Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Aneurin Bevan University Health Board Annual Report from Healthcare Inspectorate Wales 2015-16

August 2016

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

 WG29477 Digital ISBN 978 1 4734 7207 5

Contents

1. Purpose

Healthcare Inspectorate Wales (HIW) is the lead independent inspectorate and regulator of health care in Wales. Our purpose is to provide the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

This annual report has been produced by HIW as a summary of the activity that HIW carried out between 1 April 2015 and 31 March 2016 of Aneurin Bevan University Health Board.

The outcomes we seek to influence as a result of our activity within this and other health boards/trusts are that:

- Citizen experience of healthcare is improved
- Citizens are able to access clear and timely information on the quality, safety and effectiveness of healthcare services in Wales
- Citizens are confident that inspection and regulation of the healthcare sector in Wales is sufficient, proportionate, professional, co-ordinated, and adds value.

2. Overview

During the year, HIW conducted 39 inspections to Aneurin Bevan University Health Board settings, these included:

- 1 hospital
- 4 general practices
- 28 dental practices
- 4 Mental Health Act
- 1 Community Treatment Order
- 1 Learning Disability.

In the independent sector, HIW has conducted 25 inspections to settings based within the Aneurin Bevan area; these included:

- 1 hospice
- 12 Mental Health Act
- 5 Mental Health Unit
- 1 dental hospital
- 5 laser
- 1 Pre-registration manager interview.

3. Key Themes

The following key themes were picked up at our inspections during 2015-16.

NHS Hospital Inspections

- Patients and/or their carers told us they were happy with the quality of care and treatment they had received. We suggested the health board consider additional methods of gathering patient feedback on services.
- We found staff teams who were kind, caring and committed to delivering patient care that was safe and effective.
- We saw that staff worked to maintain patient's privacy and dignity within the environment. We found that there was awareness of dementia friendly initiatives but these were not always applied and we suggested the wider use of dignity signs to further promote patient's dignity.
- There was some variability and inconsistency in the application of the health and care standards across areas for providing high quality patient care. Specifically, aspects of how medicines are managed and how patients' care records are completed needed to be improved and processes needed to be made consistent.
- Within patients' care records we found the quality of record keeping needed to be improved in terms of falls risk assessments, pressure damage care plans and nutritional risk assessments. There was the need for processes to be made clearer and more consistent, when risks were identified.
- Within medicines management improvements needed to be made to clarify roles and responsibilities for medicines management at ward level, to some aspects of storage, audit and stock checks and ensuring all patients wore identification wristbands.
- The training records we saw showed various levels of compliance with mandatory and basic training. An educational package had recently been developed and introduced specifically to help develop the skills of new and existing staff working within the trauma and orthopaedic directorate. Training compliance in Mental Capacity Act and DOLS needed to be improved.

- We found some examples of strong, clear ward level leadership which resulted in well run teams and well run wards. However, we also found areas where leadership was weaker and the team and ward structure suffered as a consequence.

- We saw that there had been many positive changes and initiatives introduced by senior directorate level nurses. However, some staff told us that they did not feel well connected to senior managers.

- There was clear evidence of systems in place to monitor the effectiveness and safety of services but we found that at individual ward level, these were more effectively used in some areas compared to others.

NHS Dental Practice Inspections

- Patients and/or their carers told us they were happy with their dental treatment.

- Overall, we found good clinical facilities within practices.

- A number of practices needed to make improvements to complaints policies and arrangements. Specifically in ensuring complaints arrangements specified the separate NHS and private arrangements and in ensuring policies met the Putting Things Right requirements.

- A number of practices needed to improve their child and adult protection policies and ensure staff were trained in adult and child protection matters.

- We also found that a number of dentists needed to improve aspects of their record keeping to demonstrate they were planning care to promote patient safety and wellbeing.

General Practice Inspections

- We worked with members of the local Community Health Council when inspecting General Practices. Patients told the CHC that they were happy with the service provided by their GP and practice team.

- The main frustration for some patients was access to appointments and in some cases that they had difficulty getting through to practices by phone to book an appointment.

- We saw good practice particularly in relation to record keeping, effective internal communication systems and good examples of complaints management.

- Some General Practices needed to improve the provision of accessible information to patients and methods of gathering patients' feedback about services on an ongoing basis.

- Some General Practices needed to improve the quality of child and adult protection policies and ensuring that all staff had POVA and child protection training at a level appropriate to their role.

NHS Mental Health Services

Mental Health Act Monitoring Inspections

- The units we visited were generally well maintained and were equipped with appropriate furniture for the patient group. We also noted that there was a calm and relaxed atmosphere during all inspections.

- In two of the units inspected we found that statutory documentation was compliant with the Mental Health Act however there were a number of areas where record keeping could be improved in line with good practice and the Mental Health Act Code of Practice for Wales.

- In one unit (Maindiff Court) our review of statutory documentation identified that it was poorly organised and in some cases, files were missing copies of statutory documentation. We also had concerns with regards to the implementation of the Act.

Community Treatment Orders (CTOs)

- We noted that provision of CTOs was managed via multidisciplinary team working with views from all disciplines considered and valued.

- We saw good communication between the different teams involved and good record keeping maintained by care teams.

- The use of CTOs enabled patients to receive care in the least restrictive way as guided by the Mental Health Code of Practice for Wales.

- Staff spoke of good external review of CTOs by Hospital Manager Hearings and the Mental Health Review Tribunal.

Learning Disability

- This was a joint piece of work undertaken with CSSIW where we visited 6 local authorities including Torfaen within the Aneurin Bevan University Health Board Area.

- Overall we concluded that the health team on the ground and those in the management structure have a clear vision for the care and support they were providing for people with learning disabilities, aimed at improving outcomes.

- We saw health and social care staff working well together in providing information, advice, assistance, assessment and care planning to people with learning disabilities. This included some excellent examples of multi-disciplinary team working involving the community learning disability team, social services, care providers and wider health professionals in primary and secondary care.

- We noted the *'Strategy for Adults with a Learning Disability'* and that all members of the health teams we spoke to were aware of the strategy and how their work fits in.

- However there did not appear to be any strategic future planning taking place on a joint level with the local authority to identify what will happen at end of the current joint strategy period in 2017.

4. Special Reviews and Investigations

In March 2016, HIW published the findings of a review[1] into the homicide committed by a mental health service user. The report (*Mr N and the provision of Mental Health Services, following a Homicide Committed in November 2014*) made a number of findings and recommendations relating to mental health services in Aneurin Bevan University Health Board. This report found:

- Aneurin Bevan University Health Board, Abertawe Bro Morgannwg University Health Board, Cardiff and Vale University Health Board, HMP Cardiff and HMP Parc should develop a process whereby case formulation is routinely introduced and updated, as a prisoner moves from prison to prison and mental health care services. This supports and improves availability, continuity and sharing of information which helps clinicians understand and consider care and treatment planning programmes where appropriate, regarding longstanding and complex cases.

- Aneurin Bevan University Health Board, Abertawe Bro Morgannwg University Health Board, Cardiff and Vale University Health Board, HMP Cardiff and HMP Parc should ensure procedures are in place the check the rationale for prescribed medication, especially when an individual presents a history of non-compliance.

- Stakeholders involved in prison discharge and aftercare planning should:

  a) ensure systems are in place to allow better sharing of healthcare information prior to discharge from prison. This would help ensure consistency and act as a protective measure against possible relapse in any mental health condition; and

  b) Prison In-Reach Mental Health Teams and CMHT's to implement a voluntary follow-up appointment within one month of an individual's release from prison. The offer such a follow-up appointment would help with consistency of care and help support any immediate care issues in an initial period of high risk.

- Aneurin Bevan University Health Board, Abertawe Bro Morgannwg University Health Board and Cardiff and Vale University Health Board should develop clear lines of accountability regarding the responsibility

[1] http://hiw.org.uk/docs/hiw/reports/160330argoedhomicideen.pdf

for attempting to engage with individuals who regularly do not attend appointments.

- Stakeholders who have staff involved either directly or indirectly in, or with serious incidents, should have clear and confidential procedures in place to offer them appropriate and timely psychological and trauma support services.

- Stakeholders should ensure that support is provided, either directly or via signposting, to families by such incidents. Support should also include ongoing dialogue regarding investigation processes that enables the basis for mutual understanding and trust.

HIW's review did not identify any significant root causes or factors that led to the unfortunate and tragic event of 6 November 2014. Whilst HIW did find areas for improvement relating to healthcare and support in the course of our review and those relating to Aneurin Bevan University Health Board are highlighted above, we do not believe that the presence of these issues contributed to the tragic incident.

Welsh Health Specialised Services Committee review

During 2015-16 we published a review of the clinical governance arrangements WHSSC has in place, and how these related to patient outcomes. In undertaking this work we focused upon cardiac services. The key findings from our review were:

- WHSSC was in a period of transition working towards placing a much greater emphasis on quality when commissioning services. We found that this focus on quality had not always been present in the way that WHSSC discharged its functions

- WHSSC had published a report providing a review of the outcomes and impact of its work to reduce cardiac waiting times. This review highlighted deficiencies in its processes for the governance of this project - for instance we were not provided with assurance that the documentation of the process surrounding the selection of providers in England was robust

- We found weaknesses in the operation of WHSSC's Quality and Patient Safety Committee. For instance, information relating to initial concerns regarding cardiac waiting times had not been reported into the committee in a timely manner

- Our review raises the question of whether WHSSC's Joint Committee can be a truly independent decision making body when it is made up of both the providers and commissioners of specialised services in Wales

- There is an external perception that WHSSC's role and responsibility in managing specialised services is unclear

Overall, our review has highlighted that WHSSC is at the beginning of a process to strengthen its clinical governance arrangements.

All health boards need to learn from this review and consider the actions they need to take.

Evaluation of homicide reviews undertaken by HIW since 2007

During 2015-16 HIW published an evaluation of homicide reviews it had undertaken since 2007. The purpose of the evaluation was to assess the impact the HIW reports, and the recommendations issued since 2007, have had on services that are being provided to mental health service users.

The broad themes covered in HIW's evaluation report were:

- Care planning, assessment and engagement with families/carers

- Risk management

- diagnosis

- discharge and aftercare planning

- integrated and co-ordinated services

- communication and information sharing.

We found that the impact of our reports had been variable. Some organisations which were not the direct subject of a review, had established their own internal process to look at the recommendations from each report. However, some organisations had no formal process or mechanism in place to ensure wider learning from our reports. Barriers to the implementation of the recommendations arose when action was required across multiple organisations or agencies, including non-health bodies. However, all of the stakeholders who had been subject to review said that our reviews were invaluable and should continue.

HIW has made changes to the way in which it conducts these reviews, in particular to promote learning amongst stakeholders directly involved in each review. HIW is asking all health boards to consider how they learn from these reviews, particularly if they were not directly involved in an investigation conducted by HIW.

Death in Custody Reviews

During 2015-16 HIW contributed to one (natural cause) death in custody review relating to HMP Usk and Prescoed. HIW's main finding from this review was in relation to difficulties with the communication and relationship between HMP Usk and the Nevill Hall hospital (NHH). In particular, for complex patients who are being discharged from hospital back to HMP Usk and Prescoed (a prison without 24/7 healthcare). The clinical review also revealed several problems with the arrangements at NHH. The issues identified were shared with the health board and an action plan produced to address the recommendations.

5. Follow Up and Immediate Assurance

Follow Up

Following each of our inspections we issued an inspection report of our findings. Where we identified improvement was needed, we also required the health board or practice to provide us with an improvement plan to demonstrate how they were going to make the improvements.

The plans from General Practices and Dental Practices were generally provided within the given timescale. The plans from the health board were always detailed, robust and received within timescales. Each response was individually evaluated by HIW and further information and assurance was sought where needed. As a result the responses provided us with sufficient assurance that the improvements identified had either been, or were being, addressed.

We also wrote to the health board in 2015 and requested an update on the progress made in making the improvements identified from our inspections during 2014-15.

We have been provided with assurance that the health board has taken the action necessary to address the improvements we identified and/or has provided evidence to demonstrate that sufficient progress is being made in response to the majority of these matters.

HIW has gained some additional assurance in this respect during our programme of hospital inspections during 2015/2016. Whilst different clinical areas were visited, we took account of the previous year's recommendations. This was to determine whether these issues were confined to the areas inspected in 2014/2015 or evident elsewhere within the health board.

Whilst broadly assured in this respect, our inspection activity at the health board this year has identified that further improvement action is necessary in some areas, as we again made recommendations in the following areas:

- Quality of nursing records
- Medicines management
- Ensuring the privacy and dignity of patients.

We are aware, however, that the health board continues to take action to address these matters and will further update HIW in this respect.

It was evident from this follow up activity that the health board uses our inspections to improve the quality and safety of its services by ensuring that the

recommendations made by HIW are actioned and not replicated elsewhere within the health board. We are particularly pleased to note the development of a Health Board Thematic Action Plan drawing together common themes arising from our inspections and that this will be overseen by the *'Trusted to Care Steering Group'.*

Immediate Assurance

Where we identified a risk to patient safety that required immediate improvement action, we issued letters to the health board and practices in accordance with HIW's immediate assurance process.

During 2015-16 we issued 4 immediate assurance letters (three immediate assurance letters for dental practices, and one immediate assurance letter for the Royal Gwent hospital inspection).

The issues requiring immediate assurance for dental practices were:

- Decontamination and infection control
- Not notifying the Health and Safety Executive of radiographic equipment being used on the premises
- Out of date training on Cardiopulmonary Resuscitation
- Insufficient availability of emergency drugs and equipment

The issues requiring immediate assurance for the hospital inspection were:

- Patients not wearing wristbands
- Out of date Adrenaline and Glucose were found in the emergency drugs 'grab bag' held on the ward

In all cases we received sufficient assurance that swift action have been taken to resolve the issues identified.

6. Governance and Accountability

The governance arrangements for NHS Wales are set out within *Safe Care, Compassionate Care – A National Governance Framework to enable high quality Care in NHS Wales*[2]. Aneurin Bevan University Health Board is responsible for the quality and safety of services it provides and commissions.

HIW has observed a number of Quality & Safety Committees held at Aneurin Bevan University Health Board. We have also observed sub-committee meetings for Dental and Mental Health. Observing these committees has provided clarity to HIW on the strategic approach for assessing quality and safety within the health board. At these committees we have observed HIW inspection reports being scrutinised along with the associated action plans by both staff and independent members.

Annually, each health board and trust in Wales has been required, by Welsh Government, to complete a self-assessment of their position in relation to the Governance and Accountability module of Healthcare Standards for Wales, scoring their maturity on a scale of 1-5.

The self assessment conducted and submitted by Aneurin Bevan University Health Board for 2014-15 indicated the organisation's evaluation of its governance arrangements are effective. In particular, it indicated the following:

Under the 'Setting the Direction' theme, the board believed that they had demonstrated Level 4 maturity and that it is governing its business well highlighting the Dignity campaign and the work on the Values and Behaviours Framework as noteworthy practice. The board indicated Level 4 maturity for the 'Enabling Delivery' theme identifying the approach to collaboration and partnership working as a key focus for the health board. Similarly, for the 'Delivering Results, Achieving Excellence' theme the health board again scored themselves at Level 4 maturity.

In addition, statements from the Wales Audit Office Annual Report 2015 for Aneurin Bevan University Health Board concluded that the health board seeks

---

[2] *Safe Care, Compassionate Care – A National Governance Framework to enable high quality Care in NHS Wales* describes roles and responsibilities and what needs to be in place to seek and provide assurance about the quality and safety of health care services http://www.wales.nhs.uk/sitesplus/documents/888/Appendix%20Item%206%20Safe%20Care%2C%20Compassionate%20Care.pdf

continuous improvement, but it faces a number of challenges in the short term, while also working to transform services over the next three years.

7. Engagement

HIW has observed a number of Quality & Safety meetings and we have been invited and attended events held by the health board highlighting local improvements in processes.

The Relationship Manager and the Chief Executive of HIW have met with the Chief Executive and Chair of the health board during the year. Also, a number of HIW staff have been in discussion on a variety of matters with staff of the health board. On all occasions the health board has responded to requests for information meetings positively and promptly. There have been a number of occasions when HIW has written to the health board to follow up on specific concerns relating to local intelligence and these have also been dealt with appropriately. When asked, the health board has shared investigations with HIW. On some occasions the timeliness of these internal reports have taken longer than expected potentially due to their complexity.

Responses to inspection findings and immediate assurance letters have also been dealt with quickly and comprehensively.

8. Inspection Activity

National Health Service

Hospital

1. Royal Gwent and St Woolos	3 & 4 November 2015

General Practice

2. Bellevue Group Practice	23 February 2016
3. The Rugby Surgery	1 March 2016
4. Ringland Medical Practice	7 March 2016
5. Avicenna Medical Centre	9 March 2016

Dental Practice

6. Ringland Dental Practice	20 April 2015
7. St Julians Dental Practice	22 April 2015
8. Malpas Dental Practice	28 April 2015
9. Castle Street Dental, Tredegar	8 May 2015
10. Crown Cottage Dental Care, The Square, Bedwas, Caerphilly CF83 8DY	1 June 2015
11. Llantarnam Dental Practice	16 June 2015
12. Goodwin Partnership Practice	17 June 2015
13. Gateway OHS Limited	30 June 2015
14. Lawn Dental Practice, Unit 22, Lawn Industrial Estate, Rhymney, Tredegar NP22 5PW	28 July 2015
15. The Bridges Dental Surgery, Caldicot, Gwent	28 August 2015
16. IDH Dental Clinic 13 High Street, Bargoed, Caerphilly CF81 8QZ	1 December 2015
17. Usk Dental Practice	2 February 2016
18. Ponthir Dental Practice (Restore Dental Group)	2 March 2016
19. Beaufort Park Dental Surgery, Unit 1 Beaufort Park, Thornwell, Chepstow NP16 5UH	2 March 2016
20. Chepstow Orthodontics Ltd, 6A St Mary's Arcade, Chepstow, NP16 5EU	8 March 2016
21. Thomas & Stroud Dental Surgery, 383 Chepstow Road, Newport, NP19 8HL	9 March 2016
22. M J Dental Services Limited, 4 Mervyn Terrace, Osborne Road, Pontypool, NP4 6NW	10 March 2016
23. Abertridwr Dental Surgery, 5 Thomas Street, Abertridwr, Caerphilly, CF83 4AU	14 March 2016
24. Matthews and Jones Dental Practice, 5 Worcester Street, Monmouth, NP25 3DF	15 March 2016
25. Abersychan Dental Surgery	16 March 2016
26. Cardiff Road Dental Practice, 67 Cardiff Road, Newport, NP20 2EN	21 March 2016
27. S Lodge, New Inn Surgery, 111 The Highway, New Inn, Pontypool, NP4 0PJ	22 March 2016
28. Bridge Dental Care, Llanover Buildings, Newbrigde,	22 March 2016

Gwent, NP11 4EX	
29. Angel Way Dental Care, 58 Cardiff Road, Bargoed, CF81 8PA	23 March 2016
30. Mr R Isaac, Dental Surgery, 17 St James Square, Monmouth, NP25 3DN	29 March 2016
31. A & M Jones Healthcare, 26 Commercial Street, Pontnewydd, Cwmbran, NP44 1DZ	30 March 2016
32. J Woodward, 89 Bailey Street, Brynmawr, NP23 4AN	30 March 2016
33. Family Dental Health Centre, 19 Bedwlwyn Road, Ystrad Mynach, CF82 7AA	31 March 2016

Mental Health Act

34. Llanfrechfa Grange	19 May 2015
35. Ysbyty Aneurin Bevan	21 July 2015
36. Maindiff Court, Abergavenny (2 Wards)	9 September 2015

Community Treatment Order (CTO)

38. Aneurin Bevan CTO	9 March 2016

Learning Disability

39. Aneurin Bevan/Torfaen	27 January 2016

Independent Healthcare

Hospice (Adult)

1. St Annes Hospice	29 July 2015

Mental Health Act

2. St Teilos	28 April 2015
3. Llanarth Court (7 Wards)	11 May 2015
10. Aderyn	17 May 2015
11. Regis Healthcare, Ebbw Vale	23 June 2015
12. Cefn Carnau (2 Wards)	11 August 2015

Mental Health Unit

14. St Teilos	28 April 2015
15. Llanarth Court	11 May 2015
16. Aderyn	17 May 2015
17. Regis Healthcare, Ebbw Vale	23 June 2015
18. Cefn Carnau	11 August 2015

Dental Hospital

19. Kensington Court Clinic	12 November 2015

Laser

20. The Beauty Therapy & Electrosis Clinic, Llawr 1af, 46a Commercial Street. Casnewydd	10 June 2015
21. Chepstow Clinc	13 July 2015
22. CosmetixliniC	5 August 2015
23. AMA Limited	21 January 2016
24. MYA Cosmetic Surgery Ltd, 13 Castle Street, Cardiff	26 January 2016

Investigation – Deaths in Custody

25. HMP Usk and Prescoed	22 January 2016