Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Powys Teaching 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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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 Powys Teaching Health Board.

2. Overview

During the year, HIW conducted nine inspections or visits at Powys Teaching Health Board settings, these included:

- 1 hospital inspection
- 4 general practice inspections
- 2 dental practice inspections
- 1 learning disability inspection
- 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection.

3. Key messages

The inspections conducted within Powys Teaching Health Board indicate that overall, the care provided to patients is being delivered by committed and enthusiastic staff in a manner which is kind and dignified.

During 2016-17 our work highlighted the following issues that the Board will wish to reflect upon:

- Inspection findings at the Brecon and Knighton hospital inspection visit and one dental practice inspection both resulted in HIW needing to follow its' immediate assurance process. The immediate assurance findings at both inspections were improvements HIW has identified within previous annual thematic reports. HIW expects that the health board takes steps to ensure these findings are not replicated across their service areas
- A need to improve the quality and consistency of specific mental health documentation within hospital inpatient notes
- To ensure that infection prevention and control guidelines are consistently implemented.

4. Inspection findings

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

Hospital inspections

During 2016-17, we visited Brecon War Memorial Hospital (Epynt ward) and Knighton Community Hospital (Panpwnton Ward). These were both considered during one multi site inspection visit. Our findings at this inspection were mixed.

We received some positive feedback from those in receipt of care and / or their relatives and visitors. Both wards visited appeared clean, tidy and free of obvious hazards. We found evidence of clear, senior management leadership and a stable senior management structure. Ward managers at both locations were new but we saw evidence that they were making good initial impact and that they were receiving good support from the senior management team to develop in their roles.

We made a number of recommendations for improvement, including two improvements which were raised with an urgent timescale for action to resolve them. Please see section 6 later on in this report for further detail on the improvements which were made with an urgent timescale. We recommended improved staffing levels and supervision of patients at mealtimes; improved security of patient records; the need to ensure consistent application of infection prevention and control measures; some improvements around record keeping, particularly in relation to mental health documentation, and also a better, more robust application of dementia and cognitive impairment friendly initiatives.

Ionising Radiation (Medical Exposure) Regulations

We visited the diagnostic imaging departments (radiography) at three of Powys' community hospitals; Victoria War Memorial Hospital in Welshpool; Brecon War Memorial Hospital and Ystradgynlais Community Hospital.

Patients made positive comments to us about the approach of the staff treating them in these areas. We also observed staff treating patients with dignity and respect.

We found that there was a lack of clarity in some of the written procedures governing the use and application of radiographic equipment within the departments which could have led to some confusion. We also found that the written procedures did not in all cases, correctly identify those who were

performing practitioner and operator functions – a process within the IR(ME)R regulations known as ‘entitlement’.

General practice

We visited four GP practices in Powys to carry out inspection visits. Across these visits, we found evidence of practices which were working hard to provide high quality care and to provide patient continuity despite general challenges across the sector in recruiting sufficient numbers of GPs. Practice teams were committed and enthusiastic about their work and took pride in contributing to effective primary care provision within their communities.

We made recommendations for improvement at all four practices which included:

- The need to improve the provision of patient information and signage through the medium of Welsh
- To ensure that patient feedback is sought and that there is a means to communicate back with action taken as a result of the feedback
- To ensure that aspects of staff performance management, including appraisals and training are undertaken appropriately.

Dental

We visited two mixed provision dental practices during 2016-17.

We consistently heard from patients that they were happy with the provision of dental care they were receiving. We found that the dental teams were highly committed to their patients and to the provision of good quality dental care. We also found that both practices appeared clean, tidy and well equipped, providing as positive an experience as possible for patients.

We found the following themes for improvement at both practices:

- Improvements were needed to aspects of the decontamination process
- Improvements were necessary to raise the standard of patient records
- Some improvements were needed in relation to the arrangements for ensuring safe radiographic systems and processes.

We also issued one immediate assurance letter as a result of findings at one of the two dental practices; please see section 6 for further details.

Learning disabilities

We visited the South Powys Community Learning Disability Team during our thematic learning disability work undertaken in 2016-17. We also took account of some elements of the North Powys Community team but this was generally in relation to the structure and support services available in the North Powys area.

We found that staff working within this area were passionate and committed to their work. We were confident that the team knew the needs of those they supported very well.

We found that some elements of the service were insufficiently resourced – particularly speech and language therapy provision and complex behaviour support to the core team of staff. We found that the health board needed to strengthen its' approach to future planning within the service and to ensure it was being more responsive to the changing demographic of the learning disability population within Powys. There was also a need to ensure greater engagement with this service user group in the planning of current and future services.

The South Powys health team was not co-located with local authority colleagues and as a result their ability to collaborate effectively and work in partnership was impaired.

5. Special reviews, investigations and thematic findings

We did not undertake any special reviews or investigations in Powys Teaching 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

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

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
- 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.

We did not undertake any specific follow up inspection work in Powys Teaching Health Board during 2016-17. However, we had previously visited Epynt ward at Brecon War Memorial hospital and in our 2016-17 inspection to this ward we took the opportunity to consider whether their had been improvements against the recommendations we made previously. We found that some themes identified in the previous inspection were still being raised as negative findings during 2016-17 (a need to improve mental health documentation in patient notes and to ensure that infection prevention and control precautions were being consistently applied). However, we were equally able to acknowledge that progress had been made in other areas such as a stable senior management structure and support being provided to ward managers.

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 NHS services within the health board.

During our multi site hospital inspection visit we identified that not all patients were wearing identification wrist bands. This can present a greater risk of error in treatment and procedures where positive patient identification is necessary. We also asked that the health board provide us with assurance that there would be sufficient management support to a hospital ward which was isolated due to location, at a time when the ward manager was away. We raised both issues urgently and requested that the health board take immediate steps to address the findings and ensure issues were not widespread. We received a timely and satisfactory response from the health board to both issues.

At one of the dental inspections we carried out, we identified that the emergency kit (for patient collapse) contained out of date medicines and out of date equipment. This poses a high risk to patients since it means they may not be able to receive the correct treatment in the event of collapse and we therefore requested the practice take immediate steps to rectify this finding.

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.

The health board has ensured that HIW hospital inspection reports are discussed at its Patient Experience, Quality and Safety meetings in 2016-17. This committee also appears firmly focussed on exploring and addressing some of the major challenges to patient safety not covered by HIW's inspection work.

However primary care inspection activity does not seem to be discussed by this committee in the same way as inspection activity within secondary care. Given that of the two immediate assurance issues HIW identified in Powys, one related to issues found within a dental practice, the health board may wish to consider whether current governance arrangements surrounding dental practices are sufficient.

8. Engagement

During 2016-17, the HIW Relationship Manager presented the 2015-16 HIW Health Board report at a Public Board meeting.

In addition to this, the Chief Executive of HIW and the Relationship Manager met with the Chief Executive and Chair of the health board in July 2016.

The health board were welcoming and responsive to all requests from HIW for further information during the year. HIW's Relationship Manager wrote to the health board on three separate occasions during 2016-17 with a request for further information and assurance on issues that had come to our attention. On all three occasions the Director of Nursing responded on behalf of the health board with full and timely responses.

HIW met with members of the health board's Quality and Safety team on one occasion to discuss matters of safety and assurance relating to dental services, in addition to this was other constructive and open communication with the team where needed and appropriate.

During 2016-17, the health board took the opportunity to refresh their open invite for HIW to attend any of their Patient Experience, Quality and Safety Committee meetings. Where HIW has not attended these, minutes and agendas which are available online have been considered.

9. Inspection, special review, investigation and thematic activity

Hospital inspection

1. Brecon War Memorial & Knighton Hospitals	10 August 2016

GP inspections

2. Wylcwm St Surgery, Wylcwm St, Knighton. LD7 1AD	10 January 2017
3. Llandrindod Wells Medical, Spa Road East, Llandrindod Wells. LD1 5ES	24 January 2017
4. Builth Wells Medical Practice, Glandwr Park, Builth Wells. LD2 3DZ	6 February 2017
5. Rhayader Medical Centre, Cae Herbert Lane, Rhayader. LD6 5ED	21 February 2017

Dental inspections

6. E G Davies, Llys Einion Dental Practice, 60 Heol Maengwyn, Powys, Machynlleth. SY20 8DY	12 July 2016
7. River Wye Dental Care, Oxford Road, Hay on Wye, Hereford. HR3 5AL	27 September 2016

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

8. Diagnostic Imaging Departments	13 September 2016

Learning disability inspection

9. Powys Learning Disability Community Team	15 June 2016