Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Cwm Taf University Health Board Annual Report from Healthcare Inspectorate Wales 2015-16

August 2016

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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 Cwm Taf University Health Board.

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 21 inspections at Cwm Taf University Health Board settings, these included:

- 2 hospital inspections
- 4 general practices inspections
- 9 dental practices inspections
- 4 Mental Health Act visits
- 1 Mental Health Unit inspections
- 1 Community Treatment Order (CTO) review.

In the independent sector within the Cwm Taf area, HIW has conducted 10 inspections to settings, these included:

- 4 Mental Health Act visits
- 3 Mental Health Unit inspections
- 1 IVF clinic inspection
- 2 laser inspections.

3. Key Themes

During 2015-16 HIW conducted a variety of work within Cwm Taf University Health Board. There are a number of key themes that have emerged through the work this year. These are summarised below.

NHS Hospital Inspections

The inspections we conducted indicated the services generally provided person-centred care that was safe, effective, dignified and timely.

The women and child health directorate placed considerable emphasis on ensuring that people had a positive experience of services provided. It was evident that the directorate made every effort to listen to people who received care and their families. The health board actively sought people's views concerning the quality and effectiveness of its services.

We found that leadership and management was visible, strong and effective within the women and child health directorate; senior nurses and ward managers providing us with descriptions of how they strive to ensure a high standard of care to their patients. In all areas visited, staff were clear and knowledgeable about their particular roles and responsibilities and enjoyed working as part of well established teams.

Overall, we found that there was enough staff, with the right knowledge and skills to meet people's needs.

Discussions with a wide range of staff throughout the women and child health directorate and the content of completed HIW staff questionnaires demonstrated that the health board fostered a culture of learning and personal and professional integrity.

HIW issued the health board with an immediate assurance letter as a result of this inspection. This was to ensure that there was a suitable system in place for the identification and safety of all patients across the organisation at all times. HIW has since received a satisfactory response from the health board in terms of their stated monitoring arrangements and action taken following our findings. The immediate assurance letter was responded to promptly and satisfactorily.

We also identified the need for some improvement with regard the timely access to Child and Adolescent Mental Health Service crisis assessment for children and young people within the women and child health directorate. These aspects were addressed within the improvement plan submitted by the health board. Again, HIW has since received a satisfactory response to our findings.

NHS Dental Practice Inspections

The inspections conducted within dental practices within the Cwm Taf area highlighted the following themes:

- 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.
- Our inspections found that some practices needed to make improvements to show they were fully complying with infection control and decontamination procedures.
- We also found that some dentists needed to improve their record keeping to demonstrate they were planning care to promote patient safety and wellbeing.
- We noted for a number of practices that improvements should be made to patient records with regards to patient medical history and evidence that this has been discussed with the patient
- A number of practices lacked a display of private price. This is required so that patients are fully informed of the costs associated with their dental treatment.
- Not all practices displayed complaints notices for both the NHS and Private Dentistry complaints procedure, nor displayed other relevant organisations for patients to contact about their treatment such as HIW and the Public Services Ombudsman for Wales.

General Practice Inspections

We conducted a number of GP inspections during 2015-16. Universally the appointment system was one area which all service users we asked commented upon. In particular patients raised the issue of not always having their choice of GP. However, practice managers were aware of this and appeared to be reviewing their approach to booking appointments on a regular basis . There have been a number of approaches utilised within the practices, which were informed by appropriate review of service user feedback.

We found that creative approaches were being used to encourage patients to positively manage their lifestyles. This including weight management sessions during the patient visits. There was an appropriate use and display of information covering a range of health and lifestyle subjects including access details and contact numbers. Overall service users appeared happy with the services provided.

There was a strong sense of community commitment to the individual practices with a number of patients referring positively to the staff team members within the individual practices. It was noted that the role of the practice manager was an important element within the practices.

Environmentally, where practice buildings were leased, there were potential problems regarding alterations and extensions. A number of the practices had small teams with very limited gender mix.

No assurance letters were required or issued with regard to these visits.

NHS Mental Health Services

It was pleasing to note that the majority of patients we spoke to during our inspections said they felt safe at the hospitals.

At one hospital there were concerns regarding nurse staffing levels, particularly at night. During our inspection the staff levels had the potential to compromise patient and staff safety if an incident was to occur.

At one hospital there were significant environmental and maintenance issues were identified which were having an impact upon staff and patients.

We noted that provision of Community Treatment Orders (CTOs) was managed via multidisciplinary team working which included staff from local authorities and the independent sector. 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].

4. Special Reviews and Investigations

During 2015-16 HIW conducted a follow up of the governance arrangements in Cwm Taf University Health Board. This was published in August 2015. The review assessed the progress made against the previous governance review published in 2012 and focussed on three areas: general practice, mental health services and stroke services.

Generally HIW were pleased with the progress made since the previous review with most areas showing improvement. The findings of the report highlighted how the health board had evolved over the past few years. There was evidence of improvements in mental health services including a shift from hospital to community based services.

The review also identified some areas which required focus including some inconsistency across the health board in following processes and procedures, for example, the methods for recording complaints and incidents.

Welsh Health Specialised Services Committee (WHSSC) review

During 2015-16 we published a review[2] 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

[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

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

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[3] 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

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

- 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.

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 on how they were going to make the improvements.

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 by the inspected body. In addition, the plans from dental practices were generally provided within the given timescale.

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 the majority of these matters.

HIW has gained some additional assurance in this respect during our 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 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.

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 2 immediate assurance letters to the health board. Our inspection across Prince Charles Hospital and Royal Glamorgan hospital resulted in an immediate assurance letter as we identified identification wristbands were not in place for all in-patient babies/children and young persons.

Following our inspection to the mental health service based at Royal Glamorgan Hospital we issued an immediate assurance letter with regards to:

- Low staffing numbers on two of the wards which had the potential for impacting on patient safety.
- Unsuitable furniture that was not appropriate to the type of mental health ward as it had fittings that could be used to cause self-harm.

On both occasions these were responded to in a timely fashion.

Independent Healthcare

In addition, we issued an immediate assurance letter to an independent provider following a laser Inspection to Little Acorns which identified that a large number of improvements were needed, many of which are breaches to the Independent Health Care (Wales) Regulations 2011. Given the extent of our

concerns, HIW informed the service that they should stop providing all laser treatments to patients until such time they had taken appropriate action to address the breaches of the regulations and provided HIW with sufficient assurance of the action you have taken to comply with the regulations. Following the inspection the service stopped providing services that required registration and de-registered.

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]. Cwm Taf University Health Board is responsible for the quality and safety of services it provides and commissions.

As outlined above during 2015-16 HIW conducted a follow up of the governance review of Cwm Taf University Health Board and a clinical governance review of WHSSC.

In addition, HIW has observed a number of Quality & Safety Committees held at Cwm Taf University Health Board. 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.

Cwm Taf University Health Board's vision is to "care for our communities and patients by preventing ill health, promoting better health, providing excellent services and reducing the need for inpatient care wherever possible through the provision of strengthened home, primary and community care".

Annually, each health board and trust in Wales is 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.

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[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

The self assessment conducted and submitted by Cwm Taf 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 strengthened assurance processes and the integrated performance dashboard. The board indicated Level 4 maturity for the 'Enabling Delivery' theme highlighting improvements in the Quality & Safety Committee and the mortality review process which as been shared as a national exemplar. 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 Cwm Taf University Health Board concluded "Governance arrangements continue to evolve but some aspects, particularly ICT, are making insufficient progress, and achieving financial balance for 2015-16 remains a challenge."

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 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.

8. Inspection Activity

National Health Service

Hospital Inspections

1. Royal Glamorgan & Prince Charles	28 June 2015
2. Royal Glamorgan	16 October 2015

GP Inspections

3. Practice 1 Kier Hardie Health Park, Aberdare Road, Merthyr Tydfil CF47 1BZ	16 February 2016
4. St David's Surgery, St David's Street, Ton Pentre CF41 7BD	23 February 2016
5. Penygraig Surgery, George Street, Penygraig CF40 1QN	1 March 2016
6. Talbot Green Group Practice, Newpark Surgery, Heol Y Gyffraith, Llantrisant CF72 8AJ	8 March 2016

Dental Inspections

7. The Dental Surgery 5 Ceridwen Terrace, Pontypridd CF37 4PD	16 June 2015
8. Porth Dental Teaching Unit, Leith House, 5-6 Pontypridd Road, Porth CF39 9PH	23 June 2015
9. Bryant Dental Practice, 18 High Street, Treorchy Mid Glam CF42 6AA	7 July 2015
10. Cyfartha Dental Care, Rookwood House, Gwaelodygarth Lane, Merthyr Tydfil CF47 8EX	2 December 2015
11. Whitcombe Dental Surgery, 19 Whitcombe Street, Aberdare, CF44 7AU	5 January 2016
12. Maendy Dental Practice, 3 Maendy Place, Aberdare	9 February 2016
13. Dental Department, Keir Hardie Health Park, Aberdare Road, Merthyr Tydfil, CF48 1BZ	23 February 2016
14. IDH Courtyards Dental Centre, 73 - 75 Talbot Road, Talbot Green, CF72 8AE	8 March 2016
15. Goodwin Partnership DBS Ltd, 21 Grawen Street, Porth, CF39 0BU	9 March 2016

Mental Health Act

16. Ty Llidiard, Bridgend (2 Wards)	12 May 2015
18. Pinewood House, Treorchy	11 August 2015
19. Royal Glamorgan	13 October 2015

Mental Health Unit

20. Royal Glamorgan	13 October 2015

Community Treatment Order (CTO) Inspections

21. Cwm Taf	16 November 2015

Independent Healthcare

Mental Health Act

1. Heatherwood Court (2 Wards)	2 June 2015
3. Priory, Aberdare	11 January 2016
4. Priory Church Village	22 March 2016

Mental Health Unit

5. Heatherwood Court	2 June 2015
6. Priory, Aberdare	11 January 2016
7. Priory, Church Village	22 March 2016

IVF

8. Centre for Reproduction & Gynaecology Wales (CRGW)	12 January 2016

Laser

9. Bliss Beauty by Cerys	11 January 2016
10. Little Acorns	19 January 2016