

Appendix 1

No.	Component/ Chapter	Recommendation	Action Point	Target Date	HIW Review of Progress made against CHI Recommendation
1	Strategic Priorities	The devolved management style could detract from the identity of the Trust.	Chairman to consider the current management style. Discuss with Trust Board	June 2003	Following the publication of the CHI report in December 2002 the Chief Executive and the Chairman discussed and considered with the Board the management style of the Trust. The Trust Board has taken a conscious decision to pro-actively promote the individual Divisions of the organisation. This has been achieved through an Organisation Development Strategy and Plan (May 2005) which aims to implement a common approach to the development of the Trust whilst retaining the individuality of the Divisions. A Trust Board development programme has been held to establish rapport and to clarify the roles and responsibilities of Trust Board members. Each Division has a Service Director who is accountable for the delivery of services within their division. HIW found this approach, with each division maintaining its own identity but following a corporate approach to work well across the organisation and staff were clear on the management structure and how they fitted into the Trust.
2	Strategic Priorities	Encourage integration at a strategic level which will facilitate sharing of good practice and ensure the devolved management style does not lead to individually managed units with no cohesive overview.	Identify duplication. Ensure appropriate mechanisms are in place for sharing of good practice and minimisation of bureaucracy and duplication of support services.	January 2004	The Trust has a comprehensive governance framework that incorporates all service divisions, there is a library of Trust policies that are supported by divisional procedures. During 2005/2006 a Memoranda of Understanding (MoU) was agreed for the main areas of central support services provided by the corporate departments of the Trust, these describe the working relationships between Velindre Trust service divisions and corporate support services. The main objective of the MoUs is to clarify the requirements and responsibilities, to promote good communication and to ensure efficiency in the delivery of quality support services across the Trust. HIW found that there is good strategic cohesion from the top team, all Divisional Directors come together at Executive Board and Trust Board meetings. Trust wide Clinical Governance and Risk Management meetings facilitate cross-fertilisation of ideas and good practise. Due to the diverse nature of the services provided by the organisation it was difficult to identify a specific example of good practice in the minutes of meetings, as something that was identified in one division is unlikely to apply to other areas. However it was identified that the Trust would approach this in a different way, such as by setting up a Trust wide group, such as the group established to review the processes for work life balance in the Trust.

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3	Strategic Priorities	Ensure the Trust Board continues to be informed of activity and performance within each Division.	<p>Reporting arrangements to continue as present.</p> <p>Review reporting arrangements to reflect WAG Performance Management Framework</p> <p>Agree with Chairman format of reporting mechanisms to the Trust Board</p>	<p>Ongoing</p> <p>October 2003</p> <p>Ongoing</p>	<p>The Trust has an effective performance management monitoring system in place and has fully implemented the balanced scorecard in line with NHS Wales guidance. Each division has a balanced scorecard and Directors have 24 hour live access to the scorecards to ensure they have up to date performance data for all service divisions. The Trust's Planning and Performance Management Advisory Group, which is attended by all Service Directors, monitors the scorecards where red areas are discussed along with the associated highlight reports. Minutes of these meetings are presented to the Trust Board on a regular basis to keep them informed of performance in each division. The Planning and Performance Management Advisory Group also links the balanced scorecards with the Operational Plan to ensure it takes account of issues, such as service quality, continuity and improvement.</p>
4	Strategic Priorities	A comprehensive strategic vision and development plan for the future delivery of services should be devised, which should be widely distributed to ensure there is common understanding across all divisions of future plans and goals.	<p>The Trust will develop a strategic plan, taking into account the requirements of the WAG and the Welsh 5 Year Plan.</p> <p>The Trust has a rolling 3 year Trust Plan, with action plans attached for key areas of service delivery.</p>	July 2004	<p>Following the CHI review the post of Head of Planning and Corporate Development was created to co-ordinate these activities and this appears to work well with each of the divisions being able to contribute fully to the strategic planning process.</p> <p>The Trust Operational Plan is in place and is reviewed on an annual basis, it sets out the annual work plan and the developmental operational objectives for the Trust, which is monitored via the balanced scorecards. The Trust Clinical Governance Development Plan (July 2006) is monitored by the Clinical Governance and Risk Management Committee on a quarterly basis.</p>

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5	Strategic Priorities	Work with partners to develop systems that ensure clear lines of accountability for staff who are working for more than one organisation and effective arrangements to support the proactive sharing of information relating to performance and appraisal.	Identify staff involved. Agree with partners' appropriate mechanisms to support the proactive sharing of information.	June 2004	The Trust submission to HIW indicated that there are clear procedures for performance management and appraisal of consultants/medical staff who have responsibilities and accountabilities to more than one organisation. However the review identified that there is no policy/protocol in place. It was identified during the HIW review that a policy needs to be put in place to ensure clear accountability and information sharing relating to performance and appraisal of staff.
6	Strategic Priorities	Currently there is no Trust Board lead for clinical effectiveness or research.	Chief Executive to identify a lead for Clinical Effectiveness/Research	June 2003	The Trust has developed a strategy for Research and Development (July 2005), the Executive Director of Nursing and the Medical Director are the joint leads for research and development in the Trust and there is a Trust Research and Development Committee. The systems for research and development in the Trust are clear and well established. The responsibility and strategic approach to clinical effectiveness however is unclear, it appears on the surface to be included within the research and development framework although it is not explicit in any of the documentary evidence reviewed. The HIW review identified that staff were unclear where the Board level responsibility for clinical effectiveness rests and therefore there does not appear to be a clear lead. The Medical Directors job description does not detail clinical effectiveness and the Executive Director of Nursing job description was not available but it was indicated that the responsibility for clinical effectiveness was not detailed in the document. Confirmation and clarity is required to establish where the Board level responsibility for clinical effectiveness rests and this should be communicated Trust wide.

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7	Strategic Priorities	The role of the Medical Director is narrow.	Chief Executive to discuss role of Medical Director with Chairman and Chief Medical Officer and to redefine the role following those discussions.	October 2003	Following the CHI report the Trust consulted with the Chief Medical Officer for Wales (CMO) and it was agreed that given the nature of the Trust a full time 'supernumerary/non clinical' Medical Director could not be justified, also given the diversity of the Trust one part time individual was not best placed to cover all activities. Therefore it was agreed that the Trust Board would approve the creation of two Associate Medical Directors reporting to the Medical Director. Further the role of the Medical Director would be kept under review and included in future Trust Board development programmes e.g. the identification of Medical Director as joint lead for the Trust for Research and Development. HIW consider this to be an appropriate response to this recommendation. However the Medical Director's job description is out of date and therefore does not detail any change in role such as the responsibility for Research and Development and should be updated.
8	Strategic Priorities	Urgent action is required to reduce the length of clinics within Cancer Services outpatients and improve the environment for those patients waiting.	<p>Work continuing with Breast Outpatient follow-up waiting times.</p> <p>Outpatient Clinical Process Team established to address length of clinic waits.</p> <p>To be considered with other Capital bids and WAG Innovations in Care Team.</p>	<p>September 2003</p> <p>Ongoing</p> <p>2003/04</p>	<p>The Trust has undertaken a number of measures in an attempt to improve the lengths of clinics within Cancer Services Outpatients, such as the appointment of the Outpatient Improvement Manager whose role is to lead, develop and co-ordinate improvements in outpatient, chemotherapy and radiotherapy services. Initiatives undertaken by the Trust include development of a radiography led mammography breast clinic, introduction of supplementary prescribers and redesigning the patient pathways for chemotherapy and follow-up outpatients (Nurse led clinics, changes to the clinic templates). These initiatives enable the time of the Consultants and other clinical staff to be targeted more effectively. Such measures do appear to have had an impact on waiting times according to staff, although there is acknowledgement that there is still more that needs to be done. The balanced scorecard indicates that the waiting time target in outpatient clinics was orange.</p> <p>The main outpatient area in Cancer Services Outpatients was observed and is clean and tidy, although it is due for redecoration. The areas outside the main entrance are free of litter and the reviewers felt there was a welcoming ambience. There is a range of refreshments offered by the Women's Royal Voluntary Service at a brightly decorated counter area, which is much used in this busy sector. Reception staff were observed to</p>

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					be friendly and welcoming.
9	Strategic Priorities	Urgent action is required within Cancer Services to address the lack of privacy for patients.	<p>Explore potential for interim arrangements.</p> <p>Addressed as part of all new capital schemes.</p> <p>Awaiting outcome of a site survey to ensure that adequate space is available for future planning.</p> <p>A NOF bid has been placed to address refurbishment issues.</p>	June 2004	<p>The Trust has secured funding for major improvements and enhancements to the Active Support Unit (ASU) at Velindre Hospital. The resulting accommodation will involve refurbishment of the existing area and an increase in the physical space on the ward and will provide a range of single en suite rooms and four bedded wards with relative and patient sitting areas. This work is due to commence in January 2007 and will take a year. Temporary arrangements are to be put in place while the work is ongoing and these arrangements have been discussed and agreed with the Patient Liaison Group.</p> <p>During HIW visit it was observed that curtain screens have been added to all outpatient examination rooms and a new toilet added for female patients in the ward area.</p>
10	Strategic Priorities	Explore ways of providing quiet rooms for patients within Cancer Services.	<p>As above (No 9)</p> <p>Use of established 'quiet' areas within ward environment.</p>	June 2004	<p>There are dining room areas on each of the wards which provide an opportunity for patients to leave their bed areas, these were observed during the HIW visit and were felt not to be ideal for the purpose as they do not provide sufficient comfort or privacy. However the family room was observed to be quiet with warm colours and many activities for children, there is a sofa bed for the use of the family and space for a bed to be wheeled in, it was felt this provides an appropriate intimate space for families.</p> <p>Plans for the ASU identify areas where patients will be able to spend time in comfortable areas.</p>

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					A spiritual/contemplation room is being created for use by patients, with much thought being placed on the needs of different ethnic groups.
11	Strategic Priorities	Review arrangements for catering with Cancer Services outside of normal working hours and the availability of special diets.	Assessment being undertaken of financial implications of extending catering arrangements. Special diets are available on the wards. Awareness training for staff on special needs is being developed and information for patients is being developed.	September 2003 December 2003	The hospital dining room opening hours have been extended to 8pm to provide a range of hot and cold snacks. Out of these hours a section remains open for visitors/patients too use and has basic catering facilities including vending machines. Velindre hospital operates a ward based catering service where food preparation is carried out in ward kitchens where there are arrangements for meal preparation at any time of the day. Specialist meals can be arranged for various needs/religions and a file is located in ward kitchens which details how this can be achieved.
12	Strategic Priorities	Ensure privacy within the ward environment at Cancer Services Division.	Explore potential for interim improvements.	June 2004	See comments for recommendation 9 and 10.
13	Strategic Priorities	Extend facilities for patients spending long periods of time at the Cancer Services Division.	Explore potential for interim improvements. As No 9 above	June 2004	See comments for recommendation 9,10 and 11.

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14	Strategic Priorities	Concerns at the level of maintenance at the back of the Cancer Services hospital site.	Graffiti has been removed. Maintenance requests for this area will be monitored	On going	A contract has been set up with gardeners at Velindre Hospital, the Trust reports that graffiti levels have greatly reduced over recent years, although a small amount of graffiti was observed to be present at the rear of the building during HIW visit to the area. To prevent further incidents tall metal railings have been constructed to protect the building. CCTV cameras were also observed which will help to deter further incidents and a security firm is employed from 5pm each day until the morning.
15	Strategic Priorities	Delivery of results to breast screening women is currently not being achieved.	Delivery of breast screening results slowed temporarily and organisational issues addressed. Now acceptable.	Achieved November 2002 Ongoing	The Trust submission to HIW indicated that 95% of women screened were receiving results within 3 weeks and 60% within 2 weeks (2 weeks is the national target). On further analysis during the site visit the balanced scorecard for Mar-May 2006 indicated that these had fallen to 65% within 3 weeks and 38% in 2 weeks. The key issue for the Trust is the lack of specialist Radiologists. The Trust has been working hard to address this with the appointment of a number of key medical posts and developing the role of radiographer reader and a contract for films to be read in Nottingham, which appreciably lengthens the process. The Trust is aware of the target not being met and there is a highlight report that identifies the action being taken. The Trust indicated in its submission that the issue of results does not effect the time to treatment from the point of diagnosis and the standard is monitored in order to minimise anxiety to women waiting for results.
16	Service User Involvement	A more consistent approach and corporate style to leaflets.	Dependent on outcome of (No 1) Discussions with WAG & service users to identify their requirements and where appropriate	October 2003	The Trust's system of producing divisional leaflets appears to be working well. The leaflets are clear and informative and cover key areas. The very different nature of the divisions does not easily lend itself to a more corporate approach and hence the display of the Trust logo on each of the publications would appear to be sufficient.

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			redesign and plan a phased implementation		
17	Service User Involvement	Limited arrangements in place to meet the needs of ethnic minorities.	Baseline assessment and identify action plan. Share good practice identified in Breast Screening Services across the Trust.	March 2004	A Trust Race Equality Scheme 2005-2008 exists which is supported by divisional Race Equality Action Plans. A Trust Diversity and Equality Group has been established for leading on this agenda and impact assessments on all Trust wide strategic and operational policy decisions is being undertaken. Current arrangements to meet the needs of ethnic groups varies across the divisions, in some areas such as Cancer Services where interactivity has been high, there are effective arrangements, but in other areas more needs to be done. A Trust Diversity and Equality Manager was appointed in March 2006 and priorities have been identified for this role and to take this work forward.
18	Service User Involvement	Action needs to be taken to agree and disseminate 'do not resuscitate' policy.	Revision completed and signed off by Trust solicitor.	Started Jan 2003 Ongoing training	A 'Do Not Resuscitate' Policy is in place and is in the process of being reviewed, the Trust indicated in the original submission that a leaflet was available for patients and relatives, this was not seen during the observational visit to the Hospital, but was forwarded to HIW after the visit. In practice the policy does not appear to be working well and the Trust should ensure that all staff are consulted on the policy and its review and once the revised policy is in place this should be communicated to all staff and training provided if required.
19	Service User Involvement	All complaints should be reported and recorded centrally.	Trust wide system currently under review in line with changes within the WAG for complaints procedures in Wales.	January 2004	The Trust has a complaints register which records both oral and written complaints received by the divisions. These are amalgamated on a quarterly basis to monitor complaints activity. The Corporate Services Manager reports complaints from each division on a quarterly basis to the Trusts Clinical Governance and Risk Management Committee. A Complaints Annual Report brings together the key themes from each division and this is presented to the Trust Board. During 2004/2005 the Trust held the first meeting of the Trust Claims, Complaints and Incidents Review Group which meets on an annual basis to discuss lessons learnt and share best practice. The DATIX system is now being implemented and by the end of 2006 the coding will be completed and the system will

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					be able to be used for the management of complaints.
20	Service User Involvement	Training in customer care should be provided to all staff that work directly with service users.	Identify current position in Divisions. Devise action to be incorporated into the current Divisional Training and Development Plans	January 2004	<p>There is a Trust Training and Continuous Development Strategy (May 2004), its aim is to have a more co-ordinated approach to training and development and includes an action plan. This is supported by Divisional Training Programmes which outline how training will be delivered locally and includes in some the statutory and mandatory training that staff should undertake. A Training Leads Group was set up in 2003 to help inform the strategic direction of training and development within the Divisions and across the Trust and this includes membership from all divisions.</p> <p>The review team found the picture with regard to customer care training to be inconsistent. Whilst most members of staff interviewed stated that they had received customer care training it does not often appear as a distinct training element within the Divisional Training Programmes. In most cases it was part of a more general training programme, but some divisions are delivering training specific to their individual service need. This is something that could be more sharply focused and defined centrally within the Trust and identified clearly on the Divisional Training Programmes.</p>
21	Service User Involvement	Continue exploration of alternative methods and systems for communicating with patients whose first language is not English.	Baseline assessment and identify action plans to be incorporated into the Service User Strategy. Language line in place across the Trust	March 2004	Language line is widely used across the Trust to assist in the interpretation process. The Screening Division use Nationally produced pictorial information leaflets/books which are used to overcome language barriers. The Trust has set out in its Race Equality Scheme 2005-2008, the need to review its communication policy. This will also be a key task for the Trust Diversity and Equality Manager appointed in March 2006.

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22	Risk Management	Continue to implement a single incident reporting form and central reporting structure.	Continue work towards the standardisation of reports and centralised reporting, to meet NPSA and Welsh Risk Standards.	November 2003	The Trust has made good progress with the roll out of the DATIX system across the organisation with all but screening services and the North and Mid Wales NPHS laboratories able to report onto the system. Some divisions are able to input onto an online form, while others are using paper. Training is in place for staff and reports are being produced for the Clinical Governance and Risk Management Committee. There was a common understanding of the incident reporting system by staff interviewed by HIW.
23	Risk Management	Consider the development of trigger events to promote consistency amongst all staff in the reporting of clinical incidents and near misses.	Trigger points to be developed with Divisions to meet requirements of Welsh Risk Standard. In addition there will be consistency in reporting of significant incidents, as required under NPSA procedures.	November 2003	The Divisional Incident Reporting Procedures all follow a similar format and identify general trigger events, such as incident, near miss, hazard etc. Most staff interviewed indicated what would initiate an incident report which suggests a common understanding of when and what staff should report.
24	Risk Management	Continue to promote an open and learning culture across the Trust.	Identification of practice that can be shared across Divisions. Work ongoing	December 2003 Ongoing	The Trust Policy and Procedure for Reporting Incidents and Hazards 2003 includes a section on encouraging a learning environment and supports a fair culture within the organisation. Staff were found to be comfortable with the culture of the organisation in that it is an open learning organisation and that they would report incidents.

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25	Risk Management	Action must be taken to improve security within the Cancer Services Division.	<p>Undertake review of security systems.</p> <p>Provision of lockable cabinet within the mortuary area.</p> <p>Security camera to be installed outside mortuary area.</p> <p>Security guards employed.</p> <p>Partnership working with local police on security issues.</p>	<p>June 2004</p> <p>June 2003</p> <p>July 2003</p> <p>Ongoing</p> <p>Ongoing</p>	See comments for recommendation 14.
26	Clinical Audit	Clinical audit is not systematically linked with other aspects of clinical governance, in particular risk management and complaints.	<p>Work to develop a systematic approach to include clinical audit into risk management and complaints.</p> <p>Ensure links with audit plans.</p>	June 2004	<p>The Trust has a healthy audit programme in place. There is a draft Clinical Audit Strategy which covers the links to the Trust policies and strategies, identification and prioritising audit topics, how patients/service users and the public/stakeholders will be involved, sharing of results and the audit development plan. Once this is approved it will ensure strategic direction in the audit process and help to improve co-ordination at corporate level. Clinical Audit is discussed at the Clinical Governance and Risk Management Committee.</p> <p>It should be noted that some divisions had difficulty interpreting this recommendation due to the word 'clinical', all Divisions undertake audits to different levels and many are heavily regulated, e.g. Welsh Blood Service</p>

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					by external agencies and the term 'clinical' may not have been appropriate.
27	Clinical Audit	Clinical audit needs to be co-ordinated at a corporate level.	Trust Board lead to be identified. Audits to be reported on a regular basis.	July 2003 June 2004.	See comments for recommendation 26.
28	Clinical Audit	Develop service user involvement in the audit process.	Work is ongoing within Divisions to establish the desired result.	March 2005	Velindre Cancer Centre involves services users and/or carers in all of its meetings, with representatives from the Patient Liaison Group. This group has discussed setting up of a Clinical Audit Patient Panel which is still under discussion. However further work is required across the rest of the Trust to establish what involvement is appropriate for service users in the audit process, due to the different nature of the divisions, and how this is to be addressed.
29	Staffing and Staff Management	Develop corporate induction programme for all new trust staff.	Corporate induction programme taking into account existing induction arrangements will be introduced.	February 2004	Induction at present is delivered on a divisional basis and the perception among staff is that the process has improved in recent years. The Trust has initiated a project to develop an e-Induction product which is designed to be a generic All Wales Induction and is not intended to be specific to Velindre NHS Trust and therefore once this is introduced the Trust will need to address any Trust specific corporate induction elements.
30	Staffing and Staff Management	Establish regular reporting to the Board on key human resource indicators.	To be reported as part of Trust's arrangements under the Performance Management	Dependent on WAG report	Key human resource indicators, such as sickness, absence and turnover rates are included in the Divisional Balanced Scorecard and are reported to the Board on a regular basis (as indicated in the comments in recommendation 3)

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			Framework. (Link with No 3)		
31	Staffing and Staff Management	Continue to develop the workforce planning framework.	To continue, taking particular account of the Trust and WAG's Recruitment and Retention Strategies, available finance, WAG staffing targets and developing All Wales Workforce Management Structures.	Ongoing	Workforce plans are submitted annually to the Welsh Assembly Government and the Trust continues to develop its workforce planning framework with the Workforce Survey 2006 which covers all divisions.
32	Staffing and Staff Management	Develop a trust wide appraisal process to include standardised paperwork.	Review existing appraisal processes taking advantage of good practices to incorporate Trust wide principles and objectives and paying due attention to Agenda for Change principles. Division wide processes to be	September 2003	The Appraisal and Continuous Development Policy (Jan 2006) aims to assist individuals and managers to have a clear understanding of the required appraisal process via the Knowledge and Skills Framework Development Review and includes standardised paperwork. This will ensure that all staff have the same opportunities for learning and development. Each division is responsible for its own staff. There is appraisal training available from the corporate part of the Trust. The percentage of staff who have received an appraisal was unclear from the interviews undertaken, this varied from 75% to 95%. Most staff interviewed indicated they had an up to date appraisal and Personal Development Plans and hence it would appear good progress is being made in this area.

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			developed and/or maintained.		
33	Education and Training	Must develop a more co-ordinated strategic approach to education and training.	Production of Education and Training Strategy to encourage and promote development of existing Divisional Plans and priorities within a more strategic framework. Establish a Trust wide Education and Training Group.	June 2004 December 2003	See comments for recommendation 20.
34	Education and Training	Must develop an annual educational plan, setting out the priorities for education and training.	Linked with (33). Plan to be produced.	December 2003	See comments for recommendation 20.
35	Education and Training	Ensure all staff have appraisals and develop personal development plans.	All staff will be appraised annually and have a personal development plan	June 2004	See comments for recommendation 32.
36	Education	Ensure all staff	Trust embraces	Ongoing	The release of staff for training cannot always be assured but tailoring of

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	and Training	can be released from clinical duties to attend training.	the ethos of CPD as far as service delivery enables.		training is ongoing to try and address this issue, interview evidence indicates that this is sometimes an issue.
37	Education and Training	Must ensure that senior house officers have adequate educational support during their placements with the Trust.	A new mentoring system for SHOs will be introduced Bleeps are now taken from the SHO's during teaching time.	September 2003	A mentoring system is in place and SHO's attend a weekly training session. Comments from staff suggest that the new system is working well.
38	Clinical Effectiveness	Develop a trust wide strategic approach to clinical effectiveness.	Trust will develop a Research and Effectiveness Strategy that encourages a culture of good practice. (Link with No 6 & No 27)	June 2004	See comments for recommendation 6.
39	Clinical Effectiveness	Continue to develop care pathways within Cancer Services.	Development continues within Clinical Process Teams.	Ongoing	The Trust continues to develop care pathways with a standard approach being adopted. This includes Care of the Dying, Malignant Spinal Cord Compression and Admission/Discharge care pathway.
40	Clinical Effectiveness	Encourage and support research undertaken by nurses and allied health professionals.	Incorporated within the Research Strategy. (Links to No 38)	June 2004	A Small Grants Scheme has been established in order to pump prime new research activity within the Trust. It is intended to provide funding for small research projects to test feasibility and/or obtain results that will enhance the chances of success in obtaining a substantive grant. An example given where a number of grant applications from nurses were turned down and the nurses were given help to develop their applications for future schemes, which were successful.
41	Clinical Effectiveness	Ensure training in research design	Linked to Research	June 2004	Critical appraisal and research and design skills training is available to staff. The Trust is holding the first Research and Development

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		and critical appraisal skills is available to all staff.	strategy. (Links to No 38)		Conference, with abstract papers and poster presentations from across the whole Trust.
42	Using Information	Ensure all staff have access to IM&T training at a basic level.	A revised Trust IM&T Strategy in line with WAG strategy on 'Informing Healthcare' will be produced Ensure IM&T training available to appropriate staff.	December 2003	The Trust is taking forward the European Driving License Training (ECDL) for all staff and a project group has been set up to take forward the implementation of the ECDL across the Trust between 2004-07. All staff appear to have access to IM&T. however training in this area is more difficult to organise. In areas such as laboratories, it appears to be easier to release staff for training. For nurses on the wards it is difficult to arrange cover for training purposes. The statistics for July 2006 indicate that 61% of staff have registered and 35% have completed the ECDL.
43	Using Information	Explore ways of improving communication with GPs and primary care within Cancer Services.	Continue partnership working with GPs, primary care and particularly through new LHB's. Continue to strive to achieve minimum standard for all discharges. Issue to be raised with the Cancer Network and Cancer	Ongoing	Efforts have been made to improve links with primary partners and communication has improved, but some staff indicated that the measures need to go further. On discharge of patients, letters are now sent to GP's within 48 hours. Velindre Cancer Centre has created a specific project to ensure that the patient services provided by centre meet the current and future needs of the patients. A 'Beyond Good' project was initiated to improve clinical governance issues and four sub groups were established, including an out of hours group and discharge planning group. The Trust has made good progress but needs to ensure that the problem of communication over such a large geographical areas continues to be addressed.

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			Information Framework for Wales		
44	Using Information	Continue efforts to develop IM&T links between strategic and divisional levels.	<p>Revise Trust IM&T Strategy in line with WAG strategy on 'Informing Healthcare'</p> <p>The revised strategy will focus on Trust wide 'cross cutting issues' as well as Service division specific issues.</p>	December 2003	The Trust has an IM&T Strategy (April 2005) which covers corporate and divisional IM&T development. This provides a broad basis for expansion of the IM&T links which appear to be evolving satisfactorily.