Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Cwm Taf University Health Board Annual Report from Healthcare Inspectorate Wales 2016-17

July 2017

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In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

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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 Cwm Taf University Health Board.

2. Overview

During the year, HIW conducted 18 inspections or visits at Cwm Taf University Health Board settings, these included:

- 2 hospital inspections; one was a follow-up inspection
- 3 general practices inspections
- 4 dental practices inspections
- 3 learning disability inspections
- 2 Mental Health Act (MHA) visits
- 3 mental health unit inspections; two were follow-up inspections
- 1 joint inspection.

3. Key messages

The inspections conducted within the Cwm Taf University Health Board generally indicate the care provided to patients is kind and compassionate. However the HIW activity conducted during 2016-17 highlighted the following issues that the board will wish to reflect upon.

- The quality of documentation, such as recording of pain assessments, patient risk assessments and Mental Health Act monitoring
- The maintenance and improvement of the environmental conditions of those patients in mental health wards and units.

4. Inspection findings

During 2016-17 HIW conducted a variety of work within Cwm Taf 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 again identified an improvement was needed around the recording of patients' pain and monitoring of treatment. Patients were observed on trolleys in corridors which presented challenges around their dignity and privacy. Improvements were also needed when recording the timeliness of risk assessments for patients' wellbeing and safety, particularly for pressure and tissue damage, and falls. Documentation also needs to be improved for monitoring the temperatures of fridges used to store medication.

Mental health

During this inspection we identified areas of good practice around the provision of respectful care and the quality of the care treatment plans. However, further improvement was needed on the environment. In addition the quality of record keeping in some areas of the Mental Health Act documentation needed improving and the completion of clinical audits could be increased.

General practice

There were three GP inspections in the Cwm Taf area in 2016-17. All of the inspections were led by HIW inspectors with support from the Cwm Taf Community Health Council. Positively, staff appeared to be happy and supported by good leadership. However, there were recommendations requiring practices to comply with the Welsh Language Standards for Healthcare, and to ensure employment and recruitment processes are improved.

Dental

There were four dental practice inspections in the Cwm Taf area in 2016-17. The key themes from the inspections of these practices were largely positive, with one practice having no areas of non-compliance. Of those issues that were raised they generally related to reviewing and maintaining policies and procedures, improved record keeping and checking maintenance of equipment.

Learning disability

Community health learning disability services are the responsibility of Cwm Taf University Health Board. However, these, and residential services, are provided by Abertawe Bro Morgannwg University Health Board. During 2016-17 HIW undertook three inspections of residential settings in the Cwm Taf area.

We found that improvement was needed to the overall governance of learning disability service provision so that there was clarity about population needs, Abertawe Bro Morgannwg University Health Board's service specification and oversight of the commissioning arrangements in place.

Youth offending services

There was one inspection of the Youth Offending Services Team within Cwm Taf. The inspection was led by HMI Probations with support from HIW inspectors. During the inspection we noted good collaborative working between the health board and the Youth Offending Service in certain areas leading to reducing waiting times for young people to access services. There were issues around the number of systems for recording patient notes and the fact that no psychiatric expertise was based within the structure of the Youth Offending Service.

5. Special reviews, investigations and thematic findings

We did not undertake any special reviews or investigations in Cwm Taf 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 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
- 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.

- Ysbyty Cwm Cynon - Improvements were noted following the previous inspection, specifically relating to continence assessment and records of multi-disciplinary meetings associated with discharge. However, further improvements were required in recording and monitoring assessment of pain. This was also highlighted as an area for improvement in the health board annual report for 2015-16.

- Royal Glamorgan - There were two follow up inspections conducted during 2016-17, one in July 2016 and a second in January 2017. On both occasions we saw some positive findings when compared to previous visits, such as an increase in night staff and some improvements to the environment. In January 2017, we also saw some improvement in food provision. However, on both occasions three were further improvements required relating to the ward environment, and specifically in January 2017 recommendations were made relating to the maintenance of the environment. Patient dignity was mentioned in both reports relating to the follow up visits this year.

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.

Of the inspections conducted across Cwm Taf University Health board only one inspection resulted in an immediate assurance letter. This was in the Royal Glamorgan Mental Health follow up inspection to Seren ward and focussed on the maintenance of the environment such as damaged rails and handles that could cause accidents.

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 responded soundly.

Inspection reports were observed being discussed at the Quality & Safety meetings.

However, the health board has not yet effectively embedded successful methods for sharing all best practice. For example, the follow up inspection of Ysbyty Cwm Cynon highlighted that pain assessment was not being recorded effectively. This issue was also found in the A&E inspections that occurred later in the year and has been mentioned in previous health board annual reports.

8. Engagement

During 2016-17 the HIW Relationship Manager attended a number of meetings at the health board including presenting the 2015-16 Health Board report to the Public Board and attending Quality & Safety meetings.

HIW's Relationship Manager attended the Quality Taster day at Prince Charles hospital at the invitation of the health board.

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

During the year the health board was very welcoming to any approaches from HIW.

Correspondence between HIW and the health board was dealt with in a timely and satisfactory way. During the year HIW wrote to the health board three times with details of concerns raised and prompt responses were received on each occasion.

9. Inspection, special review, investigation and thematic activity

Hospital inspections

1. Ysbyty Cwm Cynon (Follow-up inspection)	5 May 2016
2. Prince Charles and Royal Glamorgan Hospital	29 November 2016

GP inspections

3. Porth Farm Surgery, Porth Street, Porth. CF39 9RR	7 February 2017
4. The Surgery, 150 Tyntyla Rd, Llwynypia, Tonypandy. CF40 2SX	14 February 2017
5. Park Lane Surgery, Mill Street, Tonyrefail. CF39 8AG	14 March 2017

Dental inspections

6. Smiles Dental Care, 29 High Street, Merthyr Tydfil. CF47 8DP	9 August 2016
7. Morgan Street Dental Surgery, 20 Morgan Street, Pontypridd. CF37 2DS	14 November 2016
8. Glenhaven Dental Care, 129 Cardiff Road, Taffs Well. CF15 7PP	12 December 2016
9. Cefn Coed Dental Practice, 148 High Street, Merthyr Tydfil. CF48 2PL	6 February 2017

Learning disability inspections

10. ABMU managed residential service	7 June 2016
11. ABMU managed residential service	27 June 2016
12. ABMU managed residential service	7 July 2016

Mental Health Act monitoring inspections

13. Ty Llidiard (2 visits)	27 March 2017

Mental Health unit inspections

15. Royal Glamorgan Hospital (Follow-up inspection)	11 July 2016
16. Royal Glamorgan Hospital (Follow-up inspection)	9 January 2017
17. Ty Llidiard	27 March 2017

Joint inspection

18. Youth Offending Services (Not published by HIW)	27 March 2017