Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Abertawe Bro Morgannwg University Health Board Annual Report from Healthcare Inspectorate Wales 2015-16

August 2016

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This document is also available in Welsh.

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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 Abertawe Bro Morgannwg 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 40 inspections to Abertawe Bro Morgannwg University Health Board settings, these included:

- 1 hospital inspection
- 4 general practices inspections
- 24 dental practices inspections
- 8 Mental Health Act visits
- 1 Mental Health Unit follow-up inspection
- 2 Learning Disability inspections.

In the independent sector within the Abertawe Bro Morgannwg area, HIW has conducted 16 inspections to settings; these included:

- 1 acute hospital inspection
- 1 Mental Health Unit follow-up inspection
- 1 independent clinic inspection
- 1 dental hospital inspection
- 3 laser inspections
- 8 Death in Custody investigations
- 1 Pre-registration manager interview.

3. Key Themes

During 2015-16 HIW conducted a variety of work within Abertawe Bro Morgannwg 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

- Generally patients and/or their carers told us they were happy with the quality of care and treatment they had received.
- We found staff teams committed to delivering patient care that was safe and effective.
- Aspects of how medicines are managed and how patients' care records are completed needed to be improved.
- We saw strong leadership and direction provided to staff teams by senior ward and hospital staff.

NHS Dental Practice Inspections

- 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 decontamination procedures. Improvements were also needed around checking emergency (resuscitation) drugs and equipment to confirm they were safe to use.

- Some practices needed to improve the information provided to patients on how to raise a concern (complaint).

- We also found that some dentists needed to improve 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 (CHC) 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 patients was that they had difficulty getting through to the practice by phone to book an appointment.

- Some General Practices needed to improve the information provided to patients on how to raise a concern (complaint).

NHS Mental Health Services

- Patients told us that they felt safe and well cared for. Patients also told us that staff were helpful.

- The furniture in some wards needed to be replaced. We also identified some areas were in need of redecorating and maintenance work.

- The provision and maintenance of personal alarms for staff needed reviewing to promote staff and patient safety.

- Whilst records complied with the Mental Health Act we identified that some improvements could be made to meet guidelines set out within the Welsh Mental Health Act Code of Practice.

4. Special Reviews and Investigations

Death in Custody Reviews

During 2015-16 HIW contributed to eight death in custody reviews relating to HMP Parc or HMP Swansea.

Reports of the findings from death in custody reviews together with any recommendations are published on the Prisons and Probation Ombudsman website http://www.ppo.gov.uk/

Homicide Reviews

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 recommendations relating to mental health services in Abertawe Bro Morgannwg University Health Board. This review found:

- Abertawe Bro Morgannwg University Health Board, Aneurin Bevan 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.

- Abertawe Bro Morgannwg University Health Board, Aneurin Bevan 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

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

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. To offer such a follow-up appointment would help with consistency of care and to help support any immediate care issues in an initial period of high risk.

- Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Cardiff and Vale 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 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 Abertawe Bro Morgannwg University Health Board are highlighted above, we do not believe that the presence of these issues contributed to the tragic incident.

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 of 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 Dental Practices and General Practices were generally provided within the given timescale. The plans from the health board were sometimes provided late. This resulted in HIW having to write to the health board again before revised plans were received. Each response was individually evaluated by HIW and provided us with sufficient assurance that the improvements needed had either been, or were being, addressed.

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. The health board's initial response did not provide us with sufficient assurance that it had fully implemented its improvement plans. Nor did the health board provide evidence that significant progress had been made in response to the matters identified. This resulted in HIW requesting further information. The health board's subsequent and more detailed response provided us with sufficient assurance.

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 seven immediate assurance letters. These followed inspections of dental practices. We sought immediate assurance that action had been taken to address the improvement needed around compliance with aspects of the Welsh Health Technical Memorandum (WHTM) 01-05[4], systems

[4] The Welsh Health Technical Memorandum (WHTM 01-05) (Revision 1) document provides professionals with guidance on decontamination in primary care practices and community dental practices

for checking emergency drugs and equipment and paperwork to demonstrate X-ray equipment was being used safely.

HIW received and evaluated responses to the immediate assurance letters and was assured that suitable action was being taken to address the improvement needed.

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*[5]. Abertawe Bro Morgannwg 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. 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.

Improvement needed was identified at HIW's Mental Health Inspection to the Princess of Wales Hospital in December 2014. Similar issues were identified at a follow up inspection in November 2015. This was despite an assurance from the health board that improvement action had been taken. The health board has provided HIW with a firm assurance that it has reviewed the process for monitoring progress with improvement plans submitted in response to HIW's inspection activity.

HIW has observed a meeting of the health board's Quality and Safety Committee during 2015-16. HIW has also been provided with minutes of meetings and papers presented to the Committee. We saw that information on quality and safety issues were presented and subject to scrutiny by Committee members as part of the health board's governance arrangements.

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[5] *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

Annually, each health board and trust in Wales is required, by Welsh Government, to complete a self-assessment of their position in relation to Governance and Accountability, scoring their maturity level on a scale of 1-5. The self assessment considers three themes:

- Setting the Direction
- Enabling Delivery
- Delivering Results, Achieving Excellence

The self assessment conducted and submitted by the health board for 2014-15 confirmed the health board had well developed plans and processes and could demonstrate sustainable improvement (maturity level - 4) for theme, Setting the Direction. For themes, Enabling Delivery and Delivering Results, Achieving Excellence the self assessment confirmed the health board was developing plans and processes and could demonstrate progress with some of its key areas for improvement (maturity level - 3).

7. Engagement

Engagement with the health board has been through a combination of correspondence, telephone and face to face meetings as necessary. HIW has met mainly with the health board's Director of Nursing and Patient Experience to ensure that any concerns that HIW holds can be discussed and assurance provided.

Staff at all levels within the health board have engaged fully with inspection teams visiting hospital services operated by Abertawe Bro Morgannwg University Health Board.

Similarly, senior representatives of the health board have made themselves available to attend feedback sessions. These are held after each HIW inspection and provide an opportunity for the inspection team to share feedback on their findings. Inspection teams have found health board representatives to be receptive to their feedback and have shown a willingness to take improvement action where necessary.

8. Inspection Activity

National Health Service

Hospital

1. Singleton & Morriston Hospitals	9 September 2015

General Practice

2. Oaktree Surgery, Whitethorn Drive, Brackla, Bridgend CF31 2PQ	13 October 2015
3. Clydach Primary Care Centre, 80 High Street, Clydach, Swansea SA6 5LN	5 January 2016
4. Riversdale House Surgery, Merthyr Mawr Road, Bridgend CF31 3NL	22 February 2016
5. New Cross Surgery, 48 Sway Road, Morriston, Swansea SA6 6HR	15 March 2016

Dental Practice

6. Llynfi Dental Practice, 14 Talbot Street, Maesteg, CF34 9BU	5 May 2015
7. Cwmtawe Dental Practice, 36 High Street, Clydach, Swansea, SA6 5LQ	13 May 2015
8. Ty Gwyn Dental Practice, 14 Sway Road, Morriston, Swansea SA6 6HT	18 May 2015
9. Pentreporth Dental Practice, 9 Penterporth Road, Morriston, Swansea, SA6 6AA	19 May 2015
10. Glynneath Dental Practice, 25 High Street, Glynneath SA11 5BS	18 June 2015
11. Russell Street Dental Clinic, 27 Russell Street, Swansea SA1 4HR	29 June 2015
12. Woods Dental, 65 Walter Road Swansea SA1 4PT	7 July 2015
13. Mansel Street Dental Practice, 77 Mansel Street, Swansea SA1 5TW	14 July 2015
14. Whitehouse Dental Clinic, 14 Coychurch Road, Pencoed, Bridgend, Pencoed, CF35 5NG	28 September 2015
15. Llangyfelach Road Dental Practice, 956 Llangyfelach Road, Swansea, SA5 7HR	29 September 2015
16. uSmile, 21 Hillsboro Place, Porthcawl, CF36 3BH	16 November 2015
17. Q Dental Care Limited, 49 Merthyr Mawr Road, Bridgend, Bridgend, CF31 3NN	17 November 2015
18. Village Dental Practice, 61 New Road, Skewen, Neath, SA10 6HA	11 January 2016
19. Court Road Dental Practice, Dental Practice and A & E S Turpy, 4 Court Road, Bridgend	19 January 2016

20. St Teilo Dental Centre, 168 St Teilo Street, Pontarddulais, Swansea, SA4 8LH	11 February 2016
21. IDH Dental, 54-58 Nolton Street, Bridgend, CF31 3BP	16 February 2016
22. 102 Woodfield Street, Morriston, Swansea, SA6 8AS	18 February 2016
23. 36 Victoria Gardens, Neath, SA11 3BH	25 February 2016
24. JD Isaac, 68 Commercial Road, Taibach, Port Talbot, SA13 1LP	29 February 2016
25. Penclawdd Dental Practice, 2 Compton Houses, West End, Penclawdd, Swansea SA4 3YU	29 February 2016
26. Gardenside Dental Practice, 23 Victoria Gardens, Neath, SA11 3AY	1 March 2016
27. Dental Surgery, 26 Dillwyn Road, Sketty, Swansea, SA2 9AE	3 March 2016
28. Barry Jones Dental Practice, 10 Whitethorn Drive, Brackla, Bridgend, Bridgend, CF31 2PQ	7 March 2016
29. Port Talbot Resource Centre, Moor Road, Baglan Industrial Estate, Port Talbot, SA12 7JB	9 March 2016

Mental Health Act

30. Llwyneryr Assessment & Treatment Centre	15 April 2015
31. Hafod y Wennol (Hensol)	28 April 2015
32. Rowan House	13 July 2015
33. Cefn yr Afon, Bridgend	18 August 2015
34. Princess of Wales (4 wards)	16 November 2015

Mental Health Unit follow-up

38. Princess of Wales	16 November 2015

Learning Disability

39. ABMU/Bridgend	9 December 2015
40. ABMU/Merthyr	25 January 2016

Independent Healthcare

Acute Hospital

1. Sancta Maria	29 September 2015

Mental Health Unit follow-up

2. Rushcliffe	23 June 2015

Independent Clinic

3. National Slimming & Cosmetic Clinic – 391 Kingsway, Swansea, SA1 5LQ	14 October 2015

Dental Hospital

4. Parkway Clinic	20 October 2015

Laser

5. Swansea Laser Clinic	3 September 2015
6. Cutis Cosmetic Clinic	27 October 2015
7. Sun Lounge, 52 Woodfield Street, Morriston, Swansea	16 November 2015

Pre-Registration Manager Interview

8. Rushcliffe Independent Hospital	15 April 2015

Investigation – Deaths in Custody

9. HMP Parc (AO)	1 May 2015
10. HMP Parc (DG)	2 June 2015
11. HMP Swansea (PP)	21 July 2015
12. HMP Parc (LP)	15 September 2015
13. HMP Parc (JC)	6 October 2015
14. HMP Parc (MT)	22 January 2016
15. HMP Parc (JG)	15 February 2016
16. HMP Parc (AN)	22 February 2016