Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Betsi Cadwaladr 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 Betsi Cadwaladr 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 48 inspections to Betsi Cadwaladr University Health Board settings, these included:

- 1 hospital inspection
- 4 general practices inspections
- 30 dental practices inspections
- 7 Mental Health Act visits
- 3 Mental Health Unit inspections
- 1 Community Treatment Order (CTO) review
- 2 Learning Disability inspections.

In the independent sector within the Betsi Cadwaladr area, HIW has conducted 22 inspections to settings, these included:

- 2 hospice inspections
- 11 Mental Health Act visits
- 7 Mental Health Unit inspections
- 2 laser inspections.

3. Key Themes

During 2015-16 HIW conducted a variety of work within Betsi Cadwaladr 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

During 2015-16 we undertook an inspection of three community hospitals Penrhos Stanley, Mold and Denbigh, in Betsi Cadwaladr University Health Board.

Overall, we found patients had a good experience of care in the hospitals we visited. We received several positive comments about the staff and the care and treatment received. However, patients indicated that staff were sometimes too busy to provide individualised or timely care.

With the exception of Fali Ward, Penrhos Stanley Hospital, staff were delivering safe and effective care in line with the Health and Care Standards. Additionally, we found that staff training and the delivery of care to people with dementia had improved since our 2014-5 Dignity and Essential Care Inspections.

We found that the records completed about patients' care and treatment was generally good, although there were inconsistencies in some areas. For instance, we found gaps in falls assessment documentation and there were various duplications amongst the large volume of information held.

We found evidence of strong leadership and management by the five ward managers we saw.

We found that staff were able to access training opportunities and work was in progress to ensure that all staff would be up to date with mandatory training within the next three months.

In relation to Fali Ward, Penrhos Stanley, we found some significant issues:

- During the course of our inspection, we found significant shortcomings on Fali Ward, some of which could have potentially posed an immediate risk to patient safety.
- As a result, we referred one patient to the local authority to be considered under the protection of vulnerable adults (POVA) procedures.
- Staff practices fell well below standards in several areas. In particular, there were significant shortfalls in record keeping and medication practices.
- The serious shortcomings we found on Fali Ward led HIW to question the effectiveness of the Health Board's governance arrangements for the overall management and leadership of this ward. Subsequently we have been informed about the staffing changes and additional resources put in place to support and sustain effective leadership and management of this ward.
- It took three attempts for HIW to receive sufficient assurance that the health board had put in place the necessary arrangements to ensure improvements on Fali Ward. However this matter was eventually resolved satisfactorily.

NHS Dental Practice Inspections

The inspections conducted within dental practices within the Betsi Cadwaladr area highlighted the following themes:

- Patients and/or their carers told us they were happy with their dental treatment.
- During one inspection, we had serious concerns regarding decontamination facilities and systems. As a consequence the matter was escalated to the health board and Public Health Wales was informed.

- We found some inconsistency in relation to evidence that dentists had undertaken IR(ME)R[1] training.
- Our inspections found that some practices needed to make improvements to show they were fully complying with decontamination procedures.

General Practice Inspections

We conducted a number of GP inspections during 2015-16. We worked with members of the local Community Health Council (CHC) when inspecting General Practices. Generally, patients told the CHC that they were happy with the service provided by their GP and practice team.

One of the issues that consistently arose from our inspections related to the frustration experienced by some patients in attempting to book appointments with their GP.

In some instances General Practices needed to improve the quality of child and adult protection policies and ensuring that all staff had POVA and child protection training at a level appropriate to their role.

In one inspection of a health board managed practice, a high use of locum GPs was impacting upon patient experience and continuity of care. Furthermore we found that leadership and management of this practice needed to be strengthened.

NHS Mental Health Services

Patients were generally very complimentary about staff attitudes and approach and we observed a caring approach and a good rapport between staff and patients.

We found staffing levels to be inadequate on some of our inspections. Some staff had accumulated significant time owed to them due to staff shortages and the need to work overtime.

[1] Ionising Radiation (Medical Exposure) Regulations 2000

On some inspections we were concerned about the amount of time nursing staff were spending performing non-nursing tasks that was taking them away from patient care and the ward.

We noted many maintenance and estates issues across our inspections.

We found gaps in staff mandatory training that required immediate action and also supervision and appraisals needed some attention, especially for those staff members who had not received any training and supervision for some time.

It was pleasing to note improvements to the system that captured statistics for mandatory training which included an entry for when staff were scheduled for specific training. However, some areas had poor completion rates and at the time of our visit were at 0%.

The administration of the Mental Health Act was overall good.

There was a considerable pressure on in-patient beds and during our inspections with 100% occupancy on the wards. This prevented existing patients being unable to return from home leave. This situation was very unsettling for patients and created difficulties for staff.

4. Special Reviews and Investigations

In June 2015 the health board was placed in Special Measures by the Minister for Health and Social Services following its failure to make sufficient improvement against long-standing concerns about governance, leadership and other issues. The Minister set out a number of areas in which tangible improvement needed to be demonstrated by the health board. These were:

- Governance, leadership and oversight
- Mental health services
- Maternity services at Ysbyty Glan Clwyd
- GP and primary care services, including out-of-hours services
- Reconnecting with the public and regaining the public's confidence.

During the autumn of 2015 HIW and the Wales Audit Office (WAO) undertook a high-level review to assess progress made by the health board in respect of these areas. Overall, it was clear that much work and effort has gone into tackling the key challenges that had been identified previously by us and other

external reviewers, and also by the Minister when he placed the health hoard into special measures. There had been positive developments in a number of areas; however, some fundamental challenges remained.

In particular:

- The health board needed to secure a permanent Chief Executive
- A cohesive Board and executive management team remained a problem with further work required on board etiquette and behaviours
- The health board needed help with some basic aspects of governance, leadership, and service planning and turnaround
- Revised committee structures still required work
- A long term plan was required for Mental Health services;

HIW and the WAO will be undertaking a further follow-up review during 2016-17.

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

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

- 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.

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

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

- 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.

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. Each response was individually evaluated by HIW and further information and assurance was sought where needed.

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.

We were provided with some assurance that the health board uses our inspections to improve the quality and safety of its services by ensuring that the recommendations are actioned and not replicated elsewhere within the health

board. However this is an aspect that required strengthening.

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 14 immediate assurance letters. These followed our NHS hospital inspection (1 issued), Dental Inspections (8), GP Inspections (1), NHS mental health inspections (3), and learning disability thematic inspection (1). As mentioned, whilst it took three attempts for HIW to receive sufficient assurance that the health board had put in place the necessary arrangements to ensure improvements following our NHS hospital inspection, sufficient assurances were eventually provided. HIW received sufficient responses to all other immediate assurance letters.

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

HIW has observed a number of Quality & Safety Committees held at the 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 reports being scrutinised and tracked along with the associated recommendations by both staff and independent members.

Further to the joint work undertaken by HIW and the WAO relating to Special Measures which examined aspects of governance and leadership, annually, each health board and trust in Wales is required, by Welsh Government, to

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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

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.

The self assessment conducted and submitted by Betsi Cadwaladr University Health Board for 2014-15 recognised that:

- In advance of finalising its 3-year Integrated Medium Term Plan (IMTP), there was a need for 'wider public engagement regarding the vision for future services and the case for change'.
- The health board scored itself as a 'disagree' in relation to 'the different services and parts of our organisation/business work well together, and everyone understands who does what and why'.
- As evidenced by our own inspections, the health board conceded that compliance with mandatory training has been poor.

In addition, statements from the Wales Audit Office Annual Report 2015 for Betsi Cadwaladr University Health Board concluded: "despite a positive response to special measures, the Health Board still has a number of fundamental challenges to address…Leadership capacity, capability and resilience are key risks and the absence of a clinical strategy and integrated medium term plan continue to hinder the Health Board's ability to deliver necessary changes quickly."

7. Engagement

HIW has observed a number of Quality & Safety meetings during 2015-16.

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.

Aside from the previously mentioned issues regarding HIW's community hospitals inspection, in general responses to inspection findings and immediate assurance letters have also been dealt with quickly.

Furthermore, there was positive engagement with the health board regarding the placement of its patients during the period that preceded the closure of Plas Coch independent mental health hospital.

8. Inspection Activity

National Health Service

Hospital

1. Penrhos Stanley, Denbigh and Mold community hospitals	24 & 25 November 2015

General Practice

2. Plas Menai Surgery, Penmaenmawr, llanfairfechan, Conwy, LL33 0PE	3 September 2015
3. Cambria Surgery	28 October 2015
4. BCUHB Managed Practice, Health Service Centre, Wynne Road, Blaenau Ffestiniog	11 November 2015
5. Kinmel Bay Med. Centre, The Square, Kinmel Bay, Conwy, LL18 5AU	2 February 2016

Dental Practice

6. Oasis, Flint, Dental Practice	2 April 2015
7. Oasis Dental Care, Ewloe	9 April 2015
8. Mervinian House Denticare, Dolgellau	6 May 2015
9. White Cross Dental Practice, Ground Floor, Kingsway House, Wrexham Technology Park, Wrexham LL13 7YP	12 May 2015
10. Fern Avenue Dental Practice, 1 Fern Avenue, Prestatyn, LL19 9DN	28 May 2015
11. Connahs Quay Dental Practice, 107A High Street, Connahs Quay, Flintshire CH5 4DF	3 June 2015
12. Coppersun Dental Care, 12 Grosvenor Street, Mold CH7 1EJ	24 June 2015
13. Dant Y Coed Dental Practice, 1&2 Maelor Buildings, Heol Maelor, Coedpoeth, Wrexham LL11 3NG	8 July 2015
14. Abergele Dental Surgery. Groes Lwyd, Abergele, Conwy LL22 7TA	15 July 2015
15. Rosehill Dental Practice, Rosehill Street, Conwy, LL32 8LD	21 July 2015
16. My Dentist – Ruabon, High Street, Ruabon, Wrexham LL14 6NH	29 July 2015
17. Rhos Road Dental Practice, 55 Rhos Road, RHOS ON SEA, Colwyn Bay, LL28 4RY	4 August 2015
18. Ffordd Elan Dental Practice, 43 Fford Elan, Rhyl Denbighshire LL18 4HZ	18 August 2015
19. Ruabon Road Dental Practice, 96 Ruabon Road, Wrexham LL13 7PH	18 August 2015
20. Prestatyn Dental Centre, HSBC Bank Chambers, 37 High Street, Prestatyn Denbighshire LL19 9DN	19 August 2015
21. Dental Surgery, Bangor Road, BENLLECH, Anglesey,	25 August 2015

LL74 8QJ	
22. i Dental, Unit 2, The New Development, Charles Street, WREXHAM, Wrexham, LL13 8BT	6 October 2015
23. Chapel Cottage Dental Practice, 5 Chapel Cottages, High Street, GRESFORD, Wrexham, LL12 8PS	7 October 2015
24. Elmhurst, Garth Road, BANGOR, Gwynedd, LL57 2RT	6 January 2016
25. Tywyn Dental Practice, Gwynedd	12 January 2016
26. Oasis Dental Care Ltd, 23 Grosvenor Road, WREXHAM, Wrexham, LL11 1BT	19 January 2016
27. The Coach House Dental Practice, 4A Grosvenor Road, Wrexham, LL11 1BU	20 January 2016
28. Rossett Dental Care, Station Road, Rossett, Wrexham, LL12 0ER	21 January 2016
29. White Arcade Dental Practice, Gwynedd	25 January 2016
30. Bryn Siriol Dental Practice, Gwernaffield Road, MOLD, Flintshire, CH7 1RA	9 February 2016
31. Bistre Dental Practice, 85 Mold Road, BUCKLEY, Flintshire, CH7 2JA	10 February 2016
32. Craig-y-Don Dental Practice, Shirley, 28 Mostyn Avenue, LLANDUDNO, LL30 1YY	11 February 2016
33. West End Dental, 15 Snowdon Street, PORTHMADOG, Gwynedd, LL49 9BT	16 February 2016
34. Oasis Dental Care, Unit 1E Cibyn Industrial Estate, Ffordd Llanberis, CAERNARFON, Gwynedd, LL55 2BG	16 March 2016
35. Mr Bellingham and Mr IG Hughes, Dental Surgery, 19 Padeswood Road North, BUCKLEY, Flintshire, CH7 2JL	31 March 2016

Mental Health Act

36. Heddfan (2 Wards)	15 pril 2015
37. Ablett Unit (2 Wards)	6 July 2015

Mental Health Unit

38. Heddfan	15 April 2015
39. Ablett Unit	6 July 2015

Independent Healthcare

Hospice (Adult)

1. St Kentigerns Hospice	13 January 2016
2. St David's Hospice	10 March 2016

Mental Health Act

3. Delfryn House (2 Wards)	13 April 2015
5. Plas Coch (2 Wards)	8 July 2015
7. Delfryn Lodge (2 Wards)	21 September 2015
9. Coed Du Hall (2 Wards)	23 September 2015
11. Plas Coch (2 Wards)	14 October 2015
13. St David's	9 March 2016

Mental Health Unit

14. Delfryn House	13 April 2015
15. Plas Coch	8 July 2015
16. Coed Du Hall	23 September 2015
17. Delfryn Lodge	21 September 2015
18. Plas Coch	14 October 2015
19. Plas Coch	7 March 2016
20. St David's	9 March 2016

Laser

21. Utopia Salons Ltd	8 March 2016
22. Laser Clinic North Wales	8 March 2016