Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Insight Bulletin

Introduction

Welcome to our first 2023 edition of Healthcare Inspectorate Wales' (HIW) Insight Bulletin.

Each quarter we issue an Insight Bulletin, to share our latest news, and highlight key themes emerging from our work.

It is part of our commitment to better understand our stakeholders' expectations, proactively engage, share our findings and report on our activity.

It has been a busy few months for HIW with the introduction of a revised publication policy, attending a variety of conferences, including one international conference and undertaking a diverse range of assurance and inspection activity.

This edition's 'learning and insight' section shares how we are working with other agencies to review child protection arrangements across Wales. Also, during our most recent NHS inpatient mental health inspections, we have found low levels of physical restraint training – find out how we are working with healthcare settings to improve this to ensure patients and staff are protected.

We would love to hear from you so please don't forget to provide your feedback to us.

Thank you.

Contents

Business Update

Our Healthcare Summit

Our Healthcare Summit is now a well-established mechanism which provides an interactive forum for sharing intelligence on the quality and safety of healthcare services provided by NHS Wales. Membership of the Healthcare Summit is made up of audit, inspectorate, improvement, and regulatory bodies who work across Wales. The Summit is held twice each year. We have now introduced a new process known as the Extraordinary Summit: collaborative response to emerging concerns. The Extraordinary Summit process, enables members of the Healthcare Summit to raise significant emerging patient safety issues and risks. Where emerging risks or significant concerns to patient safety are identified, Summit members can trigger the Extraordinary Summit process. The core principle for this work is to ensure relevant organisations can share and triangulate information in a nimble and timely manner, to respond to patient safety concerns. We introduced this process as of 1 February 2023.

Out and about

HIW has been out and about meeting new faces at a variety of conferences over the last few months.

Welsh NHS Confederation Annual Conference and Exhibition

In November our Strategy, Policy and Engagement Team, along with our Director of Strategy and Engagement and Head of NHS Inspection, attended the Welsh NHS Confederation Annual Conference and Exhibition. The theme of the conference was 'Enabling the future of health and care in Wales'. It was great to be back meeting colleagues across healthcare services in person.

Business Update

HIW in Latvia

Our Director of Clinical Advice and Quality Governance, Katherine Williams and Director of Strategy and Engagement, Abubakar Askira set off to Latvia in late November to participate in the European Partnership for Supervisory Organisations in Health Services and Social Care (EPSO) conference. EPSO consists of governmental and government-related organisations involved in law enforcement, supervisory activities, monitoring and accreditation, related to Health Services and Social Care in European countries or regions.

Abubakar said:

> The conference was an excellent platform for networking and shared learning on a variety of topics such as health and care regulation in an increasing digital landscape, and the role of supervisory organisations in adapting to a new focus on healthy lifestyles and illness prevention. The conference held at Pauls Stradiņš Medicine History Museum provided a unique opportunity to gain insight into Latvian culture and the history of medicine in Latvia. We are also excited to share that during the conference, Wales was offered a place on a pilot course, the first of its kind. This course has been developed by EPSO and Rotterdam University and will be the first internationally recognised training course for healthcare inspection staff. The training course will be delivered remotely.

Business Update

Royal College of Psychiatrists Academic Winter Conference

We were invited to exhibit at the Royal College of Psychiatrists Academic Winter Conference in early December. It was a fantastic opportunity to talk to psychiatrists about our second opinion appointed doctor service.

Join Us

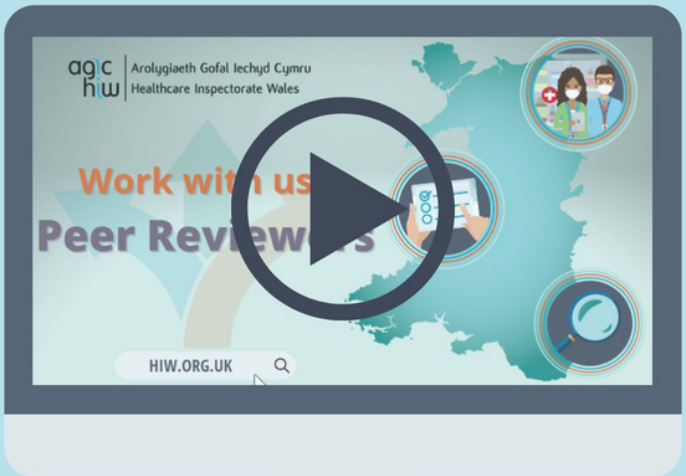
New year, new you, new challenge?

HIW is a busy and fast-paced organisation with people at its core.

We're currently recruiting for the following:

- **Senior Enforcement and Escalation Manager**
- **Peer Reviewers**
- **Second Opinion Appointed Doctors (SOADs)**

Find out more about the roles and how to apply on our website.



Activity Update

Assurance and Inspection Activity - Updated Publication Policy

You may have seen more of our work being highlighted on the news in recent weeks. We have introduced a new process for sharing the findings of our inspections to certain types of healthcare setting.

Owing to the importance and sheer number of people who use emergency departments, maternity services, and inpatient mental health units across Wales, HIW now briefs media outlets and stakeholders under embargo, immediately before publishing a report of this type, regardless of whether the inspection findings were positive or negative.

This process will be used for other types of inspection where there are findings of a significant nature. The introduction of this process meets HIWs strategic commitment of driving system and service improvement within healthcare.

Following this revised process for publishing reports, please s

- The Grange Hospital Emergency Department
- Morriston Hospital Emergency Department
- Ysbyty Ystrad Fawr's Mental Health Wards
- Hillview Hospital (Mental Health)
- Princess of Wales Hospital Emergency Department
- St Peter's Hospital (Mental Health)
- Prince Charles Hospital Maternity Service
- Bryn Hesketh Unit (Mental Health)
- Wrexham Maelor Hospital Emergency Department
- Heddfan Unit (Mental Health)

Ongoing Reviews

Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

Following an assessment of information from a range of sources which indicated significant concerns about mental health services in Cwm Taf Morgannwg University Health Board (CTMUHB), we made the decision to undertake this review. The focus of the work was to explore the quality and safety of discharge for adult patients leaving inpatient mental health units and going back into the community.

The review started in January 2022 and evidence gathering continued into late summer 2022. The report is due to be published on 7th March 2023.

Vascular Service, Betsi Cadwaladr University Health Board

In line with our NHS service of concern process, in February 2022 we designated the Vascular Services at Betsi Cadwaladr University Health Board as a Service Requiring Significant Improvement (SRSI).

We are therefore undertaking a local review within the health board's vascular services, to explore the progress made by the health board on the recommendations highlighted by the earlier Royal College of Surgeons report, to gain assurances on patient safety and the quality of care being provided.

We aim to publish the findings this Spring.

Ongoing Reviews

National Review of Patient Flow (Stroke Pathway)

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. As a result, HIW is undertaking a national review to explore this area in detail.
To assess the impact of challenges with patient flow on the quality and safety of care delivered to patients awaiting assessment and treatment, we will be focusing our review on the Stroke pathway.

We started planning the review in autumn 2021, and the field work began in March 2022. We have considered how the NHS in Wales addresses peoples' access to acute care at the right time and if care is received in the right place, by people with the right skills, through to timely discharge. We aim to publish the review report in Spring this year.

Planned Care National Review Update

We have previously referred to our plan to undertake a National Review of Planned Care. Due to the significant pressures within the healthcare system in Wales, we have decided not to progress with this work but to focus our resources on other areas of emerging risk and patient safety concerns.

Learning and Insight

Working with others

HIW works closely with other regulators and inspectorates in Wales, and also with other inspectorates across the UK.

During the course of our assurance work in Wales, we work closely with Care Inspectorate Wales (CIW), Estyn and Audit Wales. The Well-being of Future Generations (Wales) Act 2015 and Local Government (Wales) Act 2015 supports joint working between the inspection and audit bodies in Wales.

An example of this is our cross-inspectorate review work to explore the effectiveness of child protection arrangements, known as Joint Inspectorate Review of Child Protection Arrangements (JICPA). JICPA is a cross inspectorate approach which considers how well safeguarding partners work together to protect children.

In 2019 and 2021, HIW worked jointly with CIW, Estyn, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services and His Majesty's Inspectorate of Probation to undertake two pilot JICPA reviews. The pilot JICPA reviews focused on childhood sexual and criminal exploitation in Newport Local Authority within Aneurin Bevan University Health Board and Neath Port Talbot local Authority within Swansea Bay University Health Board.

Learning and Insight

Working with others

The methodology for this work focused on three main areas:

- An evaluation of the multi-agency 'front door' for child protection when children at risk of harm first become known to local services
- A 'deep dive' evaluation of the experiences of children at risk
- An evaluation of the quality of the leadership, management, and governance arrangements in place to develop and support service delivery.

The full inspection team evaluated the three areas above and utilised two key inspection methods: 'tracking' and 'sampling' the experiences of children.

Tracking involved an in-depth, end-to-end review of the experiences of six children who were at risk of exploitation. Family context was also taken into consideration; however, the experiences of any siblings were not evaluated in detail. Inspectors focused on practice in the six months before the inspection, but where appropriate, took into account the child's experiences prior to this point.

Sampling involved a cross inspectorate evaluation of the multi-agency 'front door', with particular emphasis on Information, Advice and Assistance. This included evaluation of the local authority 'front door' and multi-agency safeguarding arrangements for education, healthcare, police and probation services. It also focused on how well organisations communicate, share information and contribute to safeguarding arrangements. For example, schools' approach to supporting multi-agency safeguarding arrangements, such as core groups and GPs and Emergency Department risk assessment procedures.

Learning and Insight

Working with others

Our work also focused on direct practice by:

- Meeting with children, parents and carers
- Scrutinising and discussing children's experiences alongside practitioners and staff working with the child
- Observing practice in multi-agency meetings
- Examining key documents
- Interviewing staff to understand the support provided by senior members and the impact of quality assurance
- Evaluating the effectiveness of safeguarding arrangements and protecting children at risk of harm.

The published reports on the JICPA pilots can be found on the CIW website.

We will review:

- The response to allegations of abuse and neglect at the point of identification
- The quality and impact of assessment, planning and decision-making in response to notifications and referrals
- Protecting children aged 11 and under at risk of abuse and neglect
- The leadership and management
- The effectiveness of the multi-agency safeguarding partner arrangements.

Learning and Insight

Shared Learning for all Health Boards - NHS Physical Restraint Training

In all inpatient mental health inspections, we check staff are compliant with restrictive physical restraint training. This is because physical restraint can be harmful to patients or staff if not conducted properly or safely. Training, and refreshers of training, are vital in ensuring patients and staff are protected from injury.

Three of our recent NHS inpatient mental health inspections found very low levels of compliance with this training, as low as 16% in one ward. This poses a significant risk to patients and staff.In addition, we checked recent records of incidents of restraint in these inspections and noted non-compliant staff had been involved in incidents. Again, this poses a significant risk to the patients and staff involved, and we are not assured patients or staff are protected and safeguarded from injury.

Some of our inspections also noted physical restraint policies were out of date, and some records of incidents involving restraint were difficult to locate, navigate, or contained insufficient detail. Again, this poses a significant risk to patients and staff should someone be injured due to incorrect restraint.

We understand that some face-to-face training has been delayed due to the pandemic. However, it is important health boards ensure staff remain compliant with training to protect patients and staff from the risk of injury.

Learning and Insight

Shared Learning for all Health Boards - NHS Physical Restraint Training

In summary, we advise health boards should:

- **Retain accurate information on all staff mandatory training compliance**
- **Ensure all relevant staff complete full or refresher training as soon as possible**
- **Maintain an ongoing programme of refresher training**
- **In the absence of all staff being compliant, ensure all shifts have at least one compliant member of staff**
- **Ensure policies on the use of physical restraint are up to date**
- **Ensure records of incidents of restraint are easy to locate and are sufficiently detailed.**

Working Together

The vast majority of our interactions with health care services are positive and productive.

As we carry out our role, we will treat you with courtesy and respect and in return our staff have the right to expect the same. The safety of our staff is very important to us.

All our staff have the right to work in a safe and healthy environment. Verbal abuse, threats, intimidation, aggression, racial or sexual abuse, discrimination or physical assault will not be tolerated under any circumstances. Violence against our staff is a crime and we will not accept this behaviour.

Have Your Say

We carry out surveys when we want your views on particular topics.

We have a range of staff and patient surveys now open and we welcome your views on any of the topics.

All open surveys can now be found on our surveys page on our website.

Got a minute?

We'd love to know what you think about our Insight Bulletin – just a few questions and you're done!

Contact us

HIW.ORG.UK

0300 062 8163