

**Cardiff and Vale NHS Trust  
Appendix 1: Acute Services**

<b>Rec No</b>	<b>Chapter</b>	<b>CHI Action point</b>	<b>Action Required by CHI</b>	<b>Target Date</b>	<b>HIW findings</b>
1.	Patient experience	The Trust must work with clinicians to develop robust systems to analyse and understand the causes of high rates of non-emergency deaths at the hospital and take action to reduce them	Detailed analysis of non-emergency deaths over the last three years and identification of the key reasons contributing to such deaths.	Oct 2002	Some work was undertaken soon after the CHI review to examine the high rates of non-emergency deaths. Data submitted during the review appears to indicate an improvement in rates and that the Trust performs better than some of its peers. HIW saw evidence of regular examination of mortality rates at a local level but not of a regular programme of review and/or monitoring of figures on a Trust-wide basis. This was underlined by a lack of awareness or incorrect knowledge of the Trust's performance amongst senior staff.
			Having identified and gained a clear understanding of the reasons behind the Trust's current non-emergency deaths, profile, develop and put in place procedures, where appropriate, to change systems and clinical practice in order to both improve the outcome of patients and the recording of information.	Jan 2003	
			Put in place systems and procedures to ensure that there is ownership and regular review of clinical data by senior clinicians and their teams – leading to improved understanding of clinical data and the messages carried therein.	Dec 2002	
			Ensure that the discussion and review of death rate deviations is made a mandatory component of the Clinical Appraisal process.	December 2002	
2.	Patient experience	The Trust must establish robust systems at directorate level for inputting patient data and work with staff to improve	Ensure that there are clear lines of professional accountability for patient administration, including data quality as a corporate function. (A Data Quality	July 2002	From the discussions that took place during the visit it was difficult to determine where responsibility for ensuring consistent quality of data entry across the Trust lay. There is a data quality policy in place, but several areas reported

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		the validity of the PMS dataset	Assurance Group )		that data quality was not regularly checked.
Ensure clear guidance notes detailing data entry requirements and procedures are agreed and issued to all relevant staff.	July 2002		A training programme is in place for staff who input patient information, which is integrated with Patient Management System (PMS) technical training and linked to induction. Individual directorates are responsible for identifying staff who require training.		
To develop the role profiles of staff required to enter data on PMS (and feeder systems, electronic or manual) reflecting the importance of accurate and complete data entry	Dec 2002		There was no evidence that the scoping exercise to identify the resources required to maintain the PMS in a timely manner had been undertaken. One ward visited reported that there was a four month backup of notes that need to be filed and incorporated.		
To review the PMS training policy and training plan to ensure both more accurately reflect the training need and demand at directorate and ward level.	Dec 2002		The Trust has been undertaking projects, funded by the Informing Healthcare programme. One aims to determine where transfer of care between consultants during a patient's journey is being missed or recorded incorrectly whilst another all Wales project is working on identifying and removing duplicate patient records from the PMS		
To undertake a scoping exercise to identify the staffing resource needed at directorate level to ensure the proper and timely maintenance of PMS data; and if a gap is identified look at ways of bridging the gap and better managing the risk.	Oct 2002				
To continue with the current daily programme of data quality reviews of in-patient data and follow-up of action by the data quality assurance team.	Ongoing				

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3.	Patient experience	The Trust must take action to increase the number of patients who are operated on within 24 hours of diagnosis of a fractured neck of femur	To put actions in place that ensure patients with fractured neck of femur are admitted to a trauma ward within an hour of admission.	Action plan in progress	There was little evidence that the Trust had taken any action to address this recommendation until fairly recently.  Clinical Governance Committee minutes from June 2006 stated that a data audit had showed very little change in performance from 2003 to 2006 and it appears that this may have triggered the decision to progress work in this area. A trauma bed capacity and allocation review in respect of Fractured Neck of Femur was being undertaken. Theatre capacity is one of the key issues being considered as part of this work. Just prior to HIW's visit changes had been made to staff patterns in order to improve access to theatres. We would hope that this work continues and produces further improvements in performance
			To review the current theatre capacity, theatre operating times and procedures for allocating theatre slots and identify how compliance with 24 hour recommendation may be achieved	March 2003	
4.	Patient experience	The Trust must take urgent action and work with commissioning bodies to agree some long term solutions to manage non emergency, elective surgery at the Trust more effectively to improve the patient experience	To look with partners and commissioning bodies at referral patterns (both DGH and tertiary elements) and emergency admission flows to the Trust to develop and implement: <ul style="list-style-type: none"> <li>▪ Referral protocols for GPs, and inter-hospital transfers;</li> <li>▪ New models of service delivery;</li> <li>▪ Alternatives to hospital admission.</li> </ul>	Jan 2003	Recommendations 4 and 5 are being considered together, as they both relate to issues of bed management and patient flow and their consequent effect on the ability to manage their elective capacity  There does not appear to have been any significant changes towards resolving capacity issues until recently, although some of the factors lie outwith the Trust's control. A revised clinical services strategy was agreed by the Trust Board
			To complete the implementation of the Clinical Services Strategy (Phase 1) which includes plans to reconfigure surgical services.	Oct 2002	

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			To develop the Ambulatory care Services at UHW to ensure maximum capacity is delivered.	Dec 2002	<p>in January 2006. However we were told that the Local Delivery Plan for 2006-07 had significant shortfalls in commissioned elective capacity in certain areas.</p> <p>The Trust is developing the Cardiff &amp; Vale Orthopaedic Centre at Llandough Hospital, which is intended to increase the amount of elective orthopaedic activity. There had been resourcing problems which resulted in a phased approach to the centre becoming fully operational. At the time of the visit outpatient clinics were being held there and the first two theatres and associated wards were due to open shortly.</p> <p>There have been recent changes to both surgical and medical assessment facilities at the University of Wales Hospital following the work undertaken by the Delivery Support Unit (DSU) to determine the issues and blockages to achieving the national A&amp;E targets. The Trust has developed an Emergency Care Improvement Plan in response to this work, however there continue to be a number of barriers to enabling its effective implementation.</p> <p>Across the local health economy there are significant problems with delayed transfers of care (DToCs) which, combined with issues with bed management within the Trust, contribute to poor patient experience on emergency and elective care pathways. There was an issue about the timeliness of local authorities' allocation of social workers to patients who due to be discharged. This often does not happen until the patient is</p>
			To progress the business case for the development of orthopaedic ambulatory care services at Llandough hospital.	July 2003	
			To progress the implementation of the rehabilitation and Intermediate Care strategy.	Oct 2002	
			To implement the Emergency Medical Admissions action plan as submitted to the NafW in October 2001.	Aug 2002	
			To implement the Strategy for the Improvement of the management of emergency Medical Admissions.	March 2002	
			To reflect on the findings of the Tertiary Services Review and the review of Children's Tertiary Services and fully assess their impact on capacity; and with partners draw up plans to address the impact on routine elective surgery	Dec 2002	
			Partners draw up plans to address the impact on routine elective surgery		

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			To continue to work with the Performance Management Division of the NAFW to identify better ways of managing the flow of emergency patients.	Work in progress	<p>ready for discharge, so that work on ensuring the required package of care is in place has not commenced although the patient is ready to move on. There is a discharge liaison team looking at delayed discharges. It was reported that there has been some improvement in bed management in the last year, through the use of a predictor tool. There are daily meetings within the emergency unit to discuss capacity issues. However we were told that some bed management staff did not feel they were of sufficient seniority to challenge clinical staff regarding the timeliness of their decision making, for example obtaining an estimated date of discharge that would help forecast bed availability in the short term</p> <p>We had specific concern regarding the situation at Llandough Hospital, where there seemed to have been little progress since the DSU report, which had also examined their Medical Assessment Unit. There still seemed to be a culture of admitting patients for assessment rather than vice versa, poor use of the discharge lounge and a lack of urgency to discharge patients and improve flow through the hospital. Patients could wait all day in the Unit before being discharged, or were kept in overnight, sometimes in the unacceptable conditions described in Recommendation 6. For example, when we visited, two patients had slept in the waiting area overnight and were by then sitting in a day area, receiving no treatment. We</p>
			To put in place procedures to ensure that elective patients are appropriately managed and monitored when clinical staff have planned absence.	Work in progress	
			To continue to validate waiting lists so ensuring waiting lists are kept clean and up to date.	Work in progress	
			To consolidate and develop the Admissions Manager role.	Work in progress	
			To review and improve bed management and admission procedures ensuring that via admission processes and protocols that long waiting patients are prioritised appropriately	Work in progress	
			Implement improved profiling of activity which takes into consideration peaks and troughs in activity in previous years		

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5.	Patient experience	<p>The Trust must take urgent action both internally and externally to agree an achievable action plan. First it must work with service groups to prioritise bed allocation to streamline the bed management process. The Trust must also continue to work with the National Assembly for Wales, the Specialist Health Services Commission for Wales and Bro Taf Health Authority to agree ways to minimise the clinical risk associated with outliers caused by inadequate bed capacity and delayed transfers of care at the Trust. A clear action plan with achievable milestones must be developed.</p>	<p>The strategies and plans outlined above have been developed with a view to improving the patients' experience and better managing clinical risk. They will address the issue of bed allocation and the streamlining of bed management processes. These will be drawn together, prioritised and developed into a performance plan for the Trust – this will have clear actions and milestones. In addition to the above the performance plan will address:</p> <ul style="list-style-type: none"> <li>▪ Protocols and an action plan for repatriating and corralling outliers.</li> <li>▪ Opportunities for closer working with social care partners.</li> </ul> <p>The Trust will continue to take an active part in national and regional capacity reviews responding to recommendations in a timely fashion.</p>		<p>also heard that difficulties in arranging access to diagnostics tests led to patients being admitted solely for this purpose, rather than discharged to wait 7 weeks for a scan. In comparison the assessment units at the University Hospital of Wales (UHW) have a number of dedicated slots daily so patients can access the diagnostic tests they need swiftly</p> <p>These issues have been well know for some time, yet staff did not feel anyone at a senior level was regularly monitoring the current state of play. There needs to be ownership of the issues and strong leadership to take this agenda forward.</p>
6.	Patient experience	<p>The Trust must take action to improve its complaints system. It must agree an action plan to improve its response rates to patients and meet the standards</p>	<p>To review the complaints process in consultation with patient representatives with a review to streamlining the process and ensuring it is fit for purpose.</p>	Dec 2002	<p>The complaints policy was revised and approved in 2005 and all staff we talked to were aware of it. The 20 day target for responding to complaints is monitored at Management Board. It was reported that the targets for dealing with complaints in a timely manner are not being met.</p>

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		stated in its own complaints policy	Issue 'plain English' user friendly step by step guides to the complaints process	Jan 2003	<p>There are some concerns that complaints regarding waiting times were reported to be treated as enquiries rather than complaints. Ward staff dealing with complaints about cancellations are not trained to deal with difficult customers</p> <p>The Trust carries out patient surveys, however it seemed that it was possible for certain management staff to opt out of receiving survey results for their area by either actively requesting not to receive them or passively, by not responding to findings. There was little evidence that action plans were drawn up in response to surveys or of improvements made as a consequence.</p> <p>Training on complaints exists as part of induction for all staff. An e-learning package is available for staff, however, a lack of terminals and time available restricts access.</p> <p>There were a number of clinical areas where no complaints leaflets were observed at the time of the visit</p>
			Re-focus role profile of complaints staff ensuring that they proactively support ward and clinic staff in managing and improving patient satisfaction.	Dec 2002	
			<p>Development and implementation of a communication and training plan to ensure:</p> <ul style="list-style-type: none"> <li>▪ that all staff are aware of the Trust's complaints policy and their own personal responsibilities and role in ensuring compliance.</li> <li>▪ staff specifically involved in the management and investigation of complaints have the necessary skills and knowledge.</li> <li>▪ Key front line staff have the necessary customer care skills.</li> </ul>	Dec 2002	
7.	Patient experience	The Trust must take action to improve standards of basic cleanliness including external parts of buildings	Grounds and Gardens contract to be brought in-house. A new specification for the contract has been agreed which covers all hospital entrances.	May 2002	Hand gels were available and in use in all clinical areas. A cleaning strategy is being developed and was due to go to the Board in the week following HIW's visit. Regular audits of cleanliness are undertaken and results are reported to the Cleaning Strategy Group. However it was unclear

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		(Reference to detailed action required and agreed timescales in separate column)	New monitoring arrangements have been agreed to ensure improvement in cleanliness of sites particularly UHW.	May 2003	as to how these outcomes were reported and monitored within wider Trust performance management structures, for example there was no evidence of measures being reported on the Balanced Scorecard or at the Clinical Governance Committee. In addition there is room to improve the connection between cleanliness audits and patient surveys with Trust audit and patient satisfaction programmes  Concerns were expressed around the level and types of comment received via the patients' survey undertaken in May 2006, in particular surrounding cleanliness at UHW's A&E department
	An action plan is being developed in response to a recent National Audit report on internal cleaning arrangements.		Action complete		
	Revenue implications of the re-specification of Llandough cleaning services following District Audit report to be considered by Executive Board.		May 2003		
	To continue with monitoring arrangements in place at UHW and Whitchurch.		On going		
8.	Patient experience	The Trust must take action to ensure consistent and appropriate signage is in place for patients	To undertake a full review of current signage across all sites	Work already started	There is a 'Wayfinding' group in place that gives consideration to signage. There does seem to be variation between sites with it being reported in the Hospital Patient Experience surveys produced by local Community Health Councils that Barry Hospital is poor & Llandough Hospital generally good. We noted the opportunity for confusion at the new Cardiff and Vale Orthopaedic Centre. This had different entrances for those attending as outpatients or as a daycase, with no publicly accessible direct route between the two.
	In consultation with patient representative bodies to identify the most appropriate signage for each site.		Dec 2002		

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			To develop a roll-out programme for introduction of improved signage.	Dec 2002	<p>There was also variation at UHW, with the trauma ward particularly confusing. It was also noted that a line painted on the floor to guide patients to a particular unit had been carpeted over. West Wing at Cardiff Royal Infirmary had lots of paper signage and an untidy appearance</p> <p>Patient comments highlighted that it would be helpful to include site maps with appointment letters.</p>
9.	Patient experience	The Trust must take action to provide suitable accommodation for staff and patients	The capital programme development process will address accommodation issues as part of its prioritisation process.	March 2003	<p>We had serious concerns about the environment of care at the Medical Assessment Unit of Llandough Hospital. We were told how the waiting area was used as an overflow ward at night, with up to 3 patients sleeping on trolleys. There were no curtains on the window, across the opening space or between trolleys, meaning no privacy could be given to those staying there. This practice had been common for at least 2 years, but there seemed to be little ownership or action to improve this situation. There were very few toilets available to patients and the adjacent short stay ward was cramped and tatty in décor. The average length of stay for patients in this area is currently 5 days.</p> <p>At UHW the Emergency Surgical Admission Ward had no dining area for patients, a small and shabby day area and a tiny staff room. The Medical Assessment Unit here suffers from a lack of storage space for patients' belongings. West Wing of Cardiff Royal Infirmary was found to be not fit for purpose, with a lack of space and storage and very cluttered patient areas.</p>
	The capital programme development process will be reviewed to ensure it better reflects the issues of demand and activity				
	A full review of current clinical and office provision will be undertaken to ensure compliance with health and safety standards, guidelines on working space ratios and capacity provision (clinic space) in relation to demand				

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					We did not visit Rookwood Hospital, but were told by the Trust that its buildings were poor, although the site itself was excellent
10.	Patient experience	The Trust should take action to ensure that there is an appropriate level of clean linen and pillows to meet the individual needs and requirements of patients	A review of the number of pillows held by each of the linen rooms confirmed that the Trust has more than an adequate supply of linen and pillows.	Action complete	Generally there are now no serious shortages of linen and pillows, but it was reported that there can be some problems with these items, particularly at weekends, along with blankets and gowns.  Staff and patients commented about the shortage of wheelchairs. We were told that the Trust have had to have high bars attached to them to prevent patients taking them home in their cars. Very few wheelchairs were observed throughout the visit. Staff in clinical areas reported difficulties in obtaining them.
			Patient satisfaction surveys will be implemented in September 2002 and will include specific questions regarding the environment of care.		
11.	Use of Information	Information on the adverse events of patients waiting for access to clinical services should be collected, analysed and fed back to clinical teams. Teams should then agree action plans and strategies to reduce the risk of these adverse events	To put in place procedures to ensure that types of adverse events and reasons for event occurring are identified and actions to address these reasons put in place : <ul style="list-style-type: none"> <li>Establish joint clinical audit with primary healthcare teams of mortality and morbidity (if possible including mental health issues) in selected clinical areas.</li> <li>Undertake clinical audit of emergency admission of patients on waiting lists in selected areas.</li> </ul>	Dec 2002 Commence  Dec 2002 Commence	Cardiac, trauma and orthopaedic directorates undertake validation exercises to ensure those who have been admitted as emergencies before their expected admission time are no longer on waiting lists. There is no evidence of any specific clinical audit of factors surrounding the emergency admissions of patients who are on waiting lists.  There was no evidence of an improvement in communication with patients on waiting lists and it was of concern to be told that complaints regarding waiting lists were not dealt with through the complaints process  The Trust is developing a GP portal, described in more detail under Recommendation 12

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			<ul style="list-style-type: none"> <li>Develop with PHCTs strategies to alleviate risk/improve quality for patients on waiting lists (include structured care/review with PHCT's and feedback where necessary to inform prioritisation)</li> </ul>	Dec 2002	
			<p>To ensure that communication with patients on the waiting list is improved:</p> <ul style="list-style-type: none"> <li>Put in place systems to allow patients (via controlled access by GPs) to electronically access information regarding their waiting list status.</li> </ul>	April 2003	
12.	Use of Information	The Trust must take action to improve the quality and timeliness of information provided to GPs	To review current communication procedures and identify barriers to communication and possible causes for delays in communication.	March 2003	<p>The Trust has made some progress in this area. It has been working on a project to develop a GP portal, to which 7 GPs currently have access. This allows GPs access to information about their patients on the Trust's clinical portal, such as referrals, test results and letters. We were told the project was proceeding more slowly than planned as a number of staff had left.</p> <p>The Trust's Medical Director meets the Local Health Boards and the Local Medical Councils as well as some local GPs but it was reported that more recently the level of interaction with the latter had decreased.</p>
			Revise procedures in consultation with GPs to ensure they meet the needs of GPs and that patient care is not compromised due to delays	March 2003	
			To take forward the GP information requirements of the cancer information framework and NSFs .	March 2003	

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			To take forward the further development of the GP portal as part of the eHealth website development	March 2003	
13.	Use of Information	The Trust must take action to increase the accessibility of electronic information relevant to evidence based practice for all clinical staff	<p>To increase clinical staff access to electronic information sources by maximising the use of current resources:</p> <ul style="list-style-type: none"> <li>• Review current PC stock in relation to position and usage and ensure every PC is placed where it will have maximum usage and hence be of most benefit.</li> <li>• Develop a staff awareness and training programme to ensure that there is greater awareness of the knowledge based information already available through HOWIS.</li> <li>• Ensure all policies, protocols and guidelines are made accessible via the Intranet.</li> <li>• To receive funding recognition from the Assembly's IM&amp;T Strategy.</li> </ul>	March 2003	<p>The Trust has made progress in this area with staff access to IT having. However it was reported that it can be difficult to find time to make use of the resources available on the Trust's intranet. We did find some evidence based practice, although such developments were hampered by the lack of information, such as via IT access or through the use of performance and outcomes data which was collected but not fed back to individual ward managers</p> <p>Further comments about learning from activities such as audit can be found under Recommendations 15 and 20-22</p>

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14.	Use of Information	Implementation of the eHealth IM&T strategy is key to the successful use of information in the Trust	To approve the SOC for the electronic health record. 2.5 To approve the SOC for the electronic health record.	Oct 2002	The Trust's IM&T strategy is being developed in accordance with the Assembly's Informing Health Care initiative.
			To develop and take forward an organisational readiness programme	Oct 2002	
15.	Resources and Processes: Consultation & patient involvement	The Trust must find additional ways of achieving effective team feedback and learning lessons from complaints at operational level.	To revise the complaints management process to incorporate mechanisms for timely feedback of the results of formal complaints to staff.	Dec 2002	<p>It was unclear from the complaints policy how lessons learned should filter through to service groups, directorates and managers. However we saw and heard evidence that trends and lessons learned are reported to the Trust's Clinical Governance Committee. A detailed analysis of trends in complaints is undertaken at the Clinical Standards and Patient Experience Committee. There was evidence of 'Lessons Learned' being discussed at Directorate level and cascaded by senior nurses to clinical staff through a number of conduits, such as monthly lessons learned meetings, 3 monthly audit meetings etc. Information on lessons learned is also included in newsletters.</p> <p>The process for managing complaints appeared to be fragmented. There is one complaints co-ordinator per Service Group who is responsible for administering the complaints process.</p> <p>Responsibility for learning from complaints is devolved to Directorate Managers. There seems to be little co-ordination between complaints and other clinical governance processes, for example</p>
			To review directorate governance arrangements to ensure that they are effectively 'closing the loop' and ensuring changes are implemented as a result of the lessons learnt from complaints.	Dec 2002	
			Introduce an annual report on complaints management and related clinical governance arrangements.	Dec 2002	
			Extend the use of the central complaints database to include informal verbal complaints.	Dec 2002	
			Introduce and disseminate the 'Safecode' information package to all service groups.	Dec 2002	

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			Implement audit systems to monitor actions taken following the outcome of Independent Review process and feedback lessons learnt across all service groups.		there was no evidence that audit of activities was triggered by complaints.
16.	Resources and Processes: Consultation & patient involvement	The Trust must take action to ensure that the new consent policy is implemented throughout all directorates	To reaffirm guidance already issued on the new consent policy.	May 2002	The Trust's new consent policy was launched 2004. Training on the consent policy is included within the Trust's induction programme, with update training available as an e-learning package. Staff reported it was difficult to find time to access this training  We saw few patient leaflets outlining consent issues during our visit  We saw evidence of local and Trust-wide audits of consent forms against compliance with the policy. However we were concerned that other staff, including some senior officers, seemed to be unaware that this work is undertaken.
			To ensure that all relevant members of staff have access to the new policy and have received appropriate training	March 2003	
			To undertake an audit of compliance to identify areas where there may be confusion and a need for additional training.	March 2003	
17.	Resources and Processes: clinical risk management	The Trust must take action to improve the effectiveness of infection prevention and control within the Trust	To strengthen clinical risk accountability structure.	May 2002	Recommendations 17-19 are being considered together  The Trust has undertaken some work in this area We saw plenty of alcohol handwash facilities during our visits.  The Trust Infection Prevention and Control Committee discusses levels of infection and monitors prevention measures. It was unclear as to how these outcomes were reported and monitored within wider Trust performance
			To put in place procedures for the effective dissemination of infection prevention and control policies.	May 2002	
			To improve staff and patient awareness by the production and dissemination of 'key facts' summaries.	July 2002 (staff) Aug 2002 (patients)	

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			Undertake an audit of availability of policies in clinical areas.	Nov 2003	management structures, for example there was no evidence of measures being reported on the Balanced Scorecard or at the Clinical Governance Committee
			To put in place procedures to ensure improved compliance with the Trust policy on hand hygiene: <ul style="list-style-type: none"> <li>▪ Audit availability and compliance with policy;</li> <li>▪ Agree remedial action where necessary</li> <li>▪ Provide briefing sessions.</li> </ul>	Feb 2003	Infection control audits are undertaken and reported in the Infection Control annual report. In addition a number of infection control audits are listed in the annual audit report but results, conclusions or recommendations were not detailed  An audit of MRSA has been undertaken and apparently there was some robust discussions when results were presented back to directorates.
			To implement reviews of cleaning monitoring reports against agreed standards and IPC requirements.	Aug 2003	There will be a policy review, training and re-audit as a consequence. The National Public Health Service for Wales has reported that MRSA rates are lower than would be expected by chance.
			To review resources available for IPC and produce a business case for additional resources if deficiencies identified.	Dec 2002	alone which may reflect the Trust's infection management strategy
			Develop a range of indicators/data to highlight adverse variances in performance in a timely manner facilitating proactive infection prevention and control.	Sept 2002	The numbers of patients being treated on wards not appropriate to their condition due to bed capacity issues (outliers), have not changed much since the CHI review. Staff told us that the infection control nurse was their first point of contact for advice on infected or high risk patients. Consultant microbiologists regularly attend ward rounds on critical care wards and are available to give telephone advice..
			Develop and implement appropriate performance management systems with service groups to include clinical audit.	Dec 2002	Some wards have local policies to reduce the infection risk from outliers, for example orthopaedic wards at Llandough Hospital will cancel all operations if a medical outlier is on the ward. Patients are screened for

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18.	Resources and Processes: clinical risk management	The Trust must take action to reduce the risk of infection by reducing the number of outliers on wards	The key actions required here relate to improved management of emergency admissions – these have been set out in detail on previous pages.		their infection status prior to surgery
			To further reduce the risk of infection the Trust will also introduce an action plan to increase the intervention by infection prevention control staff in clinical areas affected by outliers. This will include: <ul style="list-style-type: none"> <li>▪ A programme of targeted visits;</li> <li>▪ Spot checks to monitor policy compliance;</li> <li>▪ Regular consultant microbiologist attendance on ward rounds for those wards where clinical risk is deemed high;</li> <li>▪ Development of a joint strategy with the PHLS for microbiologist input into clinical care;</li> </ul>	Dec 2002	
			Agree a policy for the ring fencing of certain wards from outliers.	Oct 2002	
19.	Resources and Processes: clinical risk management	The Trust must take action to ensure staff comply with infection control polices	Introduction of an incentive scheme, which rewards those directorates and wards that reach and exceed infection prevention control standards and targets.	Dec 2002	
			Ensure that good IPC practices are integrated into clinical pathways at development stage	Ongoing	

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20.	Resources and Processes: clinical audit	The Trust must take action to improve communication between directorates so that learning from clinical audits can be shared	Review current clinical audit arrangements and structures with a view to widening the membership of the clinical audit group (look to include primary care colleagues)	March 2003	<p>Recommendations 20 – 22 are being considered together</p> <p>There appears to be no one system of planning and prioritising audits within the Trust. The Medical Director and Nurse Director are responsible for the delivery and robustness of the clinical audit programme. Service Groups and Directorates are encouraged to draw up audit plans but we were told that it was not a priority for them. The Trust had a Clinical Audit Committee which no longer meets. Clinical Audit is reported through clinical governance meeting structures. There is a central Audit Department whose role is to concentrate on national and core audits. It also provides audit training to Trust staff. There is a register of audits and an annual report is produced</p> <p>There appeared not to be any central co-ordination or cross-departmental development of audit. For example we found several audits covering different aspects of the same area of work being undertaken in isolation by different departments or professions. We heard varying views as to whether Allied Health Professionals are included in multi-disciplinary audits</p> <p>The main list of audits provided tended to be fairly medically orientated, although some nurse-led audits were also reported. We have previously mentioned in Recommendations 7 and 17-19 how</p>
			Introduce a more disciplined approach to clinical audit which focuses on key risk areas and the requirements of NSF, NICE etc. Taking the ad-hoc nature out of clinical audit will require a more disciplined approach conducive to the implementation of an associated communication strategy.	March 2003	
			To circulate generally information on current audit activity i.e. who, where, when, outcome etc through Trust in Focus or other Trust mechanism (info already available) This should include info etc relating to Grand Rounds i.e. audit of the month in Grand Rounds. This would then generate the possibility of horizontal audit.	May 2002	
			To ensure the publication of the results of all audits.	July 2002	

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			To take forward the integration of clinical audit plans with those for main stream audits and the development of an annual assurance plan for the Trust.	Aug 2002	we have found a number of audits that have not been included in the Trust wide report, presumably because they have not been reported centrally. There is evidence that this might also be the case with nurse-led audits. Recommendation 16 also discusses audit work undertaken that is not widely known about.
21.	Resources and Processes: clinical audit	The Trust must take action to increase multidisciplinary involvement in clinical audit. Nurses and AHPs should be supported to contribute as equal partners to all stages of directorate audit programmes	The development of clear terms of reference for each individual clinical audit leading to the scoping of the study and identification of knowledge and expertise needed.	June 2002	We were also told that audits are often led by individual clinicians as a personal project. This leads to many audits being started but not completed or no results recorded when staff move on. There seems to be little co-ordination between the various sectors of the Trust that undertake clinical governance activities. We were told there was no connection between patient support and audit staff, which was reflected by there being little evidence that audits were triggered by learning from complaints.  There was little evidence of processes to share learning from audit. Time pressures impact on this area of work, for example we heard that an open day was shelved due to workloads, and a newsletter covering clinical audit activity now discussed wider clinical governance issues. There was a Surgical Services Celebration day held during our visit to Llandough Hospital where posters describing nurse and multi-disciplinary team audits within that Group were displayed. This was a repeat of an event held at UHW, although not all posters from this previous event were available for display at Llandough. We commend this event and would encourage the Trust to organise more such activities.
			Implementation of procedures for the early identification of the skill mix needed on the team so that staff who are required to undertake the audit have adequate notice and arrange cover for their normal duties.	Dec 2002	
			To ensure that a training plan is developed for those staff who wish to be involved in clinical audits.	July 2002	
			To ensure that support mechanisms are put in place for those nurses and AHPs who wish to be involved in clinical audits – enabling them to be allocated time to be involved and to take an active role.	March 2003	
22.	Resources and Processes:	The Trust must take action to increase patient involvement	Hold an Audit 'Open Day' involving patients and general public	March 2003	

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	clinical audit	in clinical audit activities	Work with CHC to set up patients' panel with audit remit.	Sept 2002	We were told that there is currently no patient involvement in audit activities, although they had been involved in previous work looking at the specialist seating service. There was patient involvement in the former Trust Clinical Audit Committee
23.	Resources and Processes: clinical audit	The Trust make take action to comply with the requirements of national confidential enquiries	To implement revised procedures for the management of responses to confidential enquiries – ensuring 100% response rate.	Sept 2002	There appeared to be some confusion surrounding the process for implementing recommendations of confidential enquiries. We were told that this went through clinical governance mechanisms, but some clinical governance staff we spoke to had no knowledge of or involvement in this.
			To review procedures for the management of the implementation of findings and recommendations arising from confidential enquiries and ensuring on-going compliance	March 2003	
			Invite Community Health Council rep or lay member from LHB to join audit teams /committees	Sept 2002	
24.	Resources and Processes: research and effectiveness	The Trust should take action to agree and implement a mechanism to ensure that research priorities in the clinical fields of the allied health professions contribute to the strategic direction of research and effectiveness	To increase the number of research projects led by or involving Allied Professionals within the Trust.	March 2003	A Clinical Audit and Effectiveness strategy was launched in September 2005. We were told that there is not really a process for allied health professionals to identify research priorities.
			To put procedures in place that ensure the views of the Allied Research Professions are fed into decision making processes related to the strategic development.	March 2003	

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Rec No	Chapter	CHI Action point	Action Required by CHI	Target Date	HIW findings
			To produce an annual report for submission to the Trust R&D committee that reflects the views of the Allied Health professions.	March 2003	
			Promotion of awareness amongst Allied Health Professions of schemes available to support R&D.	March 2003	
25.	Resources and Processes: research and effectiveness	The Trust must take action to support staff to implement evidence based practice. This should include an action plan to ensure that staff are able to easily access relevantdatabases and develop skills to apply research evidence relevant to their specialist area of patient care	Issues relating to access to information and data sources have been addressed on previous pages.		See also Recommendation 13  The Trust has employed practice development nurses to ensure evidence base practice is in place
			To develop and roll-out a training programme for all staff, that covers the use of relevant databases and the interpretation of results of searches etc.	Dec 2002	We have previously mentioned the clinical portal. It was reported to us that there was no link within the portal system to the evidence base behind any area
			To raise awareness of the training already available to staff	Dec 2002	
26.	Resources and Processes: staff and staff management	The Trust should work with Higher Education partners and other commissioners of education to agree and implement a workforce plan to support future staffing needs at the Trust	Development of an appropriate workforce plan for the Trust.	March 2003	The Trust has made good progress in appointing staff to key posts and developing a workforce plan. We were told that managers needed to be more skilled at workforce planning and looking at new ways of working
			To link closely with the workforce steering group to be set up by the NafW.	March 2003	
			To feed Trust workforce plan into all-Wales discussions and developments.	March 2003	

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<b>Rec No</b>	<b>Chapter</b>	<b>CHI Action point</b>	<b>Action Required by CHI</b>	<b>Target Date</b>	<b>HIW findings</b>
27.	Resources and Processes: staff and staff management	The Trust should develop systems to ensure all staff receive an appraisal each year so that their development needs can be fully considered (the current appraisal system is implemented and monitored through the Service Group and Executive Management Groups	To further develop current system of appraisal.	March 2003	Staff reported that they have regular PDPs and that the Knowledge and Skills Framework was being introduced.  There appeared to be no overarching clinical supervision policy.  The Balanced Scorecard and Performance Reports contain space for information on PDP performance but no data was recorded.
			To build on baseline assessment	March 2003	
			To ensure service groups take forward their action plans	March 2003	
			To implement an annual audit cycle.	March 2003	
28.	Resources and Processes: education, training, CPPD	The Trust should continue with its strategy to support the training for health care support workers	To pilot health care support worker competency framework in 3 clinical areas.		The Trust supports a programme of NVQs for Healthcare Support Workers, but it needs to develop a clear strategy and identify how it fits with the modernisation of new roles.
			Dependent on the outcome of the pilots the roll out of the competency framework across the Trust.	Jan 2003	
29.	Resources and Processes: education, training, CPPD	The Trust should review the time available for experienced nurses to provide workplace based training to students and new staff and ensure that they are given appropriate support to do this	To appoint clinical teachers and implement a model for clinical teaching	May 2002	The Trust has made progress in this area. Clinical teachers are now in place. All students have an identified mentor and there is a specific post in place to support nursing students on placement. Appropriate training is available to mentors but they have problems making time to attend this.
			To assess the time available for baseline assessment	Dec 2002	
			Undertake workload assessment of those nurses providing training	March 2003	
30.	Resources and Processes: ,	The Trust must provide appropriate support and training for frontline staff	Identify posts where there is a front-line element to the role	July 2002	The Trust appears to have made little progress in this area. We were told that there is little support for frontline staff. They do not receive specific

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Rec No	Chapter	CHI Action point	Action Required by CHI	Target Date	HIW findings
	education training, CPPD	who liaise with patients and carers about cancellations and appointments on a daily basis	Develop training plans specific to these posts.	Dec 2002	training to deal with difficult situations and any issues are "dealt with on the job."
			Develop support mechanisms for such posts to ensure that individuals don't get over stressed.	Sept 2002	Contacts from concerned patients regarding their list status are not recorded as complaints but queries. The Trust may need to explore this further in respect of the level of importance attached to this area of work.
31.	Resources and Processes:, education training, CPPD	The Trust needs to establish a comprehensive system to record training courses completed by staff to help in the assessment of future training needs. For mandatory training, the system should ensure that all staff attend appropriate courses at the right time	To introduce a central register of training needs and courses attended.	April 2003	The Trust's electronic staff record was due to go live in November 2006. There is some uncertainty as to whether it will be able to match the booking of training with attendance. Until this is in place there are various methods to monitor attendance at mandatory training. There is a mandatory training assessment questionnaire to identify staff training needs. However this was completed by only 25% of staff. The Trust needs to ensure its staff engages better with this process
			Introduce electronic staff record.		The Balanced Scorecard and Performance Reports contain space for information on mandatory training performance but no data had been filled in
32.	Strategic capacity	The Trust must take action to improve communication at the Trust and ensure that learning is shared across directorates and service groups	To identify the key areas of weakness in terms of communication – consulting with staff and reflecting on the findings arising from annual staff surveys.	April 2003	The Trust emphasises the importance of the intranet in improving communication. However many staff reported having little time to access it. Others, especially those working away from UHW did not feel that communication was good. We have also highlighted problems in respect of sharing of learning against Recommendations 13, 15 and 20-22
			To review the Trust corporate communication strategy and processes and amend in line with findings from above.		

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Rec No	Chapter	CHI Action point	Action Required by CHI	Target Date	HIW findings
			To improve the dissemination of information via the development of the Trust intranet and a web-site.		
			Ensure each service group has processes in place to ensure information is cascaded down as well as up to Executive and Trust board.		
			To review the processes in place for the submission of business cases to ensure there is clarity in relation to the decision making process, a mechanism for tracking the progress of the case and for feeding back on decisions.		