sub groups. CYFPF and OPSPT hold an annual standing conference to engage with practitioners/service users and carers and to reflect on progress to date / future priority planning. Service priorities outlined in Health Social Care and Well Being Strategy, NSFs and national Strategies. Services for people with a sensory/physical disability are planned through workshop meetings involving service users. Strategy launched in February 2006.</p> <p>Part of Quality and Outcomes Framework Patient Experience. Information provided on language line, interpreting services. Disability Awareness training sessions offered to all professions. Part of implementation of all Contracts. Through implementation of estates strategy to ensure Disability Discrimination Act compliance. Implementation of the Access Direct Enhanced Service, including opportunities for training.</p> <p>1. Launch of Physical and Sensory Disability Strategy Feb 06. Service model for Physical and Sensory service agreed and recruitment process underway, service due to commence on 1 Aug 2006 (Specialist SALT, OT, Physio, Nurse, Social Worker). 2. Launch of Crisis Resolution/Home Treatment service for Mental Health Service Users. 3. Establishment of Carers Forum. 4. Establishment of SHOUT, Voice of the older Person. 5. Pilot School Health Nurse (Sexual Health Specialist) post in Youth Offending Team Team. 6. Learning Disabilities & Mental Health Crisis cards.</p>	<p>The LHB has local equality arrangements in place, through the Welsh Language Scheme, Race Equality Scheme and an Equality and Human Rights Action Plan. Mechanisms are in place within the LHB to monitor compliance with these and arrangements for independent contractor settings the LHB monitors compliance through the Quality Outcomes Framework (QoF). The LHB has demonstrated that it has a clear joint planning strategy and involves patients and the public in all work streams.</p> <p>The LHB has provided training on equality issues to LHB and independent contractor staff.</p> <p>The LHB has actively sought the views of minority groups in their community and examples of appropriately developed services are evident.</p>

1 Patient Experience				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 2.	Access to primary and secondary care services are monitored and evaluated.	Corporate		
		1. How does the Board monitor and evaluate access to primary and secondary care (including out of hours services) and how is this information used to evaluate your primary care strategy?	Performance Management Committee. Balanced Scorecard and SaFF targets. LTA meetings. Out of Hours service data. Primary Care Steering Group, anonymous telephone survey in primary care. Primary Care: For 2005/06, the LHB monitored compliance of practices against the SaFF target for patients to access a member of their practice primary care team within 24 hours. Monitoring was undertaken in accordance with the cycle set within the SFE and the LHBs monitoring framework, and reported within the LHBs quarterly balanced scorecard. For 2006/07, the LHB will be implementing the new Access DES and is awaiting national guidance on the patient experience survey. New contracts for Dentists and pharmacies provide a framework for monitoring and increased access. The GP Out of Hours service monitored through detailed monthly monitoring reports and monthly cycle of meetings which ensure monthly face to face dialogue with provider. The NHS monitors activity not access, NHS information systems are designed to monitor activities not access to service. As this has never been a key performance indicator there is a lack of this information	Mechanisms are in place to monitor and evaluate access to primary care services, however mechanisms for secondary care services appear limited and the LHB pointed out that NHS information systems are designed to monitor activity and not access to service. The Dental contracts have allowed provision of emergency care during the 'in-hours' period for their patients. A collaborative arrangement is in place with Neath Port Talbot and Swansea LHBs for 'out of hours' emergency dental access, with treatment provided via a rota arrangement with participating Dentists. The LHB has also established a new Dental practice providing up to 10,000 patient places. The LHB monitors access and suitability of care and services provided through various mechanisms, such as external reviews, etc and information from patients and public opinions is being used by the LHB to further develop access to services, e.g. a Saturday morning clinic for sexual health services.
		Operational		
		2. Does the LHB have a SLA for emergency access to NHS Dentistry?	Yes. Dentists holding NHS contracts with the LHB are responsible for the provision of emergency /urgent care during the "in hours" period for their patients. During the out-of-hours period, Bridgend has a collaborative arrangement in place with Neath Port Talbot and Swansea, with treatment provided through a rota arrangement of participating dentists and call-handling through NHS Direct Wales. Capacity of access sessions for patients without a regular dentist, has also increased locally.	The Children's and Young Peoples Framework Partnership commissioned Advocacy services for children and young people and services of the Community Health Council are also publicised to children and young people. The LHB is working with the Local Strategic Partnership to implement the Community Strategy and consider physical and transport access to services.
		3. How has the availability of access to local dentistry improved over the past year? Please give examples.	By 31/03/06, all NHS dentists in the locality had signed contracts in place with the LHB. Through contract discussions, the LHB was able to agree increased activity with a number of dentists. Also under the PDS arrangements, the LHB agreed a contract for the establishment of a new practice providing up to 10,000 patient places (under the former registration regime). This practice became operational from June 2006. Capacity of access sessions for patients without a regular dentist, has also increased locally.	
		4. How do you ensure children in need of advocacy services have access to them?	Children and Young Peoples (CYP) Framework Partnership commissioned Advocacy service for CYP. In addition services of CHC publicised to CYP. Supporting Evidence: Advocacy service tender, CHC leaflets	
		5. What are your current initiatives / developments designed to improve access for patients?	Scheme in Community Pharmacies improves access to Emergency Hormonal Contraception. Patient education has been undertaken for access to appropriate healthcare. Implementation of the new GMS Access DES. Crisis Resolution / Home Treatment Service; Physical Disability Service; Substance misuse service; Redesign of the Diabetes & Cardiology Out patient service; Osteoporosis service development; Sleep apnoea service established; Anti TNF - Rheumatology service; Redesign of the Musculoskeletal Service including fracture fragility and falls and rapid access orthopaedic list and appropriate use of therapies	
		6. How do you monitor the accessibility and suitability of the care and services you provide to the population you serve?	External reviews and prioritisation of key service areas. Implementation of SaFF Targets (national and local). Through the commissioning cycle and complaints process and clinical governance concerns. Restructured the LTA document with a section on Health care standards and quality of service which is expected to be signed by all provider organisations for 2006-07. Quality Assurance in GP Practice document developed benchmarking all 19 practices across the patch, updated Health Needs Assessment. All service user groups. Uptake of Emergency Hormonal Contraception is monitored with respect to age group of client, where the client is from and whether there is a supply made. The LHB has commissioned Swansea University to measure success of service development in Diabetes	
7. How do you work with other organisations and agencies, including local and public transport providers and local authorities to ensure all patients and members of the public have physical access to the services you commission and/or provide?	Working with Local Strategic Partnership to implement Community Strategy - key theme access and transport. Inequality impact Assessments on all new service developments. Partnership Board and supporting Joint Strategy Planning Teams.			
		Impact on Patient Care/Experience		
		8. How have you responded to themes emerging from patient satisfaction questionnaires relating to access? Please give examples.	Sexual health Services to Children and Young People - need identified for a Saturday morning clinic - weekday services reconfigured and Saturday morning clinic commissioned. Primary Care QoF PE questionnaire - area below standard addressed by practices eg, telephone access, doctor of choice - see separate PE reports for each practice. Transport has been a key theme emerging through consultation with patients and public and is identified within the Health Social Care and Well-being Strategy, as well as other partnership strategic plans. Given the topic is broader than health and social care, it has been raised for action through the Local Strategic Partnership, the body responsible for the Community Strategy. Involvement in multi-agency public and patient involvement group. Direct representation at Joint Disability Strategy. The LHB will pick up any themes arising from last years patient surveys into this years QOF/CG self assessment tool.	

2 Public and Patient Involvement				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 3.	The views of patients / public and staff are sought and used to make changes and improvements.	Corporate		
		1. Is there an up-to-date Public and Patient Involvement Strategy agreed at Board level?	LHB PPI Action Plan is an element of CG Strategy and 3 year rolling programme	The LHB does not have a Public and Patient Involvement (PPI) Strategy, but there is a PPI Action Plan which is encompassed within the three year Clinical Governance Development Plan. However in practice the LHB frequently involves the public in consultations and examples are evident. Throughout, the LHB patient and public members are seen as integral members of all planning groups and committees, which includes a very active mental health forum. The LHB can point to many examples where it has made changes during the last 12 months as a direct result of feedback and consultation with patients. Mechanisms are in place to capture staff views through national and local surveys and an active staff forum. There is a 'buddy system' at induction for new members of staff and three days per annum protected learning time for all staff. It is therefore recommended that the LHB develop a PPI Strategy.
		Operational		
		2. What examples are there of consultations with local population and patient surveys undertaken over the past two years?	Consultations: 1. Health Social Care & Well Being Needs Assessment and Draft Strategy. 2. Reconfiguration of Community Mental Health Teams. 3. Pencoed primary care centre. 4. Physical & Sensory Disability Strategy. 5. Mental Health Matters Mental Health Service Users survey. 6. Equality & Human Rights Action Plan and Race Equality Scheme. 7. Mid & West Wales Acute Services Review. 8. Young People's Emotional Health. Establishment of SHOUT, the voice of older people. Children and Young People's Annual Conference, Prison Health Needs Assessment; Mental Health Acute Service Review. Patient Surveys: As in LHB 2 impact on pt care/experience 8. The LHB has recently commissioned Swansea University to undertake an evaluation of the Diabetes service development, this will be a Quality of life survey using EQ5D & SF12.	
		3. What examples are there of consultation / staff surveys undertaken over the past 2 years?	A recent survey of the prescribing clerks scheme has been undertaken which included gaining responses from the clerks and practice managers. Other surveys include NHS Wales Staff Survey, Travel/Transport Survey, Staff health and attitude survey for Corporate Health Standard, Fair Trade Survey, Flexible Working Policy, plus other draft HR policies. Welsh Language Scheme and Race Equality Scheme.	
		4. Which planning groups / committees have patient / public representatives as standing members?	LHB Board. Children's Partnership, Young People's Partnership, Joint Mental Health Strategy Planning Team, Older Persons Strategy Planning Team, Learning Disabilities Strategy Planning Team, PPI Group, Carers forum, Physical & Sensory Disability Forum, Voluntary Sector Liaison Group, Health Alliance, Continuing Health Care, Performance Management Committee, Individual Patient Commissioning; Diabetes & CHD NSF Project Boards.	
Impact on Patient Care/Experience				
5. What changes have been made during the past 12 months as a direct result of specific feedback / consultation with patients and the public? Please give examples.	Saturday morning Youth Advice Service clinic, establishment of Carers Forum. Physical Activity Action Plan launched March 2006. HSCWB Strategy developed following full public consultation and ongoing involvement with subsequent service development. Emotional Health and Well Being survey amongst young people led to the introduction of a Anti-Bullying Initiative. Feedback from Diabetes Service user group resulted in the LHB purchasing Diabetes Patient Information box for each GP Practice in the area. twelve month counselling service pilot which may be rolled out to Primary care; developed mental health education teaching pack for Primary and Secondary schools across the County Borough; framework partnership designated 2006 theme as emotional health.			
6. What changes / improvements have been made as a direct result of specific feedback from staff during the past 12 months? Please give examples.	Training programme amended following feedback. Action Plan for Corporate Health Standard developed. Work Life Balance initiatives, response to immediate needs of staff regarding environmental issues.			

3 Use of Information				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 4.	There is a clear strategic direction and coordinated approach to Information Management and Technology, which considers all contractor professions.	<p>Corporate</p> <p>1. Is there an up-to-date local IM&T Strategy and Readiness Plan agreed at Board level?</p> <p>Operational</p> <p>2. What IM&T actions been progressed over the past two years, which have relevance to contractor professions? Please give examples.</p> <p>Impact on Patient Care/Experience</p> <p>3. What specific IM&T developments have taken place during the last 12 months (such as electronic prescribing systems)?</p>	<p>Yes. Board approved a draft IM&T Strategy in December 05. However it was agreed that further work was required to reflect the national Informing Healthcare plans once finalised. In June 06 BSC Head of IM&T presented an update to Board on Informing Healthcare which has agreed to develop the LHB response plan and update the strategy. An SLA exists with BSC regarding provision of maintenance of all LHB IM&T Hardware, Software and upgrades. The LHB strategy and response plans also take account of WAG IMT division which includes direction around primary care, information quality etc.</p> <p>ETD training and education events held which target GPs and their staff on use of clinical systems. ECDL training. ISMS programme. Improving links with secondary care systems to facilitate improved transfer of patient information. Prescribing team have provided training for Prescribing clerks, this has included training days, and development of training packs for the clerks and other practice staff with regard to repeat prescribing. Practices have been supported to develop repeat prescribing policies. The Team has been involved in the Medicines Management Collaborative. Training has been provided for the VTS scheme and for Optometrists with regard to Amiodarone. Ongoing replacement programme for GP IM&T hardware and Information and clinical systems replacement. Electronic and paper pathology results from local Trust to GPs. LHB funds dedicated IM&T facilitator providing support to GP practices.</p> <p>Joint working with the Trust as part of the Medicines Management Collaborative to develop electronic discharge information to GPs. Development of shared care protocols, Joint formulary and local guidelines for treatment. Electronic transfer of diabetic patient information to primary care. Electronic transfer of OOHs reports for GPs from OOHs provider.</p>	<p>The LHB has an up-to-date Information Management and Technology (IM&T) Strategy, however due to delays with implementing Informing Healthcare there is no agreed IM&T Action Plan. The LHB has, however developed certain IM&T initiatives to improve patient care services with electronic transfer of information ie patient contact data from Primicare is sent electronically to practices and the LHB has supported primary care IM&T developments such as the Information Security Management System (ISMS). The LHB has also ensured that staff have access to the Electronic Computer Driving Licence training.</p>

3 Use of Information			
LHB 5.	Information / learning is shared with public / patients, stakeholders / partners and clinical and non-clinical staff.	<p>Corporate</p> <p>1. Is there an up-to-date Communications Strategy agreed at Board level?</p> <p>2. What information protocols are in place?</p> <p>3. How are outcomes of clinical audit activity reported to the Board?</p> <p>Operational</p> <p>4. What are the mechanisms in place to disseminate clinical outcomes information across the primary and secondary care interface and within the LHB?</p> <p>5. What changes / modifications have been made to communication strategy, policy and procedures as a result of outcomes from monitoring and feedback of your communication activity?</p> <p>6. What examples are there of joint working / initiatives with stakeholders relating to information sharing and learning?</p> <p>Impact on Patient Care/Experience</p> <p>7. What channels are used for communicating patient information, i.e. Mail drops, local media, newsletters, leaflets and posters? Please give examples.</p> <p>8. How do you ensure your Service directory is kept up to date?</p>	<p>Yes. Communications Strategy signed off by Board 2003-04. Updated Strategy to be endorsed by Board August 2006. Internal Communications Group established to coordinate work across LHB Directorates.</p> <p>Unified Assessment information protocol taken to Board. South Wales Domestic violence Information Sharing protocol. Crime and Disorder Information Sharing protocol and Children and Young People Information Sharing protocol. ACPC/Safeguarding Children have information sharing protocols in place.</p> <p>Key themes arising from Clinical Audit in primary and secondary care are reported via Risk Management Group and Clinical Governance Committee. Annual report of outcomes from GMS QOF was presented to the Board in June 2006. A more detailed report was then discussed at Primary Care Steering Group in June 06 and Performance Management Committee in July 06. Clinical audit has been undertaken in relation to clinical governance concerns this information is then used to aid in the resolution of these issues via the Clinical Governance Committee to the Board examples of these are Mental Health service, Haematology services, transportation of childhood immunisations</p> <p>Via Clinical Network and commissioning and planning groups. Outcome of Medicines Compliance Aids reported to pharmacist development group. Will be taken to CG Committee in September 2006. Other groups etc which receive this type of information are Prescribing leads, Pharmacy forum, IPAG, Prescribing Advisory Group, Interface Pharmacist, Substance misuse pharmacist and GP annual workshops. The LHB has made specific requirement in the Quality in commissioning LTA document. However there have been barriers in having transparent discussions with primary, secondary and tertiary providers of service to explore some of these frontline statistics. Internally we have been running mortality outcome statistics</p> <p>Development of LHB Intranet. Staff forum established and ongoing. Content of Time to Learn to Change changed in response to feedback. Use of local radio for campaigns.</p> <p>Outside agencies utilised to deliver Time to Learn to Change sessions. Joint working between the Trust /LHB and IPAG on the joint formulary and treatment guidelines and more recently SCEP. Partnership agenda involves significant sharing and learning between stakeholders. Joint training initiatives.</p> <p>Use of Website, information leaflets, radio campaign, TV advert, Local Authority newspaper, distribution to public outlets. Information is made available in Braille, large print and audio CDs. Language Line promoted to contractors. Merchandise. Attendance at various conferences.</p> <p>Regular update of posters eg EHC posters recently updated also re-run of training for Emergency Hormonal Contraception in April, development of a signposting document for Community Pharmacy. Periodic review of printed literature. Timely changes to web site. Reprinting of directories as appropriate, e.g. MHM MH Directory.</p>
			<p>The LHB has a Communication Strategy and mechanisms / protocols for sharing information with the public, patients and partners. Dissemination of clinical outcomes information take place through various Network and primary care groups, however the LHB are having difficulty with secondary and tertiary providers to develop mechanisms for reporting clinical outcomes. The LHB has developed a Quality in Commissioning LTA document which sets out specific requirements and this has been accepted by several secondary care providers, however the document has not yet been accepted by Bro Morgannwg NHS Trust. The LHB uses a range of channels to communicate patient information, such as leaflets, press and radio. The LHB has received feedback on the many leaflets it has produced.</p> <p>It is therefore recommended that the LHB continue to work with its partners to resolve issues in relation to the sharing of clinical outcomes information.</p>

3 Use of Information			
LHB 6.	Information is subject to quality assurance and confidentiality is considered.	<p>Corporate</p> <p>1. Is there an up-to-date Records Management Policy agreed at Board level?</p> <p>2. Is there an up-to-date Informed Consent Policy agreed at Board level?</p> <p>3. Is there an up-to-date Confidentiality Agreement?</p> <p>4. Who is your named Caldicott Guardian?</p> <p>5. Is there an up-to-date Caldicott Improvement Plan that has been agreed at Board level?</p> <p>6. What committee has lead responsibility for overseeing the implementation and operation of your information governance framework?</p> <p>Operational</p> <p>7. How do you monitor information security in contractor organisations? Please give examples.</p> <p>8. What progress has there been against Caldicott Improvement Plans? Please give examples.</p> <p>9. How do you monitor and check the consistency of the information used by staff?</p> <p>10. Who are your Caldicott leads in primary care?</p> <p>Impact on Patient Care/Experience</p> <p>11. How do you monitor and assess the suitability, relevance and value of the information you provide to patients and the public?</p>	<p>The Records Management Policy was approved by the Audit Committee in May2005</p> <p>This has been identified as an objective to achieve in the CG Development Plan. Use of National Guidance, currently being localised. Workshop for GPs and GDPs have been undertaken on 3 occasions over the last 12 months with a view to practices having localised policies in place.</p> <p>Yes. Confidentiality agreement identified in IM&T Strategy. Staff contracts and Job Description include confidentiality clause. All non-officer members have signed accountability agreements, which includes a clause in respect of confidentiality. The e mail and Security Policy are to be agreed at Board.</p> <p>The LHB Medical Director is the Caldicott Guardian.</p> <p>Internal Audit undertook a review of Data protection Act/ Caldicott compliance from which an action plan has been developed and is being progressed. The LHB's Three Year Clinical Governance Development Plan contains an objective to meet the requirements of Caldicott.</p> <p>Audit Committee.</p> <p>Baseline Audit of compliance with information security standards carried out early 2006 (GPs). Action plan to bring all GPs up to required standards agreed Summer 2006. for implementation by April 2007. Standard Operating Procedures in pharmacy include information security, Pharmacy clinical governance visits cover issues of information security. BDA toolkit covers information security and one for each Dental practice was purchased and disseminated to each practice.</p> <p>Form developed to alert sender of inappropriate patient identifiable information has reduced instances of breach of Caldicott. Training to all contractors on Freedom Information Act undertaken.</p> <p>CASPA data is regularly updated on LHB computers from online source-HOWIS. Data produced is double checked and there has been a training session on use of CASPA for LHB staff and practice staff. Guidance issued by WAG re disclosure of patient information circulated to all contractors by BSC.</p> <p>GP - Evidence of Caldicott leads contained in QA document. Pharmacy - Caldicott principles within Pharmacy CG Tool and CG Lead identified. Optometry - CG Lead identified.</p> <p>LHB Communication Group monitors information on LHB website. Process in place to review and monitor all LHB produced information leaflets, internally developed leaflets are discussed and tested with pilot groups and circulated to patient support and service user groups.- eg get the right treatment campaign was shared with PPI group and service user group to inform final edit. A survey was carried out on people attending the Older persons conference to assess the impact of information on waste medicines eg the TV advert and other materials.</p>
			The LHB recognises the need for confidentiality and security of information and have put in place a range of mechanisms to achieve this. There is a Records Management Policy, various associated protocols and procedures and an Informed Consent Policy is in development. The LHB does not have a specific Caldicott Action plan, but an Internal Audit was carried out on data protection and Caldicott compliance and an Action Plan produced. The LHB has a nominated Caldicott Guardian and the LHB are currently rolling out an Information Security Management System (ISMS) which addresses all aspects of IT security including Caldicott, to GP practices and plans to implement further are in place. Primary care practices have nominated Caldicott Guardians or Clinical Governance Leads that deal with Caldicott issues. The quality of data from the local NHS Trust is a cause for concern and needs to be resolved.

4 Process for Quality Improvement				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 7.	Risk Management is in place throughout the LHB and its contractor services.	<p>Corporate</p> <p>1. Is there an up-to-date Risk Management Strategy agreed at Board level?</p> <p>2. How do you ensure risk management information supports the decision making of Executive / Management Teams?</p> <p>Operational</p> <p>3. Does the LHB have a Risk Register in place that includes contractor professions?</p> <p>4. What is your risk management reporting system and does it encompass all contractor organisations?</p> <p>5. How is your risk management framework integrated with those of other organisations?</p> <p>6. What was your overall external WRMS Score for 05-06?</p> <p>Impact on Patient Care/Experience</p> <p>7. Describe a recent example (from within the last 12 months) of improvement resulting from your use of risk management data and information.</p>	<p>Yes. Updated Risk management Strategy agreed at April 2005 Board.</p> <p>Risk Management Working Group and Clinical Risk Management Group. Regular risk management reports to Board. An awareness raising session was completed with the Board in March 2006.</p> <p>Yes Directorate registers and Clinical Risk Registers includes risk areas in primary care.</p> <p>The LHB Risk Management reporting system is via quarterly reports to Risk Management Working Group which are then reported to Audit Committee and Board. There is a rolling programme for individual directorates to present key risks to the Board. GPs contractors report risks in via the NPSA reporting system. Other contractors are aware of the system and an action for rolling out the system to other contractors is contained in the 3 yr CG Plan. The LHB incident and hazard and Near Miss reporting policy and procedure and complaints process feed risks into the overall risk management system. The LHB Risk Management Procedure clearly identifies the mechanism for all staff to report risks through their individual directorate meetings or their line manager or Director.</p> <p>Currently reviewing the LHBs relationship with other organisations and the level of risk sharing but have yet to roll out integration with all organisations apart from our key partners Bro Morgannwg NHS Trust and Local Authority via partnership Board. Risks identified by Trust are shared with LHB. SUI s reported to Regional office by the Trust are shared with LHB. Serious patient safety incidents occurring in the Prison are also shared with the LHB.</p> <p>Overall weighted average score=79%</p> <p>Mental Health Workshop held as a result of concerns raised by Bridgend GPs (on risk register). This workshop has opened lines of communication and provided a forum for resolution of risk areas. Establishment of a waste collection service in conjunction with local authority for disposal of needles for diabetic patients. Establishment of the Dexa scanning service. The LHB actively uses the CG Leads forum to raise awareness of any risk management issues examples of this would be self prescribing and referrals to private healthcare providers.</p>	<p>The LHB has demonstrated that risk management is in place throughout the LHB and its contractor services. The LHB has a Risk Management Strategy and Risk Registers that encompass independent contractors. Risk Management issues are considered within the LHBs Committee structure and most notably Board papers that require a decision are also risk assessed and where appropriate entered onto the Directorate Risk Register. The LHB has ensured that risk management training has been provided for all LHB staff and to all contractor organisations that now report regularly to the LHB. The LHB was able to demonstrate many examples of risk reporting which had been followed through and the resulting action and service development taking place.</p>

4 Process for Quality Improvement				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 8.	The Clinical Audit and Clinical Effectiveness programme: * Encompasses the clinical governance framework, including NICE & NSFs. * Provides evidence of implementation and evaluation of NICE guidance and evidence-based practice * Crosses organisational boundaries * Allows sharing of audit findings	<p>Corporate</p> <p>1. Is there an up-to-date Clinical Audit Strategy agreed at Board level?</p> <p>2. Is there an up-to-date Clinical Effectiveness Strategy agreed at Board level?</p> <p>3. What processes do you have in place to manage and reconcile potentially competing demands and requirements arising from different national standards, guidance and policies?</p> <p>Operational</p> <p>4. What national / local audits been undertaken during the past 12 months?</p> <p>5. What procedures do you have in place to disseminate / implement national clinical standards guidance and policies (i.e. NICE & NSFs).</p> <p>6. Identify the groups or committees linked to the LHB which include clinical audit in their terms of reference.</p> <p>7. Identify the groups or committees linked to the LHB which include clinical effectiveness in their terms of reference.</p> <p>8. What examples of integrated care pathways are there and how have they been implemented?</p> <p>9. Who takes the lead for ensuring implementation and compliance with national standards, guidance and policies?</p>	<p>Identified for action in the CG Development Plan</p> <p>Identified for action in the CG Development Plan</p> <p>Annual Service and Commissioning Plan brings together all the competing national and local demands from a quality perspective. The LHB has a commissioning and prioritisation panel which directs its limited financial resource to those service improvement areas of priority according to agreed criteria within the Board agreed criteria.</p> <p>Community pharmacy have audited use of Medicines Compliance Aids and GPs have audited prescribing of Amiodarone. Enhanced service Audits. Trust audit programme 2006-07; audit GP practice transportation of childhood immunisations; Haematology service; Mental health; Quality Assurance - CG/QOF audit.</p> <p>Integrated Prescribing Advisory Group, Prescribing Advisory Group, Prescribing leads, Prescribing newsletters, Time to Learn to Change sessions. Multi agency working groups established to develop implementation plans e.g. stroke, Mental Health, CHD. Objective and actions identified in CG Development plan to develop policy for implementation of national guidance. Dissemination of NICE guidance is undertaken centrally. NSFs are disseminated to key stakeholders. Other existing planning mechanisms ie Joint Mental Health Strategy & Planning Team, CYPFP</p> <p>Clinical Governance Committee</p> <p>Prescribing Advisory Group, Clinical Governance Committee; Commissioning Committee</p> <p>Stroke, End of life care. Both pathways are being developed in consultation with primary and secondary care and the independent sector. Use of study days, workshops, and visits by relevant staff. Currently being developed are: Osteoporosis management, Musculoskeletal and chronic disease ICPs. The Framework for Partnership led service redesign includes the engagement of primary care in the development of integrated care pathways, which have resulted (post review visit) in the development of Demand Management Plans.</p> <p>CEO nominates lead Executive for topic area.</p>	<p>The LHB does not have separate Clinical Audit or Clinical Effectiveness Strategy's and the development of these has been identified as an objective within the Clinical Governance Development Plan for this financial year. The LHB has experienced confusion about National Audit requirements and its input into these audits, as they are not a statutory duty and some audits are uniquely secondary care. The LHB have undertaken clinical audits within primary care, such as medicines compliance aids and the LHB would benefit from the development of an Action Plan to co-ordinate clinical audit priorities and involvement. Mechanisms are in place to National Institute for Health and Clinical Effectiveness (NICE) guidelines and National Service Frameworks (NSFs) across primary and secondary care and the LHB is taking part in several integrated care pathway work streams. The LHBs Annual Service and Commissioning Plan brings together all the competing national and local demands from a quality perspective.</p> <p>It is therefore recommended that the LHB develops a strategic direction and co-ordinated programmes for Clinical Audit and Clinical Effectiveness and reviews its processes for the implementation of NICE guidance and for the engagement of primary care practices in the development of Integrated Care Pathways.</p>

4 Process for Quality Improvement				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
		<p>Impact on Patient Care/Experience</p> <p>10. What have been your key achievements in improving patient care and outcomes during the past 12 months?</p> <p>11. How do you promote the active involvement of all patients and the public in enhancing the effectiveness and quality of the care and services you provide?</p>	<p>Achievement of SaFF targets for waiting times, access, crisis resolution and home treatment, diabetes etc. Refer to Balanced Scorecard and LHB Annual Report. Outcomes are in the process of being evaluated.</p> <p>Development of Shared care for Rheumatology drugs and Amiodarone and Enhanced services. HSCWB NA and Draft Strategy. Reconfiguration of Community Mental Health Teams. Pencoed primary care centre. Physical & Sensory Disability Strategy. Mental Health Matters Mental Health Service Users survey. Equality & Human Rights Action Plan and Race Equality Scheme. Mid & West Wales Acute Services Review. Young People's Emotional Health. Establishment of SHOUT, the voice of older people. Children and Young People's Annual Conference, Prison Health Needs Assessment; Mental Health Acute Service Review. Patient Surveys. The LHB has recently commissioned Swansea University to undertake an evaluation of the Diabetes service development, this will be a Quality of life survey using EQ5D & SF1; Planning Team work in partnership with statutory and non-statutory partners, service users and carers to plan, commission and monitor service developments.</p> <p>11 Continued: Work co-ordinated through service/patient specific joint strategy planning teams (eg Children and Young People's Framework Partnership (CYPFP), Older Persons Strategy Planning Team (OPSPT), Learning Disabilities Joint Partnership Planning Team and Joint Mental Health Strategy Planning Team which all report to an executive Partnership Board (CEO and Member representation), supported by Joint Executive Team (CEO & Senior Officers). Regular reports to LHB Performance Management Committee and Board. Planning Teams meeting bimonthly/quarterly and are supported by sub groups. CYPFP and OPSPT hold an annual standing conference to engage with practitioners/service users and carers and to reflect on progress to date / future priority planning. Service priorities outlined in Health Social Care and Well Being Strategy, NSFs and national Strategies. Services for people with a sensory/physical disability are planned through workshop meetings involving service users. Strategy launched in February 2006.</p>	

4 Process for Quality Improvement				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 9.	Incidents (including serious untoward incidents) are reported, monitored and required changes implemented.	<p>Corporate</p> <p>1. Is there an up-to-date Incident Reporting Policy, which encompasses all contractor organisations, agreed at Board level?</p> <p>2. At which Committees / Groups are incidents considered?</p> <p>Operational</p> <p>3. What are the mechanisms for dissemination and sharing of lessons learned from incidents and near misses?</p> <p>Impact on Patient Care/Experience</p> <p>4. Describe a recent example (from within the last 12 months) of improvement resulting from your use of incident data and information.</p>	<p>Yes. All Wales Policy adopted by LHB Board in April 2003. LHB has written a revised Policy and local procedure which has been shared with staff for implementation and is awaiting approval by Audit Committee. This revised policy and procedure encompasses contractor organisations.</p> <p>LHB Board, Clinical Risk Management Group/ Risk Management, LHB & Trust Clinical Governance Committees</p> <p>Via TLC sessions, CG Leads, Pharmacy and Optometry Fora. Risk Management Committee and Clinical Governance Committee & Board.</p> <p>We are currently looking at INR services in primary care, Mental Health and transportation of childhood immunisations; Haematology; procedures of limited clinical effectiveness</p>	<p>The LHB has adopted the All Wales Policy on Incident and Hazard Reporting and has developed a revised policy and procedure which is currently awaiting approval by the Audit Committee. Incidents including Serious Untoward Incidents are reported and monitored quarterly by the Board, this includes trends and any lessons learnt following incidents. The clinical governance and Quality Outcomes Framework (QoF) visits are integrated with regular protected learning time for clinical governance leads and primary care practices. Complaints, incidents and near miss reporting is integrated into the Clinical Governance structure for primary care, but needs to be developed further to encompass Dental settings.</p> <p>Mechanisms are in place to disseminate and share lessons learnt through various educational sessions and primary care groups.</p> <p>It is recommended that the LHB reviews the current arrangements to ensure that monitoring mechanisms which cover all primary care professions are put in place.</p>
LHB 10.	Sufficient information is provided to patients and the public on the complaints procedure for primary and secondary care services and demonstrates these are monitored.	<p>Corporate</p> <p>1. Are there up-to-date complaints management policy and procedures in line with all-Wales NHS complaints procedure agreed at Board level?</p> <p>2. At which Committees / Groups are complaints considered?</p> <p>Operational</p> <p>3. How does the complaints management process encompass contractor services?</p> <p>4. What are the mechanisms for dissemination of complaints trends analysis?</p> <p>5. What actions have been taken from the Quality and Outcomes Framework surveys that relate to complaints management? Please give examples.</p> <p>6. Is there a process to record / capture written and verbal enquires from within the LHB and contractor organisations?</p> <p>Impact on Patient Care/Experience</p> <p>7. Have complaints leaflets / posters been put on display at the point of service delivery (all GP practices, pharmacies, dentists, opticians, etc)?</p> <p>8. What are the numbers / response times for written and verbal enquiries recorded within the LHB and contractor organisations?</p> <p>9. What changes have there been made as a result of complaints management over past 2 years? Please give examples.</p>	<p>Yes, local policy and procedure based on All Wales complaints procedure</p> <p>Clinical Risk Management Group/Risk Management, Clinical Governance</p> <p>Quarterly audit returns include information gathered from Primary care. The complaints management policy advocates a local resolution .Training in Complaints management has been delivered to Practice Mangers in June 2005.</p> <p>Clinical Governance Committee, CG Leads, via the Quality Assurance document to the Board, Quarterly reports to the Board</p> <p>The Quality Assurance document for GP Practices benchmarked practices, it highlighted that the highest incidents related to diagnosis/treatment/care and attitudes. The QA document emphasised that ongoing training in customer care and handling of complaints will help minimise complaints in the latter area. The CG leads have been asked to discuss the tool within their practice and a further discussion will take place in Septembers meeting to agree areas of improvement.</p> <p>There is form for staff to complete taking personal details in regard to enquiries and complaints, it is then forwarded to the Patient care co-ordinator.</p> <p>Checked at QOF /CG visits, Pharmacy CG tool, Dental Visits, complaints process on website</p> <p>LHB complaints =1 within 20 days ; GP practice =79 ; Dental Practice = 109 ;Optometry = 0 ; Pharmacy = 67 (no requirement for pharmacists to report complaints). The LHB has developed a proforma for 2006-07 to capture response times for primary care</p> <p>Establishment of the Clinical Risk Management Group; Training of A&C staff in GP practice regarding attitudes;improving systems and processes internally and training staff within the LHB to that effect; Practice managers have received complaints training.</p>	<p>The LHB has a Complaints Policy and Procedure based on the All Wales NHS Complaints Procedure. Quarterly audit returns and a proforma to monitor response times for complaints within primary care practices are recorded and the LHB staff complete forms to record enquiries and complaints. Mechanisms are in place to monitor complaint information through the LHB Committee structure. The LHB has tried to ensure sufficient information is provided to patients and public on the complaints procedure and this includes full details on the LHB website and comprehensive leaflets available and distributed to all contractor services. The QoF and Clinical Governance visits to primary care practices are used to ensure complaint information is available and displayed.</p>

5 Staff Focus				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 11.	<p>The LHB demonstrates:</p> <ul style="list-style-type: none"> * Training & Development (incl. Induction & Mandatory) for LHB and contractor staff on clinical governance issues. * Development of Non-Officer members in support of their roles. * Reporting Staff Based Indicator Outcomes. * Development of mechanisms for monitoring / implementing CRN / Professional registration checks. 	Corporate		
		1. Is there an up-to-date Training and Development Strategy agreed at Board level?	Yes. The Organisation development and training strategy was agreed by the Board in December 2003. The review and updating of this has been identified and is a key action within the CG 3 year Plan.	<p>The LHB has an Organisation Development and Training strategy, but this is in the process of being reviewed. The LHB does not have a separate Appraisal Policy and Process, this is incorporated within the Organisational Development and Training Strategy, however there is a process of objective setting and review in operation. The LHB monitors attendance of LHB and primary care staff at mandatory and general training programmes through signing of attendance sheets and use of a central database. The LHB uses the QoF process to check that appraisal processes are in place within primary care contractor organisations, however it is unclear if the LHB are informed by primary care contractors that appraisals have taken place for all staff. The LHB has a process for objective setting and staff are entitled to 3 days education time annually, however current numbers for LHB staff who have received appraisals within LHB Directorates is variable.</p> <p>Criminal Records Bureau (CRB) and professional registration checks for LHB and primary care contractor staff are undertaken and monitored by the Business Service Centre (BSC). The LHB use the QoF process to check that processes to take forward these checks are in place within primary care contractors, however it is unclear what information is provided back to the LHB to assure themselves that these checks have taken place. The LHB actively encourages the reporting of poor performance directly back to the LHB. The balance scorecard indicators from the BSC are delivered promptly, however the LHB has identified certain problem areas in their relationship with the BSC such as feedback on staff absences. The LHB regularly evaluates training and makes changes as a result.</p> <p>It is recommended that the LHB strengthens its current performance review processes through the development of a separate Appraisal Policy and Process, this should also include the review of mechanisms to monitor appraisals taking place for both LHB and primary care staff. Further, we recommend the LHB develops systems that will provide Board assurance that CRB are being undertaken for all primary care staff.</p>
		2. Is there an up-to-date Appraisal Policy and Process agreed at Board level?	This is part of the Organisational Development and Training Strategy . Development & Training needs will now be identified Via Agenda for Change, Key Skills Framework and is identified on the CG three year plan. To date a process of objective setting within Directorates allows focussed discussion about progress and enables identification & discussion about any issues or concerns and learning needs.	
		Operational		
		3. What staff based indicators are reported to the Board and how often are they reported?	Balanced Scorecard Indicators; Staff changes reported in Chief Executives report to the Board.	
		4. What is the process for monitoring attendance of LHB/Primary Care staff on mandatory/general training programmes?	LHB- Staff sign an attendance sheet for internal training. This information is then transferred onto a database so that the LHB can ensure that staff access training as required Primary Care All groups of General Practice staff sign attendance sheets this information is then entered onto a database for analysis, QA document includes statistics for attendance at prescribing & Clinical Governance Leads meetings. Any protected learning time events or fora for the other contractors are monitored in a similar way.	
		5. Is there a process for the LHB to ensure CRB / registration checks are monitored / implemented for LHB and directly managed primary care staff?	Nursing- There is a process to monitor Practice nurse Registration by the LHB Practice Nurse Facilitator. QOF/CG visits check whether processes are in place. Pharmacy CG tool checks there is a process in place, the BSC are responsible for checking performers lists/registration for Primary care contractors. The BSC are responsible for checking CRB checks and professional registration checks are in place for LHB staff. The LHBs December Audit Committee received a letter regarding the legality of checking and has revised our CRB policy in light of this position as advised by the CRB Agency. The policy on CRB checking adopted by BSC HR has been challenged as unlawful by the CRB Agency and the policy is currently under review at an All Wales level.	
		6. What percentage of LHB / Primary Care staff that have received a CRB / Registration check during the past two years.	100% of LHB staff have received CRB/Registration checks. For Primary care staff the LHB check that there are systems and processes in place, as described above.	
		7. What percentage of staff have had an appraisal and opportunity for CPD in the past 12 months?	All staff have had an opportunity for CPD. There is a CPD policy which allows staff 3 days annually for CPD, in addition to the normal access to education and training. To date a process of objective setting within Directorates linked to Corporate/ Executive Directors Objectives with six month reviews or as necessary.	
8. How are staffing and human resource issues which are impacting upon the delivery of safer, effective, patient focussed care, escalated to the lead committee with responsibility for clinical governance?	Issues concerning capacity within the LHB are highlighted on Directorate Risk Registers. There was a significant risk identified within the Medical Directorate and the ability to deliver the Clinical Governance agenda. Resources were therefore identified for the post Head of Clinical Governance. Within the Health Improvement and Performance Directorate maternity leave was covered in a key Primary care role by a temporary contract post. Policy and Procedure for managing concerns about performance in Primary care are in place. Concerns are reported and monitored via Clinical Risk management Group, Clinical Governance Committee, Executive Team meetings and Board as necessary.			
	Impact on Patient Care/Experience			

5 Staff Focus

Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
		<p>8. Is there a process for evaluating training programmes?</p> <p>9. Give examples of any changes to training programmes that have been made as a direct result of evaluation.</p>	<p>Regular evaluation of Prescribing leads collated by the prescribing team. TLC has an inbuilt evaluation process in place, this is used to develop future sessions.</p> <p>Content of Prescribing sessions and Prescription clerk sessions changed as a result of feedback. Evaluation and feedback from TLC has shaped a more clinically orientated programme for the year. The results arising from staff survey led to cycle of team training being changed to all time for ECDL</p>	

6 Leadership, Strategy and Planning				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 12.	All aspects of clinical governance are integrated equally into the decision-making processes.	<p>Corporate</p> <p>1. Is there a Clinical Governance Strategy agreed at Board Level?</p> <p>2. Is there an up-to-date Balanced scorecard?</p> <p>3. Is there an up-to-date Corporate / Operational Plan agreed at Board level?</p> <p>Operational</p> <p>5. Is there an up-to-date Clinical Governance Development Plan agreed at Board level?</p> <p>Impact on Patient Care/Experience</p> <p>6. Give examples of where clinical governance issues have influenced decisions made by the Board on service delivery / patient care over the past 2 years.</p>	<p>Yes, updated CG Strategy & Development Plan agreed by Board in June 2006.</p> <p>Yes, Balanced Scorecard reporting for 2006/07 is being undertaken on the national template in accordance with WAG guidance and first quarter's report will be complete by 31/07/06.</p> <p>Yes, Annual Corporate Objectives are agreed by the Board and for 2006/07 this agreement was secured at the LHB Board meeting on 13.04.06.</p> <p>Yes. CG Strategy & Development Plan agreed by Board in June 2006.</p> <p>A&E workshops undertaken with primary & secondary care. Emergency Hormonal Contraception. CG development tool for pharmacy. Prioritisation of service developments in Diabetes and Cardiology were influenced by clinical governance concerns regarding waiting times for these groups of patients. This has led to the development of a more responsive and accessible service for patients. Sleep apnoea; Osteoporosis; Anti TNF nurse.</p>	The LHB has a Clinical Governance Strategy and Development Plan and uses this and the Balanced Scorecard to monitor progress against organisational objectives. The LHB has shown a determination to integrate clinical governance into every aspect of the decision making process, examples of this include integration of QoF and clinical governance visits. The LHB is actively looking at the level and balance of information received by the Board to inform their decision-making ability. However it is felt that current difficulties with secondary and tertiary care data being received by the LHB could be having an impact on the Boards decision making ability and the challenge now for the LHB will be to work with partners to resolve these issues. Examples demonstrating decisions that have benefited the public are evident.

6 Leadership, Strategy and Planning				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 13.	Sound clinical and corporate governance arrangements are in place and are integrated in the Boards decision making processes.	<p>Corporate</p> <p>1. Are there clear lines of accountability and reporting arrangements?</p> <p>2. Are all Board members clear as to their roles, responsibilities and delegated powers?</p> <p>3. List groups / committees where Clinical Governance is part of the Terms of Reference.</p> <p>Operational</p> <p>4. How do your schemes of delegation ensure that principles and processes for good corporate and clinical governance are in place at all levels of your organisation?</p> <p>5. Who are the Executive and Non-Executive members with specific responsibility for:</p> <p>* Child Protection</p> <p>* Children's Issues</p> <p>* Clinical Governance</p> <p>* Public and Patient Involvement</p> <p>Impact on Patient Care/Experience</p> <p>6. What reporting structures do you have in place to monitor the effectiveness of quality assurance improvement activities at all levels of your organisation?</p>	<p>Yes. The LHB has SOs which include a chain of delegation identifying which decisions can be made by officers and Board Sub-Committees and which decisions are reserved for the Board. The lines of accountability between the Board and its Sub Committees is identified in the LHB Committee structure organisational chart. Clinical Governance Strategy defines accountability in appendix A. Terms of reference of all groups and committees set out reporting arrangements. A piece of development work has been identified in the 3 year plan and Gill Gerge is facilitating a workshop in October.</p> <p>Yes. Non Officer members receive a comprehensive induction pack, they sign an accountability agreement; they have an annual with the Chairman;there are lunch and learn seesions arranged which includes roles and responsibilities, accountability and governance; they attend local and corpoate induction.WAG has organised Non Officer Board Member training programme during 2005-06.</p> <p>Clinical Governance; Clinical Risk Management Group, CG Leads Forum;</p> <p>Terms of reference for all Sub-Committees of Board must be approved by Board and reviewed annually. All Board sub-committees have Non-Executive members sitting on them to ensure decisions are subject to independent scrutiny from the Executive officers. Both Executive and Non- Executive Officers are required to sign the NHS Code of Ethics which requires them to follow the NHS seven core principles of governance. The scheme of delegation does not allow certain decisions to be delegated to a Sub-Committee or Officer. These decisions are reserved for the Board only.</p> <p>XXX is the nominated LHB Board Champion for Child Protection. XXX, LHB Acting Nurse Director, is the nominated LHB Executive Lead Officer for Child Protection.</p> <p>XXX is the nominated LHB Board Champion for C&YP. XXX, Director of Health Improvement and Performance is the nominated LHB Executive Lead Officer for C&YP</p> <p>XXX is the nominated Board Champion for Clinical Governance and Chairs the CG Committee. XXX is the nominated LHB Executive lead officer for Clinical Governance</p> <p>XXX is the nominated LHB Board Champion for PPI. XXX, Director of Health Improvement and Performance is the nominated LHB Executive Lead Officer for PPI</p> <p>Prescribing indicators which monitor cost and quality of prescribing and form part of the Prescribing incentive scheme. Indicators are local and high level and are reported Bi-monthly to PAG quarterly to prescribing leads and six monthly to performance committee. The Quality Assurance document for GP Practice collated intelligence across the organisation in relation to the practices, this gave a rounded view of each practice and easily identified where support or training was required either with an individual practice or across all practices. This was presented to the Board in June 06, to the clinical governance committee and to GP CG Leads.Joint NICE implementation group; LTA monitoring meetings;Integrated service commissioning group;Access 2009 Board;DIS project Board</p>	<p>The LHB has demonstrated that it has good clinical and corporate governance in place, which is integrated into the Board's decision making process. The role and responsibilities of committees, the organisation structure and reporting arrangements are clear. Nominated members of the Executive and Non-Officer Board members also have specific responsibility for Child Protection, Children's Issues, Clinical Governance and Public and Patient Involvement. Board members are well briefed and understand their responsibilities in relation to all clinical governance issues and the organisational structure and quality improvement has been shown to be at the heart of the LHB work.</p>

7 Public Health				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
LHB 14.	The health of the local population is continually improved and its needs met through: * Screening Services * Communicable Disease * Immunisation and Vaccination * Emergency Planning	Corporate		
		1. Is there an up-to-date SLA with NPHS?	Yes. LHB signed off local NPHS Workplan each year at the August Board. There is an SLA between the Welsh Assembly Government (Office of the Chief Medical Officer) and Velindre NHS Trust (of which the NPHS is a part). This agreement requires the NPHS to provide a wide range of public health services to every LHB in Wales. Within the framework set by this SLA, the NPHS, through the Local Public Health Director, agrees an annual local Work Plan with the LHB Chief Executive, setting out the main work to be undertaken by the Director and Local Public Health Team. Progress against this Work Plan is monitored quarterly	A Service Level Agreement (SLA) currently exists on an All Wales basis between the Welsh Assembly Government and the National Public Health Service (NPHS) to assist the delivery of the public health function of Local Health Boards in their locality. There is a Work Plan, which indicates local priorities and is monitored quarterly. Mechanisms are in place between the LHB and NPHS to obtain and use information to monitor the needs of the local population. The LHB, through the NPHS, is attempting to meet the local needs through programmes for screening and immunisation and are being pro-active in looking at alternative ways of increasing the uptake of the flu immunisation.
		2. Is there a Major Incident Plan in place?	Yes. The LHB Major Incident Plan is reported to the Board Annually and was agreed by the Board in June 2006	
		Operational		
		3. What is the staff support / input from NPHS including the Public Health Lead for the LHB?	Local Public Health team has a director (4 sessions) and 3.5 core staff and 6 staff on programmes. Specialist teams of the NPHS provide input to other directorates as per the NPHS Local Work Plan	
		4. Is the LHB routinely represented at the NPHS Stakeholder Forum?	Senior officers of the LHB have attended the stakeholder forum since its inception	
		5. What are the integrated governance arrangements between NPHS and the LHB?	The key instrument is the Local Work Plan - signed off each year, monitored by the CEO quarterly. Specific areas of corporate governance structures (eg risk registers and assessments) are co-reported. The NPHS Clinical Governance arrangements are shared with the Clinical Governance Committee of the LHB. Detailed issues of compliance ie Health and Safety are handled through joint report. Each organisation is responsible for its own governance and has its own governance processes and structures. The NPHS is responsible for the quality of its services and the health and safety of its staff. However, there is an interplay between the two structures. The overall relationship between the two organisations is as set out in SLA referred to in the answer to Q1. Whilst the Local Public Health Director is an employee of the NPHS, s/he is managerially accountable, in the first instance, to the LHB Chief Executive for her/his performance and that of her/his Team in undertaking work on behalf of the LHB. Risk management and health and safety requires close cooperation between the two organisations, particularly as NPHS staff work from LHB	
		6. List the LHBs latest performance results against all SaFF targets for: * Screening Services	We have had confirmation from Adrian Davies, Senior Analyst in the WAG NHS Performance and Operations Directorate, that there are no current SaFF targets relating to screening or immunisation and so, as far as WAG are concerned. The only screening related SaFF target for 05/06 was: To extend the routine age for breast cancer screening under the National Breast Screening Programme to age 70 in all parts of Wales by the end of March 2006. This was achieved by Breast Test Wales, which now routinely invites women for screening every three years between the ages of 50 and 70.	
		* Communicable Diseases * Immunisation and Vaccination	We have had confirmation from Adrian Davies, Senior Analyst in the WAG NHS Performance and Operations Directorate, that there are no current SaFF targets relating to screening or immunisation and so, as far as WAG are concerned, there is no need for LHBs to be reporting against any previous year's SaFF targets. Influenza uptake for 2005-06 position is 68.9% a 9.9% improvement on 2004-05 position of 59%. MMR for the first quarter 2006 1st dose age 2 years= 85.6%; 5th Birthday, 2 doses= 71.7%; 6th Birthday, 2 doses = 78%	
		7. How do you monitor improvements in the health of your local population?	HSCWB Needs Assessment process - baseline undertaken 2003-04. Rolling programme of review required under HSCWB. Updated of NA being undertaken currently and will be complete by end of 2006. National Monitoring data sets to include, Welsh Health Survey, national data sets: screening, smoking, drug and alcohol use, Census data. QoF annual data returns.	
8. Please provide examples of your key achievements in improving the health of your population during the past 12 months.	Dental initiative for the under 5's commissioned, improved access to sexual health services through commissioning of Saturday morning Youth Advice service clinic and Well Sexual Health Clinic(WeLSH). Physical Disability Service; Diabetes service; Mental Health Crisis Resolution service; Nutritional Strategy; Healthy schools scheme; Exercise on referral; Smoking Cessation Service; Emotional Health work; Mental Health Bibliotherapy service.			
9. How have you evaluated, tested and appraised the robustness and effectiveness of your emergency plans?	Yes. The LHBs Major Incident Plan is reviewed on an annual basis, in conjunction with Neath Port Talbot and Swansea LHBs, and reported to the Board (see LHB Board papers - June 2006). The LHB participated in a multi-agency table-top exercise in September 2004 and provides annual awareness training for on-call officers and the whole LHB team. Pandemic Flu planning has been underway for some months; an exercise was held in January 2006 across South Wales with a further exercise planned for Oct 2006.			
Impact on Patient Care/Experience				

7 Public Health				
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion
		10. Have you had any public health / major incidents that your LHB have had to manage during the past 2 years? Please give examples.	E Coli outbreak with cases in Bridgend Autumn 2005 - Health Impact Assessment with Welsh Health Impact Assessment Unit of planning application to extend open cast mining in the Kenfig Hill Area	

8 Commissioning					
Reference Number	Theme	Key Questions	Self-Assessment Response / Comment	HIW Summary Conclusion	
LHB 15.	The LHB demonstrates the needs of the population are met through commissioning / de-commissioning in: * Primary Care * Secondary Care * Continuing Care * Non-Clinical * Voluntary Services	Corporate			
		1. Is there an up-to-date HSC&WB Strategy agreed at Board level?	Yes, 2005-2008 HSCWB Strategy endorsed by the LHB Board December 2004	The LHB have developed a Health Social Care and Well-Being Strategy (HSCWB), informed by a Needs Impact Assessment and is reviewed regularly and provides the LHB strategic direction. A Board approved Annual Service and Commissioning Plan is in place and the LHB has demonstrated that it has commissioning and decommissioning processes in place to meet the needs of the local population. The LHB has very good relationships with social care and the voluntary sector and has joint arrangements with Neath Port Talbot LHB. The LHB feel that the commissioning arrangements between Health Commission Wales and the LHB are not always clear, which is frequently leading to delays in patient care and patient incidents and much time is spent within the LHB on chasing the referrals made through HCW. Mechanisms are in place to discuss commissioning arrangements with the local NHS Trusts, however Bro Morgannwg NHS Trust has still not signed its Long Term Agreement (LTA) which contains quality assurance clauses.	
		2. Is there a HSCWB Needs Impact Assessment agreed at Board level?	Yes, HSCWB Needs Assessment (NA) undertaken 2003-04, endorsed by LHB Board and utilised to support the development of the HSCWB strategy and LSP Community Strategy. Programme of work underway to update NA, revised NA to be presented to the Board for endorsement in late 2006 / early 2007.		
		3. Is there an up-to-date Annual Service and Commissioning Plan that included clinical and non-clinical commissioning, agreed at Board level?	Yes. The 2006-07 ASCP was approved by the Board in April 2006. The plan focuses on clinical commissioning. It is not clear what is meant by non-clinical commissioning but if this relates to the Business Services Centre Support functions, National Public Health Service etc these are commissioned through SLA agreements which detail the specific services and functions to be provided.		
		4. Does the LHB have up-to-date commissioning arrangements with Health Commission Wales? Please give examples.	HCW commissions specialised services on behalf of the residents of Bridgend. The services and treatments that HCW are responsible for commissioning are set out in the Planning and Commissioning Guidance WHC(2003)063. The LHB attends HCW Stakeholder forums where key issues are discussed and actions agreed. The LHB also liaises on key issues through normal correspondence. Ongoing dialogue with HCW on a number of fundamental principles around commissioning responsibility continues to improve the arrangements between the LHB and HCW with regards commissioning functions and processes.		
		Operational			It is recommended that the LHB work with its partners to resolve commissioning issues with HCW and to get sign-off of the Bro Morganwg NHS Trust LTA.
		5. Who are the Executive and Non-Executive leads for commissioning?	XXX - Director of Finance and Commissioning -Executive Lead Board Member- Non Executive Director Lead	XXX - Therapist	
	6. Do you have care pathways that cross-organisational boundaries? If so, please give examples.	Stroke, End of Life- All Wales care pathway for Last Days of Life			
	Impact on Patient Care/Experience				
	7. What new services within the health community have been commissioned during the past 2 years and what services have you de-commissioned during the same timeframe?	Local and National Enhanced schemes both for GPs and Pharmacies. New Services include Osteoporosis - Dexa Scanning, Fast Track Cardiology; Cardiology model; Bobarth; Marie Currie; Anti TNF nurse; Sleep Apnoea ;non surgical oncology; Herceptin for Early stage Breast Cancer;. Decommission - Old Diabetes Model; old Cardiology model; Services of Limited Clinical Effectiveness. The LHBs undertakes a programme of programme budget and marginal analysis which has been indicated in Commissioning plan 2006-07, this will identify both priority and anti priority areas.			