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Dear Hugh

HEALTHCARE INSPECTORATE WALES (HIW) REVIEW OF CARDIFF & VALE NHS TRUST'S PROGRESS AGAINST THE COMMISSION FOR HEALTH IMPROVEMENT (CHI) ACTION PLANS.

I write further to Healthcare Inspectorate Wales' recent review of Cardiff & Vale NHS Trust's progress against the action plans prepared following publication of the CHI reports on your acute services in March 2002 and mental health services in 2003.

Further details of the progress that your organisation has made against the recommendations made by CHI are set out in the attached Appendices. Our findings have been drawn from your self assessment submission, our review of documentary evidence and site visits. Mental health services were visited between 26 and 29 September and acute services between 3 and 6 October 2006. The recommendations from each report have been considered separately, ie taking into account only the evidence gathered during the specific site visit, however the two reports overlap in some areas, for example clinical audit and where this occurs the findings contained within both grids need to be considered together.

Some general comments emerged from both parts of the review and apply to the Trust as a whole, specifically:

- All staff, without exception, were found to be friendly, open and helpful.
- The workforce is stable with generally low vacancy levels.

- Progress has been made in relation to access to PCs, network access, email etc and this is to be commended, however, there is an issue in relation to staff having the time to access information and training. E-learning packages are increasingly being used to deliver training. If this is to be successful staff need to be supported and allowed to have dedicated time to access and complete these courses.
- A great deal of clinical audit is being undertaken. There is a central register of clinical audit activity, however systems for reporting local activity to this register could be strengthened to ensure all audits are captured. At a corporate level the focus is mainly on National audits. Audit activity tends to be 'siloed,' eg nursing or departmental, with little evidence of learning from clinical audits being shared more widely.
- Stronger links need to be established between complaints management and other clinical governance activities to ensure issues identified through complaints inform the broader clinical governance agenda.
- The poor use of information, including issues in relation to collection of data, access by front line clinical staff to relevant local performance and outcomes information and the sharing of learning from clinical audit and complaints.
- Little progress has been made in respect of Patient and Public Involvement.

Acute services

During our review of acute services it was disappointing to note that there were a number of recommendations made by CHI where little or no progress has been made against the agreed actions, including:

- Some work has been undertaken to properly investigate the higher than average number of non-emergency deaths highlighted in the CHI report but this figure does not appear to be regularly reviewed. (CHI Recommendation 1).
- Work had only very recently begun in relation to addressing the issues surrounding fractured neck of femur reported in 2002. There are some very committed staff working in this area and we would hope that the changes they put in place will lead to improvement for patients. (CHI Recommendation 3).
- General capacity issues remain a problem for the organisation with exceptionally high numbers of delayed transfers of care and issues with bed management and patient flow (CHI Recommendations 4 and 5).

Other areas we wish to highlight include:

- Problems at the Medical Assessment Unit at Llandough Hospital, where patient flow management problems can result in patients being looked after in inappropriate care settings. This long running situation requires urgent action. (CHI Recommendations 4, 5 and 9).
- The level and types of comment received via the patients' survey undertaken in May 2006, in particular regarding cleanliness at the University Hospital of Wales' A&E department (CHI Recommendation 7).
- Contacts from concerned patients regarding their list status are not recorded as complaints but queries. The Trust needs to consider how it best captures and uses this information in terms of managing access to care (CHI Recommendations 6, 11 and 30).

Mental Health Services

It should be noted that, unlike the original CHI review, our review of mental health services did not examine Child and Adolescent Mental Health Services (CAMHS) as these will be considered during HIW's forthcoming all-Wales review of CAMHS.

We found that in adult and elderly mental health services the Trust has made good progress in taking forward many of the recommendations made by CHI and implementing the agreed action plan. The review team considered the Trust to have given careful consideration to the recommendations made and the impact that they have on the organisation. Specifically the HIW review team considered the Trust to have made positive progress in:

- Rolling out the Care Programme Approach across all areas with a comprehensive training programme in place and the use of a very user-friendly patient information booklet produced by Hafal.
- Developing the Bibliotherapy book prescription scheme which has now been adopted Wales wide.
- Developing the role of clinical nurse leaders.
- The establishment of more effective management and clinical governance links between the Mental Health Service Group and the wider Trust.

We would particularly like to note the commitment and motivation demonstrated by staff despite the challenging environment in which they work.

There are, however, areas where progress against the actions has been slow which the Trust now needs to address, specifically:

- There was little improvement in the provision of therapy services with provision varying widely between wards. We were particularly concerned by the risk posed by the lack of speech and language therapists to undertake swallowing assessments for vulnerable elderly patients. Efforts by refocusing nurses to provide more activities should be commended but this should be seen as complementary to rather than replacing therapeutic work (CHI Recommendation 3).
- The Trust's user involvement strategy and patient and public involvement work is not well developed. This was reflected by findings in the Mental Health Service Group regarding engagement of users and carers when planning service developments and communication with them about recent or proposed changes to service provision. For example, concerns were expressed by some service users about the consistency of messages being received from the Trust about service developments (CHI Recommendation 6).
- There were significant concerns raised during the review regarding difficulties in the relationship between CAMHS and the Mental Health Service Group (CHI Recommendation 21).
- Staffing levels on wards at St David's and Whitchurch Hospitals did not reflect the levels of dependency of the potentially volatile mix of aggressive, frail and physically needy elderly patients (CHI Recommendations 26 and 27).

There are other concerns that are not directly related to specific recommendations in the CHI review, but which we feel need to be brought to the attention of the Trust. We noted that:

- The wards for elderly patients at Whitchurch Hospital are not fit for purpose being old fashioned and institutional.
- Ward East 2A at Whitchurch Hospital, given current night staffing levels, design of ward and lack of alarms does not always provide a safe environment of care.
- The layout of Ward W2A at Whitchurch Hospital means that female patients have to walk through the male dormitory to access their dormitory and bathroom and hence dignity of care requirements are not being fully met.
- A shortage of suitable beds within the local health and social care community for older people with mental health problems, is resulting in high levels of delayed transfers of care.
- Whilst the Mental Health Service Group is now better integrated into and engaged with formal Trust structures there did seem to be compartmentalisation between sites and areas of service within the Group.
- Liaison between mental health and acute services needs strengthening, as there can be problems in addressing the physical health needs of mentally ill patients and the psychiatric needs of patients being treated in acute settings.

If you have any queries relating to factual accuracy of this response then please would you contact Ann Bateman, Inspections Manager on 02920 928860 to discuss this. We intend to make this letter and appendices available on HIW's website, but publication will be delayed until after the elections for the National Assembly for Wales being held on 3 May 2007. We will inform you of the publication date in due course.

The Trust should now prepare a response based on the recommendations made within the letter and appendices.

- The response will need to be approved by your Board and returned to us within 8 weeks of receipt of this letter.
- Final sign off of your Action Plan will then be agreed jointly between HIW, the Trust and the Regional Office.
- The Regional Office will then monitor progress against the agreed Action Plan as part of its routine performance management arrangements.

May I take this opportunity to thank you and all of the staff in your organisation who have contributed to this review for their hospitality and for being so helpful, it is much appreciated.

I am copying this letter to Jenny Jones, Clinical Governance Manager.

Yours sincerely

DR PETER HIGSON
Chief Executive

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