

Cardiff and Vale NHS Trust

HIW Acute Review 2006 Action Plan

CHI Action Plan 2002		HIW Findings 2006	Self ass'mt score	Improvement Actions	By whom	By when
1	The Trust must work with clinicians to develop robust systems to analyse and understand the causes of high rates of non-emergency deaths at the hospital and take action to reduce them.	HIW saw evidence of regular examination of mortality rates at a local level but not of a regular programme of review and/or monitoring of figures on a Trust-wide basis.	C: O: U:	There is information from CHKS to support mortality at or below that of peer. Mortality and Morbidity meetings undertaken at service level within CG Programme	Completed	
		lack of awareness or incorrect knowledge of the Trust's performance amongst senior staff.	C: O: U:	Signpost system being rolled out to include General Mangers and Executive directors but aimed mainly at clinicians. This will provide individual and specialist data measured against peers	Completed	
2	The Trust must establish robust systems at directorate level for inputting patient data and work with staff to improve the validity of the PMS dataset.	1. It was difficult to determine where responsibility for ensuring consistent quality of data entry lay across the Trust.	C: O: U:	The Medical Director is responsible for data quality.	Completed	
		2. Data quality was not regularly checked.	C: O: U:	Systems reviews commenced & to be continued. The coding of case-notes is regularly checked and improvements made in speed and quantity of coding during 2007. Internal Audit have mapped the process for emergency admissions onto the PMS system and through the care pathway. Raising the profile of data quality together with information coming from iLab. This information is targeted at clinicians and their involvement with data quality. There are internal and external views of measurements of data quality with the quality index, according to CHKS, showing improvement. Data Quality is also on Trust Risk Register with actions monitored	Completed	Ongoing
		3. There was no evidence that the scoping exercise to identify the resources required to maintain the PMS in a timely manner had been undertaken.	C: O: U:	This has been commenced within the IHI project & introduction of clinical workstations	Completed	Ongoing
		4. One ward visited reported that there was a four month backup of notes that need to be filed and incorporated	C: O: U:	A check of the robustness of health records handling underway	Completed	Ongoing

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3	The Trust must take action to increase the number of patients who are operated on within 24 hours of diagnosis of a fractured neck of femur	A trauma bed capacity and allocation review in respect of Fractured Neck of Femur was being undertaken. HIW hopes this work continues and produces further improvements in performance.	C: O: U:	Improvements being led through a multidisciplinary Trauma Working Group. Proven improvements made in reducing both mortality and theatre access, with performance at the upper quartile for peer Trusts. Three reports made to Management Board since September 2006. Additional physiotherapy resources being sought to promote rehabilitation and reduce patient stay and dependency. Configuration of Trauma beds is subject to Trust wide review, with care of outlying Trauma patients supported by a well evaluated Trauma Outlier Nurse.	Completed	
4	The Trust must take urgent action and work with commissioning bodies to agree some long term solutions to manage non emergency, elective surgery at the trust more effectively to improve the patient experience	1. There does not appear to have been any significant changes towards resolving capacity issues until recently, although some of the factors lie outwith the trust's control.	C: O: U:	Development of an Emergency Care Action Plan with an emphasis on improving the patient pathway encompassing. - Unscheduled care/admission avoidance - Strengthening and refocusing community nursing services to focus on maintenance in the community, facilitated discharge and LTC management in the community - Reductions in LOS - Closure of uncommissioned capacity - Implementation of Discharge Policy - Timely Discharge Programme Board focussing on DTOC escalation issues - PHSI – development of care pathways to support primary/secondary care interface - Clinical Services Strategy to support PHSI - Bed base reconfiguration to support changing models of care	GMs	Ongoing
		2. HIW was told that the Local Delivery Plan for 2006 – 2007 had significant shortfalls in commissioned elective capacity in certain areas. – can they be more specific	C: O: U:	LDP elective capacity has been resourced through Local Delivery Plans, with additional capacity commissioned together with a contribution from internal efficiencies. Analysis has demonstrated that the gaps for the trust are proportionally larger than other Trusts within Wales, notable for key specialities such as orthopaedics. This has led to the commissioning of the Cardiff and Vale Orthopaedic Centre. For the surgical specialities, the LDP process has identified additional capacity to bridge gaps. This is however subject to planning assumptions, such as no demand growth, and evidence for the year to date demonstrates increased elective demand, notably in orthopaedics. The Trust is working with the LHBs to balance demand and capacity.	Completed	

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	<p>3. The Trust has developed an Emergency Care Improvement Plan in response to this Delivery Support Unit work, however there continue to be a number of barriers to enabling its effective implementation.</p>	<p>C: O: U:</p>	<p>Positive progress achieved at UHW, with notably improvements in performance in the minors and paediatric streams. A new MAU was commissioned in May 2006, and a separate SAU created. There have been infrastructure changes to the Minors stream.</p> <p>Operational buffer meetings in place daily to plan and review demand and capacity requirements and constraints, with good links to bed management.</p> <p>Additional action plan will be developed to support emergency care pathway (to include organisational and operational criteria).</p> <p>Bed availability is the principal residual constraint for the emergency stream, with a clear link to the increase number of Delayed Transfers of Care.</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p> <p>GMs</p>	<p>Ongoing</p>
	<p>4. Across the local health economy there are significant problems with delayed transfers of care (DTOCs) which, combined with issues of bed management within the Trust, contribute to poor patient experience on emergency and elective care pathways. There was an issue about the timeliness of local authorities' allocation of social workers to patients who were due to be discharged.</p>	<p>C: O: U:</p>	<p>Significant improvements in social worker allocation in Cardiff. Progress impeded in the Vale as a result of "frozen" posts, this has since been lifted (May 2007).</p> <p>Improved collaboration through Timely Discharge Programme Board and various DTOC operational meetings which has resulted in an improved DTOC position (numbers and occupied bed days). Issues outstanding relate to choice and CHC processes and represent the equivalent of an average of 101 lost beds each day.</p> <p>A review of bed management practices has been completed (Mar-April 07) and a revised model developed. Consultation required, implementation date of October / November 2007.</p>	<p>Completed</p> <p>GMs</p> <p>GMs</p> <p>Completed GMs</p>	<p>Oct 2007</p>
	<p>5. HIW was told that some bed management staff did not feel that they were of sufficient seniority to challenge clinical staff regarding the timelessness of their decision making, for example obtaining an estimated date of discharge that would help forecast bed availability in the short term.</p>	<p>C: O: U:</p>	<p>Discharge lounge closed due to low utilisation rates.</p> <p>Two Acute Physicians appointed to refocus and rebalance the emergency medical model in the MEAU. Poster display insitu confirming the purpose of the MEAU.</p> <p>Capital plans developed to reconfigure to MEAU to provide additional assessment space. Work to be completed by Nov 07-Mar 08.</p> <p>Appointment of AMD for Emergency Care in March 07 has resulted in the development of a revised emergency medical model, one model across the 2 acute sites.</p>	<p>Completed</p> <p>Completed</p>	<p>March 2008</p>

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	6. HIW had specific concern regarding the situation at Llandough Hospital, where there seemed to have been little progress since the DSU report, which had also examined their Medical Assessment Unit. There still seemed to be a culture of admitting patients for assessment rather than vice versa, poor use of the discharge lounge and a lack of urgency to discharge patients and improve flow through the hospital.	C: O: U:				
5	The Trust must take urgent action both internally and externally to agree an achievable action plan. First it must work with service groups to prioritise bed allocation to streamline the bed management process. The Trust must also continue to work with the National Assembly for Wales, the Specialist Health Services Commission for Wales and Bro Taf Health Authority to agree ways to minimise the clinical risk associated with outliers caused by inadequate bed capacity and delayed transfers of care at the Trust. A clear action plan with achievable milestones must be developed.	7. HIW also heard that difficulties in arranging access to diagnostics tests led to patients being admitted solely for this purpose, rather than be discharged to wait 7 weeks for a scan. There needs to be ownership of the issues and strong leadership to take this agenda forward.	C: O: U:	The Trust will be reducing waiting times for diagnostic tests in line with Welsh Assembly Government targets. The targets for 2006/7 were achieved and actions are in place to achieve those for 2007/8. The CHI action plan was looking at bed management processes in 2002. HIW then moved from this to relaying a 7-week delay for a scan. The improvement actions quite rightly speak about reducing waiting times and then HIW come back and talk about different practices in access to diagnostic services between the MAU and MEAU at Llandough. The apparent inequities in accessing diagnostics within the MAU/MEAU have never been raised as an issue. If the comments about the 7-week delay are comments which reflected the inequities in access to Angio's as there were inordinate delays occurring in transferring pts from Llandough to UHW. , this delay has been minimised since the introduction of the regional transfer unit.	Relevant Service Groups	March 2008
6	The Trust must take action to improve its complaints system. It must agree an action plan to improve its response rates to patients and meet the standards stated in its own complaints policy	8. It was reported that the targets for dealing with complaints in a timely manner are not being met.	C: O: U:	Being reviewed at Trust Board level Targets set for coming year by Nurse Director are 100% at 2 day and 70% at 20 day	GM's PE. team	March 2008
		9. Ward staff dealing with complaints about cancellations are not trained to deal with difficult customers.	C: O: U:	Patient Experience team have undertaken Customer Care training across all sites and have Trained 92 trainers trust wide	SG trainers	On-going

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		10. There was little evidence that action plans were drawn up in response to surveys or of improvements made as a consequence.		Some Action plans are drawn up by Service Groups in response to individual complaints. However the Trust will be looking at developing a quarterly action plan by service group showing themes. With General Managers now members of Clinical Governance Committee audit plans will be received and shared along with significant lessons learned	SGs and PE team	Ongoing
		11. There were a number of clinical areas where no complaints leaflets were observed at the time of the visit.	C: O: U:	Patient Experience Team have written to all DM's and HOD to ensure supplies of leaflets are available. When further supplies of leaflets are required managers contact the PE team for further supplies The Trust is re-looking at availability of patient information leaflets in 2008.	PE team	Ongoing
7	The Trust must take action to improve standards of basic cleanliness including external parts of buildings (Reference to detailed action required and agreed timescales in separate column)	12. It was unclear as to how these cleaning outcomes were reported and monitored within wider Trust performance management structures, for example there was no evidence of measures being reported on the Balanced Scorecard or at the Clinical Governance Committee.	C: O: U:	Cleaning outcomes are reviewed monthly at the Facilities and Clinical Support Service Management Team meetings. The Cleaning Strategy group also receives the reports and will report in future to the Clinical Standards and Patient Experience Committee. An annual report which encompasses all aspects of the National Standards on Cleanliness will go in future through Management Board to Trust Board	Nurse Director	March 2008
		there is room to improve the connection between cleanliness audits and patient surveys with Trust audit and patient satisfaction programmes	C: O: U:	The Facilities and Clinical Support Service group surveys patient views and experiences with regard to cleaning on a monthly basis and reports these together with the cleaning scores. Cleaning audit part of central audit programme in 2006. Relevant cleaning questions form part of on-going Hipo questionnaires	Complete	
		13. Concerns were expressed around the level and types of comment received via the patients. Survey undertaken in May 2006, in particular surrounding cleanliness at UHW's A&E department.	C: O: U:	Action plan completed following survey – survey will be repeated in summer 2007.	Completed	

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8	The Trust must take action to ensure consistent and appropriate signage is in place for patients	14. HIW noted the opportunity for confusion at the new Cardiff and Vale Orthopaedic Centre. This had different entrances for those attending as outpatients or as a daycase, with no publicly accessible direct route between the two.	C: O: U:	Internal and external signage has been improved since the review.	Completed	
		15. West Wing at Cardiff Royal Infirmary had lots of paper signage and an untidy appearance.	C: O: U:	The Trust is progressing with plans to eliminate paper signage – use of laminated signs as a temporary measure. The estate at West Wing is acknowledged as being of a mediocre standard. Through PHSI and the Estate Strategy the intention is that West Wing will close in the next 3 years.	Line managers	Ongoing
		16. Patient comments highlighted that it would be helpful to include site maps with appointment letters.	C: O: U:	All new outpatient appointments booked through Medical Records are sent a map of the appropriate hospital. The Trust are reviewing the maps provided and will consider how this can be rolled out across all new patient appointments	Corporate Management	Dec 2007
9	The Trust must take action to provide suitable accommodation for staff and patients	17. HIW had serious concerns about the environment of care at the Medical Assessment Unit of Llandough Hospital. The average length of stay for patients in this area is currently 5 days. Need to ensure concerns around the use of the waiting area and general facilities are reflected and address. Would suggest tying to Rec 4 given the interdependence with patient flow	C: O: U:	The ALOS within MEAU is <24hrs and through the implementation of the emergency care model it is expected that the AVLOS will be within the 8hr target. Please refer to section 4.6.	GMs	March 2008
		18. At UHW the Emergency Surgical Admission Ward had no dining area for patients, a small and shabby day area and a tiny staff room.	C: O: U:	The trust will improve the infrastructure of the SAU to ensure it complies with accommodation standards for an assessment unit, replicating those on MAU. This will address a recent recommendation of the DSU.	GM	November 2007.
		19. The Medical Assessment Unit here suffers from a lack of storage space for patients' belongings.	C: O: U:	The relocation of the MAU from the front door to the A1 ward area has resulted in an area that is constricted, the GP lounge in particular. However, as the assessment area is where decisions regarding admission/discharge are made there is little opportunity to provide storage space for the duration of the assessment (8hr target).	Complete	
		20. West Wing of Cardiff Royal Infirmary was found to be not fit for purpose, with lack of space and storage and very cluttered patient areas.	C: O: U:	. Please refer to 8.15.		

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10	The Trust should take action to ensure that there is an appropriate level of clean linen and pillows to meet the individual needs and requirements of patients	21. There can be some problems with linen and pillows, particularly at weekends, along with blankets and gowns.	C: O: U:	Noted & systems reviewed	Completed	
		22. Staff and patients commented about the shortage of wheelchairs. HIW was told that the Trust has had to have high bars attached to them to prevent patients taking them home in their cars. Very few wheelchairs were observed throughout the visit. Staff in clinical areas reported difficulties in obtaining them.	C: O: U:	To address the shortfall in the Emergency Unit, an order has been placed for an additional 20 wheelchairs, with enhanced security features to prevent their loss. (IM)	Completed	
11	Information on the adverse events of patients waiting for access to clinical services should be collected, analysed and fed back to clinical teams. Teams should then agree action plans and strategies to reduce the risk of these adverse events	23. There is no evidence of any specific clinical audit of factors surrounding the emergency admissions of patients who are on waiting lists.	C: O: U:	Cardiology maintain a profile of patients who require intra-hospital transfer for angiograms. This is reviewed and audited. Similarly, as a consequence of the revised Dermatology service model, an audit of delays in dermatology patient admissions is undertaken. Haematology in process of developing an admission audit proforma. Agreed to look at adding auditing of all patients on medical waiting lists to their audit programme	Completed GM	 2008
		24. There was no evidence of an improvement in communication with patients on waiting lists and it was of concern to be told that complaints regarding waiting lists are not dealt with through the complaints process.	C: O: U:	Implementation of pooling has improved information processes. Trust also considering implementing a text reminder system for patient's on outpatient waiting list. Complaints regarding waiting list processes are managed through the complaints process.	Completed	
13	The Trust must take action to increase the accessibility of electronic information relevant to evidence based practice for all clinical staff	HIW did find some evidence based practice, although such developments were hampered by the lack of information, such as via IT access or through the use of performance and outcomes data which was collected but not fed back to individual ward managers	C: O: U:	The Trust Datawarehouse is being cascaded to Clinical Directors, Directorate Managers and other relevant staff. Together with Signpost, this provides a valuable tool review variations in clinical performance.	Completed	

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15	The Trust must find additional ways of achieving effective team feedback and learning lessons from complaints at operational level.	25. The process for managing complaints appeared to be fragmented. There seems to be little co-ordination between complaints and other clinical governance processes, for example there was no evidence that audit activities were triggered by complaints.	C: O: U:	To be considered within CG program. Directorates are encouraged to share experiences of complaints through their clinical governance meetings, with examples of best practice noted in the Emergency Unit where regular lessons learnt meetings are held. Office Clinical Governance meetings held monthly with 2 Lead Executives and Clinical Governance and Patient Experience Managers identify recurring themes or serious issues with complaints that are then considered for the Clinical Governance Programme. Examples of this are: Improving communications both by education and customer care programme and improving data quality by encouraging accurate and timely written information, the latter being added to the Audit Programme.	Pat. Exp. Man and CG manager	Nov 2007
16	The Trust must take action to ensure that the new consent policy is implemented throughout all directorates	26. HIW saw few patient leaflets outlining consent issues during their visit.	C: O: U:	This will be considered along with revised Consent policy and launch.	Medical Director	January 2008.
		HIW were concerned that other staff, including some senior officers, seemed to be unaware that work to audit consent practices is undertaken.	C: O: U:	This will be considered along with revised Consent policy and launch The central Clinical Governance programme, which is directed by the Clinical Governance Committee, will now ensure that audits they commission are presented back to Clinical Governance Committee and Clinical Standards and Patient Experience Committee, which will then be picked up by Service Group Leads and taken into those areas. Together with the encouragement of service areas to both have wide attendance at their audit presentations and sharing this information further.	Medical Director	January 2008.

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17 - 19	The Trust must take action to improve the effectiveness of infection prevention and control within the Trust	27. The Trust Infection Prevention and Control Committee discusses the levels of infection and monitors prevention measures. It was unclear as to how these outcomes were reported and monitored within wider Trust performance management structures, for example, there was no evidence if measures being reported on the Balanced Scorecard or at the Clinical Governance Committee.	C: O: U:	The Trust Director of Infection Prevention and Control presents an annual report to the Clinical Standards Patient Experience Committee. This report is then taken to Clinical Governance Committee where the General Managers are present and all papers are encouraged to be taken back into service areas. this report will also be taken to Trust Board.	Medical Director	March 2008
	The Trust must take action to reduce the risk of infection by reducing the number of outliers on wards			Infection Control performance indicators to be added to Clinical Governance indicators for monitoring.	Medical Director	July 2007
	The Trust must take action to ensure staff comply with infection control polices			The Clinical Governance Indicator Report is taken to Clinical Governance Committee and on to Trust Board on a bi-annual basis.		
		28. The numbers of patients being treated on wards not appropriate to their condition due to bed capacity issue (outliers), have not changed much since the CHI review.	C: O: U:	Since the implementation of the MAU (May 06), West 7 at Llandough (21 Dec 06) and the acute rehabilitation model (19 April 07). The Trust has experienced a significant reduction in medical outliers across the two acute sites (average currently of C.70 versus a previous average of C.120). The implementation of the emergency care and revision to the bed management model should further reduce the outlier position.	GMs	Ongoing
		A number of infection control audits are listed in the annual audit report but results, conclusions or recommendations were not detailed	C: O: U:	The Trust will review the presentation of audit outcomes in the annual audit report	Medical Director	July 2007

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<p>20 - 22</p> <p>The Trust must take action to improve communication between directorates so that learning from clinical audits can be shared</p> <p>The Trust must take action to increase multidisciplinary involvement in clinical audit. Nurses and AHPs should be supported to contribute as equal partners to all stages of directorate audit programmes.</p> <p>The Trust must take action to increase patient involvement in clinical audit activities.</p>	<p>29. There appears to be no one system of planning and prioritising audits within the Trust. The Medical Director and Nurse Director are responsible for the delivery and robustness of the clinical audit programme. Service groups and directorates are encouraged to draw up audit plans but HIW was told that it was not a priority for them.</p>	<p>C: O: U:</p>	<p>Work underway to develop a revised Clinical Governance Program that will be taken to July 2007 Clinical Governance Committee for agreement and dissemination through service areas. Review of clinical governance half day sessions seen as part of this work.</p> <p>The Clinical Governance Committee directs the central Clinical Governance Trust-wide Audit Programme.</p> <p>General Managers who are part of the Clinical Governance Committee pick up on issues that need to be audited at all areas in the Trust and the most recent issues are patient identification, processing of abnormal results, and data quality.</p> <p>As previously, the centrally commissioned audits are presented to Clinical Governance and Clinical Standards and Patient Experience Committee and picked up by service areas there for further dissemination, together with this process being encouraged at Service Group level and across.</p>	<p>Completed</p>	<p>July 07</p>
	<p>30. There appeared not to be any central co-ordination or cross-departmental development of audit. For example, HIW found several audits covering different aspects of the same area of work being undertaken in isolation by different departments or professions. HIW found a number of audits that have not been included in the Trust-wide report, presumably because they have not been reported centrally.</p>	<p>C: O: U:</p>	<p>Each of the Service Groups are working with Directorates to develop an audit plan which can be reported formally through its Clinical Governance mechanism.</p> <p>Within the Medicine Directorate, for example, an audit of medication errors is routinely completed and lessons learnt are shared at the Clinical Governance meeting. As a result a number of Directorates are developing and implementing a review of medication errors within their respective clinical areas.</p>	<p>GMs</p>	<p>Ongoing</p>
	<p>audits are often led by individual clinicians as a personal project. This leads to many audits being started but not completed or no results recorded when staff move on</p>	<p>C: O: U:</p>	<p>Directorate audit plans to be focused upon clinical governance priorities, with formal feedback to Service Group meetings (IM)</p>	<p>GMs CDs</p>	<p>Ongoing</p>
	<p>There was little evidence of processes to share learning from audit.</p>	<p>C: O: U:</p>	<p>As above</p>		

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	<p>31. There seems to be little co-ordination between the various sectors of the Trust that undertake clinical governance activities. HIW was told there was no connection between patient support and audit staff. There was little evidence of processes to share learning from audit.</p> <p>32. HIW was told that that there is currently no patient involvement in audit activities.</p>	<p>C: O: U:</p>	<p>As above</p> <p>Clinical Governance Committee workplan and programme taken to November 2007 Trust meeting</p>			
23	The trust make take action to comply with the requirements of national confidential enquiries	33. There appeared to be some confusion surrounding the process for implementing recommendations of confidential enquiries.	<p>C: O: U:</p>	Paper taken to April CS/PEC outlining current situation and agreement to produce over-arching protocol	Medical Director	Nov 07
24	The Trust should take action to agree and implement a mechanism to ensure that research priorities in the clinical fields of the allied health professions contribute to the strategic direction of research and effectiveness	34. HIW was told that there is not really a process for allied health professionals to identify research priorities.	<p>C: O: U:</p>	Directorate R&D lead identified within the Directorate. That lead sits on the Trust RD group. Therapies R&D strategy and action plan in place , developing a business case to try and support a WTE R&D lead to be dedicated to support AHP research	CD Therapies	Completed
25	The Trust must take action to support staff to implement evidence based practice. This should include an action plan to ensure that staff are able to easily access relevant databases and develop skills to apply research evidence relevant to their specialist area of patient care.	35. It was reported to HIW that there was no link within the portal system to the evidence base behind any area.	<p>C: O: U:</p>	Every PC in the Trust can access the Clinical portal. The Clinical Portal contains links to multiple internal and external Evidence Based Practice publications and databases. The Portal brings access to these together in summary through its "Evidence Base" page which can be accessed via the resources tab on the Portal Home page. The gathering of evidence base information links together in this way makes access to required information straightforward	IM&T	Completed
26	The Trust should work with Higher Education partners and other commissioners of education to agree and implement a workforce plan to support future staffing needs at the Trust	HIW were told that managers needed to be more skilled at workforce planning and looking at new ways of working.	<p>C: O: U:</p>	Significant OD agenda underway as a consequence of Agenda for Change, EWTD and Access 2009. Many workforce modernization initiatives have been successfully completed:- - ECHO dept. - C6 – Acute rehabilitation ward - Nurse-led Thrombolysis - MEAU	HR Exec & Line Managers	Ongoing
27	The Trust should develop systems to ensure all staff receive an appraisal each year so that their development needs can be fully considered (the current appraisal system is implemented and monitored through the Service Group and Executive Management Groups.	36. There appeared to be no overarching clinical supervision policy.	<p>C: O: U:</p>	Draft Clinical Supervision policy available – will be ratified during year after further consultation	Medical Director	December 2007.

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	37. The Balanced Scorecard and Performance Reports contain space for information on PDP performance but no data was recorded.	C: O: U:	The Balanced Scorecard is set by the Welsh Assembly Government and currently does not have an indicator on this subject. This scorecard will however over time evolve to become more comprehensive and the Trust will contribute to this process. The Trust's Performance Report is currently being reviewed in light of evolving national targets and PDP performance. PDP reporting is provided bi-annually to the HR Committee, a sub-group of the Trust Board and also feature as part of the HR Director's performance reports to Trust Board.	Completed		
28.	The Trust should continue with its strategy to support the training for health care support workers	38. The Trust supports a programme of NVQs for Healthcare Support Workers, but it needs to develop a clear strategy and identify how it fits with the modernisation of new roles.	C: O: U:	Evaluate the Modern Apprenticeship Program. Scope current position for HCSW for nursing Develop Strategy for role development and modernization of Health Care Support workers	HR Managers	May 07 Sept 07 Sept 08
29	The Trust should review the time available for experienced nurses to provide workplace based training to students and new staff and ensure that they are given appropriate support to do this	Appropriate training is available to mentors but they have problems making time to attend this.		Establish Trust Data base for Mentors Joint review with Cardiff University of Training in light of revised NMC Standards to support learning and assessment in practice. Review to be staged in line with NMC requirements	Director of Nursing	June 07
30	The Trust must provide appropriate support and training for frontline staff who liaise with patients and carers about cancellations and appointments on a daily basis	39. The Trust appears to have made little progress in this area. HIW was told that there is little support for frontline staff. They do not receive specific training to deal with difficult situations and any issues are dealt with "on the job".	C: O: U:	Patient Experience team have undertaken Customer Care training Trust wide and have trained trainers	SG trainers	Ongoing
		40. Contacts from concerned patients regarding their list status are not recorded as complaints but as queries. The Trust may need to explore this further in respect of the level of importance attached to this area of work.	C: O: U:	To be discussed at All Wales Complaints Network meeting – currently in line with other Trusts All complaints are recorded some formally and some informally as they are enquiries often from AM and PM's. There is no complaint, compliment, enquiry concern which is not recorded either on complaints or the PALS database. Directorate staff who review formal and concerns enquiries are aware that all are logged and counted and reported on within the CLIP report	Pat Exp Manager	Ongoing

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				The Trust is following WAG guidance in the management of such concerns. They are subject to the same process as a formal complaint, with evidence demonstrating their turnaround within 20 days.		
31	The Trust needs to establish a comprehensive system to record training courses completed by staff to help in the assessment of future training needs. For mandatory training, the system should ensure that all staff attend appropriate courses at the right time	41. There is a mandatory training assessment questionnaire to identify staff needs. However, this was completed by 25% of staff. The Trust needs to ensure its staff engages better with this process.	C: O: U:	<p>An annual Training Needs Analysis is undertaken by the Trust which assesses the Mandatory Training requirements of all staff employed within the Trust.</p> <p>Completion of the Training Needs Analysis is supported by the evidence provided through the Mandatory Training Assessment Questionnaire. (MTAQ).</p> <p>In order to improve communication and engage with staff the MTAQ is now available on-line.</p> <p>40% of staff have completed the MTAQ since it has been made available via the Trust intranet. This percentage will be further improved as the computer generated MTAQ certificate will be formally reviewed as evidence within the annual KSF PDR appraisal.</p>	OD&T	Completed
		The Balanced Scorecard and Performance Reports contain space for information on mandatory training performance but no data had been filled in	C: O: U:	<p>The Balanced Scorecard is now preset by the Welsh Assembly Government and does not focus have an indicator on this subject. HR indicators for the future are being considered through the HR committee which reports directly through to the Trust Board.</p> <p>Mandatory training compliance is reported via Human Resources and Risk Management Committee – both sub-groups of Trust Board</p>	OD&T	Complete