

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
1.1	Patient, service user, carer and public involvement	Ensure that services and facilities are readily accessible for people with disabilities during construction work and improve the availability of information about works in hand or planned.	April 2004	<p>The Facilities department has undertaken a survey in relation to the Disability Discrimination Act (DDA) 1995 and prepared an action plan from the findings. Sign posting has been improved and information about planned work has appeared in the local press. In terms of access for wheelchair users, patients are advised to contact the Trust Support Services if assistance is needed.</p> <p>Feedback on the adequacy of signposting and information has been gathered through the CHC and league of friends. We observed health and safety protection notices, tape and barriers at the sites of major construction work.</p> <p>However some temporary building work was observed on certain wards with no prior risk assessment or appropriate signage in place. We noted that the Trust's risk register still contains a significant number of high scoring (20+) estates related risks.</p>
1.2		Review Nurse Management of Incontinence to ensure that standards throughout the Trust are consistent with good practice.	September 2003	<p>Open access community based satellite clinics currently offer continence assessments and conservative treatments from nurses with specialist skills. The clinics report a high percentage of success in alleviating symptoms. The majority of patients with continence problems however need to have their symptoms managed as part of their overall care either as in-patients or community patients. Continence Resource Folders are available on all wards and ward staff have access to continence link nurses who are trained by the Continence Advisor and are responsible for disseminating good practice within their own teams.</p> <p>Training programmes on the management of incontinence are published via the training department using flyers and the training prospectus. There are ad hoc training sessions and monthly training awareness sessions available as well as catheter management training for nursing home staff and continence care included in fundamentals of care sessions for social services staff.</p> <p>It is clear that the systems and training in place have been designed to improve standards in continence care. The Trust does however need to consider how to evidence the effectiveness of these in terms of the evaluation of training and of the patient experience at ward level.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
1.3		Review Management of Nutrition	November 2003	<p>The Trust has a Nutrition Strategy Group that meets monthly and which includes representation from disciplines that can influence nutrition. A catering sub group specifically concerned with menus and meals for patients is launching new menus in January 2007.</p> <p>The Nutrition Strategy Group has developed processes for nutritional assessment of in-patients as part of the Unified Assessment process and an outpatient assessment tool is currently being piloted. It has also been responsible for updating and developing guidelines and policies relating to the nutritional needs of patients in line with the All Wales Catering and Nutrition Standards.</p> <p>Dietetics led on the development and initiation of a comprehensive training programme which is now being rolled out further and which includes the assessment of competence for enteral feeding at ward level.</p> <p>We were pleased to note evidence of changes to practice as a direct result of audit activity such as the introduction of modified diets (pureed foods) to help overcome adult nutrition inadequacy. There are also plans to review current patient feeding processes to include patients with special needs.</p> <p>We were particularly impressed by how well the Trusts 'Red Tray' system is working in practice. This was introduced to highlight patients requiring assistance at mealtimes feedback from nursing and domestic staff in the clinical areas we visited was positive. We also noted some positive comments from patients and visitors about the system. Early concerns that patients may be stigmatised by the red trays appear to have been unfounded.</p> <p>The WRP standard on nutrition was audited for the first time externally this year (2006) and a score of 88% compliance was achieved by the Trust. Further improvements are planned through the development of a nursing competence tool, as part of the overall nutritional assessment. This will allow nurses to plan workforce needs by linking together feeding and dependency. The Trust is also working towards the full introduction of protected meal times.</p>
1.4		Ensure that information	December	A Welsh Language Working Party has been established and meets regularly.

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
		<p>for the public is provided in a consistent, organised and accessible format, including for Welsh Speakers and other non-English speaking members of the public.</p>	<p>2003</p>	<p>The Trust has made good progress in taking forward its Welsh Language Scheme after the Directorates completed a baseline assessment in 2003. It is currently revisiting the Scheme and action plan and finalising the Welsh Language Boards 10 pledges for 2006/7.</p> <p>We noted a number of achievements and initiatives during our visit that provided evidence of the progress that has been made against this recommendation in terms of the Welsh Language.</p> <p>The Trust has a contract with Language Line which staff generally find works well. It has, however, proved insufficient in dealing with the significant number of Eastern Europeans working or passing through the area, that use the services of the Trust. To remedy this problem the Trust now accesses the translator services used Police and Local Authority. There have been instances, however, where lack of availability has been an issue. There are a number of staff who speak other languages in addition to English and/or Welsh and their skills are used when necessary but this is an informal arrangement based on staff knowledge. There is currently no database of staff with these language skills.</p> <p>The Patient Information Policy is reviewed annually, against feedback from communication effectiveness monitoring mechanisms. Monitoring of effectiveness at directorate level is undertaken through local processes which differ according to the needs of the directorate but which all adhere to the principles contained within the Trust's Patient Information Policy. Additionally the use of patient friendly language is audited routinely and inpatient exit surveys are completed to capture the patients perspective. We understand that software to capture this information and provide further feedback is under review.</p> <p>Whilst it is clear that a lot of work has been taken forward in this area, we found a number of documents and printed patient information to be available in English only. The Trust needs to consider how it is going to address the issue of providing consistent and accessible information to increasing numbers of non-English speaking patients. If the trend in the rise of Eastern European visiting and/or settling in the Carmarthenshire area continues, present arrangements may become inadequate.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
1.5		Review Complaints process and scrutiny of complaints to ensure that clinical content of responses is appropriate.	September 2003	<p>The Complaints Policy was reviewed in 2003, after a half day multi-professional workshop was held to review the complaints process. The Policy and process have been regularly reviewed since. An audit of clinical staff satisfaction with the complaints system noted that feedback was positive.</p> <p>The Trust's Complaints Committee has clinical representation and committee meetings include feedback from monthly informal complaint reviews. Methods of learning from complaints continue to be developed, and we noted good examples during our visit.</p> <p>An action plan and has recently been prepared for submission to directorates and the Complaints Committee is continuing to strive to improve the effectiveness of processes and communication.</p> <p>Clinicians and other healthcare professionals vet the clinical content of responses to complainants and complaints and litigation are included as part of the consultant appraisal process.</p> <p>There is a comprehensive training programme in place for all staff and in addition, complaints management is an integral part of induction and other training programmes. The Trust does however need to identify and target low attendance groups and in addition, needs to ensure that long-standing staff are included.</p>
2.1	Risk Management	Consider increasing proactive assessment of clinical task to ensure all clinical risks are identified and controlled.	December 2003	<p>Serious risks are managed using the Critical Incident Policy. Once a potential or actual incident has been identified it is reported using Incident Reporting Form 2 (IR2). Online reporting is available but this is only in Pathology and Pharmacy at present. There are plans for this is to be extended for use by parents in relation to issues concerning child health, which we would encourage as a point of good practice.</p> <p>Directorates identify risks and give them a rate according to the severity, based on a standard scoring system. These risk ratings are considered by the Risk Management Committee, which takes action as needed. Any new initiatives are risk assessed in the same way, for example the Hospital at Night scheme.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				<p>Risk management is based on a standard scoring system but we found that risk scores appear to be interpreted and recorded differently by different directorates and departments (See response to recommendation 1 above and recommendation 3 of the CHI Investigation report). We recommend that our findings under rec. 3 of the investigation report and recommendation to ensure equitable assessment of risk across all areas of the Trust are cross-referenced and that the practice of comparing scores becomes consistent across the Trust.</p>
2.2		<p>Ensure that front line staff receive feedback from Directorate Governance Groups</p>	<p>September 2003</p>	<p>There are regular staff meetings and quarterly directorate reports are produced and made available to all staff within the directorate. Risk management newsletters provide examples of changes to practice as a result of incident reporting and these are available along with directorate reports on the intranet.</p> <p>Access to computers is a problem for some staff but this has been recognised by the Trust and work to improve access in the near future is being taken forward.</p> <p>Achievement against the Welsh Risk Pool standard for risk assessment has been maintained at 100% until this year when it dropped to 93%. The Trust believes that this is due to changes in the assessment process, specifically staff interviews. We found staff to generally understand their roles in relation to risk management and incident reporting although some fairly senior staff were unclear as to what are the key risks faced by the organisation. This suggests a gap in feedback mechanisms, which needs to be addressed.</p>
2.3		<p>The Trust should consider introducing a system so that completed incident forms could be tracked to prevent information being lost.</p>	<p>September 2003</p>	<p>All IR2 forms are logged centrally on issue and those returned constitute an audit trail. Partial on line reporting has been introduced and there are plans to extend this facility. It is not yet clear how effective this system will be in tracking and preventing information being lost. We found that a substantial amount of information is received, however, there is still work to be done in this area by the Trust to make the system more sharply focused and to ensure that there are sufficient resources to handle the volume of work. Training for personnel using the online system must be a priority for the Trust to prevent the loss of documentation.</p>
2.4		<p>Ensure that staff comply</p>	<p>December</p>	<p>There is a regular programme of directorate risk management inspections (audit)</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
		with risk prevention measures	2003	<p>with results feedback given to directorates. Action plans are developed as a result and to close the loop are included in the next round of.</p> <p>The Clinical Performance Management Committee is revising the directorate performance monitoring process to include information on outcome measurements and non-reporting.</p> <p>Comprehensive training on all aspects of risk management is provided, and risk management is addressed as part of induction training but it is unclear how these are evaluated in terms of their impact on compliance, timing, focus and experience of risk and incident reporting.</p> <p>We found processes for risk and incident reporting to be embedded in the organisation but we found little evidence of benchmarking or analysis where there is suspected under reporting. Inconsistencies in reporting style and scores across directorates and departments suggest a lack of analysis, which would highlight these problems. These issues need to be addressed to ensure full and equal compliance across the organisation.</p>
2.5		Continue to develop open learning environment & actively encourage staff to feel able to raise concerns about actual and potential risk	September 2003	<p>A newsletter is published quarterly which includes information on risks and hazards and there is a clear culture of staff being risk aware. Staff interviewed felt able to raise concerns about actual and potential risks and were confident that their concerns would be taken seriously.</p> <p>All new members of staff, including junior doctors, receive induction training, which includes risk reporting. We found, however, that staff who have been in post for a number of years have not all received incident training and may not therefore fully competent in reporting risks. The Trust must address this issue.</p>
3.1	Clinical Audit	Review Clinical Audit Strategy and systems for determining audit priorities to ensure that audit supports service delivery and drives improvement.	November 2003	<p>The Audit Strategy was reviewed in 2003 and again in 2005. The terms of reference and constitution of the audit committee were also reviewed in 2003 the next review is due in 2008.</p> <p>All directorates have a clinical audit lead who works with to identify priorities, feed back results, produce and monitor action plans, and support re-audit.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				<p>The audit department is in the process of adapting a Prioritisation Clinical Audit Scoring Tool. This will help to prioritise future audit programmes by testing proposed audit against set criteria. We found little awareness about this change of approach outside the audit department, which suggests the need for awareness raising to avoid problems in implementing the new system in practice. We also found that the current audit programme lacks integration in terms of crosscutting issues within nursing, health and safety, patient surveys and complaints. The audit department needs to consider this in the development of its Prioritisation Clinical Audit Scoring Tool</p> <p>The Clinical Audit Committee meets quarterly and is responsible for providing assurance to the Board that appropriate audits against National guidance take place. The audit committee scrutiny audit processes (prioritisation, management, communications, compliance and follow up) as suggested in the audit committee handbook. It is however less clear how the content and findings of clinical audit are used to influence service planning and development decisions the Board.</p> <p>The Trust has clearly made good progress against this recommendation. Approaches to managing the audit programme, auditing compliance with National Institute for Clinical Effectiveness (NICE) guidance and National Service Frameworks and dissemination of findings are robust and the organisation developing further mechanisms to ensure the focus is right and that action and resources follow findings.</p> <p>The Trust now needs to ensure that future clinical audit programmes integration of different disciplines and elements of clinical governance. It also needs to review the role and functions of the audit committee to ensure that findings from clinical audit are influence planning and service development.</p>
3.2		3.2 Continue to develop joint audit with partners, in particular, audits which may help resolve service delivery difficulties or	December 2003	A Collaborative Primary/Secondary Care Audit Group has been established as a sub-group to the Clinical Audit Committee. The Carmarthenshire LHB is represented on this group. To date the group has been key to developing Standardised Discharge/ Referral Letters, Open Access Endoscopy Referral Letter and new Death Documentation.

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
		support clinical initiatives		<p>Collaborative audits have been undertaken with the Welsh Ambulance Services Trust and Pembrokeshire and Derwen NHS Trust, For example is the audit of 'door to needle' performance for patients with Myocardial Infarction.</p> <p>There is clear evidence that the Trust is using audit to support clinical initiatives. However, there is little to suggest that audit is being used to resolve service delivery difficulties on a wider scale. We understand that two additional information analyst posts have recently been appointed to.</p>
3.3		Additional dissemination of audit results to ensure that all staff have the opportunity to share learning	December 2003  December 2003	<p>Good progress has been made. Lists of completed audits are available on the Trust intranet with contact details for further information. Additionally, audit results are e-mailed to key Trust individuals.</p> <p>Directorate audit link staff are fully aware of their roles and responsibilities regarding audit, although as previously mentioned there is a lack of clarity about how the new Prioritisation Clinical Audit Scoring Tool work. There are established relationships with the lead nurses who carry out compliance audits.</p> <p>Directorate meetings are held at which research and development, audit, policy issues and benchmarking are addressed. Feedback to ward level includes, the sharing of trends and non-compliance issues. Directorates are performance reviewed by the Clinical Performance Management Committee and this includes consideration of audit activity, outcomes and changes to practice.</p> <p>Audit awareness sessions are included in in-house training programmes, the Junior Doctor Programme and corporate induction. Clinical audit staff deliver one-to-one or small group training as required.</p> <p>Interviews with staff indicated that sharing and learning from audit findings is taking place. However, we found that staff who have been in post for some time may not have benefited from training opportunities, which is a point for the Trust to consider.</p>
3.4		3.4 Encourage further involvement of patients	December 2003	Complaints management falls under the remit of the Deputy Chief Executive. Complaints are dealt with at ward level in the first instance and then escalated if not

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
		and carers in audit		<p>resolved at this level. Mechanisms are not in place to use complaints to inform clinical audit programme development [see 3.1 above].</p> <p>Examples of patient involvement in audit include a current Amputation Audit, patient satisfaction and 'Exit' (discharge) surveys. There are some limitations to these surveys as no survey is done prior to, or on admission, to assess patients' expectations. This may devalue the effect of the exit survey, as there is no objective measure for the Trust to use in identifying whether or not the service provided actually met the patients' expectations.</p> <p>The Trust considers PPI to be a joint responsibility of the Trust and the Community Health Council but as yet there are no examples of joint audit. There is a PPI policy and action plan in place and a community strategy is in the process of being developed with partners. There are clearly opportunities here for identifying audit needs to for inclusion in future programmes and we endorse the fact that the audit department are now working more closely with senior managers to feedback findings from patient centred audit with this aim in mind.</p>
4.1	4. Clinical Effectiveness	4.1 Review accessibility of guidelines for staff in clinical areas	March 2004	<p>A database of policies, procedures and guidelines with review dates is available on the Trust Intranet. The database highlights documents within a month of the due review date and notification is sent to the author / person responsible. This system is designed to ensure that policies and guidelines are kept in line with current practice and national guidance. However, it is unclear as to how this system is monitored and the Trusts needs to ensure that backup systems are in place if the responsible person / author is unavailable for any reason.</p> <p>The Trust also needs to ensure that there is a final high-level sign off of updated policies / guidelines prior to their issue and that update of the Intranet is timely. Concerns were raised that delays in gaining director sign-off can lead to out of date information remaining on the Intranet The Trust should put arrangements in place to minimise this risk.</p> <p>In terms of staff access to electronic information, a baseline audit of I.T. access was carried out in 2004 as part of the Access to Information Technology work sponsored by Informing Healthcare. As a result of this audit, a replacement programme for new</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				<p>and replacement PCs has been implemented. 190 new PCs were provided in 2004/05 and a further 243 in 2005/06. A further £50k has been identified within the Trust's Capital Programme 2006/07 for IT replacement equipment.</p> <p>The current plan is for all staff to have access to PCs and to have received appropriate training by the end of 2007. There were no issues of access identified in the clinical areas we visited and guidelines were found to be available in hard copy where electronic access was difficult.</p>
4.2		4.2 Develop Clinical Effectiveness Strategy to promote a systematic and planned approach to the selection, prioritisation and implementation of evidence based practice allied to strategic plans for service delivery and staff development	December 2003	<p>A stand alone Clinical Effectiveness Strategy has not been developed, the rationale being that clinical effectiveness is integral to the Trust's Clinical Governance Strategy. It is deemed to be part of the role of the Clinical Effectiveness Support Unit under the leadership of the Medical Director and Director of Nursing.</p> <p>The role and function of the Support Unit is currently under review.</p> <p>There are a number of different strands of work already mentioned which contribute to the clinical effectiveness agenda, such as the processes in place for implementation of national guidelines and electronic availability of policies and guidelines. In addition, there is a framework for integrated care pathway development and the learning that takes place through audit activity.</p> <p>A score of 97% compliance was achieved against WRP standard 10, '<i>Clinical Effectiveness and Risk Management</i>' this year and the Trust believes that clinical effectiveness is embedded throughout the organisation as a result of the systems it has put in place.</p> <p>It appears that this recommendation has been addressed to a certain extent in the work that the Trust has taken forward in developing a culture of evidence based clinical practice. While it is acknowledged that this responds to the recommendation in part it is difficult to see how it links to plans for service delivery and staff development have been made..</p> <p>For example, we learned that the development of integrated care pathways to date has been slow in terms of drawing in primary care. At present pathways are narrow and mainly confined to secondary care. There is a considerable amount of work to</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				<p>be done in increasing the level of understanding of wider integrated care pathways and developing ownership. It is also unclear as to how the Trust is linking its direction for clinical effectiveness to national strategy given the absence of a clear strategic document.</p> <p>The Trust needs to revisit this recommendation, pull together all the various strands of work that contribute to taking it forward and reconsider its decision not to develop a clear strategic approach as part of its current review of the Clinical Effectiveness Support Unit.</p>
5.1	Staffing and Staff Management	Ensures robust measures are in place to address poor performance, that staff understand when to use the capability or disciplinary policies and that staff can identify and report professional misconduct.	April 2004	<p>The new Capability Policy has been operational since January 2004. The Disciplinary Policy was revised in July 2004 and is currently being updated to take account of Child protection, the Protection of Vulnerable Adults and Counter fraud initiatives. Regular Management Development workshops are available for staff who may be required to take action in accordance with these policies.</p> <p>The Trust induction programme includes information on disciplinary procedures and 'whistle blowing'. Staff also receive local induction which includes guidance and training for specific pieces of equipment relevant to their job. This is followed by appraisal within two weeks of starting work in the Trust to assess levels of competence. In addition, new job outlines contain competency assessments with links to occupational standards.</p> <p>The HR department has restructured and each directorate has a named HR Manager to advise on the application of policies, procedures and HR issues. HR staff moving into new roles have identified their own development needs and undergone training where necessary, for example in the use of the Incident Decision Tree.</p> <p>Training and development for all staff is identified through the Trust's appraisal process and the development of personal development plans. Personal development planning training has been given to 652 members of staff since June 2004 and the Investors in People accreditation was awarded to the Trust in December 2004.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				<p>All staff interviewed believed that the Trusts open culture means that poor performance can be identified and dealt with promptly at line management level. There is confidence that concerns can be aired with line managers and for senior colleagues. This was a consistent finding across all staff groups. Staff also shared with us examples of themselves or colleagues using the Trust's policies and procedures in practice to effectively manage issues of poor performance.</p> <p>The Trust has consistently achieved WRP scores of between 83% and 99% in the areas of staff supervision and competence assessment. Action plans are in place to improve the competence assessment scores. Further, the Trusts success in responding to this recommendation is clear from the attitudes and behaviour of the staff we met. Its approach to human resource management is to be commended.</p>
6.1	Education Training and Continuous	Review accountabilities and structures for training and development to ensure that they adequately support the strategy and equality of access	July 2003	<p>Training budgets are devolved to Directorates as part of the Trust's strategy to improve access to training for all staff groups.</p> <p>Strategic objectives are revised regularly and reported to the Trust Board via the HR committee (sub committee of the Trust Board). An action plan has been developed and is continually monitored with objectives being reviewed on an annual basis.</p> <p>Progress is monitored through the HR committee and resources are monitored in accordance with the action plan as agreed by Trust Board.</p> <p>Development of the workforce is being considered at a corporate level and planning and implementation are being managed strategically.</p> <p>It is clear that training and development is seen as a priority by the Trust and there appears to be equal opportunities across staff groups. Staff feel they are well supported and those interviewed were complimentary about the Trusts approach to training and development.</p> <p>New ways of working are being explored and the Trust is working with the National Leadership and Innovation Agency for Health (NLI AH) in developing and changing roles. Some joint appointments have also been made.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				<p>It is anticipated that further improvements will occur with the implementation of the Knowledge And Skills (KSF) framework.</p>
6.2		Consider scope for improving training in diversity issues	July 2003	<p>raining in respect of Equality and Human Rights has included awareness raising at Trust Board level and specific equality and diversity training for managers and staff. E-learning facilities are also available on the intranet site.</p> <p>723 Knowledge and Skills Framework (KSF) outlines have been established with core dimensions on equality and diversity agreed for approximately 3200 staff. This forms part of the implementation of Agenda for Change, the new pay system for NHS staff. The Trust has developed a Race Equality scheme and actions to mainstream equality and human rights are in the early stages of implementation. The Trust is also working with the Commission for Racial Equality to progress the Race Equality scheme.</p> <p>The hospital chaplain has produced guidelines for staff in managing spiritual needs of all patients.</p> <p>The one training weakness we identified in terms of the recommendations the CHI report however, was in the area of specific training on diversity issues. Staff interviewed had not had the opportunity to access specific training although several mentioned that they gained from other, non-specific training courses. There was a lack of awareness about the KSF outlines which is a concern, considering that they have been agreed for the majority of staff working in the Trust.</p> <p>We understand that there is an arrangement in place whereby the Staff Partnership Forum should report relevant diversity issues to the training manager via the HR Director, to inform training developments. We found no direct evidence to indicate that this has happened but the new HR structures should allow issues to be identified. The culture in the Trust is very open which suggests that staff would have no difficulty in raising issues and seeking action. The Trust should therefore take advantage of this to fully inform future training programmes and ensure that diversity training is now made a priority.</p>
7.1	Systems for	Review current structure	November	It is clear from evidence reviewed and interviews with staff that clinical information is

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
	Using Information	to facilitate strong clinical lead and fully engage staff in identifying and using information to support clinical care	2003	<p>being collected and used wherever possible to inform evidence based practice and to support clinical audit.</p> <p>The Trust is participating in the implementation of the CHKS COMPASS Consultant Outcome Indicator Programme and has purchased the CHKS SIGNPOST programme with the aim of further engaging Consultants in reviewing and analysing their own data.</p> <p>We found however that there are concerns amongst clinical staff about data quality and the interpretation of data. It was not evident that issues of leadership and structure in this area have been addressed and the Trust must take further action against this recommendation.</p>
7.2		Identify and safeguard any patient files which have been issued in duplicate and introduce a single patient identification number system as a priority	August 2003	<p>Progress has been made against this recommendation to reduce risks associated with patient record duplication. It is acknowledged that progress has to be judged in the context of the national strategy for the NHS in Wales, Informing Healthcare, and the ultimate future aim of electronic patient records.</p> <p>A duplication of records project is underway across the Trust, which is due for completion within a year. The issue of duplicate patient files remains an issue in that approximately 20 new duplicates are still being set up each month. The Trust acknowledges that this is linked to split hospital sites, overloading of files with information and that there is a need for further awareness raising.</p> <p>Awareness has been raised about the risks to patients from file duplication since the project began and there is a belief within the Trust that the situation is more controlled than it was previously.</p> <p>Currently records are held in two libraries with archive facilities and records are delivered between sites as necessary. The files can be traced through a bar code and monitoring of the system indicates that between 98% and 99% of all patient records reach their required destination. Where there is a failure to have the records in the right place at the right time this is reported as an incident.</p> <p>A single Patient Administration System (PAS) has been implemented across the Trust and a work plan developed by the Project Steering Group is in place.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				We understand that consideration has been given to consolidation of both libraries at one but no steps appear to have been taken as yet to move this forward.
7.3		Review use of Community information and readmission rates to ensure optimum use in improving patient care	September 2003	<p>A work plan developed by the Project Steering Group begun to address the development of Performance Indicators for the Community in seeking to improve patient care.</p> <p>A monthly report against measurable indicators is provided for community initiatives such as Chronic Disease Management, Community Intermediate Care Team and Acute Response Team</p> <p>Directorates are developing action plans for key performance areas, for example the NLIH length of stay and daycase projects, modernisation and benefits realisation framework and acute hospital portfolio audits.</p> <p>Progress against action plans is reported to the Clinical Performance Management Committee.</p> <p>The definition of readmission rates has not been resolved, primarily because there is no nationally agreed definition in place. The issue is complex and the Trust is currently testing the definition of a re-admission rate based upon the number of emergency readmissions within 28 days of discharge for individual specialities</p> <p>An audit of patient records is underway as part of the testing of the new definitions.</p>
7.4		White boards with patients names should not be visible to members of the public	October 2003	<p>The Trust has audited the location and purpose of all white boards containing patient information and it is clear that attempts have been made to address this recommendation through benchmarking against recognised best practice and legal requirements.</p> <p>White boards are commonly used across the organisation and we observed several different styles and applications. For example, some displayed patient names only while some displayed 'codes' next to patient names relating to classifications for conditions, treatments and special needs. Unfortunately we also observed the key to some of these codes displayed on the same whiteboard, leading to the potential for disclosure of patient identifiable information.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				<p>We understand that a trial of covered white boards is in place and the Trust has also recognised the importance of the patient's opinion in this issue. However we were unable to ascertain how the trial is being monitored or how the patient's consent for their information to be displayed is gained and recorded in practice.</p> <p>Although many of the whiteboards had either pull down covers or shutter doors, most were open and visible during our visits.</p> <p>It must be pointed out that most of our visits occurred outside recognised visiting hours and it may be the case that these boards are covered during these times. We also noted that many staff have a responsible pragmatic approach in asking patients if they have objections to the whiteboards. There were however noticeable variations in approach.</p> <p>The timescale for completion of this work was October 2003. It is clear from our observations that the Trust still has some way to go in agreeing and implementing a standardised system and consistent practice across the organisation.</p>
8.1	Strategic Intent Capacity	Continue to monitor the action taken to address staff shortages in A&E, to ensure safe provision of service	April 2003	<p>The A&amp;E Departments medical staffing establishment has been increased by two House Officers and two Senior House Officers since the CHI review. An acting consultant post has been appointed to, bringing the consultant team to three.</p> <p>The medical middle grade rota has also been re-organised in an attempt to improve levels of cover.</p> <p>An initial tier of nine Emergency Nurse Practitioner ENP posts have been established with a supporting development and training programme. There is an aim to increase ENP posts over time.</p> <p>There has been very positive feedback following the introduction of ENPs. Average waiting times in the department have been reduced and feedback from the medical staff and patient survey highlighted 100% satisfaction. All ENPs have a managerial role in addition to their clinical one and a second tier of more junior ENPs has recently been introduced.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				The Trust recognises the value of the ENP role and is keen to expand the service. However, we understand that there are some funding issues that need to be resolved with the LHB.
8.2		Implement Nursing Strategy and ensure that nursing practice throughout the Trust is consistent and in accordance with best practice	January 2004	<p>The nursing structure has been revised and included the development of the Directorate Nurse role that is now firmly embedded in the directorate structure.</p> <p>A Nursing Strategy is in place that focuses on six key themes. Action plans for each of the themes are being monitored and it is clear that work is progressing well.</p> <p>A further review of the strategy is planned for September.</p>
8.3		Ensure that the 10-day cancer targets are consistently met	June 2003	<p>Monthly reports are made to the Trust Management Team. Breaches against targets are explored to identify reasons and the referrer is notified of these reasons.</p> <p>Pooled lists have been introduced and the partial booking system has been rolled out across the Trust.</p> <p>The Trust is meeting targets for colorectal, haematological, gynaecological and lung cancers. Targets for skin, urology and breast cancers are currently sitting at 92% and 93% (September 2006). The reasons for breach of the targets have been identified as mainly patient choice issues although there have been some instances of referrals being made through the wrong route, leading to delays.</p> <p>The main breaches appear to be in the areas of upper gastro-intestinal (83%) and head and neck cancers (80%), the primary reason being referrals being made through the wrong route and in the case of head and neck cancer clinical capacity.</p> <p>The Trust needs to address clinical capacity in the head and neck speciality and continue working with primary care to ensure referrals are made through appropriate routes.</p> <p>The Trusts performance against agreed national targets is being monitored by the Mid and West Regional Office of the Department of Health and Social Care.</p>
8.4		8.4 Review available	April 2003	A full skill mix review has been completed for District Nursing and changes

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
		community, acute and rehabilitation resources and communication mechanisms		<p>implemented as a result.</p> <p>Communication throughout the organisation was found to be good and the staff we spoke to confirmed that they were satisfied that communication systems are generally working well.</p> <p>Each Clinical Directorate has produced a Clinical Communications Policy and communications arrangements are in the process of being audited. Where communication breakdowns are identified, action plans are developed. We were given examples of this happening in practice such as action planning leading to improved communication with the public over the reduction in service hours at the Llandovery Minors Injuries Unit</p> <p>There is a communications group, which is responsible for supplying information to the staff corporate brief and the Trust newsletter is distributed widely across the organisation. We observed copies of the newsletter at different locations across the Trust during our visit.</p> <p>On a wider scale, the Trust is part of the Carmarthenshire Implementation Project Board for the Unified Assessment Process (UAP). While the Carmarthenshire Joint Working Group was commended by the Welsh Assembly Government on completing the process framework for the introduction of UAP across the health and social care community, the implementation process itself is ongoing and has some way to go before the process is operational. This situation is similar across the whole of the NHS in Wales and is linked to development in information management and technology and current technical difficulties in the sharing of information across different disciplines and organisations.</p>
8.5		Work with healthcare partners to address delayed transfers of care, admissions and discharges, and reduce cancellations	September 2003 Ongoing	<p>A Comprehensive Action plan has been agreed between all agencies and is monitored monthly by the Regional Office. A Multi-agency Working Group meets monthly to review progress and an audit of Delayed transfers of Care was undertaken during August, September and October 2005. This is due to be repeated.</p> <p>A Multi agency / multi disciplinary Discharge Policy is in place and in addition, a</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
				<p>multi agency Choice Policy was developed in August 2005.</p> <p>We found that measures put in place by the Trust to be having an impact on patient flow. Processes have been streamlined, there is better data collection and more effective use of the information obtained and new ways of working have been developed.</p> <p>A half way house has been developed to deal with patients' prior to discharge. This partially addresses the problem of delayed discharges. Discharges lounges are operational in both acute Hospitals although it has been recognised that they are not being used to their full potential which the Patient Flow Group intends to address</p> <p>The Trust has developed a prediction tool, which provides data on actual capacity and demand versus future capacity and demand. This informs emergency and elective capacity plans. The information is discussed weekly in the Patient Management Group (PMG) and actioned. The PMG disseminates information through Directorates down to the Service Planning Group. Trend analysis is also provided and longer term annual demand is forecast.</p> <p>The Patient Flow Group is taking forward initiatives, which are impacting on practice, for example in rehabilitation, and ward activity is far more proactive in nature.</p> <p>There is a sense that patient discharge may be delayed by factors such as issues with continuing care funding and lack of appropriate community placements, which meet the specific needs of patients.</p> <p>The resolution of some of these issues is dependant upon Trust partners and the further development of integrated care pathways (see rec.4.2)</p> <p>The Trust has taken action to reduce the impact where possible but the situation is not satisfactory. There are monthly meetings with partners but it is difficult at times for agreements to be reached despite a genuine commitment from all concerned.</p> <p>This remains an area of concern.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
8.6		Continue to develop an organisation culture in which patients, staff and the public feel encouraged to voice their views, concerns and suggestions, and to actively participate in service development	March 2004	<p>The structure, systems and processes in place for public and patient involvement appear robust and in line with best practice guidelines.</p> <p>A variety of patient feedback mechanisms are in place including: user groups, focus groups, patient surveys, suggestion boxes, patient stories and diaries. The Trust participates in the Carmarthenshire Citizens Panel Survey and Health Panels in partnership with the LHB.</p> <p>Similarly, systems designed to involve staff appear to be working well.</p> <p>Regular consultation takes place with staff over Trust developments. Monthly Staff Partnership meetings ensure good communication and allow for feedback about issues of concern. They also provide opportunities for staff involved to influence policy development.</p> <p>A monthly Corporate Brief is issued to all staff and there is an invitation for staff to feedback concerns. However, no feedback has been received via this route as yet.</p> <p>The systems and processes in place allow for the dissemination of information and collection of feedback from patients, the public and staff. With the exception of staff side involvement in policy development, it is less clear how feedback is used in terms of actively influencing service planning and development which is the next step that the Trust needs to take.</p>
8.7		Continue to monitor implementation of communication strategy to ensure effective communication with patients and the public	April 2003	<p>Progress against this recommendation is difficult to assess. The Trust's Communication Strategy (in place for several years) was formally reviewed and updated in July 2006 and we understand that the implementation process is on going.</p> <p>Progress against the policy is monitored as part of the Welsh Risk Pool Audit process. The Trust achieved a score of 84% against the WRP communication standard this year (2006) which was a reduction on previous scores. The Trust has taken measures to rectify this deficiency and is confident that it will achieve a better score at the next assessment.</p>

No.	Component / chapter	Recommendation	Target Date	HIW review of progress made against CHI recommendation
8.8		Maintain clinical governance ethos so that achievements are sustained and further progress made	September 2003 Annual Update	<p>The Clinical Governance Strategy and Clinical Governance monitoring tools were revised in 2003/4. Further revision is now in progress as described earlier (see rec. 4.2)</p> <p>We found the processes for clinical governance to be generally well managed and there is a clear commitment to the principles of clinical governance at all levels of the organisation.</p> <p>Recommendations from the CHI report have been addressed to differing degrees but all have been monitored regularly and where appropriate, incorporated into the 3 year rolling development plan in line with the WAG requirements detailed in Welsh Health Circular (WHC) 69 (2003).</p> <p>Actions have been disseminated down to directorates and action plans feed back into the corporate clinical governance development plan.</p> <p>Overall we found that the Trust has an open culture and good progress to have been made.</p>