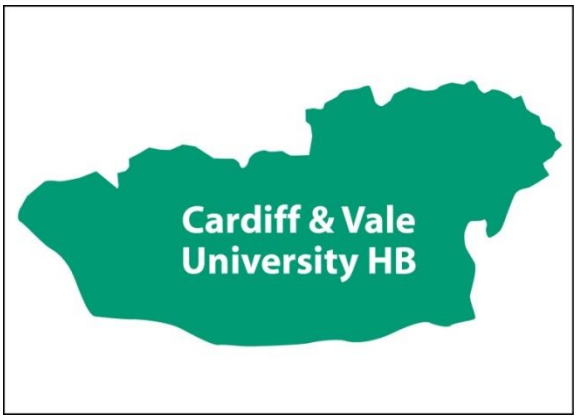
Cardiff and Vale University Health Board Annual Report from Healthcare Inspectorate Wales 2014-15

Relationship Manager: Alun Jones
Healthcare Inspectorate Wales
Tel: 0300 062 8382

Purpose

Healthcare Inspectorate Wales (HIW) is the lead independent inspectorate for healthcare in Wales. Its purpose is to provide independent and objective assurance on 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 2014 and 31 March 2015 in Cardiff and Vale 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.

Overview

During 2014-15 HIW focussed its inspection programme to create broad coverage across the NHS by type of setting and speciality. During the year HIW has conducted 30 visits to Cardiff & Vale University Health Board settings, these include 10 Dignity and Essential Care Inspections (DECI), 13 dental inspections, four GP inspections and three Mental Health Act visits. HIW has also undertaken two death in custody investigations.

In the independent sector, HIW has conducted 33 visits to the Cardiff and Vale area; these include four acute hospital inspections, three Mental Health Unit inspections, four Adult Hospice Inspections, four independent clinic inspections, one Slimming Clinic inspection, one Termination of Pregnancy service inspection, 13 laser clinics inspections. three Mental Health Act Visits (nine wards).

Key Themes

The following key themes were picked up during dignity and essential care inspections (DECIs) during 2014-15.

- Patient feedback positive with dignity and privacy maintained with patients being encouraged to regain independence
- Generally, staffing levels on wards within general hospitals have been appropriate to meet the presenting needs of patients.
- Positive staff attitude and commitment
- Good multi-disciplinary team working observed during inspections at Rookwood, CAVOC and UHW (B1)
- Assessment and management of pressure sores appears to be effective
- Pain generally assessed and managed well
- Hydration and nutritional needs of patients satisfied with some scope for better recording
- An inconsistent approach by staff to the completion of care and risk assessment documentation used on hospital wards. Whilst observations during DECIs have indicated regular care interventions by staff, written care documentation has not always supported this
- Staff on some wards require further training around the specific issue of dealing with patients who are confused or have dementia
- Issues on some older wards in relation to environment and maintenance of facilities.

We also undertook three Mental Health Act visits to Whitchurch Hospital, wards East 3, East 5A and West 3. Key findings were as follows:

- The physical environment of Whitchurch Hospital does not reflect a modern day inpatient psychiatric environment, but it is noted that a new-build facility is being constructed at Llandough Hospital. A great deal of effort has been made to upgrade and/or refurbish wards at Whitchurch to a reasonable standard, to provide the patient group as far as possible, with a more comfortable and less institutionalised environment
- There were a number of maintenance issues identified during our inspections, the Health Board's Action Plans addressed these
- Throughout our inspections we found that all staff we met were professional, helpful, caring and knowledgeable about their patient group. Patient care and treatment plans reviewed evidenced multidisciplinary and multiagency involvement. They reflected evidence based assessments, interventions and care with practice standards being in line with the criteria set out in the Mental Health (Wales) Measure.

The following themes can be drawn from our programme of dental inspections delivered during 2014-15:

- A very high level of patient satisfaction with the standard of care provided
- Patients are treated with dignity and respect, and are generally involved in discussions about their care, receiving sufficient information about their treatment
- Safe and timely delivery of dental care and treatment is generally supported by a range of established management systems and processes
- We saw clean, comfortable, appropriate and hygienic environments with wheel chair accessibility in most practices
- A number of practices had separate dedicated decontamination rooms, in line with good practice
- Scope for improvement in decontamination processes at some practices, e.g. ensuring that daily checks are made to ensure that sterilisation equipment is working effectively
- The need for new and updated medical histories to be signed by the dentist and patient
- Improvements required in the guidance and advice for patients wishing to complain. In many cases, documentation and processes needed to be updated to bring them in line with the *Putting Things Right* arrangements.

Noteworthy Practice

Noteworthy practice was identified during the course of our inspections including the skilling up of Practice Educator to deliver mandatory training through team sessions (Ward B1, UHW).

Governance and Accountability

The self assessment conducted and submitted by Cardiff & Vale University Health Board for 2014-15 indicated that the organisation had developed, and gained agreement to, an integrated medium term business plan. The Board monitors progress against improvement plans through its committees and there is evidence of staff involvement in improvement projects. The Board appears to be promoting an open, quality focused culture, but recognises that more needs to be done to in some areas including embedding organisational learning.

Engagement

During 2014-15, HIW's Chief Executive, Kate Chamberlain, along with the Relationship Manager, Alun Jones, met with Cardiff & Vale University Health Board's Chief Executive and Chair. These visits, which took place in October (CEO) and

November (Chair) were part of a programme of liaison meetings, providing HIW with an opportunity to raise any issues with health boards, to discuss future programmes of work and to gain feedback on any issues relating to the way HIW conducts its work.

Special Reviews and Investigations

During 2014-15 HIW completed two homicide reviews relating to patients treated within Cardiff and Vale University Health Board. Details of these reviews are summarised below:

In the case of Nathaniel John, who attacked Stephen Rees whilst they both resided at a hostel operated by Cardiff Mind, HIW highlighted shortcomings in communication between agencies. HIW also found that there were missed opportunities to diagnose and engage Mr John with mental health services, with deficiencies found in the referral to the Links Community Mental Health Team in Cardiff. The lack of any systematised process or approach in place to facilitate the sharing of vital information between services and organisations led to vital information about Mr John's symptoms not being shared with the mental health services. This information may have influenced any decisions regarding care and treatment. Despite the risk of violence that Mr John posed, HIW concluded that it was not predictable that he would commit an act of murder. In particular it was not predictable that he would Stephen Rees, with whom he was noted to have an excellent relationship.

In the case of Mathew Tvrdon, who was the perpetrator in the 'van driver' incident which occurred in Cardiff in October 2012. The incident sadly resulted in the death of a 32 year old female and injuries to 20 other individuals. HIW carried out a review of the provision of care following the first referral to Mental Health Services in 2003. The findings of the review suggested that the homicide could not have been predicted and given the circumstances it was difficult to see how it could have been prevented. However, the review did highlight a number of issues in relation to the care provided, which included organisational and systemic shortcomings in Community Mental Health Team responsible for Mr Tvrdon, poor communication between the CMHT and GP, and concerns around discharge planning arrangements.

Follow Up and Immediate Assurance

Follow Up

HIW issued a report following each inspection, with each report containing a plan that makes recommendations for improvement. In all cases the health board or

practices submitted timely improvement plans setting out their responses to recommendations therein. Each response was individually evaluated and found to provide HIW with sufficient assurance. This was because the improvements identified had either been addressed and or there was evidence to demonstrate that progress was being made in response to the recommendations.

HIW will continue to monitor the progress that health boards or practices make in addressing any recommendations made as a result of its inspection activity. Where actions within improvement plans remain outstanding and/or in progress, there is also an expectation that the health board or practice will provide HIW with updates, to confirm when these matters have been addressed.

HIW conducted three follow up inspections during 2014-15. All of these were at University Hospital Wales, being undertaken on Wards A6, B6 and B7. All three inspections provided assurance that the health board had dealt with, or had made significant progress in dealing with, issues previously raised in previous inspections.

Immediate assurance

HIW issued two immediate assurance letters following dignity and essential care inspections.

In relation to Ward B6 (UHW), HIW wrote to the health board in relation to:

- Variable delivery of the fundamentals of care
- Delays in responding to patient buzzers
- Leadership and communication on the ward
- Organisation of staff on the ward
- Patient information boards not being up to date/consistent with other records
- Lack of completion of documentary evidence
- Staff visibility in certain areas of the ward.

In relation to Ward A4, HIW wrote to the health board in order to:

- seek assurance that a patient was being lawfully deprived of their liberty and that appropriate DOLS procedures had been followed
- seek immediate improvement to the kitchen environment in which we observed a number of health and safety and hygiene issues.

The health board responded constructively in response to both immediate assurance letters, acting definitively to tackle the issues raised.

Inspection Activity

National Health Service

Type of inspection	Location	Date
Dignity and Essential Care Inspections	UHW	11/06/2014
	Rookwood	19/06/2014
	Llandough	01/07/2014
	UHW	22/07/2014
	Barry Hospital	05/08/2014
	UHW	21/10/2014
	Llandough	11/11/2014
Dignity and Essential Care – Follow up Inspections	Follow-up – UHW	16/04/2014
	Follow-up – UHW	29/04/2014
	Follow-up – UHW	20/01/2015
GP inspections (Pilot year - Inspection reports are not being published)	Caerau Lane Surgery	30/09/2014
	North Cardiff Medical Centre	09/10/2014
	Albert Road Surgery	14/10/2014
	Eryl Group Practice	09/12/2014
Dental inspections	VIP Dental Centre	01/09/2014
	Six Gables Dental Practice	29/10/2014
	St Mellons Dental Surgery	05/11/2014
	Rumney Hill Dental Surgery	20/11/2014
	Tongwynlais Dental Practice	28/01/2015
	Thornhill Road Dental Surgery	10/02/2015
	Hickman House Dental Clinic	18/02/2015
	Holton Dental Surgery	25/02/2015
	Churchill Way Dental Practice	05/03/2015
	Alison Jones Dental	12/03/2015
	Canton Dental Care	17/03/2015
	Charles Street Dental Surgery	19/03/2015
	Wyndham House Dental Practice	25/03/2015
Mental Health Act	Whitchurch Hospital	06/11/2014
	Whitchurch Hospital	03/02/2015
	Whitchurch Hospital	04/02/2015
Investigation-Death in Custody	Investigation-DIC (VV)	07/04/2014
	Investigation-DIC (DT)	08/05/2014

Independent Healthcare

Type of inspection	Location	Date
Acute	Vale Hospital	22/04/2014
	Cardiff Bay Hospital	23/04/2014
	Cardiff Bay Hospital	08/05/2014
	Vale Hospital	09/05/2014
Mental Health Act Visits	Ty Catrin	06/05/2014
	Pinetree court	09/12/2014
	Follow-up – Ty Catrin	04/03/2015
Mental Health Unit	Ty Catrin	06/05/2014
	Pinetree court	09/12/2014
	Follow-up – Ty Catrin	04/03/2015
Hospice – Adults	Marie Curie – Holme Towers	03/04/2014
	Follow-up – Marie Curie - Holme Towers	09/05/2014
	Follow-up – Marie Curie – Holme Towers	21/05/2014
	Follow-up – Marie Curie – Holme Towers	22/05/2014
Independent Clinic	Independent General Practice	23/04/2014
	Independent General Practice	29/04/2014
	Cardiff Diagnostic Centre	03/06/2014
	Cardiff Knee Clinic	03/06/2014
Laser	Cellite	02/05/2014
	Cellite	07/05/2014
	Ultralase Clinic	21/05/2014
	Harley Medical Group	04/06/2014
	Visible Changes	04/06/2014
	Hickman House Laser Clinic	11/06/2014
	Harley Medical Group	11/06/2014
	Clear skin dermatology treatment clinic	17/06/2014
	Skin Deep	18/06/2014
	Biothecare Estetika Clinic	18/06/2014
	Body Image	18/06/2014
	Blush Hair and Beauty	18/06/2014
	Refresh Skin Studio	19/06/2014
Slimming Clinic	National Slimming Clinic	04/06/2014
TOP	BPAS Cardiff	22/05/2014

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