



Healthcare Inspectorate Wales Inspection Report of Powys Local Health Board September 2005

Approved Action Plan

March 2006

Recommendation 1*The LHB should provide published documents in bilingual formats*

Actions:

- 1a Business case to be submitted to LHB for additional funding
- 1b Database of leaflets to be developed
- 1c Core leaflets to be identified for publishing
- 1d Core leaflets to be published and put onto intranet

Improvement outcomes:

Published documents are in bilingual format

Monitoring Process**Quarterly reports to the Public and Patient Involvement Committee**

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
1a	December 2005	Medium 15	1a- Business case submitted to Charitable Funds Committee and approved in December 2005	Director of Corporate Services	PPI Development Plan Communication Strategy Welsh Language Scheme Clinical Governance Development Plan
1b	December 2005	Failure to meet needs of Welsh speakers and failure to meet statutory requirements in Welsh Language Scheme	1b- Database available on intranet		
1c	December 2005		1c- Each Professional group has identified core leaflets required		
1d	April 2006		1d- Core leaflets will be published and added to intranet April 2006		

Recommendation 2

The LHB should take forward the integrated impact assessment process to deliver a fair and equitable approach to commissioning

Actions:

2a: The LHB will work closely with Wales Centre for Health on developing the use of integrated impact assessment both by the LHB itself & jointly with Powys County Council

2b: The LHB will pilot the use of the assessment on the draft commissioning strategy and undertake a joint integrated impact assessment on the Powys Adult Mental Health Strategy.

2c. Local Delivery Plan will be implemented

2d. The Commissioning Strategy will be signed off and implementation will be monitored quarterly

2e: All future Strategies will be impact assessed using the agreed tool

Improvement outcomes:

Powys residents have equitable access to clinically and cost effective services

Monitoring Process

Health, Social Care & Wellbeing Project Board, Central Planning and Commissioning Committee and to the Local Health Board, Board

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
2a	November 2005	Failure to improve responsiveness of services to patients needs will result in dissatisfaction and complaints Failure to put patients at centre of care Discord between Local Health Board and partner organisations HIGH RISK = 20	2a – Contact made with WCH and PCC to pilot an impact assessment	Medical Director	'Doing More Doing Better' publication Clinical Services Strategy Clinical Governance Strategy 'WAG Raising Standard: The revised adult mental health NSF and action plan for Wales' The Health, Social Care and Wellbeing Strategy
2b	May 2006		2b- Draft commissioning strategy out for consultation, November 2005. Anticipated approval, April 2006 2b- Draft Powys Adult Mental Health Strategy out for consultation December 2005. Anticipated approval in May 2006		
2c	May 2006		2c- Local Delivery Plan in process of being drafted. Consultation and approval process anticipated May 2006		
2d	May 2006		2d- Completion of impact assessment – March 2006 tool to use on each one- look to have all services in commissioning strategy.		
2e	All Strategies will be monitored quarterly		2e- Substance Misuse Strategy approved, December 2005. EMI Strategy drafted and will be put for consultation March 2006 - Older peoples Strategy drafted and out for consultation March 2006 with anticipated completion date May 2006 - Learning Difficulties and Physical Difficulties Strategies and others to be reviewed in 2007 A Joint Information Group (JIG) was established in Dec 2005. This multi-agency group will develop the next phase of needs assessment to be taken forward 2e- Approved impact assessment tool will be disseminated and utilised by each Directorate and monitored via the Planning and Commissioning Group quarterly		

Recommendation 3

The LHB should review its Public and Patient Involvement Strategy and establish Public and Patient Involvement into the routine processes of the organisation by:

- Progressing the arrangements for leadership of public and patient involvement
- Providing specific training relating to the responsibilities of staff for PPI during induction and to existing staff
- Considering extending representation to include wider groups of people to ensure a broader public and patient view
- Making explicit the plans for monitoring care from the patients perspective

Actions:

- 3a. Signposts in Baseline audit to be undertaken to identify gaps in PPI delivery
- 3b. Baseline audit results and recommendations will be used to review PPI Strategy taking into account recommendations above
- 3c. Providing specific training relating to the responsibilities of staff for PPI during induction and to existing staff
- 3d. LHB Membership and attendance at Powys Social Inclusion Committee to determine future requirements
- 3e. Process for monitoring care from the patients perspective to be developed, implemented and monitored.

Improvement outcomes:

Arrangements for involving patients, carers and the public in the development and consideration of proposals for change in the way that services are provided; and the integration with social care services is fully inclusive of the views of patients and the public

Monitoring Process

Public and Patient Involvement Committee and Health and Social Well Being Board

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
3a	December 2005	Public dissatisfaction with service	3a- Signposts II baseline audit completed	Director of Nursing	PPI Development Plan Training Strategy Human Resources Strategy Clinical Governance Strategy and Development Plan PPI Development Plan
3b	March 2006	Service change is not inclusive of public views and does not take into account the needs of the public	3b- Draft strategy will be taken to PPI committee March 2006		
3c	July and ongoing 2006		3c- Meeting with Head of Human Resources & Training & Development Lead, to identify plan of action February 2006. Training needs assessments in all areas to achieve 75% by December 2006 and customer care is included in induction training for all new staff. Workshop to identify needs and assess action required planned for May 2006		
3d	March 2006		3d Attended Powys From exclusion to inclusion workshop in November to look at Social exclusion and identify barriers to inclusion. Membership agreed.		
3e	June 2006 and quarterly monitoring	Medium 9	3e-Process drafted and will be issued for consultation Feb 2005. Aim to prioritise care episodes that can be monitored through satisfaction surveys, complaints and incidents		

Recommendation 4

The LHB should draw together the differing assessment and review work to develop an overall strategic approach to estate management.

Actions:

- 4a. Estates Strategy to be developed.
- 4b- Estates Strategy to be implemented once plans agreed by Welsh Assembly Government
- 4c- Quarterly monitoring of implementation programme

Improvement outcomes:

An overall strategic approach to estate management will ensure more clinically and cost effective use of resources.

Monitoring Process

Executive Management Team and LHB Board.

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
4a	September 2006	Facilities unfit for use and do not serve purpose of modernised and efficient service HIGH RISK = 20	4a. Primary Care Estates Strategy was submitted to the Welsh Assembly Government in late 2005 “Doing More, Doing Better” Road-shows currently underway led by the Chief Executive demonstrates LHB’s commitment to Public and staff in delivering excellent services for its population with staff, neighbouring providers PCC and voluntary sector	Director of Support Services	Estates Strategy Welsh Risk Pool Action Plans Capital Programme 2005/2006 Clinical Services Strategy ‘Doing More Doing Better’ Programme
4b	Not known		4b- Strategy approved by Welsh Assembly Government		
4c	When plan approved and ongoing		4c- Monitoring will take place quarterly of achievements made		

Recommendation 5

The LHB should continue the development of its IM & T Strategy to strengthen information management process, information security, links with other NHS organisations and compliance with required standards.

Actions:

- 5a. IM&T Strategy to be developed
- 5b. Develop system for providing information about resources and processes
- 5c. Improve telemedicine links with neighbouring DGH's and internal providers
- 5d. Continue implementation of the action plan for integrating the electronic single record
- 5e. Develop robust protocols in line with BS7799
- 5f. Continue implementation of ECDL training programme for staff
- 5g. I&MT Strategy approved and monitoring of implementation commenced

Improvement outcomes:

The LHB will have effective information systems and integrated information technology that will support and enhance patient care, and in commissioning and planning services.

Monitoring Process

Quarterly Report to Informing Health Committee, which reports to Clinical Governance & Risk Management Committee.

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
5a	March 2006	Integrate a number of sources of information required	5a- Draft Strategy circulated for comment December 2005	Medical Director	Informing Healthcare Strategy Communications Strategy Estates Strategy Welsh Risk Pool Action Plans Clinical Governance Development Plan Training and Development Strategy
5b	October 2006		5b- Draft system developed for consultation		
5c	October 2006		5c- Telemedicine links between community hospitals & Out of Hours service will be in place by March 2006		
5d	October 2006	Time, funding and software development	5d- 35,000 records currently integrated	Human Resources Director	
5e	February 2006	Failure to benefit from major investment	5e- Protocols drafted and out for consultation		
5f	December 2005. Progress will be monitored quarterly		5f- Process for providing ECDL training agreed. Two trainers appointed, training to begin December 2005 Aim to train the 195 staff who have signed up to course by October 2007		
5g	April 2006	High risk= 20	5g I&MT Strategy – to be approved through Informing Health Care and Clinical Governance and Risk management Committee by June 2006. Monitoring of implementation will be undertaken quarterly by the Informing Healthcare Committee with quarterly reports to CG/RM Committee		

Recommendation 6

The LHB should establish a system to ensure that policies and procedures are systematically reviewed/dated and an audit process developed to ensure policies and procedures have been distributed to the appropriate staff.

Actions:

- 6a. Policy for policies to be reviewed and updated.
- 6b. Central database for all policies to be maintained and policies for review to be flagged to relevant professional group
- 6c. Programme for policy development to be drafted
- 6d. Audit process developed to ensure policies and procedures have been distributed to the appropriate staff

Improvement outcomes:

All Professional groups and appropriate staff will have equitable and easy access to evidence based and up to date policies and procedures

Monitoring Process

Quarterly Reports to Clinical Governance and Risk Management Committee and Human Resources Committee.

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
6a	February 2006	Lack of co-ordinated development of evidence based policies.	6a- Policy for policies re-drafted to take into account changed requirements of LHB.	Director of Support Services	Welsh Risk Pool Action Plans Clinical Governance Development Plan Records Management Strategy Professional Operation Plans and Strategic Documents
6b	March 2006	Staff not able to access appropriate policies in timely manner	6b- Database for those policies formally approved at the Clinical Governance and Risk Management Committee held centrally and disseminated by the Clinical Governance Department. HR policy database currently available.		
6c	March 2006		6c- Clinical Governance, Audit and Medical Group reviewing clinical policy prioritisation in March 2006 and each Professional Group will produce a programme.		
6d	March 2006	Medium risk = 15	6d- Audit process include monitoring arrangements for policies approved via Clinical Governance and Risk Management Committee developed and disseminated to Heads of Service Heads of service will be expected to provide evidence of signatures and this will be monitored annually by Clinical Governance Department and outcome reported to Executive Lead		

Recommendation 7

The LHB should strengthen its consultation processes with neighbouring DGHs, other LHB's and local communities when they change or reconfigure service provision and give consideration to formalising the gathering of patients' experience so that the information can link into the framework for improving services.

Actions:

7a. Formally approve Commissioning Strategy At Board

7b. Establish formal partnership with major providers through the development of formal joint operational groups

7c. Deliver "Doing More, Doing Better" consultation process

Improvement outcomes:

Agree future configuration of services to deliver improved local care with robust mechanisms in place that demonstrate consultation with partners, key stakeholders and the public

Monitoring Process

'Doing More, Doing Better' Project Board and Executive Management Team. Central Planning and Commissioning Group

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
7a	February 2006	Partnership working fails resulting in duplication	7a- Draft Commissioning Strategy out to consultation. Approve by June 2006 at Board Formal partnership Boards established with major providers to discuss Long Term Agreements and future commissioning intention. 7b- Joint Commissioning Panel Terms of Reference issued for comment October 2005 7b- Joint working bid proforma agreed Jan 2006 7b- Health and Well-Being Partnership Board Terms of Reference agreed December 2005 with support provided by a reshaped Health Alliance function, a Joint Operational and Commissioning Group and Multi-Agency reference Groups 7c- 'Doing More, Doing Better' Is a structured consultation process actively involving the local communities, staff and neighbouring organisations. The consultation process will feed into the PPI agenda and commissioning processes	Medical Director	Clinical Services Strategy Clinical Governance Strategy and development plan Public and Patient Involvement Development Plan
7b	February 2006	Token partnership working only			
7c	December 2005	High risk = 20	Chief Executive		

Recommendation 8

The LHB should ensure that all staff are fully aware of the LHB's policies relating to Freedom of Information, the Publication Scheme and information security procedures.

Actions:

8a The Freedom of Information, Publication Scheme and Information Security procedures will be available on the intranet

8b The Freedom of Information, Publication Scheme and Information Security procedures will be available in hard copy in departments where I&MT access is not easily available

8c Essential Training will be provided on The Freedom of Information, Publication Scheme and Information Security procedures

8d Programme to audit effectiveness of training and compliance with procedures will be developed

8e Guidance on the Freedom of Information, Publication Scheme and Information Security procedures will be given via the Keybrief and Insiders

Improvement outcomes:

Audit demonstrates that LHB staff are aware of their responsibility under Freedom of Information and Information Security Procedures.

Monitoring Process

Information Security and CALDICOTT Committee, who feed into Clinical Governance & Risk Management Committee.

Action Ref	Completion date	Assessment of risk	Milestones	Lead Accountability	Relationship to Organisational Plans
8a	December 2005	Organisation fails to meet its statutory responsibilities in providing information and maintaining the security of confidential data	8a All procedures available on intranet	Director of Corporate Services	Communications Strategy
8b	August 2005		8b- Available in hard copy where intranet access not available		Information and Technology Strategy
8c	August 2005		8c- FOI and Caldicott training part of essential training plan and included in induction of all new staff		Training and Development Strategy
	June 2006		8d- Programme will be included in annual audit and effectiveness programme and quarterly monitoring of progress will be included in report		Clinical Governance Strategy
8d	April 2006				
8e	June 2006	Moderate = 15	8e- Further briefing will be prepared and disseminated across the LHB		

Recommendation 9

The LHB should ensure that all staff recognise the need for and implement risk management processes continuously.

Actions:

- 9a Develop risk assessment training as part of essential training for staff
- 9b Ensure all Directorates complete, update and monitor risk registers monthly
- 9c. Directorates report to Executive Team and Board on a quarterly basis

Improvement outcomes:

In the LHB, risk management is an integral part of good management practice, where there is a shared commitment to quality, active working with patients and carers, multi disciplinary learning, strong leadership exists at all levels and there is Board involvement to ensure that risk is minimised.

Monitoring Process

Corporate Risk Register to be monitored quarterly via Executive Management Team and to Clinical Governance and Risk Management Committee.

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
9a	March 2006	Failure to improve risk management score and so a financial penalty	9a- Training Programme drafted.	Director of Support Services	Clinical Governance Strategy
9b	Ongoing on monthly basis	Failure to risk assess clinical services	9b- Risk registers updated and submitted for inclusion in corporate risk register		Risk Management Strategy
9c	Ongoing on a quarterly basis	Services not success orientated. No outcome data to share with patients. Uncoordinated approach to clinical audit No way of reporting success and strength of services Services not keeping pace with new practice High = 20	9c- Health and Safety Quarterly monitoring report meets this requirement but will be reviewed to include clinical and non clinical risks		Training and Development Strategy Welsh Risk Pool Action Plans

Recommendation 10

The Clinical Audit programme should be implemented fully across the organisation and contribute to clinical quality and continuous improvement.

Actions:

10a. Audit training to be provided

10b. Clinicians participate in regular audit and apply changes to practice

10c- Audit participation integral to personal development plans

10d- Directorates determine priority for audit and produce plan as per Directorate Clinical Governance Performance plan and share results

Improvement outcomes:

Audit outcome demonstrates that Clinical Care and treatments are delivered by Healthcare professionals who make clinical decisions based on evidence-based practice

Monitoring Process

Quarterly audit and effectiveness reports to Clinical Governance and Risk Management Committee

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
10a	March 2006	LHB cannot be that patients and service users are provided with effective treatment and care th based on nationally agreed best practice and guidelines, as defined in National Service Frameworks, NICE clinical guidelines Patients and clinicians wish to maintain local service Cost and opportunity -Need to keep up to date -Must be done to provide LHB core purpose	10a- Critical Appraisal Skills Training planned for March with further cascade training dates to follow	Medical Director	Clinical Governance Strategy and development plan Clinical Audit and Effectiveness Strategy Welsh Risk Pool Action Plans
10b	September 2006		10b- Clinical Audit & Effectiveness Programme approved and quarterly reports provided. 10b- Heads of Service, and primary care prioritising Audit required for 2006		
10c	December 2006		10c- Meeting to be held with Training and development team and HR to determine processes for inclusion in PDPs		
10d	April 2006		10d- Audit priorities are received for inclusion in the 2006 Clinical Audit and Effectiveness Programme 10d Results are shared via the 'virtual' adverse incident group which includes managers from all directorates and Directors, via the individual team feedback and across the organisation through publication of the quarterly audit and effectiveness reports		
	Moderate risk = 15				

Recommendation 11

Lessons learned from complaints and incidents should be shared across the organisation in a consistent manner.

Actions:

11a Quarterly report on complaints and incidents to be produced and disseminated

11b Feedback to individuals to be given where appropriate

11c Clinical Governance issues including incidents and complaints to be a standing agenda item on Operational Team meetings

Improvement outcomes:

Information about the public/patient's experience including data on complaints received (and changes made as a result) and compliments received (to provide a balance to complaints) is made available so that effective and necessary changes can be made. Identify and learn from all patient safety incidents and other reportable incidents.

Monitoring Process

Quarterly report to Public and Patient Involvement Committee and also to Clinical Governance and Risk Management Committee.

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
11a	August 2005	Incidents not recorded and lessons not learnt so mishaps continue	11a- Quarterly report disseminated to Heads of Service	Medical Director	Clinical Governance Strategy and Development Plan. Risk management Strategy
11b	Ongoing as appropriate	Complainants dissatisfied with outcome	11b- Feedback is given to individuals and professional groups by the appropriate Head of Service or Manager		
11c	Standing agenda items at monthly meetings	No knowledge of outcomes No measures of achievement – loss of focus Dissatisfied patients Uncoordinated complaints handling Further complaints about same service Failure to involve staff in complaints in a positive way Moderate risk = 15	11c- Monthly Operation Team meetings discuss clinical governance issues including incidents, complaints, risk management and PPI as part of the standing agenda items		

Recommendation 12

The LHB should continue to strengthen the arrangements for “Looked after Children”.

Actions:

12a- On a multi-agency basis, co-ordinate the joint planning activity at all levels

12b- With key stakeholders, Examine the current service provision to look at best ways of providing the LAC service in Powys.

12c- Strengthen closer partnership working

12d- Highlight to the WAG the need to ensure that arrangements are in place for statutory co-operation work across the English and Welsh border for those children receiving services from English providers (or who are registered with GPs in England).

12e- Ensure continuous review monitoring and update, in partnership with Powys County Council, of looked after children arrangements. L.A. Medical staffing essential

Improvement outcomes:

Children who cannot be looked after by their own family will be looked after properly by people who respect their religion, culture and language and will be protected from violence, abuse and neglect by the people who look after them

Monitoring Process

Joint Operational Planning Group with reports to Board.

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
12a	December 2005	The LHB fails to meet its statutory duties to provide safe and effective care to Looked After Children	12a Children's partnership work as part of Joint Operational Planning Group is underway and Terms of Reference produced to include accountability and monitoring arrangements for each planning group	Director of Nursing and Medical Director	Children Act 1989 Working together to safeguard children-2000 Too Serious a Thing- The Carlile Review 2002 The Victoria Climbié Inquiry 2003
12b	December 2005				
12c	December 2005 and ongoing	Children are vulnerable and at high risk of receiving sub-standard care	12b- proposals for joint planning structures have been prepared under the auspices of the multi-agency Community Strategy Partnership and the re-launch of the Health Alliances which will monitor the activities of Multi-Agency Reference Groups (MARGs), to ensure key stakeholders are working collaboratively so that the arrangements for LAC are strengthened		
		High risk	12c- The MARG for children will lead the planning work for children's services and will have links to the Children and Young People's Partnership Framework with planning for Children's Services being brought together from 2008 in a Children		

12d	October 2005		<p>and Young People's Strategy. 12c, Specialist Child and Adolescent Mental Health Services costed plan submitted to WAG in October 2005</p> <p>12d- Position statement concerning the recruitment of paediatricians for Powys taken to Board in October 2005 setting out actions taken to secure interim arrangements and long term solutions in respect of a permanent designated doctor for child protection and looked after children. WAG aware of difficulties being faced in north Powys and arrangements are being discussed with WAG advisor to ensure compliance with essential standards and provision of safeguards for children</p>		
12e	<p>December 2005 and ongoing monitoring</p> <p>HIGH RISK = 25</p>		<p>12e- The Commissioning arm of the Local Health Board is reviewing its expenditure on children's services with neighbouring NHS Trusts. In terms of a long term solution, it will offer all neighbouring NHS Trusts and PCTs the opportunity to provide community paediatrics on behalf of Powys. Proposals will be judged within an agreed option appraisal process, in order to secure the best arrangements for Powys children.</p>		

Recommendation 13

The LHB should ensure all staff participate in an annual appraisal process.

Actions:

- 13a. Appraisal process training available for all staff
- 13b. Appraisal process template available on intranet
- 13c. Monitoring of the numbers of appraisals completed is undertaken
- 13c. Annual Audit of process in place

Improvement outcomes:

There is clear evidence that staff work for an organisation which provides:

- job satisfaction through empowerment and involvement in decision making
- equality of opportunity
- skills development
- positive and sensitive management
- the ability to demonstrate a commitment to improving the quality of working life for staff

Monitoring Process

Quarterly reports to Human Resources Committee

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
13a	March 2005	Time required to achieve standard	13a- Appraisal process training is available to all staff. KSF leads are developing in partnership, appraisal and personal development plans	Director of Human Resources	Human Resources & Training Development Strategy.
13b	August 2005				
13c	August 2005	No sharing of ideas	13b- The appraisal process template is available on the intranet		
13d	September 2006	High risk = 20	13c- Monitoring of the numbers of appraisals undertaken is completed on a quarterly basis. 50% of appraisals expected within year 13d- arrangements to undertake audit of process is being developed		

Recommendation 14

Improved and more effective systems should be put in place to seek and use the views and opinions of staff.

Actions:

- 14a. Human Resources Strategy produced
- 14b- Human Resources Strategy approved
- 14c. All Wales Staff survey issued to all staff
- 14d. Results of All Wales staff survey reviewed and action plan developed to address recommendations
- 14e Action plan implementation monitored quarterly

Improvement outcomes:

The LHB seeks to enhance patient care and to continuously improve staff satisfaction by providing best practice in human resources appropriate under-representation of working. (staffing and staff management)

Ensure that staff are supported by processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management.

Monitoring Process

Quarterly report to Human Resources Committee

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
14a	March 2006	Views and opinions of staff are not sought out resulting in dis-engaged work force who do not share the corporate vision of the LHB Recruitment and retention issues as a result of dis-engaged workforce Moderate risk = 15	14a- Strategy produced in draft for consultation.	Director of Human Resources	Human Resources and Training & Development Strategy. Clinical Governance Strategy and development plan
14b	June 2006		14b- Consultation process completed and comments incorporated into strategy		
14c	October 2005		14c- Achieved, awaiting feedback of survey outcome in January		
14d	March 2006		14d- Meeting to review outcome of staff survey and develop action plan in response		
14e	Quarterly monitoring from July 2006		14e- Key responsibilities identified and action monitored on quarterly basis		

Recommendation 15

The LHB should consider a range of approaches to ensure that staff are able to attend relevant training events.

Actions:

15a Human Resources Training and Development Strategy developed

15b Develop an integrated learning management system for on line booking and records management

15c Implement a programme for developing basic IT skills for all staff through ECDL qualification

15d Develop e-learning and distance learning packages providing opportunities for blended learning

15e Set up a system of audit/review of all programmes for monitoring access attendance and impact

15 f Study Leave budgets will be reviewed and a long term plan will be developed to balance any inconsistencies and inequity

Improvement outcomes:

The LHB is an effective learning organisation where education, training, continuing personal and professional development, and organisational development is fundamental to the delivery of high quality, effective, evidence based care.

Monitoring Process

Human Resources Committee reporting to the Board

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
15a 15b	Achieved Achieved	Staff unaware of own performance	15a- Strategy developed and approved 15b- On line booking system established. Development opportunities have been advertised via the training and development prospectus/ programme which include local and corporate initiatives. A systematic process for training and development with timescales to be implemented has been agreed for all occupational areas resulting in training and development plans for all services. A policy and procedure for appraisal and personal development planning has been agreed in partnership	Director of Human Resources	Training and Development Plan Clinical Governance Strategy Clinical Services Strategy
15c	Ongoing until implementation in June 2007	No training to support identified needs Professional staff not ensured as achieving Risk level high = 20	15c- ECDL programme in place, staff training commenced 15d- e-learning and distant learning packages agreed and in place for core training		
15d	July 2006 and ongoing with quarterly reports to Committee		15e- System of audit established and priority audit undertaken		
15e	July 2006				
15f	December 2005		15f Reviewed and long term plan to address inconsistencies drawn up and will be monitored quarterly		

Recommendation 16

The LHB should ensure effective performance monitoring with regard to patient outcomes is undertaken to enable the Board to receive reasonable assurance to the quality of services.

Actions:

16a. Implement agreed Clinical Audit and Effectiveness Programme.

16b. Agree Audit & Effectiveness Programme for forthcoming year.

16c. Monitor incidents, complaints and claims to highlight trends and concerns where poor outcomes have been identified.

Improvement outcomes:

Healthcare decisions and services will be based on what appropriately assessed research evidence has shown will provide an effective outcome for patients and service users taking account of their individual needs and preferences.

Monitoring Process

Executive Management Team and Clinical Governance & Risk Management Committee.

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
16a	Achieved	Staff not familiar with policies and procedures Professional staff not ensured as achieving professional standards	16a- Quarterly report submitted to Clinical Governance & Risk Management Committee and feedback given to professionals involved.	Medical Director	Clinical Governance Strategy. Clinical Services Strategy.
16b	April 2006	Incidents not recorded and lessons not learnt so mishaps continue	16b- NSF Implementation Groups and Professional Leads identifying audit priorities for forthcoming year.		Clinical Governance, Audit & Effectiveness Strategy
16c	March 2006 and quarterly monitoring	No knowledge of outcomes No measures of achievement – loss of focus Risk- High = 20	16c- Incidents, claims, complaints reviewed regularly to identify where audit of patient outcome is required. The Clinical Governance, Audit & Effectiveness Programme is amended accordingly. The role of the Board is to receive the reports from the Clinical Governance and Risk Management Committee and to establish and to take appropriate action based on the recommendations within the reports.		LHB Standing Orders (2005)

Recommendation 17

The LHB should continue to strengthen its Clinical Governance arrangements by:

1. Continuing to develop primary care contractor processes.
2. Ensuring there is a formal link between clinical governance and the determination of planning priorities.

Actions:

- 17a. Developing a Clinical Governance framework for adoption by primary care providers'
- 17b. Improve collaborative working with Primary Care providers to improve on culture of trust and openness.
- 17c. Develop a common understanding of Clinical Governance for planning.
- 17d. Use standards, evidence, audit and review as basis of planning.
- 17e. Develop a more robust joint planning structure.
- 17f. Board to adopt a policy about how it will prioritise planning priorities as in recommendations

Improvement outcomes:

A balance is achieved between locally identified priorities and centrally determined targets. The process of planning and commissioning ensures that all stakeholders and special interest groups are involved and that there is a local focus on the implementation and achievement of national standards and performance targets. The systematic approach to commissioning services will then clearly offer the opportunity to build clinical governance arrangements into the process.

Monitoring Process

Clinical Governance and Risk management Committee and Planning and Commissioning Group

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
17a	November 2005	-An uncoordinated approach and increased risks to patients and staff -No quality assurance mechanism in place	17a- Clinical Service Strategy has been approved and the delivery of "Doing More, Doing Better" workshops will serve to engage Primary Care Providers.	Medical Director	Clinical Services Strategy.
17b	December 2005 and ongoing	-No organisational buy in -Inability to monitor compliance	17b- Quality Outcome Framework visits have supported good practice, 'Going for Gold' project in place to support Optometrists, Community Pharmacy monitoring visits x 3 to date undertaken to support implementation of new pharmacy contract, Dental Advisory Officer appointed to support Dental Practices with implementation of new dental contract, Clinical governance monitoring visits of the ten community hospitals have been undertaken this year developing welsh health care standards within the developed self assessment tool kit		
17c		-Poorly co-ordinated care			
17d	March 2006	-Staff available to attend so many meetings -No quality assurance of care			Clinical Governance Strategy & Development Plan
	April 2006	-Partnership working fails resulting in duplication			
17e	January 2006	Risk level- High = 20			Commissioning Strategy
17f	June 2006		17c- Formal Partnership Boards established with most providers to discuss Long Term Agreements and future commissioning		

			<p>intention and Clinical Governance is integral component of agenda.</p> <p>17d- Clinical audit and effectiveness programme developed to address these issues</p> <p>17e- Commissioning Strategy outlining clearer arrangements drafted.</p> <p>17f- Policy will be agreed at Board on how to prioritise planning priorities</p>		
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Recommendation 18

The LHB should develop a strategic document setting out the arrangements for Public Health in Powys.

Actions:

18a The LHB will convene a small group under the Chair of the DPH to develop a strategic document that sets out arrangements in place for public health in Powys. Key elements will include:

- Screening
- Vaccination and Immunisation
- Communicable Disease Control including infection control in health care settings
- Development of the Health, Social Care and Wellbeing Strategy
- Health Needs Assessment for HSC&WB
- Addressing inequalities in health
- Engagement with the community
- Emergency planning and Environmental and other major public health incidents

18b. Group will identify actions required from these themes

18c. Strategy will be drafted from the requirements identified

18d. Action plan will monitor implementation of approved strategy and report outcomes quarterly

Improvement outcomes:

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

Monitoring Process

Executive Management Team which reports to the Board

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability (named)	Relationship to Organisational Plans
18a	March 2006?	Failure of organisation to meet its public health responsibilities	18a Group convened by March 2006	Director of Public Health with Medical Director and Primary Care Director	Clinical Services Strategy Health and Social Well-Being Strategy Public and Patient Involvement Development plan
18b	July 2006		18b Group will identify actions required to achieve key elements in document and draft revised strategy		
18c	October 2006	18c- Strategy out for consultation and approved			
18d	December 2006	18d Group will review quarterly implementation of key actions identifying achievements and reporting risks			
		Failure of organisation to address the inequalities in health of Powys residents Risk level- high = 20			

Recommendation 19

The control of communicable disease should be updated to ensure that it meets the requirements of the LHB.

Actions:

The LHB will update its policies and plans to include:

19a- Updated infection control policy

19b- Updated Major communicable diseases plan

19c- Development of a Pandemic flu contingency plan

19d- Development of a primary care vaccination and immunization workplan

Improvement outcomes:

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

Monitoring Process

Quarterly reports to the Infection Control Committee which reports to the Clinical Governance and Risk Management Committee

Quarterly reports to the Executive Management Team which reports to the Board

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability	Relationship to Organisational Plans
19a	December 2005	The LHB fails to meet its statutory responsibilities for the control of communicable disease arrangements	19a Infection Control Policies are updated regularly and audit of outcomes is monitored via the bi-monthly Infection Control Committee	Director of Nursing Medical Director Primary Care Director Director of Public Health	Infection Control Strategy Clinical Services Strategy Immunisation policy
19b	February 2006		19b- Awaiting All Wales and NPHS action plans to incorporate LHB requirements		
19c	April 2006	Patients, public and staff are put at risk of acquiring a communicable disease	19c- Contingency plan approved by Board. Awaiting final advice from WAG and NPHS and then piloting of plan will take place		
19d	April 2006	Risk level- moderate = 15	19d- Work-planning awareness training and presentation day to be held for professionals involved in process. 19d – develop, implement and monitor work plan		

Recommendation 20

The LHB should identify methods of improving immunisation levels to achieve the SaFF targets.

Actions:

20a. Prioritise at risk patients

20b. Target delivery of vaccine administration by going out to at risk patients where possible

20c. Raise public awareness of importance of having immunisation

20d. A baseline assessment of current activity and report with recommendations

20e. Action plan to be developed in line with recommendations including a Development of a primary care vaccination and immunization workplan

20f. Delivering action plan

Improvement outcomes:

Immunisation levels within the SaFF targets are achieved

Monitoring Process

Quarterly reports on balanced score card to Executive Management Team

Action Ref	Completion date	Assessment of risk	Milestones	Lead Accountability	Relationship to Organisational Plans
20a	2005	Failure to achieve SaFF targets	20a- All at risk patients identified and prioritised.	Medical Director & Public Health Director	Public Health Strategy Clinical Services Strategy SaFF Target Immunisation policy
20b	2005	Risk to population of communicable disease	20b- Programme of administration in place		
20c	December 2005 and ongoing	HIGH RISK = 20	20c- Public Health Department working in collaboration with LHB & Primary Care to raise awareness through information leaflets, training of staff & improved communication with the public.		
20d	April 2006		20d- Assessment of current activity being prepared		
20e	June 2006		20e- Baseline assessment will be used to develop action plan		
20f	April 2007		20f- Quarterly reports of progress to be produced identifying achievements and risk areas		

Recommendation 21

The LHB should establish a clear division between the provider and commissioning elements of the organisation.

Actions:

21a The accountability and management arrangements for provider and commissioning elements of the organisation are clearly defined

Improvement outcomes:

That there is clarity of management and accountability arrangements between the provider and commissioning elements of the organisation

Monitoring Process

Central Planning and Commissioning Group to Board

Action Ref	Completion date	Assessment of Risk	Milestones	Lead Accountability (named)	Relationship to Organisational Plans
21a	August 2005	An uncoordinated approach and increased risks to patients and staff Lack of focus in the organisation in and amongst staff Risk level- moderate = 15	21a- The Medical Director took responsibility for the commissioning elements of the organisation and the Nursing Director the provider elements. This redesigned structure was considered by the Board following the HIW visit in August 2005	Chief Executive	Clinical Services Strategy