Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Cardiff and Vale University Health Board Annual Report from Healthcare Inspectorate Wales 2015-16

August 2016

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 WG29477 Digital ISBN 978 1 4734 7211 2

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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 within the Cardiff and Vale University Health Board area.

The outcomes we seek to influence through this activity 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 25 inspections to Cardiff and Vale University Health Board settings, these included:

- 3 hospital inspections
- 4 general practice inspections
- 14 dental practice inspections
- 2 Mental Health Act visits
- 1 mental health unit inspection
- 1 Community Treatment Order (CTO) review.

In the independent sector within the Cardiff and Vale area, HIW has conducted 24 inspections to settings, these included:

- 1 hospice inspections
- 6 Mental Health Act visits
- 1 mental health unit follow-up inspection
- 2 independent clinic inspections
- 3 Ionising Radiation (Medical Exposure) Regulations IR(ME)R inspections
- 1 IVF clinic inspection
- 1 surgical laser inspection
- 7 laser inspections
- 1 Death in Custody investigation
- 1 Pre-registration manager interview.

3. Key Themes

During 2015-16 HIW conducted a variety of work within Cardiff and Vale University Health Board. A number of key themes have emerged this year and these are summarised below.

NHS Hospital Inspections

HIW undertook three hospital inspections during 2015-16. Two of these inspections were conducted in response to specific concerns brought to our attention.

St. David's Hospital, Elizabeth ward (responsive inspection): We found that the ward delivered care that was broadly consistent with most of the Health and Care Standards with an emphasis being placed on patients' health, wellbeing and dignity. We did however find scope for improvement in relation to:

- Patient continence assessments and care plans and the arrangements in place to support patients with regard to personal care and hygiene
- Lack of a mechanism to actively seek people's views concerning the quality and effectiveness of services provided

- Aspects of infection prevention and control
- Medicines management and record keeping.

HIW issued an immediate assurance letter in relation to the safe identification of patients and procedures around the safe administration of drugs to support the safety of both patients and staff.

Noah's Ark Children's Hospital: We found that each of the four clinical areas inspected were led by knowledgeable, motivated and passionate individuals who demonstrated a keen sense of purpose regarding the promotion of continuous improvement. We saw that a compassionate approach was adopted by staff, with privacy being respected and patients being treated with dignity and respect.

We received positive feedback from patients' families in general and specifically in relation to quality and presentation of meals.

We identified some areas for improvement in relation to:

- Medicines management
- Challenges presented by the layout on one ward
- Staffing levels and bed management arrangements.

We issued an immediate assurance letter due to the inadequacy of arrangements for correctly identifying children and the associated risk of medication error. This letter also asked for improvements to be made in relation to safety measures when a child has a latex allergy. HIW was sufficiently assured by the actions taken and additional information provided by the health board in response to this letter.

University Hospital Llandough (responsive inspection): HIW undertook a three day inspection as a result of concerns brought to its attention from a range of sources. HIW liaised closely with Cardiff and Vale of Glamorgan Community Health Council (CHC) in assessing these concerns and CHC members were involved in the delivery of the inspection.

Conversations with staff during this inspection demonstrated an on-going commitment to providing patients with a positive experience of NHS services. We found evidence of good leadership and management within three of the five clinical areas inspected. In the remaining areas, one ward manager was fairly new to their role and the other area required improvement with regard to leadership and management.

Overall, the quality of the patient experience was variable within the five clinical areas we visited. Feedback from patient questionnaires about the services received was generally positive. There were, however, a large number of patients who were unable to speak with us, or complete a questionnaire. This was due to their complex health needs and difficulties with communication.

As a result of very mixed findings, we were not assured that the systems in place in the areas we visited were sufficient to ensure that patients consistently received high quality, safe and reliable care.

We had serious concerns in relation to three areas of service provision:

- Record keeping within wards East 4 (Medicine) and Wards 10 and 18 Mental Health Services for Older People
- Medicines management (within each of the five areas inspected)
- Protection of patients at risk of harm (ward East 4).

This led to us take immediate corrective action. We also informed the health board of the need to address those issues as a priority.

Conversations with staff working within mental health services for older people revealed the difficulties they experienced in securing in-house general medical services during normal working hours. This undermined the ability of the ward teams to ensure that patients' physical health needs were swiftly addressed in addition to their mental health needs. This matter was discussed with senior managers who indicated that the health board was currently exploring ways to improve communication and working arrangements between clinical boards across the hospital site.

On day two of our inspection it was necessary to bring two service delivery issues, in relation to the protection of vulnerable adults, to the attention of the health board. As a result, two referrals were sent to the safeguarding team. These matters are in the process of being considered through the use of the All-Wales Protection of Vulnerable Adults (POVA) arrangements and the health board's disciplinary procedures respectively.

Findings in relation to staff insufficiency, aspects of record keeping and the management of medicines resulted in HIW issuing an immediate assurance letter. HIW took steps to meet with key representatives from the health board to seek further information and clarification on immediate improvements made. HIW was content with the improvement plan submitted by the health board although a number of actions were to be delivered in the following six month period. The health board has agreed to provide HIW with an update in

September 2016.

NHS Dental Practice Inspections

The inspections conducted within dental practices within the health board area highlighted the following themes:

- In all cases, patients and/or their carers told us they were happy with their dental treatment
- We found practice teams committed to delivering safe and effective care to patients, adopting a professional and helpful approach when speaking to patients
- Patients generally felt that they were given enough information about their treatment
- Dental care and treatment was planned and delivered in a way that was intended to ensure patients' safety and welfare
- Dental treatment was generally delivered in a safe, clean and tidy environment
- A small number of practices needed to make improvements to show they were fully complying with infection control and decontamination procedures
- We noted for a small number of practices that improvements should be made to patient records
- We recommended that four practices improve their arrangements for dealing with concerns/complaints so that they were in line with the NHS '*Putting Things Right*' arrangements and/or the requirements of the Private Dentistry Regulations
- We advised four practices of the need to invite patient comments and feedback as a means of improving services
- At three practices we made recommendations relating to the need to check emergency equipment and drugs to ensure that these remained suitable for use.

General Practice Inspections

During 2015-16 we conducted four inspections of General Practices within the health board area. The Community Health Council worked with us on these inspections to obtain patient views. Overall themes were as follows:

- Overall, patients indicated that they were treated as individuals and were satisfied with the care and support they had received
- Staff were courteous and professional when speaking with patients
- Practices were generally well run and led, with clear roles and responsibilities for team members
- Practices placed emphasis on quality and safety in accordance with the Health and Care Standards
- In three practices we concluded that further work could be done in relation to the health, safety and welfare of staff
- In two practices we asked for improvement to be made in relation to the recording of staff vaccination and immunity status
- In relation to child and adult protection arrangements, one practice demonstrated inadequate levels of staff training whilst another was asked to document its processes
- In one practice we reported that there were significant challenges in ensuring that care, treatment and support was provided in a way which met people's basic human rights such as privacy and informed choice. This conclusion related to poor layout, recent staff changes and limited resources/services relating to communicating with patients whose first language was not English.

NHS Mental Health Services

Our inspection at Iorwerth Jones Centre in June 2015 highlighted many areas of noteworthy practice. However, due to the environmental constraints of the ward, staff had many difficulties in caring for the patient group and undertaking their roles.

We observed good interactions between patients and staff. Patients' relatives spoke highly of the care that their relatives were receiving and stated that they felt that their relatives were safe at Iorwerth Jones Centre.

We noted that the Coed y Felin Ward Manager and Coed y Nant Acting Ward Manager were both enthusiastic and keen to develop their services. Both were recently appointed to their posts and were in the process of developing their teams and addressing staff training deficits. Both ward teams spoke of good team spirit and support from their colleagues.

Despite the inappropriate configuration of the wards for dementia care, a great effort had been made to create a dementia friendly design environment. The general decoration was noted to be of a good standard and suitable to the patient group. However, we did note that storage on both wards was very limited and a high number of areas where maintenance is required.

We highlighted a number of areas that required improvement with regards to medicine management, prescribing and administration practices.

Mental Health Community Treatment Order (CTO) Inspection

Our mental health Community Treatment Order inspections during 2015-16 sought to assess the quality and safety of mental health Community Treatment Order provision in Wales.

The following key findings emerged from our inspection of community mental health services:

- We found that 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[1] (the Code of Practice). Conditions of CTOs were clear and appeared consistent with the principle of being least restrictive. CTOs were kept under review by the care team to ensure that they were still necessary for providing care to the patient within the community.

- It was evident from entries in patients' notes that consideration for the commencement, extension, recall or revocation of a CTO was a multidisciplinary team decision involving staff from the health board and

[1] A guide for mental health practitioners who have to make decisions within the scope of the Mental Health Act 1983, shaping the way that the legislation is put into practice. The Code also acts as a guide to patients and those who support and advise them. http://www.wales.nhs.uk/sites3/documents/816/mental%20health%20act%201983%20code%20of%20practice%20for%20wales.pdf

local authority. The views of staff from all disciplines and teams were considered and valued.

- There was good communication between the different teams involved with the CTO process. With a unified computer system between the health board and the local authorities, up-to-date information was readily available for staff involved with the patient's care.

- However, staff raised concerns with the process of transporting a patient back to hospital when required. There was no standardised process and on occasions it could difficult to facilitate transport where different agencies were involved.

4. Special Reviews and Investigations

Homicide Review

In March 2016, HIW published the findings of a review 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 Cardiff and Vale University Health Board. This report found:

- Cardiff and Vale University Health Board, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan 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.

- Cardiff and Vale University Health Board, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board, HMP Cardiff and HMP Parc should ensure procedures are in place that 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 Community Mental Health Teams 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.

- Cardiff and Vale University Health Board, Abertawe Bro Morgannwg University Health Board and Aneurin Bevan University Health Board should develop clear lines of accountability regarding the responsibility for attempting to engage with individuals who regularly do not attend appointments.

- Stakeholders that 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 its review and those relating to Cardiff and Vale University Health Board are highlighted above, it does not believe that the presence of these issues contributed to the tragic incident.

Death In Custody Clinical Reviews

HMP Cardiff - Suicide

During 2015-16 HIW contributed to one (suicide) death in custody review relating to HMP Cardiff. From the clinical review it was evident that the individual received appropriate assessment of their physical and mental health, and that their ongoing care and treatment was congruent with their identified needs. There were no observed or expressed indications of self harm or suicide expressed by the individual throughout the period of their detention that would have alerted staff to any risk. HIW's recommendations following the review

were in relation to record keeping, in particular ensuring clinical entries are kept in line with the Nursing and Midwifery Council Code (2015).

Evaluation of homicide reviews undertaken by HIW since 2007

During 2015-16 HIW published an evaluation of homicide reviews[2] 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.

[2] http://hiw.org.uk/docs/hiw/reports/160307homicidereviewreporten.pdf

Welsh Health Specialised Services Committee (WHSSC) review

During 2015-16 we published a review[3] 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.

[3] http://hiw.org.uk/docs/hiw/reports/151221clinicalgovernancereviewen.pdf

5. Follow Up and Immediate Assurance

Follow Up

Following each of our inspections we issued an inspection report with our findings. Where we identified improvement was needed, we also required the health board or practice to provide us with an improvement plan setting out corrective actions to be taken.

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 by the inspected body.

We 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 were 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 these matters.

HIW has gained some additional assurance in this respect during its programme of hospital inspections during 2015-16. 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 2014-15 or evident elsewhere within the health board. It was evident from this follow up activity that the health board seeks to use our inspections to improve the quality and safety of its services by ensuring that the recommendations made by HIW are actioned and that any issues raised during inspections are not replicated elsewhere within the health board.

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 three immediate assurance letters in relation to the following hospital inspections:

- St David's Hospital
- Noah's Ark Children's Hospital

- University Hospital Llandough.

The identification of patients and safe administration of drugs was a common theme across all three immediate assurance letters. In the case of Llandough, HIW asked to meet with the Chief Executive of the Health Board and his representatives in order to ensure that rapid action was taken in relation to multiple issues including:

- Insufficient numbers of registered nursing staff in some areas
- Aspects of record keeping
- Management of medicines.

The health board engaged positively with HIW in relation to the immediate assurance processes outlined above.

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*[4]. Cardiff and Vale University Health Board is responsible for the quality and safety of services it provides and commissions.

HIW inspection activity during 2015-16 has considered the health board's governance arrangements. In general we found that the health board had arrangements in place to monitor the quality and safety of the services it provides through regular audit and reporting activity.

It should be noted however, that following the Llandough hospital inspection, HIW asked the health board to consider the effectiveness of governance arrangements given the extent to which it was seemingly unsighted on a number of the issues found during the inspection. In response, the health board clarified a number of internal arrangements and the actions that it proposed to take, which included:

[4] *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

- How staff escalate concerns around staffing levels
- Plans to increase the frequency of internal inspections
- The fact that Internal Audit have been commissioned to look at governance arrangements across the health board, with a specific focus on how key information from Directorate level is discussed and escalated to Clinical Board and Executive Board.

HIW was assured by the information it received and the actions to be taken by the health board. The health board has agreed to provide HIW with an update in September 2016 of progress towards delivery of proposed actions.

7. Engagement

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 meetings positively. 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 it has taken longer that expected to receive these internal reports although it is understood that this was due to the complexity of certain investigations.

HIW engaged fully with the independent review commissioned by the health board into the circumstances surrounding the incident at Splott Road Dental Practice.

HIW was encouraged that the review identified that current HIW processes are robust, and that the health board has sought to make changes to its governance arrangements of dental practices to learn from the incident.

HIW has, alongside the health board and Welsh Government, considered the recommendations in the report and will respond in due course.

It is encouraging that processes have moved on since the time of the incident, and this has been evidenced recently when information came to HIW about a practice in the Cardiff area. HIW and the health board worked together to identify appropriate steps to ensure that patients were not put at risk.

8. Inspection Activity

National Health Service

Hospital

1. St David's Hospital	26 August 2015
2. Noah's Ark Children's Hospital	7 October 2015
3. University Hospital Llandough	9 February 2016

General Practice

4. Fairwater Health Clinic, plasmawr Road, Fairwater, Cardiff, CF5 3JT	19 August 2015
5. Ravenscourt Surgery 36-38 Tynewydd Road, Barry, CF62 8AZ	12 November 2015
6. Roathwell Surgery 116 Newport Road, Cardiff, CF24 1Y	6 January 2016
7. Station Road 15/16 Station Road, Penarth, CF64 3EP	2 February 2016

Dental Practice

8. 2 Porthkerry Road, Barry, Vale of Glamorgan CF62 7AX	5 May 2015
9. Colchester Dental Surgery Ltd, 1-3 Lady Margaret Court, Colchester Avenue, Cardiff CF23 9AW	19 May 2015
10. 29 Park Crescent, Barry, Vale of Glamorgan CF62 6HE	28 May 2015
11. The Courtyard Dental Care, 4 Rachel Close, Danescourt, Cardiff CF5 2SH	2 June 2015
12. The Pines Dental Surgery, Heol Y Forlan, Whitchurch, Cardiff CF14 1AX	9 June 2015
13. Fairwater Green Dental Practice, 6 Fairwater Green, Fairwater, Cardiff CF5 3BA	11 June 2015
14. IDH Dental, 21 Splott Road, Cardiff, CF24 2BU	15 June 2015
15. Rhiwbina Dental Surgery, 25 Heol Y Deri, Rhiwbina, Cardiff CF14 6HB	25 August 2015
16. P D Care Ltd, 31 Kenmare Mews, Pontprennau, Cardiff, CF23 8RJ	27 August 2015
17. St Mary's Street Dental Surgery, 28 St Mary Street, Cardiff CF10 1AB	20 October 2015
18. Dental Surgery, 57 High Street, Cowbridge, Vale of Glamorgan, CF71 7AF	10 November 2015
19. Lakeside Dental Practice, 62 Celyn Avenue, Lakeside, Cardiff CF23 6EP	8 December 2015
20. Cowbridge Dental Care, 30 High Street, Cowbridge, Vale of Glam, CF71 7AG	16 December 2015
21. Trelai Park Dental Clinic, 122 Cowbridge Road West,	26 January 2016

Ely, Cardiff CF5 5BT	

Mental Health Act

22. Iorwerth Jones Centre (2 Wards)	16 June 2015

Mental Health Unit

24. Iorwerth Jones Centre	16 June 2015

Community Treatment Order (CTO)

25. Cardiff & Vale	19 January 2016

Independent Healthcare

Hospice (Children)

1. Ty Hafan	5 November 2015

Mental Health Act

2. Ty Catrin (6 Wards)	23 February 2016

Mental Health Unit follow-up

8. Ty Catrin	23 February 2016

Independent Clinic

9. Cyncoed Consulting Rooms, 277 & 350 Cyncoed Road, Cardiff, CF23 6PA	12 August 2015
10. Synexus Ltd, 1-2 Purbeck House, Llanishen Business Park, Cardiff CF14 5GJ	18 August 2015

IR(ME)R

11. Cardiff Bay Hospital	20 August 2015
12. Vale Hospital	21 August 2015
13. Spire	15 October 2015

IVF

14. London Women's Clinic (Cardiff)	15 September 2015

Laser - Surgical

15. Optical Express 46-48 Queen Street, Cardiff CF10 2GQ	4 August 2015

Laser

16. FACE cosmetics	30 June 2015
17. Visible Changes	29 September 2015
18. Skin Deep Beauty and Laser Clinic	14 October 2015
19. Beauty Advance Laser Therapy Ltd	17 November 2015
20. Laserase (Wales)	25 January 2016
21. Beauty Within	9 February 2016
22. DestinationSkin Ltd	16 March 2016

Pre-Registration Managers Interviews

23. TFHC Limited	9 April 2015

Investigation – Deaths in Custody

24. Cardiff HMP (Mr BT)	29 November 2015