Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Betsi Cadwaladr University Health Board Annual Report from Healthcare Inspectorate Wales 2016-17

July 2017

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This document is also available in Welsh.

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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 Betsi Cadwaladr University Health Board.

2. Overview

During the year, HIW conducted 24 inspections or visits at Betsi Cadwaladr University Health Board settings, these included:

- 3 hospital inspections, one was a follow-up inspection
- 4 general practice inspections
- 7 dental practice inspections, one was a follow-up inspection
- 3 learning disability inspections
- 3 Mental Health Act (MHA) visits
- 2 mental health unit inspections, both were follow-up inspections
- 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection
- 1 joint review.

3. Key messages

The inspections conducted within Betsi Cadwaladr University Health Board generally indicate that the care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff. Our work highlighted the following issues which may require further attention.

- Improvements are required in relation to the timely referral and processing of Deprivation of Liberty Safeguards assessments with this emerging as a consistent theme across several inspections.
- Staff training around aspects such as Deprivation of Liberty Safeguards and Mental Capacity Act requires strengthening
- Work is required to ensure that documentation reflects the person centred approach to the provision of care

- Our General Practice and Dental inspections were broadly positive with good standard of patient documentation found consistently
- Significant progress have been made in addressing the areas for improvement highlighted during the 2015 inspection of Penrhos Stanley Hospital
- Patients generally were very positive about the standard of care and treatment they received, with staff committed to providing patients with safe and effective care.

4. Inspection findings

During 2016-17 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.

Hospital inspections

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

HIW inspected both Holywell Hospital (Ffynnon A ward) and Deeside Hospital (Branwen and Gladstone wards) during November 2016. We found that patients in both hospitals confirmed that they were happy with the care provided by staff teams. We also saw staff being courteous to patients and treating them with respect and compassion and found that all ward teams were committed to providing patients with safe and effective care.

However we also found some environment issues which needed addressing, and improvements required around aspects of medication management. We also found that whilst staff described patient centred and individualised care; the care records we saw did not fully reflect this. Significantly, we issued an Immediate Assurance letter to the health board in relation to delays in undertaking Deprivation of Liberty Safeguards assessments.

HIW inspected Ysbyty Glan Clwyd's Emergency Department during November 2016. The people we spoke with commented that they were generally happy with the care and treatment provided by the staff teams, and acknowledged how busy staff were. We also observed strong medical and nursing leadership within the department with good communication and professional relationships. The hospital site management team also provided a supportive presence on site.

However we did issue an Immediate Assurance letter relating to patients who did not have identification wristbands in place, the administration of controlled

drugs, delays in prescribing, and patients who were at risk of developing pressure areas. Furthermore we made a number of observations during our inspection which informed us that the health board was not fully compliant with all Health and Care Standards. Improvements were also identified in relation to staff's knowledge and understanding with regards to Deprivation of Liberty Safeguards. While the department was observed to be providing safe and effective triage and emergency care at initial presentation, it was not providing the same level of care in the Emergency Department Observation Unit (EDOU) area, with consideration required as to how the department is effectively assessing and managing risk for patients who stay longer than expected.

Mental health

HIW undertook an inspection of the Ty Llywelyn Unit, Bryn y Neuadd Hospital during December 2016. We found that patients were happy with their care, and we witnessed caring and positive interactions between staff and patients. Staff engaged well with the inspection process and indicated to us that they felt supported to access training needed for their role and professional development. However we did find identify issues in relation to the arrangements in place for patients to access a GP, and some estates issues which had been outstanding for a period or time. We also found that improvements were required in relation to provision of occupational therapy to allow off-ward and community activities. The completion and organisation of Mental Health Act documentation and care and treatment plans needed improvements – we felt that the health board needed to address its governance systems to ensure timely identification and escalation of any quality and safety issues.

In February 2017, HIW inspected Ysbyty Cefni. This was largely a positive inspection and the patients and relatives we spoke to were complimentary about the standard of care being provided. We also saw staff treating patients with respect and compassion. Care was being provided in a patient centred and individualised way and that the care records supported this approach. Some work was needed to ensure accuracy and consistency of some of the documents maintained under the Mental Health Act 1983, and we also found issues in relation to Deprivation of Liberty Safeguards and the timely processing of Deprivation of Liberty Safeguards referrals.

Ionising Radiation (Medical Exposure) Regulations

Our inspection of the North Wales Cancer Treatment Centre, Glan Clwyd Hospital in August 2016 was largely positive. We found a well-run service, with comprehensive written procedures and protocols in place. Training records had been maintained and were available for inspection. We found effective leadership and management being provided by senior staff. Clear lines of reporting and accountability under IR(ME)R were described and demonstrated.

General practice

Overall our findings in relation to our General Practice inspections were positive. We consistently found patient records to be of a good standard, and clear arrangements in place at most practices to promote safe and effective patient care. Practices were committed to delivering a high quality service to their patients. One theme from our inspections related to the need for practices to ensure adequate facilities in reception areas for patients to have private or confidential discussions.

Dental

We completed 12 inspections of dental practices providing NHS treatment. These inspections highlighted the following themes:

- In the majority of inspections HIW noted good standard of recording in patients' records
- In the majority of inspections HIW noted facilities which were well-equipped, visibly clean and tidy
- Most inspections found excellent or good infection control and decontamination procedures in place
- In the majority of inspections the patients we spoke to were very happy with the service provided and felt that they were provided with enough information to make an informed decision about their treatment
- In some inspections we found that arrangements in relation to safeguarding arrangements needed strengthening
- Some practices need to ensure greater clarity for patients over how they may raise a concern regarding their treatment.

Learning disabilities

During 2016-17 HIW undertook three inspections of learning disability services, this consisted of a residential unit and assessment and treatment units. These three inspections resulted in the publication of a single report.

Our inspections found that staff were treating patients with respect and kindness and that the patients we saw looked happy and conveyed that they felt safe and supported. There were good relationships between the service and other primary health care providers such as, GPs, practice nurses, dentists, and opticians. We also saw detailed and timely recording of patient assessments and care plans.

However we found that Deprivation of Liberty Safeguards authorisations were not being reviewed in a timely manner to ensure the health board is compliant with law associated with Deprivation of Liberty Safeguards. Furthermore we did find issues with the arrangements for checking emergency resuscitation equipment and a need for the health board to ensure that staff were aware of what equipment needs to be available. We also found that staff needed to be supported to attend mandatory training to ensure their knowledge remains up to date. The planning of service provision needs to be in line with current best practice. However we also found very good engagement by senior staff and they demonstrated a commitment to make improvements from the inspections.

5. Special reviews, investigations and thematic findings

We did not undertake any special reviews or investigations in Betsi Cadwaladr University Health Board during 2016-17.

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

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

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 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

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

- 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.

- Penrhos Stanley Hospital - Significant progress had been made by the health board in addressing the areas for improvement highlighted during the inspection of the hospital conducted in November 2015 and the majority of those improvements had been sustained.

  We found that patients were happy with their care and saw staff being courteous to patients and treating them with respect and compassion. There was evidence of good record keeping and auditing processes.

  We also found robust management structures and lines of delegation and reporting were in place and that members of the management team were visible and accessible on both wards. Some work is required to ensure that the documentation reflects the person centred approach to the provision of care.

  We found issues with the timeliness of Deprivation of Liberty Safeguards referrals, and whether these were accurately completed. Staff who spoke to us also indicated that they would benefit from additional training on subjects such as care of people with dementia, the Mental Capacity Act and Deprivation of Liberty Safeguards.

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 two immediate assurance letters to the health board. These were in response to issues found at our inspections of Holywell, Deeside and Glan Clwyd Hospitals. As highlighted in the previous sections, these issues related to:

- Timeliness of Deprivation of Liberty Safeguards assessments (Holywell and Deeside)
- Patient Identification Wristbands (Glan Clwyd)
- Controlled Drugs procedures (Glan Clwyd)
- A delay in prescribing onto the All Wales Medication Chart of necessary regular medication for a patient with a long term condition (Glan Clwyd)
- A delay in a patient, who despite having been assessed as being at risk of developing pressure areas, receiving a pressure relieving mattress (Glan Clwyd).

In each case HIW received timely responses from the health board providing sufficient assurances that the issues raised had been addressed.

7. Governance

Joint Healthcare Inspectorate Wales and Wales Audit Office (WAO) work

During early 2017, HIW and the WAO undertook a joint review of governance arrangements in response to previous work undertaken during 2013, 2014 and 2015 respectively. The review considered the original themes from the 2013 review and also issues that have emerged since. The review work was designed to:

- provide clarity on whether the Health Board can demonstrate it is making the necessary improvements
- provide an agreed assessment to assist the Health Board and Welsh Government in ensuring that the interests of citizens and patients are protected
- fulfil our responsibilities as external review bodies to examine progress and outstanding issues and to report on them clearly and openly
- support improvement and inform any further required 'turnaround' activities.

8. Engagement

During 2016-17 the HIW Relationship Manager held regular meetings with representatives from the health board. Good relationships have been fostered with information being shared and exchanged. Where necessary, discussions regarding any further assurance required following inspection activity or issues raised with the health board.

HIW's Relationship Manager has also attended a number of Quality, Safety and Experience committees during 2016-17.

Overall the health board has been responsive to any matters raised by HIW and the quality of its responses has been satisfactory.

The Chief Executive of HIW met with the Chief Executive and Chair of the health board during May 2016.

9. Inspection, special review, investigation and thematic activity

Hospital inspections

1. Ysbyty Glan Clwyd	15 November 2016
2. Holywell and Deeside Hospitals	15 November 2016
3. Ysbyty Penrhos Stanley (Follow-up inspection)	27 March 2017

GP inspections

4. Bron Meirion, Castle Street, Penrhyndeudraeth. LL48 6AL	10 January 2017
5. Minfor Surgery, Park Road, Barmouth. LL42 1PL	25 January 2017
6. Forge Road Surgery, Forge Road, Southsea, Wrexham. LL11 5RR	22 February 2017
7. Bryn Darland Surgery, 53 High Street, Coedpoeth, Wrexham. LL11 3SA	14 March 2017

Dental inspections

8. Rosehill Dental Practice, Rosehill Street, Conwy. LL32 8LD (Follow-up inspection)	4 April 2016
9. West End Dental Surgery, 53 High Street, Llangefni. LL77 7NA	13 September 2016
10. Valley Dental Clinic, 2 Boston Terrace, Holyhead. LD65 3DU	22 November 2016
11. Glan Dwr Dental Practice, 17 Mona Terrace, Criccieth. LL52 0HG	19 January 2017
12. Amlwch Dental Surgery, 14 Salem Street, Amlwch. LL68 9BP	31 January 2017
13. MyDentist, Menai Bridge, Anglesey. LL59 5EA	14 March 2017
14. Penmaenmawr Dental Practice, Medical Hall, Pant yr Afon, Penmaenmawr, Conwy. LL34 6BA	21 March 2017

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

15. Ysbyty Glan Clwyd	24 August 2016

Learning disability inspections

16. Tan y Coed, Bryn y Neuadd Hospital	22 June 2016
17. Bryn y Neuadd Hospital	22 June 2016
18. Foelas, Bryn y Neuadd Hospital	23 June 2016

Mental Health Act monitoring inspections

19. Ty Llywelyn Unit, Bryn y Neuadd Hospital (2 visits)	5 December 2016
21. Ysbyty Cefni	14 February 2017

Mental Health Unit inspections

22. Ty Llywelyn Unit, Bryn y Neuadd Hospital (Follow-up inspection)	5 December 2016
23. Ysbyty Cefni	14 February 2017

Joint review

24. Betsi Cadwaladr Governance Arrangements	February 2017