Mr Adam Cairns
Chief Executive
Chief Executive's Office
Cardiff and Vale UHB Headquarters Building
University Hospital of Wales
Heath Park
Cardiff
CF14 4XW

28th May 2014

Dear Adam,

Meeting to review actions since April 2013 RCS Visit

Thank you for hosting our recent meetings on Friday 25th April 2014.

These meetings were held to follow up the actions taken by the Cardiff and Vale University Health Board (CVUHB) in addressing the concerns highlighted to the Royal College of Surgeons (RCS) at an RCS Professional Affairs Board (PAB) visit to CVUHB on 12th April 2013.

Our meetings took place in three parts:

1. A meeting with the CVUHB Chief Executive and Medical Director – to receive the senior management perspective on the action taken by the CVUHB since the PAB visit in April 2013.

2. A meeting with fifteen CVUHB clinical leads – to receive feedback from clinicians about progress made by CVUHB since the PAB's visit.

3. A second meeting with the CVUHB Chief Executive and Medical Director - to verbally summarise the RCS's perspective on the CVUHB's progress.

Attendees from the RCS

The meetings were attended by four representatives of the RCS, myself as RCS Vice President, Mr Peter Lamont (RCS Council member), Ms Sally Williams (RCS Lay Reviewer – representing the patient and public interest), and Mr Ralph Tomlinson from the RCS Professional and Clinical Standards department.

Methodology

Prior to the meeting the RCS had undertaken a detailed review of the CVUHB's ongoing action plan to address the concerns identified by the PAB visit in April 2013. As part of this process the RCS asked for extensive additional documentation to validate a sample of the actions reported in this document.

We note this action plan is publically available on your website and progress with actions has been reported at public CVUHB Board meetings.

Summary of meeting one

Historic position

Mr Adam Cairns (Chief Executive – CE) and Dr Graham Shortland (Medical Director - MD) provided a frank appraisal of events that led to the situation reported to the RCS PAB in April 2013. This included significant leadership instability, poor winter planning, and weak relationships between the executive team and key clinical staff.

Changes introduced since formation of the new executive team

It was also reported that a number of changes have been introduced in response to these problems, including strengthening clinical leadership, a more strategic preparation for winter, and putting additional resource into CEPOD theatre provision.

Winter 2013-2014

The CVUHB's experience of providing care in the most recent winter (2013-2014) was described as much improved in terms of a coordinated and planned response to the increased pressures provided by this time of year. It was reported for example that there were 60 cancelled operations in January 2014, compared with 500 cancellations in the previous January.

It was recognised by all parties that a commonly held perspective about healthcare pressures across the UK in winter 2013-2014 was that these had been to some extent eased by the comparatively mild winter, and that this made relative performance harder to judge. While the CE and MD were realistic in their awareness of this possible contributory factor they maintained that the progress made by CVUHB personnel in addressing the previously identified concerns had played the most significant role.

Nevertheless, it was also recognised by the CE and MD that there was still more to do, with the hospital described as being 'mid-flight' in a programme of organisational change.

Key future priorities

Key priorities in terms of providing resilience to future increased pressures were: to invest in enhancing intensive care capacity (by December 2014); to work to improve theatre productivity; the completion of the ongoing upgrade of the accident and emergency department to provide for a larger assessment area (by June 2014); and the ongoing strengthening of the GP out of hours service.

Work to strengthen the relationship between the executive team and senior clinical staff was described as ongoing and moving in a positive direction.

Information about patient experience

The RCS team provided feedback to the CE and MD that patient experience, and good quality data to reflect this, appeared to lack a significant profile within the documentation the RCS had received. The CE perceived expectations amongst patient groups to have been low historically and conceded that patients had not been involved in pathway design where they could and should have been. It was explained that this was something the executive team planned to address and that they were currently reviewing the CVUHB's whole patient experience programme.

Work to improve waiting times

The executive team also explained that they are committed to replicating and matching best practice in the United Kingdom for waiting times and outlined, for example, aspirations to eliminate 36 week waits for cardiac surgery. It was reported that modelling work had been undertaken that shows this would be achievable with modification of the cardiac pathway. Some concern was aired that a potential outcome of ongoing work was that cardiac surgeons might be left with a more complex casemix of cardiac patients. The proportion of patients treated on an expedited basis was reported to have increased.

CE and MD's approach to the ongoing operational challenges experienced at CVUHB

The CE and MD appeared to have a clear grasp of ongoing challenges, including an honest appraisal of the specific surgical areas under pressure (most notably, cardiac surgery and neurosurgery). The executive team appeared to be supportive of surgical colleagues and being keen to collaborate to improve both services for patients and working practices for staff.

The CE and MD also appeared open and keen to listen to their surgical teams and other clinical personnel, although it was recognised that building faith and confidence amongst these personnel will be an ongoing challenge given the legacy of some of the historical issues within the organisation.

Summary of meeting two

Clinical Leads' perspective on changes since PAB visit in April 2013

Overall the tone of the meeting with the CVUHB clinical leads was positive, with representatives for the most part reporting marked improvements to the situation experienced by the CVUHB since the PAB visit in April 2013. These improvements were reported to be quantifiable in terms of falls in waiting times, reductions in cancellations of patient operations, and fewer medical outliers on the wards. Better access to CEPOD theatres was frequently reported and it was consistently agreed that the CVUHB's extra CEPOD theatre had made a significant difference.

The majority (although not all) of the representatives present considered themselves to be listened to, that arrangements with their Clinical Boards were working well, and that they were able to have a dialogue with the executive team. The most commonly reported perception was of much more effective clinical engagement and clinical leadership and improving working relationships between clinical staff and the executive team. One interviewee described *'a complete sea-change in attitude'*.

At the meeting, the RCS team also observed signs of cohesive working across the specialties and greater cross-specialty interaction was highlighted specifically by one clinical lead.

Areas where clinical leads considered improvements to patient care could be made

Ongoing concerns were reported about cancellations due to insufficient intensive care capacity and, for some, postoperative care or shortages of anaesthetic cover. Whilst improvements were reported in getting patients into hospital and treated, getting them discharged into the community or repatriated to district hospitals was reported to continue to often be problematic. This led to a number of concerns about the

sustainability of efforts to improve access to *'the front door'*. Delays for rehabilitation were cited as being an ongoing problem, as was some patients continuing to have to wait a considerable period of time for surgery, with vascular surgery being cited as a particular area where long waits remained an issue.

An issue identified in the PAB visit relating to surgery to insert grommets in children was thought to have been somewhat misinterpreted. Hearing aids were reported to be routinely used with children identified as needing grommets but only as a temporary measure. It was suggested that delays continue to be a problem because of a lack of paediatric staff on the wards, but that this impacts on children requiring tonsillectomies (as they require an overnight stay) not on children requiring grommets. It was also considered that the move to the new children's hospital in April 2015 should address this issue.

Individual clinical circumstances referred to during the discussion

During the discussion reference was made to two matters involving the individual clinical circumstances of two specific patients (one involving potential delays to treatment and the other the response to a reported clinical incident) that may have required further consideration through the CVUHB's clinical governance processes. No further documentation was provided to the review team to reach a view on these circumstances. The review team highlighted to the CVUHB Medical Director directly for further consideration and action.

Areas of ongoing potential patient safety risk highlighted by clinical leads

It was clear from the discussions held that two surgical specialities in particular stood out because of the ongoing challenges they faced in delivering good quality care: cardiac surgery and neurosurgery.

- **Cardiac surgery** was still reporting constraints in access to intensive care beds and ward beds. Secretarial resource was described as being a problem, with letters to GPs, patients and cardiologists reported to be taking two to three months. Concerns were also raised about the continuing impact of delays on patient care and outcomes.

  Other concerns about the mechanisms for clinical governance relating to cardiac surgery were also highlighted, for example that problems with clinical equipment relied heavily on individual surgeons taking actions to address them. The headline issue of patients dying whilst waiting for cardiac surgery was also reported to have taken attention away from other key issues, such as many patients now coming into hospital having waited so long that their condition had deteriorated significantly, causing the surgery required to have become more complex. It was also reported that there remained patients on the waiting lists who had not been fully assessed.

- **Neurosurgery** was reported to rely heavily on neuro-radiology, which was only being provided on two and a half days a week, and was described as being a significant problem. It was also reported that in some cases interventionists were only getting their work done by abandoning their elective lists. A lack of theatre capacity was also considered to be a recurring problem.

  The executive team were however reported to have been made aware of these issues facing neurosurgery and were perceived as being receptive and keen to work with clinical staff to find solutions.

Overall summary

The RCS team was pleased to hear from both meetings that the RCS' visit to CVUHB in April 2013 had been helpful to all parties in highlighting a series of longstanding performance and quality issues requiring attention.

The RCS team was also encouraged to note that there was both documentary and verbal evidence to demonstrate that the CVUHB had taken the concerns previously raised by the College seriously and that they had initiated a clear programme of work to address these issues. It also appeared from the documentation reviewed and the meetings held that a number of improvements had already been made.

The RCS team was clear, however, that the CVUHB continues to have substantial work to be completed in order to fully address all of its priorities for improvement. The team recognises the Chief Executive's description of the organisation being "mid-flight" within this important programme of work.

Given this position, and the RCS' ongoing commitment to patients and their safety, the RCS considers it important to maintain its interest in how the CVUHB improves surgical services for patients, both as a district general hospital and a tertiary centre. The RCS will therefore consider further with you the best way to receive a final update on your progress with this work, in particular when the proposed work to improve the hospital's intensive care unit capacity and Accident and Emergency facility is intended to be complete.

Next steps

We agreed that following our meeting a copy of this letter would be made publically available, along with your response on behalf of CVUHB.

We will also then seek a final update on your progress as above.

Yours sincerely

Mr David Ward FRCS
RCS Vice President