Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Hywel Dda University Health Board Annual Report from Healthcare Inspectorate Wales 2015-16

August 2016

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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 Hywel Dda 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 26 inspections to Hywel Dda University Health Board settings, these included:

- 3 hospital inspections
- 3 general practices inspections
- 17 dental practices inspections
- 1 dental practice follow-up inspection
- 1 Mental Health Act visit
- 1 Learning Disability inspection.

In the independent sector within the Hywel Dda area, HIW has conducted 3 inspections to settings, these included:

- 1 hospital inspection
- 1 dental hospital inspection
- 1 laser inspection.

3. Key Themes

During 2015-16 HIW conducted a variety of work within Hywel Dda 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

HIW undertook three concurrent inspections of unscheduled care (A&E) over a period of three days. We visited Withybush, Glangwili and Bronglais hospitals.

- Patients and/or their carers told us they were happy with the quality of care and treatment they had received
- Generally, leadership and management was visible and effective. Consultants, senior medical staff, nursing staff and ward managers were clear and knowledgeable about their particular roles and responsibilities
- The health board demonstrated that it fostered a culture of learning and encouraged personal and professional integrity
- We found in some of the areas we inspected that safe, dignified and timely care was not consistently aligned with the Health and Care Standards. However we were able to confirm that service provision was effective for patient outcomes
- Where documentation was area specific it was of a good standard, although more generic hospital documentation and discharge planning was not completed thoroughly
- There needs to be a more collaborative approach across all hospital directorates, specifically the surgical directorate, to alleviate the pressures on the unscheduled care directorate

- Elements of infection prevention and control, medicines management (the health board had invested in an effective medicine management system but only in one area) and patient discharge planning needs improving

- Patients were not always able to communicate with staff about their care through the medium of the Welsh language

- There were on going staffing issues regarding lack of experience, inadequate numbers and skill mix.

Where HIW identified improvement was needed we were assured that work was undertaken / in progress in a robust and timely manner.

NHS Dental Practice Inspections

- Patients and/or their carers told us they were happy with their dental treatment.

- Generally we found practice teams committed to delivering safe and effective care to patients.

- Some practices needed to make improvements to show they were fully complying with;

    - Decontamination

    - Radiography practice / Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) training

    - Resuscitation / emergency drugs

    - Quality Assurance

    - Infection control

- Most dentists needed to improve their record keeping to demonstrate they were planning care to promote patient safety and wellbeing

- Most practices needed to improve their complaints information.

Where HIW identified improvement was needed we were not always assured that work was undertaken / in progress in a robust and timely manner.

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 need to improve the information they provide to patients on how to raise a concern (complaint)
- There were some issues regarding privacy and dignity in relation to conversations / health interventions. However these did not involve patient / doctor practices.
- Improvements in Health & Safety and Infection control policies and procedures.

Where HIW identified improvement was needed we were assured that work was undertaken / in progress in a robust and timely manner.

NHS Mental Health Services

HIW only undertook one Mental Health Act inspection in 2015-16. From this we found that;

- Patients we spoke to told us that they felt safe and well cared for and that staff were helpful.
- There was pressure on the availability of beds and the admission of patients to the ward in crisis because of community placement breakdown. This was exacerbated by the use of mental health beds for patients with learning disabilities in crisis.
- There were a number of environmental and maintenance issues that require addressing to ensure that the ward is suitable for the patient group.

Where HIW identified improvement was needed we were assured that work was undertaken / in progress in a robust and timely manner.

4. Special Reviews and Investigations

We did not undertake any special reviews or investigations in the health board during 2015-16.

Evaluation of homicide reviews undertaken by HIW since 2007

During 2015-16 HIW published an evaluation of homicide reviews[1] 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.

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

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 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. We were told that HDUHB have measured their performance against the findings of the WHSSC report as part of their Governance process.

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[2] 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 were often provided late; General Practices were generally provided within the given timescale and the plans from the health board were always robust and well within timescales. Each response was individually evaluated by HIW and most provided us with sufficient assurance that the improvements identified had either been, or were being, addressed. Some dental action plans required further information.

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 had 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.

We were also provided with some assurance that the health board is developing its approach to using 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.

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 eight immediate assurance letters relating to NHS hospital, dental inspections.

We issued one immediate assurance letter to the health board. Our inspection across Withybush, Glangwili and Bronglais hospitals resulted in an immediate assurance letter as we identified identification wristbands were not in place for all adult in-patients.

Following our inspections to NHS dental practices we issued seven immediate assurance letters with regard to;

- IR(ME)R training; letters notifying the Health and Safety Executive of their intention to work with radiation
- No Critical Test Certificates for X-Ray equipment
- Dental materials, emergency equipment, instruments and drugs outside the suggested expiry dates .
- No scheme of maintenance inspection certificate for compressors.
- Safe storage and satisfactory documentation of patient records
- Unsatisfactory staff recruitment practices; no confirmation of hepatitis B vaccinations, Disclosure and Barring Service (DBS) checks
- Unsafe processes for instrument sterilisation.

Independent Healthcare

On the whole the outcome of Independent health care in the HDUHB region has been satisfactory. HIW had concerns regarding a dental provider and an Immediate Assurance letter was sent with a view of possibly commencing enforcement action. We requested that the provider attend a meeting with HIW to address the findings as a first step but were assured that improvements were being undertaken and that our recommendations were met.

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*[3]. Hywel Dda University Health Board is responsible for the quality and safety of services it provides and commissions.

[3] *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

Hywel Dda University Health Board's vision statement is; "Adding life to years and years to life". The vision is to deliver a world class healthcare system of the highest quality with improved outcomes for the people of Hywel Dda.

In recognition that most effective health boards regularly reflect on their effectiveness and the robustness of their governance arrangements Hywel Dda University Health Board, towards the later part of the 2014-15 financial year, commissioned an external review of its governance arrangements. The outcome was to focus on the governance arrangements within the organisation and continual implementation of the recommendations arising from the review. To this end all board members share corporate responsibility for formulating strategy, ensuring accountability, monitoring performance and shaping culture, together with ensuring that the board operates as effectively as possible. One of the results from this external review resulted in a realignment of Executive portfolios to provide clear lines of accountability, and to ensure the Board focused on the full range of its responsibilities. This has led to a smaller Executive Team, which has raised some concern with HIW partner organisations regarding the scale of portfolios. We understand that the Health Board will be undertaking a review of its refreshed governance system one year on. We would encourage the organisation to assure itself that these enhanced portfolios are working effectively as part of this review.

Additionally the external review recognised that the health board is well organised, understands its assurance role and works hard to ensure that it covers the totality of the business, whilst also retaining its focus on assuring strong financial governance across the organisation, Hywel Dda University Health Board evaluated its audit committee and set clear expectations. This resulted in recommendations for improvement and has reinforced that the organisation has effective controls in place to manage the significant risks to achieving its strategic objectives and that controls are operating effectively.

HIW also sought assurance directly from the health board that they continue to implement changes and recommendations from our inspections in 2014-15. Future inspection activity and contact with the health board will consider the extent to which these changes have been embedded and whether the health board's arrangements have enabled lessons to be shared as part of their ongoing quality improvement work.

The health board may wish to consider the extent to which it continues to use HIW inspections as a catalyst for ongoing improvement and ongoing maturity of the organisation.

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.

The self assessment conducted and submitted by Hywel Dda University Health Board for 2014-15 indicated that the organisation's evaluation of its governance arrangements are effective.

In addition, statements from the Wales Audit Office Annual Report 2015 for Hywel Dda University Health Board concluded that;

- The Health Board had a broadly sound approach to in-year financial management but some improvements were required. The Health Board did not achieve financial breakeven in 2013-14 and was unlikely to do so in 2014-15. The Health Board needs to develop a clear strategic direction through its IMTP
- The Health Board is improving its workforce planning arrangements and further strengthening partnership working and engagement with its local population but there remains a number of significant workforce, estate and asset risks
- Although performance audit work identified some good practice areas it also identified opportunities to secure improvements in the use of resources in a number of specific areas.

7. Engagement

The outgoing 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 although the timeliness of the response has been longer than anticipated these have eventually been dealt with appropriately. When asked, the health board has shared investigations with HIW.

Responses to inspection findings and immediate assurance letters have also been dealt with promptly with clear actions and reasonable timescales.

In conversations and in their annual report the CHC commented that engagement has improved with positive examples of proposed joint working for the future.

8. Inspection Activity

National Health Service

Hospital

1. Withybush, Glangwili and Brongalis Hospitals	11 August 2015

General Practice

4. Furnace House Surgery, St Andrews Road, Carmarthen, SA31 1EX	17 November 2015
5. Tanyfron Surgery, Aberaeron	1 December 2015
6. Llanfair Surgery Llanfair Road, Llandovery, SY20 0HY	16 December 2015

Dental Practice

7. Portland Street Dental Practice, 23-25 Portland Street, Aberystwyth, SY23 2DX	6 May 2015
8. Eastgate Dental, 29 Eastgate, Aberystwyth SY23 2AR	7 May 2015
9. Achddu Villa Dental Practice, 18 Stepney Road, Burry Port, Llanelli SA16 0BH	12 May 2015
10. Brynteg Dental Practice, Dan Y Banc, Old Station Road, Carmarthen SA31 1JN	19 May 2015
11. Llannon Road Dental Practice, 25 Llannon Road, Upper Tumble, Llanelli SA14 6BW	27 May 2015
12. Brynteg Dental Surgery (Ammandford)	27 May 2015
13. Dental Excellence, 2 Station Road, Pembroke, SA71 4AH	3 June 2015
14. Dental Surgery, 6 King Edward Street, Whitland, Carmarthenshire, SA34 0AA	16 June 2015
15. Q-Dental Care Ltd, The Orthodontic Practice, 7 The Parade, Carmarthen, Carmarthenshire, SA31 1LY	18 June 2015
16. Feidr Fair Dental Practice, 7 Feidrfair, Cardigan, Ceredigion, SA43 1DU	30 June 2015
17. Charsfield Dental Surgery, Priory Street, Cardigan, Ceredigon, SA43 1BU	1 July 2015
18. Quay Street Dental Practice, The candle stores, Quay street, Haverfordwest, pembs, SA61 1BB	7 July 2015
19. Deintyddfar Capel Dental Practice, Mansel Street, Carmarthen, Carmarthenshire, SA31 1QX	28 July 2015
20. Denticare Lampeter, 2 The Market Place, Lampeter, Ceredigion, SA48 7DS	4 August 2015
21. S R Badham and Associates, 147 Charles Street, Milford Haven, Pembrokeshire, SA73 2HP	6 August 2015
22. My Smile Centre, 118 Charles Street, Milford Haven,	23 September 2015

Pembrokeshire, SA73 2HW	
23. Portfield Dental Surgery, 11 Portfield, Haverfordwest, Pembrokeshire, SA61 1BN	12 January 2016

Dental Practice Follow-up

24. IDH Mill Lane Dental Practice, Mill Lane, Llanelli, SA15 3SE	13 May 2015

Mental Health Act

25. Tudor House, Carmarthen	6 May 2015

Learning Disability

26. Hywel Dda/Pembrokeshire	16 December 2015

Independent Healthcare

Acute Hospital

1. Werndale Hospital	14 March 2016

Dental Hospital

2. Tenby Dental Haven, Ace Court,Warren Street, Tenby, Pembrokeshire, SA70 7JY	17 February 2016

Laser

3. Coolight Health & Beauty 12 Mansel Street Camarthen, SA31 1PX	16 July 2015