Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Abertawe Bro Morgannwg University Health Board Annual Report from Healthcare Inspectorate Wales 2016-17

July 2017

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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 Abertawe Bro Morgannwg University Health Board.

2. Overview

During the year, HIW conducted 39 inspections or visits at Abertawe Bro Morgannwg University Health Board settings. These included:

- 2 hospital inspections
- 4 general practice inspections
- 9 dental practice inspections
- 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection
- 12 learning disability inspections
- 1 Mental Health Act (MHA) visit
- 1 mental health unit inspection, which was a follow-up inspection
- 9 Death in Custody investigations.

3. Key messages

The inspections conducted within Abertawe Bro Morgannwg University Health Board generally indicate that the care provided to patients is kind, compassionate and being delivered by committed and enthusiastic staff.

However the HIW activity conducted during 2016-17 highlighted the following matters that the board will wish to reflect upon:

- Issues with maintenance and the improvement of clinical environments were identified at a range of settings including hospitals and learning disability residential units
- The quality of documentation was cited as requiring improvement in hospital, mental health, dental and learning disability inspections

- Evidence indicates that learning from inspections is not effectively shared
- Nearly a quarter of inspections identified concerns which resulted in the need for HIW to follow its Immediate Assurance process.

4. Inspection findings

During 2016-17 HIW conducted a variety of work within Abertawe Bro Morgannwg UHB. There are a number of key themes that have emerged through the work this year. These are summarised below.

Hospital inspections

Key findings from hospital inspections during 2016-17 are as follows:

Maesteg and Gorseinon hospitals

HIW inspected West Ward at Gorseinon Hospital and Llynfi Ward at Maesteg Hospital in September 2016. The inspection provided an opportunity for HIW to follow up on the health board's progress in addressing the improvements needed from our last inspection of West Ward at Gorseinon Hospital in September 2014. This was our first inspection of Llynfi Ward at Maesteg Hospital and was broader in scope.

Our findings were generally positive. Patients we spoke to confirmed that they were happy with the care and treatment they had received and we saw staff treating patients with kindness and respect.

However, we did identify that immediate improvement was needed around the correct use of patients' identification wrist bands at both hospitals to promote their safety and wellbeing. The health board provided a sufficient immediate improvement plan within the agreed timescale.

We found improvement was needed in relation to the environment at Gorseinon Hospital, medicine management, records (specifically written care plans and monitoring charts), management of Deprivation of Liberty Safeguards paperwork and staff appraisals at both the wards we inspected.

Princess of Wales

HIW inspected Ward 10 and the Emergency Department (ED) at the Princess of Wales Hospital in January 2017. The main focus of this inspection was to follow up on the health board's progress in addressing the improvements needed from previous inspection activity at the Princess of Wales Hospital in October 2014 and February 2015.

We chose to inspect Ward 10 to establish whether improvement action described by the health board in response to our previous inspection activity had been applied across the speciality of trauma and orthopaedics. We found that limited progress had been made in applying improvement action on Ward 10.

Within the ED, it was pleasing to see that improvement action had been implemented and sustained to address much of the improvement needed at our last inspection. There were, however, some areas where work had not progressed and improvement was still needed.

Patients we spoke to confirmed that they were happy with the care and treatment they had received and arrangements were in place for them to provide feedback on their experiences. We saw staff adhering to cross infection procedures and this was particularly evident on Ward 10.

We found that improvement was needed around promoting patients' privacy and dignity, timeliness of responding to patients' requests for assistance on Ward 10 and patient flow through the ED. On Ward 10, improvement was needed around aspects of the environment, medicines management and completion of monitoring records. We also found that security needed to be reviewed within the ED.

Mental health

Our May 2016 inspection of Cefn Coed Hospital was a follow-up visit, focussing primarily on the issues we identified in a previous inspection in November 2014. We concluded that considerable improvements had been made including the decommissioning of wards in the main building, and improvements in staff training. We also observed positive staff and patient interactions throughout our visit. However, we had concerns about the environment and about care documentation, which resulted in an immediate assurance letter to the health board.

Ionising Radiation (Medical Exposure) Regulations

Whilst the HIW inspection team did not find any imminent risk of harm to patients in receipt of services within the nuclear medicine department at Singleton Hospital, it did discover six regulatory breaches covering areas such as written procedures, training records and access to guidance. It was disappointing to find that some improvements identified during a previous HIW inspection in 2009 remained outstanding. As a result, it was necessary for HIW to issue a non-compliance letter to the health board with a requirement that outstanding matters were resolved within three months.

General practice

There were four GP inspections in the ABM UHB area in 2016-17. All of the inspections were led by HIW inspectors with support from the Abertawe Bro Morgannwg Community Health Council.

Our findings were very positive, with practices providing safe and effective care to patients who were happy with the care they received. We found evidence of good management and leadership and we saw a good standard of record keeping by GPs and nurses in all practices. We also found examples of innovative work to improve patient uptake of vaccinations in one practice; and in record keeping at another practice.

Areas for improvement were identified in staff training and appraisal; the need for two of the practices to conduct regular patient surveys; and the need for two of the practices to review their concerns/complaints procedures to ensure compliance with the NHS Wales Putting Things Right arrangements.

Dental

We completed nine inspections of dental practices providing NHS treatment.

In every practice, patients told us they were happy with the service provided. We found the majority of practices to be well equipped, clean and tidy. In most cases documentation and information was available to show that X-ray equipment was being used safely; and staff demonstrated a thorough process for cleaning and sterilising dental instruments.

However, of the nine inspections, three resulted in the need for immediate assurance as patient safety concerns were identified. Themes identified were:

- Availability and checks of emergency equipment for use in the event of a patient collapse
- Performing and recording tests and procedures on decontamination and X-ray equipment to ensure equipment is functioning correctly
- Fire safety.

Other themes identified from dental inspections were:

- Improvement needed to risk assessments, policies or procedures in seven of the ten inspections
- Some improvements required to decontamination processes noted in six inspections

- Record keeping was an issue in five practices
- Quality assurance processes required attention in five practices
- The need for further staff training was an issue at four practices
- Improvements to the physical environment were highlighted in four inspections.

Learning disability

During 2016-17 HIW undertook 12 inspections of Abertawe Bro Morgannwg University Health Board residential settings, including three assessment and treatment units. Three of these inspections resulted in the need for Immediate Assurance in relation to risk assessments/documentation and environmental issues.

We found patients were helped to stay healthy and to take part in activities they liked to do both at the units and within their local community. However, repairs and maintenance had not been completed in a timely way and we found the physical environment in many of the residential units needed improving. We found improvements were required to ensure there was effective governance, leadership and accountability to guide and support staff. In particular, staff training was a concern at many of the settings, and in two settings, staffing levels were found to be inadequate.

Abertawe Bro Morgannwg University Health Board also provides the learning disability health services in the geographical areas covered by Cwm Taf University Health Board and Cardiff and Vale University Health Board. During 2016-17 we inspected the Cardiff West Community Learning Disability health team. We found the staff team was passionate and committed to providing a range of multidisciplinary assessments and interventions. Although we saw that Abertawe Bro Morgannwg University Health Board was beginning to work more closely with Cardiff and Vale University Health Board, we found that improvement was needed to the overall governance of learning disability service provision so that there was clarity about population needs, service specification and systems of oversight.

5. Special reviews, investigations and thematic findings

We did not undertake any special reviews or investigations within Abertawe Bro Morgannwg University Health Board during 2016-17. HIW completed nine clinical reviews to support the work of the Prison and Probation Ombudsman in relation to death in custody incidents.

Death in custody clinical reviews

During 2016-17 HIW contributed to three death in custody reviews relating to HMP Swansea.

HIW made recommendations in relation to improving substance misuse assessment and treatment, and improving the mental health assessment process. We also recommended there should be a review of the process for the use of alerts to ensure the required emergency equipment is available in a timely fashion and that, where required, emergency services are requested to attend at the earliest opportunity.

At the time of one review, there were two mental health nurse vacancies at HMP Swansea, one of which had been vacant for 12 months. HIW were informed by nursing staff that they had not received clinical supervision for some time.

HIW also contributed to six death in custody reviews relating to HMP Parc.

We made recommendations in relation to sharing records, improving sexual health service provision, and monitoring missed hospital appointments.

In one case, there was a very long delay from the date of a referral to the date of an operation, which was cancelled on two occasions during that time. The review highlighted poor communication between the Princess of Wales hospital and the prison healthcare staff. Serious concerns were raised in another case where an individual's test results were not acted upon in a timely manner, which meant he did not receive treatment as he would have expected if he was in the community.

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.

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 findings from our review were:

- Eye care services across Wales have insufficient capacity in secondary care to meet current demands

[1] http://hiw.org.uk/docs/hiw/reports/161208ldreviewen.pdf

[2] http://hiw.org.uk/docs/hiw/reports/170131opreviewen.pdf

- 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.

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. For some inspections, we will undertake a follow up inspection to ensure improvement plans have been actioned.

The following inspections included follow up activity:

- Gorseinon Hospital – Our inspection of West Ward in September 2016 followed up issues raised at an inspection in 2014. We found improvements had been made in many areas, but improvements could still be made to protecting patient information

- Princess of Wales - Our inspection of Ward 10 in January 2017 was to follow up issues identified at an inspection of Ward 9 during October 2014. Both wards are trauma and orthopaedic wards, and are situated side by side. We found that limited progress had been made in applying improvement action on Ward 10 and learning had not been effectively shared following our previous inspection.

Our inspection of the ED followed up issues identified during an inspection in February 2015. We found that, in general, improvements had been made.

- Cefn Coed Hospital – Our May 2016 focussed on the issues we identified in November 2014. We found that considerable improvements had been made to address some of the matters we identified in our previous report.

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. As highlighted in previous sections of this report, these issues related to:

- Patient identification wristbands (Maesteg and Gorseinon)
- Issues with environment and care documentation (Cefn Coed Hospital)
- Issues with environment and risk assessments (Learning disability residential units)
- 3 of 9 dental practice inspections resulted in the need for an immediate assurance letter.

We also issued one non-compliance letter for breach of the Ionising Radiation (Medical Exposure) Regulations at Singleton Hospital.

7. Governance

During 2016-17 the health board had a number of opportunities to demonstrate that it is a learning organisation. As issues arose the health board generally responded soundly with improvement plans being completed and provided in good time.

Inspection reports were observed being discussed briefly at the Quality and Safety Committee and at Assurance and Learning Group. However, evidence from inspections indicates the health board has not yet effectively embedded successful methods for sharing learning and best practice. For example, the follow up inspection of Ward 10 at the Princess of Wales highlighted the same issues which were found at a previous inspection of Ward 9.

HIW identified issues which required immediate assurance at a third of dental practice inspections, which may indicate that improvements could be made to the health board's governance and oversight of dental practices.

8. Engagement

Staff at all levels engaged fully with inspection teams visiting services operated by Abertawe Bro Morgannwg University Health Board and showed a willingness to learn from the inspection.

Correspondence between HIW and the health board was generally dealt with in a timely and satisfactory way.

During 2016-17 the HIW Relationship Manager attended a number of meetings at the health board including:

- Attending a Board meeting to present the HIW 2015-16 Health Board report
- Observing Quality and Safety Committee meetings
- Observing Assurance and Learning Group meetings.

The Chief Executive of HIW met with the Chief Executive and Chair of the health board during May 2016. HIW's Relationship Manager also met regularly with the Director of Nursing and Patient Experience in order to exchange information and, where necessary, discuss any further assurance required following inspection activity or issues raised with the health board.

In October 2016, HIW gave a presentation at an Abertawe Bro Morgannwg University Health Board 'Learning from External Inspections Workshop' on 'What to Expect from Hospital Inspections'. HIW also presented information about its new surgical inspection programme at the Assurance and Learning Group in March 2017.

9. Inspection, special review, investigation and thematic activity

Hospital inspections

1. Maesteg & Gorseinon Community Hospitals	27 September 2016
2. Princess of Wales	17 January 2017

GP inspections

3. St. Thomas Surgery, Ysgol St, St. Thomas, Swansea. SA1 8LH	31 January 2017
4. University Health Centre, Penmaen Residence, Singleton Park, Swansea. SA2 8PG	14 February 2017
5. Pontardawe Primary Care Centre, Tawe Terrace, Pontardawe, Swansea. SA8 4JU	28 February 2017
6. Vale Of Neath Practice, 102 High Street, Glynneath, Neath. SA11 5AL	27 March 2017

Dental inspections

7. Nicola Hall Ltd, Compton House Dental Practice, 20 Penprysg Road, Pencoed, Bridgend. CF35 7SS	5 July 2016
8. Broadlands Dental Surgery,Unit1, Gentle Way,Broadlands,Bridgend. CF31 5EJ	20 October 2016
9. Ogmore Vale Dental Surgery, 14 Commercial Street, Ogmore Vale, Bridgend, Ogmore Valley. CF32 7BL	23 November 2016
10. Talbot Street Dental Clinic, 24 Talbot Street, Maesteg. CF34 9BW	26 January 2017
11. Pontycymmer Dental Surgery, 97 Oxford Street, Pontycymmer, Bridgend, Farw Valley. CF32 8DE	31 January 2017
12. Chapel Street Dental Practice, 15 Chapel Street, Mumbles, Swansea. SA3 4NH	9 February 2017
13. Promenade Dental, 600 Mumbles Road, Mumbles. SA3 4DL	28 February 2017
14. Belgrave Dental Centre, 91 Walter Road, Swansea. SA1 4QF	9 March 2017
15. St James Dental Practice, 71 Walter Road, Swansea. SA1 4QA	13 March 2017

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspections

16. Singleton Hospital	4 August 2016

Learning disability inspections

17. ABMU managed residential service	25 May 2016
18. ABMU managed residential service	25 May 2016
19. ABMU managed residential service	2 June 2016
20. ABMU managed residential service	8 June 2016
21. ABMU managed residential service	9 June 2016
22. ABMU managed residential service	14 June 2016
23. ABMU managed residential service	27 June 2016
24. Rowan House, Ely, Cardiff	27 June 2016
25. Hafod Y Wennol, Hensol, Nr Pontyclun	28 June 2016
26. ABMU managed residential service	5 July 2016
27. ABMU managed residential service	7 July 2016
28. Llwyneryr Asessment and Treatment Unit	18 July 2016

Mental Health Act monitoring inspections

29. Cefn Coed Hospital	10 May 2016

Mental Health unit inspections

30. Cefn Coed Hospital (Follow-up inspection)	10 May 2016

Investigation - death in custody

31. HMP Swansea	April 2016
32. HMP Parc	May 2016
33. HMP Parc	August 2016
34. HMP Parc	August 2016
35. HMP Swansea	September 2016
36. HMP Swansea	October 2016
37. HMP Parc	October 2016
38. HMP Parc	October 2016
39. HMP Parc	February 2017