Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Cardiff and Vale University Health Board Annual Report from Healthcare Inspectorate Wales 2016-17

July 2017

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This document is also available in Welsh.

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. Purpose

This annual report has been produced as a summary of the activity that HIW carried out between 1 April 2016 and 31 March 2017 within Cardiff and Vale University Health Board.

2. Overview

During the year, HIW conducted 34 inspections or visits at Cardiff and Vale University Health Board settings, these included:

- 3 hospital inspections, one was a follow-up inspection
- 4 general practice inspections
- 10 dental practice inspections
- 6 learning disability inspections
- 4 Mental Health Act (MHA) visits
- 1 mental health unit inspection
- 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection
- 5 Death in Custody investigations.

3. Key messages

The inspections conducted within Cardiff and Vale University Health Board generally indicate that the care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff. Our work highlighted the following issues which may require further attention.

- The quality of documentation was cited as requiring improvement in a range of inspection types during the 2016-17 inspection year including hospital and dental inspections
- Issues with maintenance and improvement of some clinical environments.

4. Inspection findings

During 2016-17 HIW conducted a variety of work within Cardiff and Vale University Health Board. There are a number of key themes that have emerged through the work this year. These are summarised below.

Hospital Inspections

Key findings from hospital inspections during 2016-17 are as follows:

- HIW inspected wards C6 and C7 at University Hospital of Wales (UHW) in October 2016. We found effective systems in place for the sustainable delivery of safe, effective, person centred care and patients were happy with the service being provided. All documentation was completed to a good standard and in sufficient detail. Risk assessments and plans were seen to be reviewed regularly and were up-to-date. We made recommendations in relation to health and safety, building maintenance and repair, medicines management, infection prevention and control and the recording of patients' weight.

- HIW carried out a follow up inspection at University Hospital Llandough in March 2017. We found that appropriate action had been taken in relation to our previous inspection in February 2016. We found evidence that care was safe and effective across the four wards inspected. We made recommendations in relation to a maintenance issue, correct use of door observation panels, delivery of unified care between mental health and medical services, and staff engagement on the future health board provision of Mental Health Services for Older People.

- An inspection of the Emergency Unit (EU) at UHW was completed in March 2017. Overall, we found evidence that the EU provided a good standard of care and treatment to patients. This was evidenced as we received positive feedback from patients and family with staff demonstrating enthusiasm and compassion in providing safe and dignified care. We observed senior members of nursing and medical staff providing guidance and support to junior members of staff in a timely manner. There was evidence of different staff groups working well together throughout the EU and clinical environments were clean and tidy. We made recommendations in relation to the condition of the paediatric unit environment as well as the environment leading to wards, which could pose a health and safety risk to patients and staff. There was also scope for improvement in adherence to infection control practices and principles.

Mental Health

Our inspection of the Hafan y Coed mental health unit concluded that on the whole, effective care was being provided to patients. We commented positively on the respectful manner in which care was being delivered in a safe environment and the fact that patients were provided with up-to-date information in written form or through speaking to staff. We did however have some concerns relating to the management of medication and environmental design which could impact on patient safety.

Ionising Radiation (Medical Exposure) Regulations

Whilst the HIW inspection team did not find any imminent risk of harm to patients in receipt of services within nuclear medicine services, it did discover systemic failings in relation to staff entitlement as required within the Regulations. This meant that staff in general across nuclear medicine services may not have been clear about who was entitled to act as a referrer, practitioner or operator, as required by the Regulations. This could have potentially led to an error and unnecessary harm to patients. As a result, it was necessary for HIW to issue a non-compliance letter to the health board

General Practice

We found that services were operating very well, and were providing safe and effective care, despite the challenges faced in terms of trying to provide patients with timely appointments in response to their needs. Overall we found evidence of good management and leadership, with two practices in particular having developed very good systems of audit and governance. Areas for improvement were identified in two practices, as follows:

- The need to ensure that sharps containers were securely stored in consultation rooms
- Staff training in relation to chaperone duties
- The need for display screen equipment (DSE) staff risk assessments
- The need to amend/strengthen Putting Things Right arrangements.

Dental

We completed ten inspections of dental practices providing NHS treatment. These inspections highlighted the following themes:

- In all inspections, patients told us they were happy with the service provided
- We found the majority of practices to be well equipped, clean and tidy
- In most cases, documentation and information was available to show that x-ray equipment was being used safely
- Staff felt supported or well managed in five practices
- HIW found that record keeping needed to improve at all ten inspections
- Decontamination and sterilisation issues were noted in nine inspections
- The need for further staff training, or for staff training needs to be assessed was an issue at five practices
- Poor state of repair or unsatisfactory nature of the environment was highlighted in four inspections.

Learning disabilities

Community health learning disability services in the Cardiff and the Vale of Glamorgan area are the responsibility of Cardiff and Vale University Health Board. However, these, and residential services are provided by Abertawe Bro Morgannwg University Health Board. During 2016-17 HIW undertook six inspections of residential settings and one community learning disability team inspection.

Our inspection of the community learning disability team (CLDT) revealed a passionate and committed staff team with a strong values base and we found evidence that the CLDT was effective in delivering a range of multidisciplinary assessments and interventions.

Health staff were proactive in preventative work which they undertook alongside clinical roles. However, we found that the health board needed to take a more strategic approach to raising awareness and implementing best practice for people with learning disabilities receiving primary and secondary care.

Overall, we found a lack of appropriate service provision available, particularly where specialist services were required, and a lack of effective joint planning

with Abertawe Bro Morgannwg University Health Board around future service provision. There was a need for both health boards to work together to map and understand the current needs of the Cardiff and Vale of Glamorgan learning disability population in order to effectively plan future services.

We found that improvement was needed to the overall governance of learning disability service provision so that there was clarity about population needs, Abertawe Bro Morgannwg University Health Board's service specification and systems of oversight.

5. Special reviews, investigations and thematic findings

We did not undertake any special reviews or investigations within Cardiff and Vale University Health Board during 2016-17. HIW undertook five clinical reviews to support the work of the Prison and Probation Ombudsman in relation to death in custody incidents.

Death in custody clinical reviews – HMP Cardiff

During 2016-17 HIW contributed to five (four natural and one suicide) death in custody reviews relating to HMP Cardiff. Of the five, two reviews are still ongoing.

From the three clinical reviews that have been completed, it was evident that the standard of healthcare provided to the individual during their time in custody was of a satisfactory standard and similar or better than would have been available in the community.

One case saw the individual die of an uncommon complication of a pre-existing condition which was not foreseeable before his operation. This complication was very unlikely to have been present before he was admitted to hospital prior to his death. The prison service dealt with him appropriately and promptly.

One case saw the individual diagnosed with cancer. He was seen regularly by the palliative care team and detailed care plans were created. He did not want to be admitted to hospital and he received full palliative care at HMP Cardiff. The care he received from the prison service was excellent.

One case saw the individual die due to self inflicted death. The care given to him was generally of a high standard, although some shortcomings and omissions were highlighted that needed addressing. However, there was

nothing to suggest that had these been in place, the death of the individual would have been avoided.

HIW made recommendations in relation to record keeping, transfers to secondary care appointments and the quality and completeness of discharge information.

Learning Disability Services Thematic Report 2015-16

During 2016-17 HIW published a thematic review[1] of NHS health services for people with learning disabilities in Wales. The review set out to identify common strengths and areas for improvement, and makes recommendations for health boards. It also highlights good practice, to support improvement in the services provided to people with a learning disability in Wales. The key findings for Wales are below:

- Our findings were mostly positive about the services provided by community learning disability health teams
- We found that NHS residential services for people with learning disabilities required significant improvement in many areas
- We found that people usually received good individual care from staff who tried their best to care for patients
- Care for patients was often not underpinned by good management and staffing arrangements.

All health boards need to consider the purpose of their learning disability NHS residential settings and whether the care being provided at these establishments is purely healthcare. If not, health boards should consider whether a social model of care is more appropriate.

[1] http://hiw.org.uk/docs/hiw/reports/161208ldreviewen.pdf

Ophthalmology Services Thematic Report 2015-16

During 2016-17 HIW published a thematic review[2] of Ophthalmology Services. The review set out to look across the boundaries of primary and secondary care to examine how providers were delivering and developing services. The review focussed on 'wet' Age Related Macular Degeneration (AMD), due to risks associated with any delay in treatment for patients. The key findings from our review were:

- Eye care services across Wales have insufficient capacity in secondary care to meet current demands
- The absence of key personnel can cause parts of the care pathway to stop working effectively increasing the risk of potential avoidable harm to patients
- Health boards need better information about the demand capacity gap to enable informed workforce planning decision
- We heard that poor working relationships between primary and secondary care in some health board areas have hindered efforts to improve joint working
- We saw some new initiatives across Wales relating to delivery of 'wet' AMD services, including the introduction of non-medical injectors, however progress in development and delivery of these initiatives has not been consistent across health boards.

All health boards need to understand that further development of services is required to fully utilise available resources to strengthen infrastructure and sustainability of eye care services.

[2] http://hiw.org.uk/docs/hiw/reports/170131opreviewen.pdf

6. 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. For some inspections, we will undertake a follow up inspection to ensure improvement plans have been actioned.

- University Hospital Llandough – During an unannounced inspection in February 2016, HIW highlighted significant failings within medical and mental health services for older people areas of the hospital. In order to assess progress following this inspection, HIW undertook a follow up inspection in February 2017. Whilst we made a number of recommendations, we found that appropriate action had been taken in relation to the February 2016 inspection.

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.

Of the inspections conducted across Cardiff and Vale University Health board only one inspection resulted in an immediate assurance letter. In this instance the letter was in the form of a non compliance letter associated with a breach in relation to the Ionising Radiation (Medical Exposures) Regulations (IR(ME)R). The HIW inspection team did not find any imminent risk of harm to patients in receipt of services within nuclear medicine services. However, the discovery of the systemic failure in respect of 'Entitlement' means that staff in general across nuclear medicine services may not be clear about who is entitled to act as a referrer, practitioner or operator, as required by the Regulations. This could potentially lead to an error and unnecessary harm to patients.

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7. Governance

During 2016-17 the health board had a number of opportunities to demonstrate that it is a learning organisation. As issues arose, the health board responded soundly, seeking clarification where necessary and engaging with HIW to ensure that it could improve services where necessary.

It is clear that the health board ensures that inspection reports are discussed at its Quality, Safety and Experience Committee in order to extract any learning from these inspections and to monitor the implementation of any actions required. The Committee also appears firmly focused on exploring and addressing some of the major challenges to patient safety not covered in HIW's reports.

8. Engagement

During 2016-17 the HIW Relationship Manager attended a number of meetings with health board staff including presenting the 2015-16 Health Board report to the Public Board.

HIW's Relationship Manager also meets regularly with the Director of Nursing in order to exchange information and, where necessary, discuss any further assurance required following inspection activity or issues raised with the health board.

During the year the health board was very welcoming to any approaches from HIW. This positive working relationship enabled HIW to contribute to the health board's 'when the inspector calls' workshops aimed at providing staff with a sense of what it is like to be inspected and how to engage positively with the process.

Correspondence between HIW and the health board was dealt within a timely and satisfactory way.

The Chief Executive of HIW met with the Chief Executive and Chair of the health board during July 2016.

9. Inspection, special review, investigation and thematic activity

Hospital inspections

1. University Hospital of Wales	18 October 2016
2. University Hospital of Llandough (Follow-up inspection)	27 February 2017
3. University Hospital of Wales	6 March 2017

GP inspections

4. Four Elms Medical Centre, Stirling Close, Pengam Green, Cardiff. CF24 2HB	18 January 2017
5. The City Surgery, 187 City Road, Roath Cardiff. CF24 3WD	24 January 2017
6. Cloughmore Medical Centre, 19 South Park Rd, Splott, Cardiff. CF24 2LU	31 January 2017
7. Meddygfa Albany Surgery, 219 - 221 City Rd, Roath, Cardiff. CF24 3JD	23 February 2017

Dental inspections

8. Nicola Taaffe@West Grove, Roath, Cardiff, CF24 3AN	26 September 2016
9. Ellen Davies Dental Practice, 4a Barons Close House, East Street, Llantwit Major, Vale of Glamorgan, CF61 1XY	27 October 2016
10. Dental Surgery, 57 High Street, Cowbridge, Vale of Glamorgan, CF71 7AF (Follow-up inspection)	14 November 2016
11. Cardiff Smile Centre, 113 Clare Road, Grangetown, Cardiff, CF11 6QR	15 November 2016
12. Wilson Road, Dental Surgery, 29 Wilson Road, Ely, Cardiff, CF5 4LL	18 November 2016
13. Smiles Dental, 68a Cowbridge Rd East, Cardiff, Canton, CF11 9DU	24 November 2016
14. Cathedral Orthodontics, 80 Cathedral Road, Pontcanna Cardiff, CF11 9LN	5 December 2016
15. The Orthodontic Centre, Beck Court, Cardiff Gate Business Park, Pontprennau, Cardiff, CF23 8RP	5 January 2017
16. Wilton House Dental Practice, 49 Station Road, Llandaff North, Cardiff, CF14 2FB	28 February 2017
17. My Dentist practice, 17 Quay Street, Cardiff, CF10 1EA	21 March 2017

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Inspection

18. University Hospital of Wales, Nuclear Medicine Services	5 October 2016

Learning Disability inspections

19. ABMU managed residential service	2 June 2016
20. ABMU managed residential service	14 June 2016
21. Rowan House, Ely, Cardiff	27 June 2016
22. Hafod Y Wennol, Hensol, Nr Pontyclun	28 June 2016
23. Cardiff and Vale Learning Disability Community Team	4 July 2016
24. ABMU managed residential service	5 July 2016

Mental Health Act monitoring inspection

25. Hafan Y Coed, University Hospital of Llandough (4 visits)	27 February 2017

Mental Health Unit inspection

29. Hafan Y Coed, University Hospital of Llandough	27 February 2017

Investigation - Death in Custody

30. Cardiff HMP	May 2016
31. Cardiff HMP	November 2016
32. Cardiff HMP	February 2017