Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Hywel Dda 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 Hywel Dda University Health Board.

2. Overview

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

- 3 hospital inspections, one was a follow-up inspection
- 4 general practice inspections
- 4 dental practice inspections, one was a follow-up inspection
- 5 learning disability inspections, one was a follow-up inspection
- 4 Mental Health Act (MHA) visits
- 4 mental health unit inspections.

3. Key messages

The inspections conducted within Hywel Dda 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 action.

- Significant concerns with the governance and oversight of learning disability and mental health services
- Quality of documentation – robust audit is required to ensure forms are fully completed, dated and signed
- Connectivity and individual access to IT systems, which impacts on training and the timeliness with which Electronic Staff Record (ESR) systems are updated
- More timely access to estates department for environmental improvements

- Our General Practice and Dental inspections were broadly positive with a good standard of patient documentation found consistently, although there is a concern regarding the fragility of GP services within the health board.

4. Inspection findings

During 2016-17 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.

Hospital inspections

HIW undertook inspections of a range of wards and service based inspections within hospitals. Patients in all areas confirmed that they were satisfied with the care provided by staff teams. We also saw staff being courteous to patients and treating them with respect and compassion. All teams were committed to providing patients with safe and effective care. However, we did identify some areas for improvement such as;

- Environmental issues (in all areas)
- Documentation (Ceredig Ward)
- IT accessibility (all inspections)
- Doctors prescribing of medication in a timely manner (Ceredig Ward).

Mental health

Within our mental health inspections, we found that patients were satisfied with the care they received and we witnessed caring and positive interactions between staff and patients. However, we did identify some areas for improvement such as:

- Capacity within the mental health service to meet the needs of the population it serves
- An improvement to the provision of on ward therapeutic activities
- Accessibility to IT systems and in particular, timely access to the Electronic Staff Record system in order to support accurate record keeping around staff training
- A range of environmental issues.

General practice

We inspected four General Practices (GPs). Although our findings in relation to GP services were generally positive, there continues to be a significant concern with regard to the sustainable delivery of this service throughout the health board. We did, however, consistently find 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 quality service to their patients, despite the difficult recruitment and retention climate in which they presently find themselves.

Dental

We completed six inspections of dental practices providing NHS treatment. One was a follow up. These inspections highlighted the following themes:

- In the majority of inspections, the standard of recording in patient records was good
- In the majority of inspections, facilities were well-equipped, visibly clean and tidy
- In most inspections we found satisfactory 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 needed strengthening
- Some practices need to provide greater clarity for patients on how they can raise a concern regarding their treatment.

Learning disabilities

During 2016-17, HIW completed five inspections associated with learning disability services (one of which was a follow up visit). On each occasion, the patients we saw looked happy and conveyed that they felt safe and supported. Our inspections also found that staff were committed to delivering safe, effective care in a kind and respectful manner. In addition, we concluded that there were good relationships between the service and other primary health care providers such as GPs, practice nurses and dentists. However, patient care was not always based on the medium and long term individual needs of patients. In addition, patient documentation, aspects of medicines

management, governance, staff support, the care environment and IT access in some areas was poor. We were therefore, and continue to be, concerned about the overall service provided to this patient group.

Whilst we had a number of meetings with senior health board staff, with a view to ensuring improvement action was taken, follow up inspections indicated that recommendations were not always acted upon in a timely way and learning had not been passed on across the directorate.

There appears to be significant scope for improvement in the planning of service provision within the directorate.

5. Special reviews, investigations and thematic findings

We did not undertake any special reviews or investigations within Hywel Dda 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 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

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

- 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
- 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. For some inspections, we will undertake a follow up inspection to ensure improvement plans have been actioned. During 2016-17 HIW undertook three follow up inspections;

- Bronglais Hospital - There were a number of areas identified for improvement in the 2015 report with regard to the delivery of safe and effective care. We were disappointed to find that although there had been some improvements, there remained some concerns regarding the delivery of safe, dignified and timely care that are aligned with the Health and Care Standards, particularly with regard to the use of a designated area to provide care for patients waiting for admission into the main hospital. However, HIW was still assured that the overall outcomes for patients were effective. Generally we were satisfied that the staff structure was adequate and that staff of all grades worked diligently to improve service provision and to ensure patients felt safe and supported.

  We found that leadership and management was visible and effective. Discussions with staff, demonstrated that staff relationships had improved. However, there remained concerns regarding staffing numbers. Whilst senior staff described a number of innovative ways in which staff recruitment was being carried out, it is understood that these resulted in varying levels of success.

- Ty Bryn Learning Disabilities Service - Given the number and nature of improvements identified at the initial inspection, and the very limited progress made between June 2016 and 13 February 2017, HIW took steps to meet with key representatives from the health board to seek further information and clarification on the action they intended to take. This was to ensure the delivery of safe and effective care across learning disability services.

- Portfield Dental Practice - We did not identify any further areas for improvement during the follow up inspection. We were pleased to see that the practice had addressed the improvements needed. There had been a significant improvement regarding the delivery of safe and effective care. Furthermore the management and clinical arrangements in the practice had substantially improved. This gave us the assurance that the services provided were safe and appropriately managed.

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 six immediate assurance letters to the health board. Whilst responses from the health board were generally timely, in the case of Learning Disabilities, the improvement actions did not always provide sufficient assurances that the issues raised had been addressed.

HIW requested meetings with senior representatives of the health board on four occasions in an attempt to resolve the situations, enable improvements to patient care and to ensure lessons are learned. HIW remains concerned regarding the mental health and learning disability provisions within the health board.

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 in a timely manner with robust action plans. However, the mental health and learning disability directorate has some way to go to deliver in line with other areas of the health board.

Inspection reports were observed being discussed at the dental quality & safety meetings and there is a designated member of the Governance team who deals with action plans and updates.

However, the health board has not yet effectively embedded successful methods for sharing all best practice. For example, the initial and follow up inspection of Ty Bryn highlighted the need for effective governance, leadership and accountability arrangements to guide and support staff working at the service. These issues were apparent in the subsequent inspection of Greville Court, which occurred later in the year, raising questions about the effectiveness of leadership and management of this service throughout the

health board. Across a number of inspections, we found reoccurring feedback from staff regarding delays in action on estates/maintenance requests, delays in populating the ESR system, delays in Human Resources recruitment processes and access to electronic training programmes.

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, have been positive.

The Relationship Manager has also attended a number of dental quality and safety meetings during 2016-17.

Overall the health board has been responsive to any matters raised by HIW and the quality and timeliness 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. Bronglais Hospital (Follow-up inspection)	7 September 2016
2. Bronglais Hospital	7 September 2016
3. Bronglais Hospital	11 January 2017

GP inspections

4. Andrews Medical Practice, The Old Dental Suite, Llwynhendy Road, Llanelli. SA14 9BN	29 November 2016
5. Harbour View, 56 Station Road, Burry Port. SA16 0LW	12 January 2017
6. Brynteg Surgery, Brynmawr Avenue, Ammanford. SA18 2DA	19 January 2017
7. Coalbrook Surgery, Coalbrook Road, Pontyberem. SA15 5HU	7 February 2017

Dental inspections

8. Portfield Dental Surgery, 11 Portfield, Haverfordwest. SA61 1BN (Follow-up inspection)	12 January 2017
9. Llandeilo Dental Practice, 18 Carmarthen Street, Llandeilo. SA19 6AE	14 March 2017
10. Llandovery Dental Practice, 22 Stone Street, Llandovery. SA20 0JP	15 March 2017
11. West Street Dental Practice, 23 West Street, Pembroke, Fishguard. SA65 9AL	29 March 2017

Learning disability inspections

12. HD managed residential service	7 June 2016
13. HD managed residential service	14 June 2016
14. HD managed residential service	14 June 2016
15. HD managed residential service	14 July 2016
16. HD managed residential service (Follow-up inspection)	13 February 2017

Mental Health Act monitoring inspections

17. St Davids Parc (2 visits)	23 August 2016
19. Prince Philip Hospital - Bryngolau	19 February 2017
20. Prince Philip Hospital - Bryngolaf	19 February 2017

Mental Health unit inspections

21. Bro Cerwyn Mental Health Centre	12 May 2016
22. St Davids Parc	23 August 2016
23. Prince Philip Hospital - Bryngolau	19 February 2017
24. Prince Philip Hospital - Bryngolaf	19 February 2017