Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Aneurin Bevan University Health Board Annual Report from Healthcare Inspectorate Wales 2016-17

July 2017

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 WG30954 Digital ISBN 978-1-78859-001-3

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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 Aneurin Bevan University Health Board.

2. Overview

During the year, HIW conducted 32 inspections or visits at Aneurin Bevan University Health Board settings, these included:

- 2 hospital inspections, one was a follow-up inspection
- 4 general practices inspections
- 12 dental practices inspections, one was a follow-up inspection
- 6 learning disability inspections
- 5 Mental Health Act (MHA) visits
- 2 mental health unit inspections
- 1 Death in Custody Investigation.

3. Key messages

Overall the inspections this year found that kind and respectful care is being provided to patients by a passionate and committed workforce. Good leadership and management was noted on several occasions. Our work did however highlight the following issues that require further attention:

- The need for regular documented checks of emergency medication and equipment across all services
- The need for regular review of policies and procedures and risk assessments e.g. fire and health & safety in primary care settings and ensuring they are communicated and understood by staff
- The need to eliminate inconsistencies within service areas
- The arrangements for ensuring the recommendations HIW makes are implemented in a timely way.

4. Inspection findings

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

Hospital inspections

HIW conducted two hospital inspections in Aneurin Bevan University Health Board during the year. The first of which was County Hospital with the aim of following up on progress with addressing recommendations made in our previous inspection in February 2015.

We found that improvements had been made to create a more comfortable environment, better information was available for patients and the use of the Mental Capacity Act was more consistent. However, sufficient progress had not been made on aspects of the mealtime experience, continence needs, pain assessment and oral health care needs. Proposed actions around improving appropriate stimulation for patients with dementia had also not progressed.

Our visit to the Royal Gwent Hospital (Emergency Department) in March 2017 concluded that safe and effective care was being provided. Patients spoke positively about their experiences and we found a passionate and committed staff led by an engaged senior management team. We also noted improvements to service, innovations and learning being trialled and implemented both at departmental and health board level.

However, there were two areas identified that required immediate review to ensure patient safety was being maintained. These issues centred around the risk assessments for the corridor holding area and they way in which the resuscitation area was utilised.

Mental health

On both inspections we met motivated ward teams that spoke positively about the support they received from each other and ward management. We commented positively on patient centred care that was delivered with kindness and respect. Where we reviewed the use of the Mental Health Act and the Mental Health Measure we found appropriate levels of compliance.

One area of inconsistency was around medicines management. Whist good practice was identified at County Hospital we found that there was not a robust audit and management of medication stocks at St Cadocs. We also made recommendations to address issues with the environment, equipment and appliances at both hospitals to improve the privacy and dignity of patients.

General practice

There were four GP inspections in Aneurin Bevan University Health Board in 2016-17. All inspections concluded that safe and effective care was provided. Positively, patients at all inspected practices reported that they were happy with the service received and staff told us that they were happy in their roles and felt well supported. We also noted good standards of record keeping in 3 of the 4 practices inspected.

However there were areas for improvement identified which fell into the following themes:

- Staff required training in adult and child protection in three practices
- Policies and procedures in particular health & safety, fire risk assessment and adult & child protection required development. Linked to this we identified that more formalised mechanisms for communicating these policies to staff were required in order to ensure understanding and compliance
- We recommended that two practices needed to establish formalised recruitment procedures.

Dental

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

- Patients told us they were happy with the service provided in all inspections
- We found the majority of practices to be well equipped, clean and tidy and that dental instruments were cleaned and sterilised appropriately
- In many cases we saw that arrangements were in place for the safe use of x-ray equipment
- Staff working at the practices told us they felt supported by senior staff
- Practices could improve the availability of patient information including health promotion material, practice information and complaints procedures
- More could be done to proactively seek feedback from patients

- We found record keeping needed to improve in over half of the inspections
- The need for more regular checks of emergency medication and equipment was identified in six inspections
- We recommended that five practices needed to improve quality assurance and management processes, including audit, to ensure compliance with official guidance, best practice and regulations.

During our inspections we identified issues that required immediate assurance at two dental practices. The issues related to safety of the environment, infection control, medicines management and record keeping. Both practices responded positively to these findings and have taken steps to assure HIW that action has either been taken or is in hand to address the recommendations we made.

Learning disabilities

During 2016-17 HIW undertook six inspections of learning disability services, this consisted of five residential units and an assessment and treatment unit.

On all inspections we saw staff treating patients with kindness and respect. We found effective leadership and management at most of the services inspected and found staff working there to be passionate and committed to achieving the best outcomes for patients.

Our inspections highlighted inconsistency in the standard of care planning. We saw some excellent examples that were very detailed and clearly demonstrated the involvement of the patient and relatives/carers in designing individualised and patient centred care. However we also saw examples of incomplete care plans that were not signed and/or dated that could not demonstrate the same level of patient centred care. We would urge the health board to ensure the good examples are transferred across all learning disability services.

Other issues these inspections identified that required immediate action by the health board were the need to ensure that up to date risk assessments for all patients were in place and that staff are supported to complete mandatory training particularly in resuscitation and basic life support. We have been assured that swift action was taken to respond to these recommendations.

5. Special reviews, investigations and thematic work

Towards the end of the year HIW undertook a review of governance arrangements specifically looking at the health board's arrangements for managing and learning from:

- Complaints/concerns from receipt to resolution;
- The reporting and management of incidents;
- Commissioned Reviews;
- Recommendations from External Bodies;
- Compliance with guidance and Welsh Government and Care Standards; and
- The role of the Quality and Patient Safety Committee in providing assurance regarding safeguarding and improving patient safety will also be considered.

Overall, we found that effective governance and leadership was demonstrated in relation to the areas that we examined and that this was supported by a strong commitment from staff to learn from concerns and incidents. However we did identify that further work is required to improve the timeliness of complaint responses, tackle the inconsistent use of Datix for recording concerns and the continued maturing of the Corporate Learning Committee to become an effective health board wide committee.

Death in custody clinical reviews – HMP Prescoed

HIW undertook one clinical review to support the work of the Prison and Probation Ombudsman in relation to death in custody incidents.

The root cause of death was cancer of the kidney which had spread to his bones and lungs at the time of presentation. The death was foreseeable only after the diagnosis had been made, but it was sadly not preventable. The healthcare team at HMP Usk strove to provide effective and compassionate care and, within the confines of the system they worked within, they achieved this.

Sadly, there were inadequacies in the pain-relief and dignity experienced by towards the end of life. The main reason for this was the failure of the prison

service to transfer to a unit able to provide appropriate 24 hour a day end of life care.

The problems encountered with providing end of life care were compounded by inappropriate discharges from hospital which stem from a lack of understanding of the limitations of the care facilities available at HMP Usk. It is clear that the health board and HMP clinical staff face challenges in situations like this however it is disappointing that these issues are still present given that they were also identified in a review concluded in 2015-16. Furthermore unless action is taken to resolve this situation the deficiencies in the care received, highlighted in both cases, are likely to be repeated again in the future.

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 finding 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. This year we conducted two follow up inspections to check that improvement plans have been actioned.

- Wysome, Parry and Associates Dental Practice – During our initial inspection in July 2016 we could not be satisfied that the practice was meeting standards necessary to provide safe and effective care. We found a number of significant concerns relating to the safety of the environment, infection control, medicines management and record keeping. Such was the concern that we returned in September 2016, where we saw noticeable and marked improvements across a number of areas and were able to conclude that our concerns were being sufficiently addressed.

- County Hospital – We saw that improvements, significant in some cases, had been made in a number of areas however it was disappointing to return 21 months after the original inspection and find that a number of proposed actions in the improvement plan had not been followed through.

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 2016-17 we issued eight immediate assurance letters to the health board. Half of these related to the learning disability inspections and further details are provided earlier in this report. The remainder related to two dental practices, the Royal Gwent Hospital and County Hospital however there are no themes that can be identified, with all issues identified being unique to the service inspected. Prompt action was taken to address all issues identified.

7. Governance

During 2016-17 the health board has had a number of opportunities to demonstrate that it is a learning organisation.

HIW's Relationship Manager and other HIW staff have attended the health boards Quality and Patient Safety meetings. This meetings have been well organised with detailed and challenging discussions taking place. It is also clear how this committee works within the overall board structure in order to escalate issues where necessary.

However the committee does not appear to have a formalised role in providing oversight for the implantation of HIW's recommendations. This is because our reports do not seem to be routinely reviewed at committee with no references to our Secondary Care inspections in the committee papers. Given the insufficient progress identified in the follow-up inspection at County Hospital, the board may wish to consider reviewing this arrangement.

With regards to Primary Care inspections, HIW has regularly attended the Quality and Patient Safety sub-committee for dentistry and would note that this arrangement provides significant support for the service in terms of preparing for HIW inspections, shared learning across the service and tracking completion of improvement plans. HIW understands a similar arrangement is to be put in place for General Practice.

8. Engagement

During the year HIW's Relationship Manager attended a number of meetings at the health board including presenting the 2015-16 health board annual report in June 2016, attending Quality and Patient Safety meetings and meeting with the Chief Executive and Chair in May 2016. The health board has always welcomed our attendance and engaged constructively.

Correspondence between HIW and the health board is always dealt with in a timely and satisfactory way, including responses to patient concerns that have been highlighted to us.

9. Inspection, special review, investigation and thematic activity

Hospital inspections

1. County Hospital (Follow-up inspection)	15 November 2016
2. Royal Gwent Hospital	7 March 2017

GP inspections

3. South Street Surgery, South Street, Bargoed. CF81 8ST	19 October 2016
4. Markham Medical Centre, James Street, Blackwood. NP12 0QN	20 October 2016
5. Aber Medical Practice, 30 Thomas Street, Caerphilly. CF83 4AZ	8 December 2016
6. Court House Medical Practice, Heol Bro Wen, Caerphilly. CF83 3GH	13 December 2016

Dental inspections

7. Wysome, Parry and Associates, 36 The Parade, Cwmbran. NP44 1PT	11 July 2016
8. Risca Dental Practice Limited, 3 Commercial Street, Risca. NP11 6AW	21 July 2016
9. Oasis Dental Care (Newport), 6a Caerphilly Road, Bassaleg, Newport. NP10 8LE	27 July 2016
10. Mr Evans & Mr Brunswick Dental Practice, Newport. NP19 8EA	12 September 2016
11. Wysome, Parry and Associates, 36 The Parade, Cwmbran. NP44 1PT (Follow-up inspection)	22 September 2016
12. Clive Street Dental Practice, 4 Clive Street, Caerphilly. CF83 1GE	3 October 2016
13. Delgrade Ltd, Bryntirion Dental Surgery, 23 Sir Ivors Road, Pontllanfraith. NP12 2JH	11 October 2016
14. P A Hawkins & L A Griffiths Dental Surgery, 11 Station Terrace, Caerphilly. CF83 1HD	8 November 2016
15. Parklands Dental Surgery, Bowls Terrace, Caerphilly. CF83 2RD	5 December 2016
16. Newport Orthodontic Centre, 28 Clytha Park Road, Newport. NP20 4PA	11 January 2017
17. Caerphilly Orthodontics Ltd, Dental Surgery, 5 Thomas Street, Caerphilly. CF83 4AU	18 January 2017
18. The Grove Dental Practice, Ystrad Mynach. CF82 7AN	7 March 2017

Learning disability

19. AB managed residential service	24 May 2016
20. Llanfrechfa Grange, Cwmbran	26 May 2016
21. Mitchell Close, Cwmbran	6 June 2016
22. AB managed residential service	16 June 2016
23. AB managed residential service	20 June 2016
24. AB managed residential service	23 June 2016

Mental Health Act monitoring inspections

25. St Cadocs Hospital (4 visits)	25 October 2016
29. County Hospital	15 January 2017

Mental Health unit inspections

30. St Cadocs Hospital	25 October 2016
31. County Hospital	15 January 2017

Investigation - Death in Custody

32. Prescoed HMP	May 2016