North West Wales NHS Trust

Healthcare Standards Improvement Plan 2007 - 2008

TRAFFIC LIGHT STATUS KEY:

Status	Meaning
GREEN	performance on target
AMBER	performance below target, but actions and resources are in place to ensure the target or measure will be achieved in the next period
RED	performance is below target and an action plan/additional effort or resources are required to achieve the target or measure in future

	Standard	Criteria	Result	Improvement Action	Standard Executive Lead	Standard Lead (to complete action)	By when	Traffic Light Status	Comments	Cross ref. other action plans	SAFF/QuIP cross ref
1	The views of patients, service users, their carers and relatives and the public are sought and taken into account in the design, planning, delivery, review and improvement of health care services and their integration with social care services.	1.1 Formal and informal methods are used to seek the views of patients, service users, carers, relatives and the public in line with current national guidance and legislation.	C:4	Apply the schedule of re-audits and patient questionnaires and provide regular reports to the Board	Angela Hopkins	Wynne Roberts and Liz James	Continuous process		Nursing & Midwifery and Corporate Audit Plans have been developed. A PPI and Pastoral Care Manager has been appointed. Launch of new strategy took place 24/10/07. and Non-exec champion appointed.	WRMS: 8	SAFF: 13 QIP: 12
			O:4	Re-launch of PPI Strategy planned for September 07		Wynne Roberts and Liz James	Oct-07		Launch of new strategy took place 24/10/07.	WRMS: 8	SAFF: 13 QIP: 12
			P:4	Continue to improve on the inclusion of patients, carers and users in feeding back their views on services.		Wynne Roberts and Liz James	Continuous process		Will continue on an ongoing basis as the new strategy is promulgated	WRMS: 8	SAFF: 13 QIP: 12
		1.2 Views gathered from patients, service users, carers, relatives and the public are taken into account in the design planning, delivery, review and improvement of services.	C:3		Craig Barton	Siobhan Duffy			Patient and public representation is included on a variety of projects and groups, for example, the Ysbyty Alltwen and the renewal of the Renal Contract.	WRMS: 8	SAFF: 13 QIP: 12
			O:3	Further development of Estates Strategies to optimise the utilisation of Trust property for the benefit of the patients		Siobhan Duffy	Continuous process		Comment as above - as service development takes place, needs of users are to be considered. Capital Investment Board of the Trust has identified the need for particiaption in a range of capital projects as appropriate.	WRMS: 8	SAFF: 13 QIP: 12
			P:2			Siobhan Duffy			The PPI Strategy will be used as a guidance tool, ensuring compliance with recommended best practice.	WRMS: 8	SAFF: 13 QIP: 12
		1.3 The views of patients, service users, carers, relatives and public are taken into account of across the health and social care interface.	C:2			Siobhan Duffy	Jun-07		A non executive lead has been nominated by the Board. She will provide the link between the operational and corporate and be accountable for reporting to the Board.	WRMS: 8	SAFF: 13 QIP: 12
			O:2			Siobhan Duffy	Dec-07		Several strategies in existence, questionnaires, informal and formal complaints, audits.	WRMS: 8	SAFF: 13 QIP: 12
			P:3	A project has now commenced to establish the foundations from which to launch, proactively manage and deliver on the PPI Partnership agenda in the future. The main objective of the project is to organise and host a PPI launch in October 2007, and to manage the pre-requisite activities in the run-up to this event. These activities will include refining the strategic vision, identifying current good practice, engaging with partner organisations, and establishing a permanent team to secure a sustainable future for PPI		Siobhan Duffy	Oct-07		Work ongoing and to plan	WRMS: 8	SAFF: 13 QIP: 12
2	The planning and delivery of healthcare: a. reflects the experiences, views and preferences of patients and service users; b. reflects the health needs of the population served; c. is based on nationally agreed evidence and best practice; and d. ensures equity of access to services.	2.1 The planning and delivery of healthcare takes into account the views and preferences of the service users	N/A								
		2.2 Planning and delivery of healthcare reflects the health needs of the population served	C:3	Communicate to all stakeholders the methods used for planning the delivery of services to meet the health needs of the population.	Craig Barton	Siobhan Duffy / Trystan Pritchard / Bethan Nickson	Oct-07		Stakeholders communicatied with through direct contact, Trust website, the media and formal consultation excercises as necessary.	WRMS: 8	SAFF: 1-4, 7-9, 14
			O:3	Further work needs to take place on the development of performance monitoring processess		Siobhan Duffy	Continuous process		The Board Report has been revised to provide a combined performance and finance report, improving the performance monitoring processes. This is considered to be a continuing and evolving process, ensuring opportunities for continuos improvement.	WRMS: 8	SAFF: 1-4, 7-9, 14

			P:3			Siobhan Duffy			The Trust Board report is available to the publice following the monthly meetings	WRMS: 8	SAFF: 1-4, 7-9, 14
		2.3 The planning and delivery of healthcare is based on nationally agreed evidence and best practice	C:3			Siobhan Duffy			NSF/NICE guidance is reflected in the redesign and development of services.	WRMS: 8	SAFF: 1-4, 7-9
			O:3			Siobhan Duffy			NSF/NICE guidance is reflected in the redesign and development of services.	WRMS: 8	SAFF: 1-4, 7-9
			P:3			Siobhan Duffy			Adherence to the PPI Strategy and recommendations will ensure compliance.	WRMS: 8	SAFF: 1-4, 7-9
		2.4 Planning and delivery of healthcare ensures equity of access to services	C:3	A more extensive Board report is under development with the aim of incorporating additional quality performance indicators as well as performance on access targets.	Craig Barton	Siobhan Duffy / Anwen Crawford / Keith Jones			The Board Report has been revised to provide a combined performance and finance report, improving the performance monitoring processes. This is considered to be a continuing and evolving process, ensuring opportunities for continuos improvement, and including other indicators.	WRMS: 8	SAFF: 1-4, 7-9, 14, 15
			O:3	Further implementation of recommendations of the Service Improvement Teams will take place in the coming months.		Siobhan Duffy / Anwen Crawford / Keith Jones	Continuous process		Access 2009 Manager appointed. Action plans have been developed and submitted to Trust Board. These have been approved and submitted to Directorates for implementations	WRMS: 8	SAFF: 1-4, 7-9, 14, 15
			P:2			Siobhan Duffy / Anwen Crawford / Keith Jones				WRMS: 8	SAFF: 1-4, 7-9, 14, 15
3	Patients with emergency health needs access appropriate care promptly and within national time-scales set annually by the Welsh Assembly Government.	3.1 Patients with emergency health needs access appropriate care promptly and within the national time-scales set annually by the Welsh Assembly Government	C:4	Review of SAPhTE Escalation Procedure currently being undertaken.	Craig Barton	Siobhan Duffy / Anne-Marie Rowlands	31/03/2008		Current SAPHTE escalation procedure has been reviewed (by A&E deparment), document to be submitted to bed management group.		SAFF: 5, 6, 8, 10, 17
			O:4	The Trust undertook an exercise "Perfect Week" between 13th and 20th May 2007 to test processes and identify constraints/bottlenecks within patient flow. Following analysis of the data gathered an action plan for improvement will be developed.		Keith Jones / Robyn Williams	Continuous process		Transforming Perfect Week into Perfect Month (01/09/07) to test sustainability of the Perfect Week methodology. Action plan has been developed and agreed across directorates. Monitoring of action plan continues.		SAFF: 5, 6, 8, 10, 17
			P:3			Siobhan Duffy			The Unscheduled Care project within the Trust is addressing a wide range of issues in relation to patients with emergency health needs, and will encompass the requirments of the national time-scales set by WAG.		SAFF: 5, 6, 8, 10, 17
4	Healthcare premises are well-designed and appropriate in order to: a. promote patient and staff well-being; b. respect different patients needs, privacy and confidentiality; c. have regard for the safety of patients, users and staff; and d. provide a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.	4.1 Healthcare environments are well designed and appropriate in order to promote patient and staff wellbeing	C:3	Capital Investment board present an overview to the Trust Board for each applicable scheme.	Dave Kennedy	Stan Nuttall	Continuous process		All project reporting is continued to be reported to Trust Board by the Capital Investment Board.	WRMS: 14, 22, 26, 33	
			O:3			Stan Nuttall				WRMS: 14, 22, 26, 33	
			P:3			Stan Nuttall				WRMS: 14, 22, 26, 33	
		4.2 Healthcare environments are well designed and appropriate in order to respect different patients needs, privacy and confidentiality	C:3			Stan Nuttall				WRMS: 14, 22, 26, 33	
			O:3			Stan Nuttall				WRMS: 14, 22, 26, 33	
			P:3			Stan Nuttall				WRMS: 14, 22, 26, 33	
		4.3 Healthcare environments are well designed and appropriate in order to have regard for the safety of patients, users and staff	C:3	Post project evaluation undertaken in Design and Construction.		Stan Nuttall	Continuous process		Post project evaluation is carried out following all contract completion evaluations before the end of defect period.	WRMS: 14, 22, 26, 33	
			O:3			Stan Nuttall				WRMS: 14, 22, 26, 33	

			P:3			Stan Nuttall				WRMS: 14, 22, 26, 33	
		4.4 Healthcare premises are well designed and appropriate in order to ensure safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisations.	C:2			Stan Nuttall				WRMS: 14, 22, 26, 33	
			O:3			Stan Nuttall				WRMS: 14, 22, 26, 33	
			P:3			Stan Nuttall				WRMS: 14, 22, 26, 33	
5	Healthcare services are provided in environments, which: a. are well maintained and kept at acceptable national levels of cleanliness; b. minimise the risk of healthcare associated infections to patients, staff and visitors, achieving year on year reductions in incidence; and c. emphasise high standards of hygiene and reflect best practice initiatives.	5.1 Services are provided in environments, which are well maintained	C:3		Angela Hopkins	Brian Massey				WRMS: 14, 40	
			O:3			Brian Massey				WRMS: 14, 40	
			P:3			Brian Massey				WRMS: 14, 40	
		5.2 Services are provided in environments, which are kept at acceptable national levels of cleanliness	C:3	Review reporting process to ensure robustness.	Angela Hopkins	Geraint Roberts	Dec-07		Reporting process has been reviwed. Areas of weakness are being addresses with the development of the new in house service.	WRMS: 14, 40	
			O:3	Review auditing regime as part of new cleaning specification, with a view to improvement.		Geraint Roberts	Dec-07		New management/supervisory structure will allow for increased monitoring coupled with day to day involvement of Ward Sisters in management of cleaning staff.	WRMS: 14, 40	
			P:3			Geraint Roberts			At the time of self-assessment felt any required improvement was covered within the response therefore not included within improvement plan	WRMS: 14, 40	
		5.3 Services are provided in environments, which minimise the risk of healthcare associated infections to patients, staff and visitors in line with national guidelines.	C:4	Rolling programme in progress to update policies and guidelines [see evidence: Procedures for the Control of CJD and Other Spongiform Encephalopathies (Jan 07) & C102 - Infection Control Policy (Mar 07) above]. Further development of the Infection control database so that the data can be extracted to identify local risks. These improvements are ongoing.	Angela Hopkins	Bethan Nickson / Sue Carter	Dec-07		General Manager Infection control Hygiene and Cleanliness appointed. Revised strategy for Infection Control being drafted. All surveillance continues. Revised reporting arrangements to the Board. Non executive champion working with GM Infection control	WRMS: 14, 40	SAFF: 22
			O:4	Encourage more engagement with the audit/surveillance process at Directorate level. IC link nurse role documented in IPRs and more formally involved in the audit process. Increase awareness and reporting adverse incidents relating to infection via Datix system - These improvements are expected to be completed by link nurses and infection control directorate leads with the support of the Infection Control Team on a continuous basis. Some Guidelines and Policies need to be updated - Infection Control Team and other Clinicians. This is an ongoing Trust problem at the present time.		Bethan Nickson / Sue Carter	Dec-07		Arrangements made for GM Infection Control and Lead Nurse to attend Directorate Management Teams to discuss Infection Control, Cleanliness and Hygiene and clarify expectations at Directorate Level.	WRMS: 14, 40	SAFF: 22
			P:4	Survey of patients needed to find out if practice has improved from their perspective		Bethan Nickson / Sue Carter	Dec-07		Patients and visitors surveyed, in conjunction with the CHC, regarding Protected Mealtimes Project and Restricted Visit. Feedback obtained via informal and formal complaints and during walkabouts by Executive Nurse. HPE assessment 8th October generally favourable.	WRMS: 14, 40	SAFF: 22
6	Healthcare organisations, in recognising different language, communication, physical and cultural needs: a. make information available and accessible to patients, service users, their carers and relatives and the public on their services; b. provide patients and service users with timely information on their condition; the care and treatment they	6.1 Recognising different language, communication, physical and cultural needs information on services is available and accessible to patients, service users, their carers and relatives and the public.	C:4	The Communication Procedure requires updating	Angela Hopkins	Trystan Pritchard			Corporate Communications Unit reposnsible for Corporate Communications only. Need to combine this with an identified Trust lead for clincal communication.	WRMS: 8, 9	SAFF: 13
			O:4	The Trust will produce guidelines and proformas for the production of patient information to ensure consistency in terms of format, risk, presentation and distribution.		Trystan Pritchard	Oct-07		Guidelines produced and implemented. All Trust produced patient literature checked against these and signed off by Communications Unit.	WRMS: 8, 9	SAFF: 13

	will receive as well as after-care and support arrangements; and provide patients and service users with opportunities to discuss and agree options relating to their care.		P:4	Continue to expand on information leaflets available in printed form and on Trust website. Conduct a monitoring exercise to ensure information is provided at the appropriate source		Trystan Pritchard	Ongoing from October 2007		Production of patient information ongoing and compete range is available on Trust website. Monitoring exercise	WRMS: 8, 9	SAFF: 13
		6.2 Recognising different language, communication, physical and cultural needs access to timely information is provided to patients and service users on their condition; the care and treatment they will receive as well as after-care and support arrangements (Links to 8.3)	C:4	Linked to 6.1 - Compliance with the requirements for adherence to Welsh Language Scheme means that NWWT should provide all patient information bilingually- but a Wales wide solution is required to prevent duplication	Angela Hopkins	Trystan Pritchard	Since 2001 and ongoing		This has been adhered to since inception of Trust Welsh Language Scheme in 2001. Resource sharing with other Trusts as a matter of course. Currently working with NHS Wales Welsh Language Unit to develop national resource.	WRMS: 8, 9	SAFF: 13
			O:4	Panel (from PPI membership) will act as a "reader's panel" for all new publications.		Trystan Pritchard	Oct-07		Agreed in Oct PPI meeting and will be implemented for all new publications from Novmeber 08.	WRMS: 8, 9	SAFF: 13
			P:4	Procedure for the production of Patient Information to be ensorsed by Executive Team and compliance checked.		Trystan Pritchard	Oct-07		Endorsed by Executive Team Oct 07.	WRMS: 8, 9	SAFF: 13
		6.3 Recognising different language, communication, physical and cultural needs opportunities to discuss and agree options relating to care are provided to patients and service users with opportunities to discuss and agree options relating to care.	C:4	The Communication Procedure requires updating	Angela Hopkins	Trystan Pritchard			Corporate Communications Unit reposnsible for Corporate Communications only. Need to combine this with an identified Trust lead for clincal communication.	WRMS: 8, 9	SAFF: 13
			O:4			Trystan Pritchard				WRMS: 8, 9	SAFF: 13
			P:4	Formally establish an Ethics Forum at the Trust.		Paul Birch / Angela Hopkins	Ongoing		The Trust is in the process of formalising the structure and remit of a Trust based Clinical Ethics Committee. The role of the group will be to provide advice and support to clinicians faced with patients whose management poses significant ethical dilemmas and to provide advice on broader ethical issues affecting groups of patients across the Trust and possibly into the wider health community.	WRMS: 8, 9	SAFF: 13
7	Patients and service users, including those with long-term conditions, are encouraged to contribute to their care plan and are provided with opportunities and resources to develop competence in self-care.	7.1 Patients, service users and their carers including those with long term conditions contribute to their care plan	C:3	Continue to ensure patients, service users and their careres contribute to their care plan by provison of infomation. Ensure the principles of patient and public involvement occur operationally.	Angela Hopkins	Anne-Marie Rowlands	Jan-08		Nursing documentation has been re-designed in relation to unified assessment to include carer's perspective and young carers (awaiting approval).	WRMS: 8, 18, 21	SAFF: 10, 11, 13
			O:3	All staff groups to have appraisal Personal Devlopment plans and Directorate Training Needs analysis to inform CPD Review of UCNW contract & inhouse CPD in light of changes and developments within the Trust.		Anne-Marie Rowlands	Continuous process		UCNW contract and inhouse CPD reviewed.	WRMS: 8, 18, 21	SAFF: 10, 11, 13
		(Links to 6.3)	P:3	To continue to ensure consistent approach to staff and patients working in partnership to make decisions about plan of care		Anne-Marie Rowlands	Jan-08		Nursing documentation has been re-designed in relation to unified assessment to include carer's perspective and young carers (awaiting approval).	WRMS: 8, 18, 21	SAFF: 10, 11, 13
		7.2 Patients, service users and their carers, including those with long-term conditions, are provided with opportunities and resources to develop competence in self-care.	C:3	Continued review of services and workforce modernisation	Angela Hopkins	Anne-Marie Rowlands	Jan-08		All nursing documentation has been re-designed and is in the process of being finalised and approved.	WRMS: 8, 18, 21	SAFF: 10, 11, 12, 13
			O:3	Continued reviewing of services		Anne-Marie Rowlands	Continuous process		Chronic disease strategic group led by Executive Director of Nusing in the Anglesey LHB. Executive Director of Nursing and Midwifery is leading on the Stroke Pathway.	WRMS: 8, 18, 21	SAFF: 10, 11, 12, 13
			P:3	Regular patient satisfaction surveys across all departments Strive for excellence in all departments		Anne-Marie Rowlands	Continuous process		The Trust is in the process of analysing a re-audit on Fundamentals of Care. The results are expected to be available by the end of 2007.	WRMS: 8, 18, 21	SAFF: 10, 11, 12, 13
8	Healthcare organisations ensure that: a. staff treat patients, service users, their relatives and carers with dignity and respect; b. staff themselves are treated with dignity and respect for their differences; c. informed consent is obtained	8.1 Staff treat patients, service users, their relatives and carers with dignity and respect.	C:4		Angela Hopkins	Nia Thomas				WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
			O:4			Nia Thomas				WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	

	appropriately for all contacts with patients and service users and for the use of confidential patient information; and d. patient information is treated confidentially, except where authorised by legislation to the contrary.		P:3			Nia Thomas				WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
		8.2 Staff are treated with dignity and respect for their differences, diversity is valued, difference understood and respected	C:4		Angela Hopkins	Nia Thomas				WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
			O:4	Staff suggestion scheme to be implemented. More specific reference to dignity and respect to be included in next staff survey		Nia Thomas	31/12/2007		Business Case submitted to Executive team to consider Staff suggestion scheme	WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
		(Links to 20.2)	P:4			Nia Thomas				WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
		8.3 Informed consent is obtained appropriately for all contacts with patients and service users.	C:3		Angela Hopkins	Dr K Mottart				WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
			O:3			Dr K Mottart				WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
		(Links to 6.2)	P:3			Dr K Mottart				WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
		8.4 Patient information is treated confidentially, except where authorised by legislation to the contrary.	C:4	Gain ratification for revised Information Security Policy. Complete the revision of documentation to support the Information Security Policy. Ensure that the Trust signs up to Tier 1 of the Wales Accord on the Sharing of Personal Information (WASPI).	Craig Barton	Jeff Pye	31/03/2008		The Freedom of Information Officer it currently preparing a Information Security Manual to be agreed initially by the Information Governance Group. The Trust is yet to sign up to Tier 1 of WASPI, to be discussed further.	WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
			O:4	Develop a standard confidentiality and data protection section for inclusion on all local Induction materials. Discuss the needs for a formal Information Security Training Programme with relevant individuals within the Trust.		Jeff Pye	07/12/2007		Confidentiality and Data Protection are included in Trust inductions, but are not followed up automatically with local inductions, and where there is evidence of local inductions, they are not standardised. Prior to the Data Protection Officer post becoming vacant, work had been done with the Women & Family directorate, and this was considered good practice. At the October meeting of the Information Governance Group it was agreed that the Freedom of Information Officer would pilot the e-confidentiality tool produced by NLIAH/IHC in some areas of the Trust, with a view to rolling it out further in the Trust during 2008. Feedback of the pilot will be discussed at the December Information Governance Group.	WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
			P:3	Review current information security risks held on the Trust Risk Register. Evaluate, in consultation with the Head of Risk Management, the feasibility of developing a programme to assess information security risks that have Trust-wide implications. Discuss, with the Head of Risk Management, revising Adverse Incident Codes relating to confidentiality and data protection. Undertake an audit of the physical security of patient identifiable information across all areas of the Trust and develop action plans from the findings of the audit - Caldicott / Data Protection / Information Security Officer and Internal Audit. Integrate the Internet Use Monitoring Group's role into the Trust's Information Governance Group.		Jeff Pye	31/03/2008		Information Governance Group in October discussed at length issue relating to patient identifiable information. It was agreed a work plan would be produced and agreed at the December meeting. Work would include a Trust wide audit of "white boards", develop guidance in relation to porters radio devices etc., The Internet Use Monitoring Group has disbanded and integrated into the Information Governance Group. The E-mail and Internet Policy has been revised and ratified by the Information Governance Group and Executive Team and distributed.	WRMS: 7, 8, 9, 16, 18, 21, 28, 29, 39	
9	Where food is provided there are systems in place to ensure that: a. patients and service users are provided with a choice of food which is prepared safely and provides a	9.1 Where food is provided there are systems in place to ensure that patients and service users have access to food 24 hours a day and are provided with choice and a balanced diet	C:3	Continue to evaluate and review policies and procedures, feedback to appropriate committees	Dave Kennedy	June Davies	31/01/2008		Continue to review policies & procedures and feed back trhough Nutrition & Catering Framework Multidisciplinary Group	WRMS: 23	

No.	Standard	Criterion	Rating	Action	Lead	Responsible	Date	Status	Progress	Ref	Ref
	balanced diet; and b. patients and service users individual nutritional, personal, cultural and clinical dietary requirements are met, including any necessary help with feeding and having access to food 24 hours a day.		O:3	Continue to evaluate and review policies, procedures and refresher training. Agree a formal approach to service improvement to ensure that views of Ward Managers and staff are captured.		June Davies	31/01/2008		Continuing to review policies & procedures and feed back trhough Nutrition & Catering Framework Multidisciplinary Group. Food Safety Training - e learning package being discussed and endorced by the N&CFMG	WRMS: 23	
			P:3	Continue to evaluate patient responses to satisfaction surveys and audits and take action as necessary and feedback to appropriate committee.		June Davies	31/01/2008		Patient Satisfaction Surveys evaluated monthly and feedback to N&CFMG and Heads of Nursing. Patient Satisfaction Survey being updated.	WRMS: 23	
		9.2 There are systems are in place to ensure the safe preparation, storage and handling of food	C:3	Review current practice, guidance and actions from Environmental Health Officers inspections and reports. Modernising of ward kitchens as a recommendation of ward Kitchen Audits. Aspising to awards of good practice in other appropriate areas.		June Davies	31/01/2008		Continue to review policies & procedures , and actions completed from EHO reports and inspections. Hazard Analysis Documentation on going.	WRMS: 23	
			O:3	Continue to evaluate and review Catering training and refresher training requirements. All other food handlers (Nursing, Housekeeping and Portering staff) to be trained and educated as per mandatory requirements.		June Davies	31/01/2008		Catering training and refresher training up to date. Other disciplines training available through the Infection Control e-learning package.	WRMS: 23	
			P:3	Review current practice, guidance and actions from Environmental Health Officers inspections and reports. Review Induction and Training for Nursing and other key staff involved in food handling and service.		June Davies	31/01/2008		Continue to review policies and procedures and actions completed from EHO reports and inspections.Other disciplines training aavailable through Infection Control E-Learning package.	WRMS: 23	
		9.3 Nutritional, personal, cultural and clinical dietary requirements of patients and service users are met.	C:3	Reporting outcomes to appropriate committees		June Davies / Anne-Marie Rowlands	Continuous process		The action plan following Welsh Risk Pool assessment for Nutrition and Catering is monitored at Local Executive Nurse meeting and reported to the Clinical Governance Sub Committee.	WRMS: 23	
			O:3	MUST tool to be implemented within all areas.		June Davies / Anne-Marie Rowlands	Jan-08		MUST tool has been re-designed and is in the process of being approved	WRMS: 23	
			P:3	Improve contents of snack boxes Continue to evaluate patient responses to inform appropriate action		June Davies / Anne-Marie Rowlands	31/01/2008		Survey conducted to improve the provision of the snack box, Catering to make more frequent checks.	WRMS: 23	
		9.4 Patients and service users receive the necessary help with feeding	C:3	Feedback to appropriate committees Action as a result of HIW recommendations relating to feeding		Anne-Marie Rowlands	Continuous process		Report on Protected Mealtimes submitted to Clinical Governance Sub Committee in June 2007 and the project is due to be implemented at the beginning of December 2007.	WRMS: 23	
			O:3	Implementation of Protected Mealtimes throughout the Trust Improved Dysphagia Services to ensure equity for all patients Electronic rostering implementation group to reinforce Breaks Policy		Anne-Marie Rowlands	Jan-08		Protected Mealtimes project is due to be implemented at the beginning of December 2007. The results of a staff and patient questionnaire about mealtimes will also be available by the end of 2007.	WRMS: 23	
			P:3	Continue to audit and report to the appropriate committees.		Anne-Marie Rowlands	Continuous process		The Trust is in the process of analysing a re-audit on Fundamentals of Care. The results are expected to be available by the end of 2007.	WRMS: 23	
10	Healthcare organisations ensure that people accessing healthcare are not unfairly discriminated against on the grounds of age, gender, disability, ethnicity, race, religion, or sexual orientation.	10.1 People accessing healthcare are not unfairly discriminated against on the grounds of age, gender, disability, ethnicity, race, religion, or sexual orientation.	C:5		Tania Marsden	Nia Thomas					SAFF: 13
			O:5			Nia Thomas					SAFF: 13
		(Links to 4.2)	P:4			Nia Thomas					SAFF: 13
11	Healthcare organisations ensure that: a. clinical care and treatments are delivered by healthcare professionals who make clinical decisions based on evidence based practice; b. clinical care and treatments are carried out under appropriate clinical supervision and leadership; c. clinicians continuously update skills	11.1 Clinical care and treatments are delivered by healthcare professionals who make clinical decisions based on evidence based practice and that they are involved in regular audit and review	C:4	Reviewing the TOR of all committees to ensure compliance with the aims of this standard.	Dr P Birch	Angela Hopkins / Dr K Griffiths	31/03/2008		All TOR follow a standard format based on the Healthcare Standard domains.		
				Review appraisal process to meet new standards of professional governance		Jean Williams	Continuous process		The Trust has an in-house 360/MSF questionnaire and a bilingual patient questionnaire. The status at national level is continuously monitored to ensure compliance.		

	and techniques relevant to their clinical work including peer reviews; and d. clinicians participate in regular audit and review of clinical services.			Further integrate COMPASS and COI into job planning and appraisal		Dr P Birch	Developmental Process		COI are being further integrated into the Job Planning/Appraisal process by the integration of COMPASS reports.	WRMS: 10, 11, 12	
			O:4	Investigate audit support systems. Review the organisation's capability to provide a Trust wide audit service and fulfill obligations of this standard. Improve mechanisms for top-down audits.		Angela Hopkins	Apr-08		Clinical Audit has been integrated into the Internal Audit Department and with the appointment of an additional auditor and redistribution of audit projects, there will be a dedicated senior Clinical Auditor to carry out top-down audits.	WRMS: 10, 11, 12	
			P:4	Ensure representation of CHC on the Clinical Audit committee.		Ketih Grifffiths / Angela Hopkins	31/03/2008		A CHC member will be invited to join the Clinical Audit Committee. CHC members are already involved in the Complaint's Monitoring Group and there are CHC members on the Clinical Governance Sub-Committee.	WRMS: 10, 11, 12	
		11.2 Clinical care and treatments are carried out under appropriate clinical supervision and effective leadership	C:4	Achieve improved undestanding of the leadership and supervision issues throughout the organisation and at all levels (eg. from supervision and leadership of domestic staff to supervision and leadership of professionals and senior managers) Improve communication and record keeping of training assessments for medical staff in training.	Dr P Birch	Nia Thomas and Senior Managers	31/03/2008		Strategy produced - Developing Tomorrow'a Managers - strategy to be cascaded throughout the organisation to raise awareness. Leadership programme commenced.	WRMS: 10, 11, 12	
			O:4	Additional Training the Trainers days - (2007/2008) Continue to develop simulation and skills lab.		Nia Thomas	Jan-08		The Trust commenced arrangements for Training the Trainers (TtT) in May 2007 to ensure that all its Educational Supervisors were compliant with recommendations that every trainer attend for refresher every three years. A rolling programme of sessions was put together. However, the Wales Deanery informed the Trust that it was running a scheme, free gratis, for Trusts and the NWWT accepted this invitation. Unfortunately, places were not granted to the NWWT therefore arrangements for TtT have now been re-instigated. A rolling programme, incorporating appraiser and appraisee training should be in place by January 2008.	WRMS: 10, 11, 12	
			P:4	Produce a leadership strategy to include all staff within the organisation.		Nia Thomas	31/03/2008		Strategy produced - Developing Tomorrow'a Managers - strategy to be cascaded throughout the organisation to raise awareness. Leadership programme commenced.	WRMS: 10, 11, 12	
		11.3 Clinicians continuously update their skills and techniques relevant to their clinical work including peer reviews	C:4	Review Medical Appraisal process to meet developing requirements.	Dr P Birch	Jean Williams	Continuous process		The Trust continues to develop its own medical appraisal process in line, and often ahead of national guidelines. Work continues on ensuring compliance with the GMC's Approved Working Environment (AWE). The Trust Medical Appraisal Steering Group (MASG) meets regularly to review, discuss and implement changes and improvements. The Education Centre Manager is a lay member of the All-Wales Medical Directors Appraisal Group.	WRMS: 10, 11, 12	
			O:4	The appraisal process is undergoing review at National level to ensure minimum standards which will from part of the re-validation process. The NWW Trust are improving the standards of the appraisal process and have introduced new peer review using 360 degree appraisal.		Mr Ll Jenkinson	Continuous process		The Trust has an in-house 360/MSF questionnaire and a bilingual patient questionnaire. The status at national level is continuously monitored to ensure compliance.	WRMS: 10, 11, 12	
			P:3	Morbidity and Mortality meetings are not consistently held across the Trust and attendance and records need to be improved. Increase use of SIGNPOST to identify variation from peers.		Clincal Directors	Continuous process		The Education Centre has adopted the Deanery's on-line attendance system in order to standardize attendance records in the Trust.	WRMS: 10, 11, 12	
12	Healthcare organisations ensure that patients and service users are provided with effective treatment and	12.1 Patients and users are provided with effective treatment and care that conforms to the National Institute for Clinical Excellence (NICE) technology	N/A								

	provided with effective treatment and care that: a. conforms to the National Institute for Clinical Excellence (NICE) technology appraisals and interventional procedures, and the recommendations of the All Wales Medicines Strategy Group (AWMSG); b. is based on nationally agreed best practice and guidelines, as defined in National Service Frameworks, NICE clinical guidelines, national plans and agreed national guidance on service delivery; c. takes account of patients physical, social, cultural and psychological needs and preferences; and d. is integrated to provide a seamless service across all organisations that need to be involved, including social care organisations.	Institute for Clinical Excellence (NICE) technology appraisals and interventional procedures, NSFs and agreed national guidance on service delivery (Links to 6)									
		12.2 Patients and users are provided with effective treatment and care that conforms to the recommendations of the All Wales Medicines Strategy Group (AWMSG), NSFs and agreed national guidance on service delivery (Links to 6)	N/A								
		12.3 Patients and service users are provided with effective treatment and care that takes into account of patientsL physical, social, cultural and psychological needs and preferences. (Links to 6)	C:4	Make a progress with unified assessment wider implementation in more workable format (digital)	Dr P Birch	Anne-Marie Rowlands	Nov-07		A project meeting has been arranged in November by the Executive Director of Nursing and Midwifery with Social Services.	WRMS: 10	SAFF: 13, 20, 21
			O:3			Anne-Marie Rowlands				WRMS: 10	SAFF: 13, 20, 21
			P:4	To ensure all directorate have same standards in learning from complaints and patients feed back		All DGM and Clinical Directors	Mar-08		The Executive Director of Nursing and Midwifery has reinforced the requirements to adhere to the standards to all.	WRMS: 10	SAFF: 13, 20, 21
		12.4 Patients and service users are provided with effective treatment and care that is integrated to provide seamless service across all organisations that need to be involved, including social care organisations (Links to 6)	C:4	Refine the process of developing ICP wirh partnership organisations.	Dr P Birch	Executive lead	Mar-08		ICP development reported to Clinical Governance Sub Committee	WRMS: 10	SAFF: 13, 16, 19, 20, 21
			O:4	Collect variance information to inform real benefits to patients. Developing further ICPs for stroke, COPD with partnership organisations		Olwen Chera	Mar-08		Present variance information in the ICP development report.	WRMS: 10	SAFF: 13, 16, 19, 20, 21
			P:4	Collect patient satisfaction information to evidence concrete information about the benefits of integrated care pathways.		NLIAH	Mar-08		Evaluation stage of project	WRMS: 10	SAFF: 13, 16, 19, 20, 21
13	Healthcare organisations, which either lead or participate in research, have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.	13.1 Healthcare organisations, which either lead or participate in research, have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.	C:3	Work closer with the University to share experience on governance issues, in particular, financial issues. Participate in new University Initiatives following their reorganisation through the School of Medicine Research initiative and links with other colleges to enhance research portfolio. Both Improvement points are ongoing.	Dr P Birch	Dr K Griffiths / Dr R Stoicescu	Ongoing		With new developments in the School of Medical Science, it is aimed to achieve this improvement by May 2008.	WRMS: 10	
			O:4	Develop a regular Newsletter to inform public, patients, Trust employees about relevant issues pertaining to R&D and Evidence Based Medicine		Dr K Griffiths / Dr R Stoicescu	Mar-08		Research Governance Facilitator will be in post as of 01/11/07. It is within the remit of this post to develop the Newsletter assisted by the R&D Manager.	WRMS: 10	
			P:4	Investigate means of involving patients and carers in establishing projects and monitoring progress.		Dr K Griffiths / Dr R Stoicescu	Ongoing		Together with the PPI Representatives in the Trust Research Governance Committee and the Research Grants Committee, we aim to identify means of widening involvement of patients and carers in research.	WRMS: 10	
14	Healthcare organisations continuously and systematically review and improve all aspects of their activities that directly affect the safety and health of patients, service users, staff and the public. They will not only comply with legislation, but apply best practice in assessing and managing risk.	14.1 Activities that directly affect the safety and health of patients, service users, staff and the public are continuously and systematically reviewed and improved. (Links to 4)	C:4	Continue to develop the risk register, core safety related assessments.	Angela Hopkins	Peter Barry	01/01/2008		Risk register development is an on going process. Core risk assessments have been expanded to 6 with more planned, however it is now clear that we must close out those opened or the danger of having too many open and overloaded is evident.	WRMS: 1, 2, 3, 13	
			O:4	Review present training prospectus with a view to expanding available courses. Recruit risk management trainer, ASAP		Peter Barry	12/12/2007		Training prospectus is being reviewed for fire safety and datix training. Remained of prospectus will be reviewed with the appointment of Risk Managament Trainer (as of 18th October 2007 advertisement of post is being held up by the need to allow "at risk" staff an opportunity to apply for the post	WRMS: 1, 2, 3, 13	

			P:4	Continue to develop links with external stakeholders in respect of risk management activities. Review risk register activity with a view to ensuring wider coverage of risk management topics covered.		Varied	01/03/2008		As this relates to the communication policy and standard 8 (WRMS) in respect of communications with external stakeholders, a decision is required as to how risk management information is communicated via CHC at Clinical Governance Sub-Committee	WRMS: 1, 2, 3, 13	
		14.2 Activities that directly affect the safety and health of patients, service users, staff and the public comply with legislation and best practice in assessing and managing risk. (Links to 27.4)	C:4	Review present risk assessment process	Angela Hopkins	Peter Barry	12/12/2007		Risk assessment process will be reviewed to comply with the requirements of the Datix system. Core risk assessment has been produced and need to apply this to the main risk assessment process. This is a much simplified version and will need to be launched with training.	WRMS: 1, 2, 3, 13	
			O:4	Apppoint dedicated risk management training officer		Peter Barry	07/12/2007		Awaiting release of JD & PS by personnel. These have been passed to at risk staff first to allow them to apply. This has slowed down the appoinment and will delay subsequent training etc...	WRMS: 1, 2, 3, 13	
			P:4	Ensure that training courses for nurses in respect of Radioactive Patients is maintained and guidance produced		Peter Barry	12/12/2007		RPA from C&D Trust has provided a number of training sessions for senior nursing staff. Guidance has been produced and head of RM is waiting for reply from HON as to the suitablity of the guidance. No more sessions required at this time as guidance will encompass this need.	WRMS: 1, 2, 3, 13	
15	Healthcare organisations, recognising different language and communication needs, ensure that patients, service users, relatives and carers: a. can provide feedback on their experiences and the quality of services; b. have their complaints looked at promptly and thoroughly in accordance with complaints procedures; c. are given information about complaints advocacy support provided by Community Health Councils in Wales; and d. receive assurance that organisations act on any concerns and make appropriate changes to ensure improvements in service delivery.	15.1 Recognising different language and communication needs patients, service users, relatives and careers can provide feedback on their experiences and the quality of services	C:4	Review TOR of Welsh Language Sub-committee and reporting processes influencing the work of the organisation.	Angela Hopkins	Trystan Pritchard	05/12/2007		Enhanced monitoring proceedure to be reported on in next sub-committee meeting. TOR to be reviewewd at next meeting 05/12/07	WRMS: 4, 7, 8	
			O:4	More rigourous monitoring of the patient's experience.		Wynne Roberts	Mar-08		This will now be under the remit of the PPI group.	WRMS: 4, 7, 8	
			P:4	More consideration of "other" linguistic needs in the area. eg. Polish and Chinese. Language Line services only suitable for selective patients, Trust has discontinued translators list, but alternative arrangements need to be made to provide accredited translation services. (rather than using staff or family).		Wynne Roberts	Mar-08		Through North Wales PPI links, a suitable alternative service will be developed.	WRMS: 4, 7, 8	
		15.2 Complaints are looked at promptly and thoroughly in line with complaints procedures and information about complaints advocacy support provided by CHCs in Wales provided	C:4		Angela Hopkins	Kathie Jones			Complaints continue to be looked at promptly and thoroughly in line with current policy and procedures	WRMS: 4, 7, 8	
			O:4	Trust-wide Complaints Training Programme needs to be finalised.		Kathie Jones	31/01/2008		New member of staff to be appointed shortly to assist with implementing this improvement	WRMS: 4, 7, 8	
			P:4			Kathie Jones			Trust continues to publicise timescales and inform complainants of advocacy support	WRMS: 4, 7, 8	
		15.3 Assurance is provided to patients, service users, relatives and carers that concerns are acted upon and appropriate changes made to ensure improvements in service delivery.	C:4		Angela Hopkins	Kathie Jones			Complaints continue to be looked at thoroughly by the Board	WRMS: 4, 7, 8	
			O:4			Kathie Jones			Detailed letters of response continue to be sent in addition to each complainant being offered to meet with the clinician(s) responsible for their care	WRMS: 4, 7, 8	
			P:3	Although complainants are advised within response letters of the action to be taken as a result of their complaint, it is planned to send a further letter confirming when any action has been completed, following completion of the action plan.		Kathie Jones	31/01/2008		New member of staff to be appointed shortly to assist with implementing this improvement	WRMS: 4, 7, 8	
16	Healthcare organisations have systems in place: a. to identify and learn from all patient safety incidents and other reportable	16.1 Systems are in place to identify and learn from all patient safety incidents.	C:4	Internal Audit Review Action plan in respect of adverse incidents to be implemented	Angela Hopkins	Shan Kennedy	01/03/2008		Report received and an action plan developed which is out for consultation with the DGMs.	WRMS: 3	QIP: 9, 13

	incidents; b. to report incidents to the National Patient Safety Agency s (NPSA) National Reporting and Learning System and other bodies in line with existing guidance; c. to demonstrate improvements in practice based on shared local and national experience and information derived from the analysis of incidents; and d. to ensure that patient safety notices, alerts and other communications concerning safety are acted upon within required time-scales.		O:4	Internal Audit Review Action plan in respect of adverse incidents to be implemented Implement plan in respect of Medical Staff Reporting and analysing incidents		Shan Kennedy	31/03/2008		Associate Medical Director for Patient Safety is working to raise the level of engagement by medical staff. Planned training for medical staff by NPSA on Adverse Incident Reporting and "being open".	WRMS: 3	QIP: 9, 13
		(Links to 4.4 & 14.1)	P:3	Audit the recommendations of the baby tagging report.		Peter Barry	31/10/2007		A practice of the baby abduction procedure was undertaken to test procedures. PB to chase RP for update of outcome.	WRMS: 3	QIP: 9, 13
		16.2 Incidents are reported to the NPSA and other bodies in line with existing guidance	C:4	Audit current practice in respect of hazard warning actioning Develop management procedure for combined management of all alerts, patient safety notices	Angela Hopkins	Peter Barry	08/12/2007		Datix Hazard Warning system in place. Procedures being drafted. Roll out to be agreed with Medical Directorate. Extra fields added for NPSA and now NICE will be incorporated.	WRMS: 3	
			O:3	Raise awareness of staff knowledge of NPSA and NRLS		Shan Kennedy / Peter Barry	03/12/2007		This is part of the newsletter development to staff and will also be expanded bu the use of the hazard warnings module. Link to NPSA newsletters posted on Trust Intranet. Further development of raising awareness required.	WRMS: 3	
			P:3	Continue to develop the outcome function of the incident reporting process.		Shan Kennedy / Peter Barry	12/12/2007		New forms have been developed and introduced on a rolling basis. New forms do have revised sections for outcome and lessons learnt. Reports to Patient Safety and Risk Management Group by Directorates now include requirement for outcomes and lessons learnt.	WRMS: 3	
		16.3 Improvements in practice based on shared local and national experience and information derived from the analysis of incidents is demonstrated.	C:3	Identify the assurance root to TB within the Trust Risk Management Strategy	Angela Hopkins	Peter Barry	21/11/2007		Following agreement of constitution by the Clinical Risk and Risk Management Group the Trust risk management strategy is to absorb the clinical risk strategy and assurance route agreed.	WRMS: 3	
			O:2	The Trust would benefit from a lessons learnt news letter.		Shan Kennedy	31/03/2008		Draft newsletter has been developed, but not yet finalised.	WRMS: 3	
			P:2			Shank Kennedy				WRMS: 3	
		16.4 Patient safety notices, alerts and other communications concerning safety are acted upon within required timescales.	C:3	Review existing policies and management procedures in light of the centralisation of alerts management. Install new Datix Alerts Module (1st July 2007) Roll out hazard warning module Hazard Warnings and patient safety alerts Performance to be standing agenda Items on Patient Safety and Risk Management Group.	Angela Hopkins	Peter Barry	21/12/2007		Datix installed. Agree date of roll out in Medical. Request for NICE guidance monitoring also being actioned, however demand and capacity on process does tend to slow the introduction of the initial phase - hazard warnings.	WRMS: 3	
			O:2	Review existing policies and management procedures in light of the centralisation of alerts management. Install new Datix Alerts Module (1st July 2007) Roll out hazard warning module Hazard Warnings and patient safety alerts Performance to be standing agenda Items on Patient Safety and Risk Management Group. Develop loop closing process develop compliance audit process		Peter Barry	21/12/2007		Loop closing will form part of the introduction of the warning system however the "by when" date may be optomistic when the size of the haward warning process is taken into account. Loop closing may have to become a medium term activity.	WRMS: 3	
			P:3	Incorporate patient safety alerts in revised alerts management process. PB Undertake audit of NPSA Alerts implementation of actions. SK		Shan Kennedy	21/12/2007		NPSA Patient Safety Alerts to be incorporated into the Datix Management System. Will be reported to PPI group in the future.	WRMS: 3	
17	Healthcare organisations comply with national child protection and vulnerable adult guidance within their own activities and in their dealings with other organisations.	17.1 Healthcare organisations comply with national child protection guidance within their own activities	C:4	The Safeguarding Team are in the process of updating all local child protection policies [see evidence: WRP 39 - Action Plan]	Angela Hopkins	Dr T Powell / Sharon Thomas	Continuous process		Policies are still in the process of being updated.	WRMS: 15, 17, 18, 21, 28, 39	
			O:4	Trust is exploring possibility of e-learning for level 2 training which will release time from the safeguarding team to increase the time for training at level 3		Dr T Powell / Sharon Thomas			Feasibility study to be undertaken and results to be discussed at committee in Decemeber	WRMS: 15, 17, 18, 21, 28, 39	

			P:3	Internal health reviews carried out into 2 SUDI recommendations made for the Trust to action. AIR's to be critically reviewd by the Trust child protection committee		Dr T Powell / Sharon Thomas			Recommendations implemented within the Trust to be reported to the next committee meeting	WRMS: 15, 17, 18, 21, 28, 39	
		17.2 National child protection guidance is complied with when dealing with other organisations.	C:4	Continued representation by Executive lead on both LSCB's	Angela Hopkins	Dr T Powell / Sharon Thomas			development ongoing	WRMS: 15, 17, 18, 21, 28, 39	
			O:3	Continued representaion by safegurading team members at local and north wales meetings		Dr T Powell / Sharon Thomas			development ongoing	WRMS: 15, 17, 18, 21, 28, 39	
			P:3	Stratgey for the retrospective CRB checking being considered at Trust Board		Dr T Powell / Sharon Thomas			Strategy being completed by HR department	WRMS: 15, 17, 18, 21, 28, 39	
		17.3 National vulnerable adult guidance is complied with.	C:3	There is no full time Adult Protection Co-ordinator, however the process is overseen by Senior Nurse Clinical Governance with support from Senior Nurse in LDS. Appoint permanent co-ordinator	Angela Hopkins	Shan Kennedy / Steve McGuinness	30/04/2008		An Adult Protection Co-ordinator has been appointed for one day a week. A report is currently being drafted in support of this role.	WRMS: 15, 17, 18, 21, 28, 39	SAFF: 13
			O:3	The Training Strategy - Vulnerable Adults needs to be completed and approved. Awareness Training needs to be completed by the Community Support Team Manager.		Shan Kennedy / Steve McGuinness	31/01/2008		The Training Stategy for Vulnerable Adults will be completed and approved by 31/01/2008 and Awareness Training is ongoing by the Adult Protection Co-ordinator.	WRMS: 15, 17, 18, 21, 28, 39	SAFF: 13
			P:2	Encourage staff to report using the Clinical Adverse Incident Route. this will ensure accurate records of: reporting/investigating and action taken		Shan Kennedy / Steve McGuinness	31/01/2008		The need to link in complaints and POVA investigations needs to be formalised.	WRMS: 15, 17, 18, 21, 28, 39	SAFF: 13
		17.4 National vulnerable adult guidance is complied with when in dealing with other organisations	C:3	Appoint dedicated co-ordinator. Continue to forge good links with external agencies.	Angela Hopkins	Shan Kennedy / Steve McGuinness	01/09/2007		An Adult Protection Co-ordinator has been appointed for one day a week. Links with external agencies (ie. Ynys Mon and Gwynedd Adult Protection Co-ordinators) have been established.	WRMS: 15, 17, 18, 21, 28, 39	SAFF: 13
			O:2	Appoint dedicated co-ordinator		Shan Kennedy	01/09/2007		An Adult Protection Co-ordinator has been appointed for one day a week.	WRMS: 15, 17, 18, 21, 28, 39	SAFF: 13
		(Links to 21.1)	P:2	The Trust is planning a programmed approach to undertake CRB checks on existing Trust Staff .		Tania Marsden	Continuous process		Programmed approach has been implemented priorotising CRB checks for existing trust staff.	WRMS: 15, 17, 18, 21, 28, 39	SAFF: 13
18	Healthcare organisations have planned and prepared, and where required practised, an organised response to incidents and emergency situations, which could affect the provision of normal services.	18.1 A response to incidents and emergency situations (including infectious disease outbreaks) has been planned, prepared and practised. (Links to 31.1)	C:4	Pandemic Flu - further work is required in relation to the threat faced by pregnant women in their second and third trimesters of pregnancy. This is one of the highest risk groups of mortality the Women & Families Directorate are undertaking this piece of work.	Craig Barton	Emma Binns	31/07/2008		A group has been established to prepare an addendum to the Trust Flu Pandemic Plan. This group consists of various senior members of staff from the Women & Families Directorate and the Trust's Emergency Planning Manager. The first meeting is scheduled to take place at the beginning of November.	WRMS: 25	
			O:4	Following every exercise an action plan with recommendations is drawn up. The planning department is responsible for ensuring that the actions are put into practise and that equipment requirements are undertaken. Any recommendations to the plans and procedures are carried out immediately.		Emma Binns	Quarterly		Equipment requirements are raised quarterly via the Trust's Health Emergency Preparedness Group. The group decide whether the equipment in question can be purchased from the Emergency Planning Budget. Following an exercise, a report is drafted and this is also placed on the agenda of the Health Emergency Preparedness meeting.	WRMS: 25	
			P:4	An action plan was drawn up following the outbreak and most of the actions have now been addressed.		Emma Binns	30/06/2007		All actions have now been addressed following the Avian Flu outbreak.	WRMS: 25	
19	Healthcare organisations ensure that: a. all risks associated with the acquisition and use of medical devices are minimised; b. all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed; c. quality, safety and security issues of medicines are managed; and	19.1 All risks associated with the acquisition and use of medical devices are minimised	C:3	Continuing development of the role of the Medical Devices committee. This will include overseeing and ensuring appropriate training in the use of Medical Equipment.	Dave Kennedy	Dr K Griffiths	Continuous process		Assett Register has been developed for Medical Devices and the Chair of the Committee has provided reports to the Clinical Governance Sub Committee.	WRMS: 2, 24, 26, 30, 31, 35, 36	
			O:4	A Clinical / Medical products committee is being established which will advice on procurement, particularly of new products and the utilisation of new techniques. This will be chaired by an Associate Medical Director.		Dr K Griffiths	Mar-08		No progress due to amalgamation of services and the move to BSP. Remains an aim to re-establish	WRMS: 2, 24, 26, 30, 31, 35, 36	

d. the prevention, segregation, handling, transport and disposal of waste are managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.		P:4	To increase the use of the Medical Equipment store to reduce the potential for incidents. Encourage the greater involvement of Clinicians in following up incidents		Dr K Griffiths	Mar-08		Several audits have been carried out and reported to the Clinical Governance Sub-Committee. Action plans have been developed to increase compliance. Particular attention is being given to Control of Infection and and involving clinicians through the risk management committee.	WRMS: 2, 24, 26, 30, 31, 35, 36	
	19.2 All reusable medical devices are properly decontaminated prior to use so that the risks associated with decontamination facilities and processes are well managed	C:4	1. The purchase of scanners for the main operating theatre departments in order to implement a more robust tracking and traceability service with the Sterile Services Department for all used medical devices.	Dave Kennedy	Steve Noden	Jun-08		A manual and computerised tracking system is currently in place. However, a full computerised system is the quality requirement. 70% of system currently computerised. Therefore, need a further 30% investment to implament a full computerised system	WRMS: 2, 24, 26, 30, 31, 35, 36	
			2. Programme to replace all automated endoscopic machines for endoscopy units at Ysbyty Gwynedd and Ysbyty Llandudno.			Mar-08		Funding identified and replacement programme on target.		
			3. Outpatient departments at Ysbyty Gwynedd and Ysbyty Llandudno are bidding to purchase automated and validated auto disinfectors for the decontamination of naso endoscopes, in order to replace the present manual decontamination processes. An automated system is the gold standard for decontamination, and is a thoroughly validated process.			Dec-08		Manual decontamination processes are currently being carried out. These processes have been validated and conform to current guidelines & regulations. Department is still actively working to employ an automated process, and is meeting with several companies.		
			4. Recognised training in decontamination to NVQ Level 3 for all personnel involved in decontamination.			Jun-08		Resouces required to allow staff to attend training. SSD manager to submit proposal and action plan to initiate training using KSF platform.		
			5. Podiatry services restructuring of decontamination services throughout community, with the purchase of validated Sterilisers and changes to decontamination processes to conform to national standards and guidelines.			Jun-08		Currently purchasing validated automated sterilisers and have identified certain instrumentation to be returned to the SSD for decontamination.		
		O:4	1. Outpatients and Podiatry to purchase automated re-processors for the decontamination of devices as this has been recognised as a more effective and validated way to carry out successful decontamination.		Steve Noden	Jun-08		Both Outpatients at Ysbyty Gwynedd & Llandudno are actively working to employ an automated process, and meeting with several companies to discuss various options. The community Podiatry services are replacing old Sterilisers for validated Sterilisers.	WRMS: 2, 24, 26, 30, 31, 35, 36	
			2. All personnel involved in decontamination to obtain a suitable qualification such as the NVQ level 3 in decontamination.			Jun-08		Resouces required to allow staff to attend training. SSD manager to submit proposal and action plan to initiate training using KSF platform.		
			3. Role for the Decontamination Link Nurse needs to be formalised as indicated in WRP Standard 36.			Dec-07		All link nurses have received training but the role & responsibilities for decontamination need to be formalised as part of their current role.		
		P:4	1. All instrumentation used in theatres that comes into contact with bone cement, is to be immediately cleaned and all cement removed from the devices at point of use, prior to sending back to the Sterile Service for re-processing.		Steve Noden	Aug-07		All staff in theatre informed and included in local policy & procedure.	WRMS: 2, 24, 26, 30, 31, 35, 36	
			2. As most complaints relate to specific instruments, these need to be highlighted and more appropriate and rigorous checks carried out for these devices. The SSD Manager has implemented the appropriate checks in order that these devices are identified at the point of decontamination, and appropriate measures taken to exclude or replace such instruments.			Sep-07		Policy in place and all staff are now aware of this requirement.		
			3. All Theatre staff are continuously reminded to remove all cement immediately after use.			Aug-07		All staff in theatre informed and included in local policy & procedure.		
			4. SSD Management will improve the checking processes and identify high-risk instruments.			Aug-07		A standard Operating Procedure for this is in operation and rigorous checks are carried out.		

				5. Trust decontamination officer will continue to review complaints and advise on improvements.			Aug-07		A list of high-risk instruments has been compiled and these particular instruments are checked accordingly.		
		19.3 The quality, safety and security issues of medicines are managed effectively	C:4	The medicines management role is being improved with the setting up of new groups,	Dave Kennedy	Tina Bailey / Lynne Winkler	31/07/2007		Waiting List Standards ratified, communicated and agreed – distributed. Available on the Intranet	WRMS: 2, 24, 26, 30, 31, 35, 36	SAFF: 13
				Safe Management Practice Group, PGD and Medicines Policy Group, Non-Medical Prescribing Implementation Group and Medicines Management Group. Medicines Management strategy in draft format - role out of management of clinical pharmacists within the Trust to manage risk and governance process.			31/03/2008		Currently updating further with access 2009 and Guide to Good Practice, new information to be included.		
			O:3	Acute Hospital portfolio medicines management action plan.		Tina Bailey / Berwyn Owen	29/10/2007		Management of Records Policy under consultation to be sent to Executives by 29th October for ratification		
				Training and development plan			30/09/2007		Records Strategy sent to Executives – Approved September 2007. Available on Intranet.		
				Draft Pharmacy modernisation plan to include revised pharmacy structure and integration of medicines management across the acute and primary care setting.			Ongoing		Training is on-going. Evidence inclusive. OPD Training Day - First training date will be in December 2007	WRMS: 2, 24, 26, 30, 31, 35, 36	SAFF: 13
			P:3	See Medicines Management Modernisation Plan Roll-out of medicines management Trust-wide to include community setting Roll-out of medicines management pharmacists to include interventions antibiotics pharmacist. Integration of IM&T software onto the wards and within the department to reduce risk and management document control. Review of perfect week data to set plans for pharmaceutical services/medicines management for the Trust.		Berwyn Owen / Tina Bailey / Alwen Nicholson / Ian Baker	Interventions - Dec 07 Document Control - Nov 08 IT - Nov 08		Interventions antibiotics has been in place since Jyly 2007 Interventions - December 07 Document Control - November 08 IT on Wards - November 08	WRMS: 2, 24, 26, 30, 31, 35, 36	SAFF: 13
		19.4 The prevention, segregation, handling, transport and disposal of waste is managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment	C:3		Dave Kennedy	Geraint Roberts			Awaiting result of Internal Audit review of waste management before agreeing on any improvement	WRMS: 2, 24, 26, 30, 31, 35, 36	
			O:4			Geraint Roberts			Continuing to carry out audits	WRMS: 2, 24, 26, 30, 31, 35, 36	
			P:4			Geraint Roberts			No improvements necessary as no incidents recorded.	WRMS: 2, 24, 26, 30, 31, 35, 36	
20	Healthcare organisations work to enhance patient care and to continuously improve staff satisfaction by providing best practice in human resources management.	20.1 Patient care is enhanced by encouraging staff to continuously improve the services they deliver	C:4	Implement a staff suggestion scheme and staff achievement awards	Tania Marsden	Nia Thomas	31/03/2008		Business Case submitted to Executive Team for Staff Suggestion Scheme. Staff Achievement Awards accepted by Executive Team and organisation of an event is taking place		
			O:4			Nia Thomas					
			P:4	implement formal staff suggestion scheme and staff achievement scheme.		Nia Thomas	31/03/2008		Business Case submitted to Executive Team for Staff Suggestion Scheme. Staff Achievement Awards accepted by Executive Team and organisation of an event is taking place		
		20.2 Staff satisfaction is continuously improved by providing best practice in human resources management (Links to 8.2)	C:4	Launch of Workforce Strategy and create a Designed to Work Action Plan. Launch the staff suggestion scheme	Tania Marsden	Nia Thomas	31/03/2008		Workforce Strategy currently in the consultation phase. Designed to Work action plan in place and progress is being reported on a quarterly basis to Regional Office and WAG		
			O:4			Nia Thomas					
			P:4			Nia Thomas					
21	Healthcare organisations: a. undertake all necessary employment checks and ensure that all employed or contracted professionally qualified staff are	21.1 All necessary employment checks are undertaken and all employed or contracted professionally qualified staff are registered with the relevant bodies (Links to 17.4)	C:5		Tania Marsden	Nia Thomas				WRMS: 28	
			O:5			Nia Thomas				WRMS: 28	
			P:5			Nia Thomas				WRMS: 28	

	registered with the relevant bodies; b. require that all employed professionals abide by their published codes of professional practice and conduct; and c. address where appropriate under-representation of minority groups.	21.2 All employed professionals abide by their published codes of professional practice and conduct	C:5		Tania Marsden	Nia Thomas				WRMS: 28	
			O:5			Nia Thomas				WRMS: 28	
			P:4	The HR Director is implementing a formal Lessons Learnt/Best Practice Report which emanates from disciplinaries etc		Nia Thomas	31/03/2008		Case Review Team established within the HR Directorate to monitor progress of disciplinary/grievance/capability cases. Lessons learnt quarterly briefing will be cascaded within the organsiation	WRMS: 28	
		21.3 Where appropriate under-representation of minority groups is addressed.	C:4		Tania Marsden	Nia Thomas				WRMS: 28	
			O:4			Nia Thomas				WRMS: 28	
			P:3			Nia Thomas				WRMS: 28	
22	Healthcare organisations ensure that staff: a. are appropriately recruited, trained and qualified for the work they undertake; b. participate in induction and mandatory training programmes; and c. participate in continuing professional and occupational development.	22.1 Staff are appropriately recruited, trained and qualified for the work they undertake.	C:5		Tania Marsden	Nia Thomas				WRMS: 11, 12	SAFF: 13
			O:4			Nia Thomas				WRMS: 11, 12	SAFF: 13
			P:4	Risk Management department to notify HR if Adverse Incidents are reported which include elements of competency.		Nia Thomas	31/03/2008		No formal mechanism established as yet	WRMS: 11, 12	SAFF: 13
		22.2 Staff participate in induction and mandatory training programmes.	C:5		Tania Marsden	Nia Thomas				WRMS: 11, 12	
			O:4			Nia Thomas				WRMS: 11, 12	
			P:4			Nia Thomas				WRMS: 11, 12	
		22.3 Staff participate in continuing professional and occupational development.	C:4		Tania Marsden	Nia Thomas				WRMS: 11, 12	SAFF: 13
			O:4			Nia Thomas				WRMS: 11, 12	SAFF: 13
			P:4	Roll out PDP Portfolio's to all departments.		Nia Thomas	31/03/2008		Action plan in place to cascade PDP protfolio's to the organisation	WRMS: 11, 12	SAFF: 13
23	Healthcare organisations ensure that staff are supported by: a. processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management; and b. organisational and personal development programmes which recognise the contribution and value of staff.	23.1 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.	C:5	Staff suggestion scheme to be implemented	Tania Marsden	Nia Thomas	31/03/2008		Business Case submitted to Executive Team for Staff Suggestion Scheme.	WRMS: 8, 11, 12, 28, 39	
			O:5			Nia Thomas				WRMS: 8, 11, 12, 28, 39	
			P:5			Nia Thomas				WRMS: 8, 11, 12, 28, 39	
		23.2 Staff are supported by organisational and personal development programmes which recognise the contribution and value of staff.	O:4	Ensure the Staff Achievement awards are realised.	Tania Marsden	Nia Thomas	31/03/2008		Staff Achievement Awards accepted by Executive Team and organisation of an event is taking place	WRMS: 8, 11, 12, 28, 39	
24	Healthcare organisations work together with social care and other partners to meet the health needs of their population by: a. having an appropriately constituted workforce with appropriate skill mix across the community; and b. ensuring the continuous improvement of services through better ways of working.	24.1 Healthcare organisations work together with social care and other partner agencies to meet the health needs of their population by having an appropriately constituted workforce with appropriate skill mix across the community (Links to 23.1)	C:3	Identify existing, and new, areas of service suitable for using the powers under Section 33 of the NHS Act 2006 to improve joint working across health and social care boundaries	Angela Hopkins	Rob Lewis Medwyn Williams Glynne Roberts	Ongoing		Work is ongoing to identify services suitable for using the powers under Section 33. One of the main areas of such work is a proposed agreement between 3 local authorities and 2 Trusts for the provision of an Integrated Community Equipment Service [draft agreement by 31st March 2008]	Guidance references in WRM Specialist Standards	SAFF: 13
				Continue discussing the urgent need to develop appropriate electronic sharing of information between agencies with regard to Unified Assessment		Rob Lewis	Ongoing		A meeting with Executive Director of Nursing and Midwifery and Social Services has been planned to discuss the way forward with Unified Assessment.		
				The creation of a North West Wales Commissioning Sub-Group which includes all local stakeholders for planning service developments in all tiers of child mental health. [The creation of an Action Plan and the setting up of Task and Finish Groups will develop clarity and ownership of each partner's role and responsibility around referral criteria across the spectrum of the service].		Medwyn Williams	Ongoing		The multi-agency North West Wales Commissioning Sub-Group chaired by the Gwynedd Local Health Board meets quarterly to progress this work. This Group reports to a North Wales Commissioning Group.		
				Commissioning of research to ensure the voice of chidren is heard and that their views are part of the decision-making process		Glynne Roberts	31/05/2008		On-going discussions via Strategic Partnerships and Children's Panel development (part of Trust PPI strategy)		

				Ensuring that there is external scrutiny from elected members to the decisions taken by the Chidren and Young People's Partnerships and for the projects with which they are associated.		Glynne Roberts	01/01/2008		All funded Cymorth projects beiong externally scrutinised as part of on-going review of project-funded programmes.		
			O:3	For adult mental health services it is both a NSF and SCEP target that unified management arrangements for health and social services are developed. Towards this end, a Joint Task and Finish Group has been established -preliminary meetings have been held to explore the potential of developing joint management structures with a view to making final recommendations by June 2007-06-12		Medwyn Williams	Ongoing		Joint and separate meetings with the Gwynedd and Ynys Mon Local Health Boards have been held and there is agreement in principle to progress towards joint management arrangements. The next step will be to develop a joint Adult Mental Health Strategy paper outlining a service model which will inform joint management arrangements.		
				In Gwynedd there are clear plans to move towards an integrated Learning Disability team [as already exists on Anglesey]. A joint operational management team is in place and, in two of the three geographical areas, the team manager manages both Trust and local authority staff		Medwyn Williams	Ongoing		Work is ongoing on the proposal by the Gwynedd joint operational management team to move towards an integrated learning disability team. Recent discussions have centred around identification of new joint bases .		
				A major, and continuing, review of residential services for older people within Gwynedd is currently being undertaken. The Trust will be working closely with the Council on this review and its outcome to ensure that the reconfiguration of residential and nursing care enables the future needs and expectations of frail older people to be met.		Rob Lewis	Ongoing		Following its review of residential services, Building for the Future - Residential Services for Older People in Gwynedd, the Gwynedd Council is shortly to submit a bid to the Welsh Assembly Government for capital funding for developments at both Bala and Blaenau Ffestiniog. Senior staff from the Trust will continue to contribute to the work of the Steering Groups for these projects to ensure that these proposed Extra Care Housing projects include appropriate facilities for health services such as providing safe and sheltered environments for meeting health needs; possibly offering a base for outreach clinics for therapy serrvices; potential base for the development of intermediate care services etc.		
				Need to further develop the skills of home care staff in the generic sense, in order that they can perform health care tasks as well as social care tasks.		Rob Lewis	Ongoing		Trust is currently working with the Gwynedd Council on a pilot project providing training for Health Care Assistants/Care Workers in relation to the skill set required to meet the health/social care needs for young disabled patients/clients. The project will be evaluated by the end of March 2008. If successful, this project will influence the planning and extension of the generic worker role elsewhere in the county.		
				For Children's services, there is a need to address the deficits highglighted within the NSF, specifically in relation to CAMHS services and services for disabled children. Each county has an NSF Group which reports directly to the Framework Partnerships, thereby ensuring links with key decision-makers and the commissioning process. Actions to achieve the above improvement plan are ongoing.		Medwyn Williams	31/12/2007		In 2006 a successful bid resulted in £380,000 being invested in the Child and Adolescent Mental Health Service. The Directorate has recently reviewed how this funding was spent and identified priorities for further investment. It is hoped to complete a Phase 2 bid by the end of the year.	Guidance references in WRM Specialist Standards	SAFF: 13
			P:4	The Integrated Care Pathway [ICP] project is looking at how we can deliver an agreed joint [Health, Social Services, non-statutory, User and Carer] Psychosis pathway that builds on existing collaboration and benefits of co-location of teams.		Medwyn Williams	Ongoing		It is planned to launch the pilot project in January 2008.		
				Need to ensure that the voice of children and young people is mainstreamed into the decision-making processes. This will be undertaken under the umbrella of the Framework Partnerships. Actions to achieve the above improvement plan are ongoing.		Glynne Roberts	31/03/2008		I. Children's Panel minutes discussed at Children's acute Meetings (monthly). Ii. Children's Advocacy service operating from Children's Unit (funded via Gwynedd Strategtic Partnership. On-going sdiscussions about establishming regional advocacy service - Gwynedd, Anglesey and Conwy.	Guidance references in WRM Specialist Standards	SAFF: 13

25	Healthcare organisations use effective information systems and integrated information technology to support and enhance patient care, and in commissioning and planning services.	25.1 Effective information systems and integrated information technology is used to support and enhance patient care and in commissioning and planning services.	C:3	Monitor the work of TISG in it's first year and address issues to improve service.	Craig Barton	Jeff Pye	Continuous process		The Trust Informatics Steering Group and its three sub groups, Clinical, Business and Information Governance, have met frequently since there formation at the start of the year. The groups are tasked with responding to immediate service need and to develop a strategic plan. The groups have been effective in responding to immediate service need, but less so in strategic planning were a lack of clarity in Informing Healthcares delivery plan/timetable has frustrated efforts. However, the groups are tasked with identifying future priorities by the end of December so that a strategy and delivery plan can be developed for 2008/09.	WRMS: 1, 2, 3, 7, 8, 29	
			O:2	Discuss training option for 2007/2008.		Jeff Pye	Continuous process		General skills training has been provided through ECDL courses with funding support from Informing Healthcare. This funding will cease from 2008/09. In 2007/08 NLIAH took over the responsibility for national leadership of IT Training in NHS Wales. Currently a consultation process is taking place between NLIAH, Informing Healthcare and the service to determine the best approach for delivering and supporting future IT training across NHS Wales. The Trust is fully engaged in this consultation.	WRMS: 1, 2, 3, 7, 8, 29	
			P:4			Jeff Pye				WRMS: 1, 2, 3, 7, 8, 29	
26	Healthcare organisations have effective records management processes in place to ensure that: a. from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required; and b. patient confidentiality is maintained.	26.1 Healthcare organisations have effective records management processes in place to ensure that: a. All records created are necessary. b. Records maintained are complete, accurate and account fully and transparently for all actions and decisions taken. c. All records maintained are used for their intended purpose. d. Records are retrievable. e. Records are secure and patient confidentiality is maintained. f. Records no longer required are archived and disposed of in an efficient and consistent manner.	C:3	Waiting List standards to be ratified, communicated and made available on intranet for all staff. Draft Records Management Strategy to be ratified, communicated and made available on intranet for all staff. Management of Records Policy currently under review and awaiting final draft once draft completed will be submitted to Exec Board for ratification. IHC Hi-Profile website to be communicated amongst all informatics staff in relation to learning needs, information governance and the importance of records management.	Craig Barton	Tina Bailey / Lynda Prichard / Eirian Thomas	30/11/2007		Medicine Modernisation Strategy complete – communicated to staff. Consultation process for structural changes during October/November 2007	WRMS: 7, 29	
			O:3	Medical Records Manager to compile a training programme for educating staff re: importance of record keepingMedical Records Manager to commence training sessions Trust-Wide to reinforce the importance of good record keeping.Now working towards standards and requirements of ADR. IHC Hi-Profile website to be communicated amongst all informatics staff in relation to learning needs, information governance and the importance of records management.		All DGMs and Service Support Managers	31/12/2007		Training and Development action agreed – rolling out and changes to the structure are in progress.	WRMS: 7, 29	
			P:3	Through the further development, communication and audit across Directorates it is envisaged that the profile of Records and achievement against standards (WRP/CASPE/ADR) will be addressed and improved.		All DGMs and Service Support Managers	31/03/2008		Plan to roll out e-discharge group, Pharmacy to be part of this when surgery agree to impose the plan. Awaiting IHC All Wales approach to Pharmacy IM&T Solution. Perfect Week in October 2007 awaiting results – will amalgamate with in-patients to action a per Modernisation Strategy Plans.	WRMS: 7, 29	
27	Governance arrangements representing best practice are in place which: a. apply the principles of sound clinical and corporate governance; b. ensure sound financial management and accountability in the use of resources; c. actively support all employees to	27.1 Governance arrangements representing best practice are in place which apply the principles of sound clinical and corporate governance.	C:4 O:4 P:4		Kate Elis-Williams	Executive Director of Nursing & Midwifery	Jan-08		Clarify reporting systems through to the Board	WRMS: 37, 38	QIP: 8, 12
						Executive Director of Nursing & Midwifery	Sep-07		All Trust Board papers have “top sheet” identifying what is action is expected from the Board in relation to submitted papers.		

	c. actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources; d. include systematic risk assessment and risk management; and e. are integrated across all health communities and clinical networks.					Executive Director of Nursing & Midwifery	Aug-07		Committees chaired by the Executive Director of Nursing and Midwifery have the agenda categorised under the key domains		
						Executive Director of Nursing & Midwifery	Sep-07		Integration of the Clinical Audit function under the Head of Internal Audit – providing greater assurance to the EDNM.	WRMS: 37, 38	QIP: 8, 12
						Finance Director / Executive Director of Nursing & Midwifery	Oct-07		A joint Clinical Audit and Internal Audit meeting is to be held bi annually.		
						Executive Director of Nursing & Midwifery	Dec-07		Establish and communicate the revised structure for Q&CA and Nursing Directorate	WRMS: 37, 38	QIP: 8, 12
		27.2 Governance arrangements representing best practice are in place which ensure sound financial management and accountability in the use of resources.	C:4	To strengthen the training requirements of the Trust Board Members by providing further training on financial management (this is ongoing)	Kate Elis-Williams	Finance Director and Chairman / Chief Executive following IPR	Various		WAO Seminar – 23 November 2007 / To consider HFMA Model in 2008	WRMS: 37, 38	
			O:4	Further training on innovative practices to sustain future savings and efficiency plans. This has commenced with areas such as benefits realisation but could be enhanced to ensure VFM for areas such as A4C (this is ongoing)		Finance and Modernaisation / CIP Group	Nov-07		Review after WAO Review of Finance Management November 2007 / Integrated into development of CIP Programme, as ongoing	WRMS: 37, 38	
			P:4	Further training on innovative practices to sustain future savings and efficiency plans. This has commenced with areas such as benefits realisation but could be enhanced to ensure VFM for areas such as A4C (this is ongoing)		Finance and Modernaisation / CIP Group	Nov-07		Review after WAO Review of Finance Management November 2007 / Integrated into development of CIP Programme, as ongoing	WRMS: 37, 38	
		27.3 Governance arrangements representing best practice are in place which actively support all employees to promote openess, honesty, probity, accountability and the economic, efficient and effective use of resources.	C:5		Kate Elis-Williams	Dave Harries				WRMS: 37, 38	
			O:4	It is identified that a gap currently exists in maintaining governance awareness within the senior management of the Trust.		Director of Finance / Head of Internal Audit (Chairman as part of IPR for Non Executives / Chief Executive for Executives)	Nov-07		Seminars with senior staff on role out of F14 (Scheme of Delegation) already actioned Board level WAO Seminar – 23rd November	WRMS: 37, 38	
			P:4			Dave Harries				WRMS: 37, 38	
		27.4 Governance arrangements representing best practice are in place which include systematic risk assessment and risk management processes. (Links to 14.2)	C:4	Continue to develop the assurance framework Combine clinical risk and risk management strategies	Kate Elis-Williams	Director of Nursing (Lead) with other Director	31/03/2008		1st stage in this process has been achieved in that the clinical risk and risk management and corporate governance committees have combined to form the patient safety and risk management group. This group will now be tasked with developing the strategy which is hoped to be in 1st draft by end september 2007. Development of the assurance framework has stalled somewhat, however Exec Director of Nursing and Midwifery invited Mersey Audit/Keele Uni to assist the Trust in terms of the development of a number of projects with the assurance framework being one such project. No time frame for this has been set yet, and are awaiting confirmation from Keele. Once this is agreed between all parties then a timescale can be set. PB to chase AH and continue to develop risk profiling process within Datix.	WRMS: 37, 38	

			O:4	Maintain standards in respect of wrms 2 continue to expand core risk assessments		Head of Risk Management	13/12/2007		Action plan post Welsh Risk Pool audit of standard 2 is in development and will be complete by end of August. Core risk assessments are progressing with patient falls from height being the latest to be developed. Addition to risk register process is the linking of register and profiling process to the NSF's. Coronary Heart Disease is the first to be added and work on this should be completed for transfer to ADN Anne-Marie Rowlands by end of August. This was achieved however we are awaiting feedback from LHB in respect of actions required. ER requested to expidite this matter.	WRMS: 37, 38	
			P:4	Develop corporate risk management newsletter and web pages to provide staff with increased feedback in respect of their contribution to the risk assessment process.		Head of Risk Management	17/12/2007		Information in respect of the feedback newsletter will be drawn from Directorates lessons learnt process. This is being developed at this time with new AIR forms introduced to focus on outcomes. Staff contribution in respect of risk assessment process continues with W&F being offered the services of RM to facilitate training sessions in respect of risk assessment. Newsletter draft to be completed by date noted on improvement.	WRMS: 37, 38	
		27.5 Governance arrangements representing best practice are in place which are integrated across all health communities and clinical networks	C:4	Working through the Local Service Boards - intention is to give greater focus on Integrated Governance (pilot Gwynedd)	Kate Elis-Williams	Chief Executive	31/03/2008		Project Manager appointed to implement all stages and ensure integrated governance arrangements.	WRMS: 37, 38	
			O:4	Mapping of all networks to ensure consistent integrated governance approach		Liz James	31/03/2008		Project Manager appointed to implement all stages and ensure integrated governance arrangements.	WRMS: 37, 38	
			P:3	Need to work towards being able to provide a consistent approach to Clinical and Integrated Governance throughout the wholescale services that the Trust provides.		Liz James	31/03/2008		Project Manager appointed to implement all stages and ensure integrated governance arrangements.	WRMS: 37, 38	
28	Healthcare organisations: a. ensure that the principles of clinical governance underpin the work of every team and every clinical service; b. have a cycle of continuous quality improvement, including clinical audit; and c. ensure effective clinical and managerial leadership and accountability.	28.1 The principles of clinical governance underpin the work of every team and every clinical service.	C:4	Revised structure for Clinical Govenrnance and supporting processes to be circulated and disseminated throughout the organisation. Executive Nurse has arranged meeting with Merseyside Audit to discuss the organisation wide implementation of Clinical Governance.	Angela Hopkins	Bethan Nickson	31/03/2008		A meeting has been held with Merseyside Audit and an agreement that they will review clinical governance processes across the trust .	WRMS: 10, 11, 12	QIP: 8
			O:4			Bethan Nickson				WRMS: 10, 11, 12	QIP: 8
			P:4			Bethan Nickson				WRMS: 10, 11, 12	QIP: 8
29	Healthcare organisations promote, protect and demonstrably improve the health of the community served and reduce health inequalities by: a. collaborating and working in partnership with local authorities and other agencies in the development, implementation and evaluation of health, social care and well being strategies; and b. ensuring that needs assessment and sound public health advice informs their policies and practices.	29.1 The health of the community is promoted and protected. Measurable improvements in health and a reduction in health inequalities in the community served can be demonstrated. Collaboration and partnership working with local authorities and other agencies can be demonstrated in the development, implementation and evaluation of health, social care and well being strategies (Links to 24.1)	C:4	Mapping of partnership arrangements in order that the whole organisation has a comprehensive understanding of the corporate contribution to HSCWB.	Craig Barton	Siobhan Duffy	Continuous process		LHBs take the lead on this item. This would be an ongoing process as partners are increased or revised.		
			O:4	Demonstrate compliance with agreed priorities trhough partnership processes i.e achievement of Key Performance Indicators.		Siobhan Duffy	Continuous process		LHBs have lead the development of KPIs to monitor performance against HSC&WB action plans in partnership with LA, Trust and Vountary Organisations. For example, Gwynedd LHB's 1st Strategy, "Better Health, Better Gwynedd" has supported improved working across the Partnership organisations, particularly in strengthening the role that all public sector services have in the prevention of ill health and improving well-being. An annual report summarises the achievements to date, and the 2007/2008 operational plan provides detail of the key actions for this financial year. (It is understood that patient representatives were invited to take plart in the devlopment of KPI's)		

			P:4	Performance management frameworks need to be strengthened in order to demonstrate continuous improvement against these Strategies.		Siobhan Duffy	Continuous process		Further review of performance management frameworks will continue to take place.		
		29.2 By ensuring that appropriate needs assessment and sound public health advice informs policy and practice, the health of the community served is promoted, protected and measurably improved, with a reduction in health inequalities.	C:4		Craig Barton	Siobhan Duffy			LHB lead via their NPHS officers.		SAFF: 13
			O:4			Siobhan Duffy			LHB lead via their NPHS officers.		SAFF: 13
			N/A								
30	Healthcare organisations: a. have systematic and managed disease prevention and health promotion programmes, which include staff, which meet the requirements of the National Service Frameworks, national plans and health promotion and prevention priorities; and b. take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services, and the commissioning and provision of services.	30.1 Systematic processes for the commissioning of and / or providing managed disease prevention and health promotion programmes, which include staff and meets the requirements of the National Service Frameworks, national plans and health promotion and prevention priorities are in place.	C:4	Continue promoting exercise and healthy living	Dr P Birch	Anne-Marie Rowlands	Continuous process		National Service Frameworks progress are reported to the Clinical Governance Sub-committee. Work with LHB and National Public Health Service to ensure systematic process are in place.	WRMS: 13, 14	SAFF: 13, 16, 18
			O:4			Anne-Marie Rowlands				WRMS: 13, 14	SAFF: 13, 16, 18
			P:3	Promote and deliver LDSAG action plan		Anne-Marie Rowlands	31/03/2008		LDSAG action plan to be reported to PPI group.	WRMS: 13, 14	SAFF: 13, 16, 18
31	Healthcare organisations: a. have plans in place to mobilise resources to protect the public in the event of significant infectious disease outbreaks and other health emergencies; b. identify and act upon significant public health problems and health inequality issues, with Local Health Boards taking the leading role; c. implement effective programmes to improve health and reduce health inequalities; and protect their populations from identified current and new hazards to health; and d. encourage and support individuals to recognise their own responsibilities in maintaining their health and well being.	31.1 Plans are in place to mobilise resources to protect the public in the event of significant infectious disease outbreaks and other health emergencies	N/A								
32	Healthcare organisations achieve the Corporate Health Standard, the national quality mark for workplace health, moving to a higher level on reassessment.	32.1 Achievement of the Corporate Health Standard, the national quality mark for workplace health, is achieved.	C:4	Ensure Action Plan to achieve Gold/Platinum award in January 2008 is performance managed	Tania Marsden	Nia Thomas	31/03/2008		Action Plan to achieve Gold/Platinum in place and performance managed by Deputy Director of HR and Director of HR. Mock assessment taking place in January 2008	WRMS: 13	
			O:5			Nia Thomas				WRMS: 13	
			P:4			Nia Thomas				WRMS: 13	