Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Insight Bulletin

Introduction

Welcome to the summer edition of Healthcare Inspectorate Wales' (HIW) Insight Bulletin.

Each quarter we share our 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.

The core focus of our work is on determining the quality of healthcare services being provided to patients in Wales. We consider patient safety, risk, and patient experience across all our work. The implementation of the new Health and Care Quality Standards (from 1st April 2023), arising from the Health and Social Care (Quality and Engagement) Act 2020, will now underpin our assurance work within the Welsh NHS. As the Duties of Quality and Candour, and new Standards continue to steer the focus on quality, within healthcare services, you can expect to see HIW responding to this, by adapting our inspection methodology accordingly to ensure we gain assurance on quality and safety across the NHS in Wales.

It has been a busy few months, for HIW, in April we attended a conference in Malta hosted by the European Partnership for Supervisory Organisations in Health Services and Social Care, known as EPSO. This is a valuable forum where learning and innovation is shared amongst inspectorates and regulators worldwide.

In this edition, we also introduce you to our new Director of Assurance and two new organisations who will be joining our Stakeholder Advisory Group. The group provides a unique insight into the healthcare experiences of diverse communities to help inform our work.

Our 'learning and insight' section this quarter shines a spotlight on reoccurring issues and themes emerging from our assurance work to General Medical Practices (GP Practices).

We would love to hear from you so please provide your feedback to us.

Enjoy!

Contents

Business Update

We've published our Operational Plan

This week, launched our Operational Plan 2023-2024. The plan outlines the actions we aim to take to achieve our new priorities, which were set in our Strategic Plan 2022-2025.

These are:

1. **We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.**
2. **We will adapt our approach to ensure we are responsive to emerging risks to patient safety**
3. **We will work collaboratively to drive system and service improvement within healthcare**
4. **We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.**

Read our operational plan on our website.

Business Update

New Director of Assurance

We are pleased to announce the appointment of our new Director of Assurance, Rhys Jones. Rhys brings a wealth of experience and expertise to his role having joined the organisation in 2005. Prior to joining HIW, he studied Law and Society at Exeter University and worked in the private sector for Nielsen.

In his role as Director of Assurance, Rhys provides strategic leadership to HIW's inspection, investigation, and regulatory functions. He is deeply committed to driving quality improvement and is passionate about the positive impact that HIW can have on the lives of the people of Wales.

Rhys said:

"I am delighted to be appointed as the Director of Assurance at HIW. I am deeply committed to our work and am motivated by the positive impact we can have on the lives of the people of Wales. As I take on this new role, I am keen to use my experience and expertise to ensure that we continue to work collaboratively and drive improvement in healthcare services."

Business Update

Stakeholder Advisory Group – New Members

This month our newly formed Stakeholder Advisory Group welcomes new members Stonewall Cymru and Youth Cymru. The aim of the group is to help us better understand diverse communities, so that we can ensure our work examines the issues that impact upon the quality of healthcare services delivered. The group currently has diverse representation who each individually and collectively help to advise and inform our plans and work streams.

So far, the group has met to discuss and feedback back on the development of the joint Equality, Diversity and Inclusion Strategy being created by us and Care Inspectorate Wales (CIW). They have also offered advice and guidance on the best methods of engagement and how best to increase our visibility and awareness of our role. Through this group we aim to develop our understanding of, and insight into diverse communities, working towards a shared goal of driving improvement in healthcare.

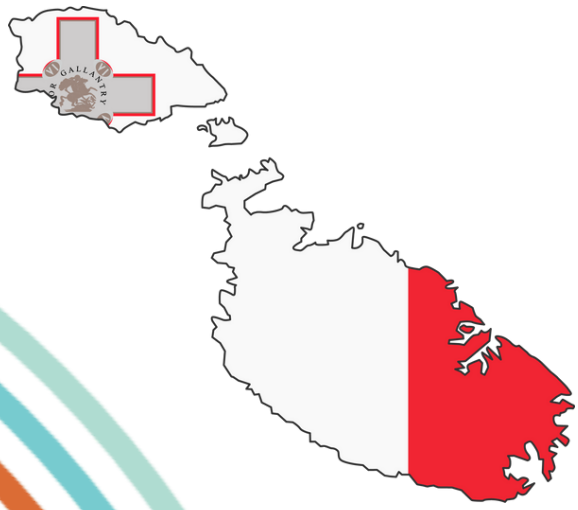
If you are interested in finding out more about the group, please email HIW.Comms@gov.wales

Business Update

HIW in Malta

Our Chief Executive, Alun Jones and Director of Assurance, Rhys Jones set off to Malta in April 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.

The conference was an excellent platform for networking and shared learning on a variety of topics such as integrated care, social care and ageing as well as the innovation of healthcare through new and emerging digital methods.



Business Update

Duty of Quality and Duty of Candour

Our work is continuing to align our existing NHS inspection methodologies (i.e. how we inspect), with the new Health and Care Quality Standards (2023), which have replaced the Health and Care Standards (2015). This involves aligning our existing methodology content against the appropriate 'Quality Domains' and taking account of the Duty of Candour.

We have also taken the opportunity to consider how we can strengthen our approach to assurance in line with the Duty of Quality. This has included adding new sections into our methodologies for areas such as consideration of efficiency, and a 'whole systems perspective', which are both taken from the new Duty of Quality.

The core focus of our assurance work remains on patient safety and risk and this will be underpinned by the new Health and Care Quality Standards (2023). This is reflected in our methodologies / how we inspect, and how we identify services to inspect via the review of intelligence.

Join us

Are you looking for a new challenge? HIW is a busy and fast-paced organisation with people at its core.

We are currently recruiting for the following:

- **Lead Second Opinion Appointed Doctor (SOAD) for Wales and a Deputy Lead SOAD**
- **Second Opinion Appointed Doctors (SOADs)**
- **Patient Experience Reviewers**
- **Mental Health – Experts by Experience**

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

Activity Update

Assurance and Inspection Activity

In advance of publishing inspection reports of emergency departments, maternity services and inpatient mental health units, HIW briefs the media amongst other key stakeholders under embargo. This process meets HIWs strategic commitment of driving system and service improvement within healthcare.

Latest highlight publications include:

Maternity services at Glangwili Hospital significantly improved since last inspection

HIW completed an unannounced, onsite inspection of the maternity unit across three consecutive days in November 2022, this included the antenatal and postnatal wards, the midwifery led unit, the labour ward and the triage assessment area. Inspectors found the maternity care provided had improved since HIW's previous inspection in 2019, but there were still some areas which required attention.

Inspection finds the need for significant improvement at specialist mental health hospital Heatherwood Court

Despite positive findings in relation to leadership and staff knowledge of patients, key improvements were required regarding the management and reporting of incidents. As a consequence of the concerns identified, and the lack of assurance over the processes in place to report, log and learn from incidents, Heatherwood Court was identified as a Service of Concern. We continue to monitor the service to ensure all improvements required are addressed without delay.

Activity Update

Assurance and Inspection Activity

Significant risks highlighted by Healthcare Inspectorate Wales's review of patients being discharged from mental health wards in Cwm Taf Morgannwg University Health Board

The review focussed on the quality and safety of discharge arrangements for adults discharged from inpatient mental health units into the community. The review considered the relevant policies and procedures in place, an evaluation of patient records, and information gained through interviews with a range of staff who worked within the health board's mental health services.
Throughout the review, HIW made 40 recommendations for improvement. Some patient safety concerns were of such significance, the health board was issued with an immediate assurance letter, following which, it was required to submit an immediate improvement plan to HIW.

HIW finds overcrowding and significant pressure within the emergency department at Glangwili General Hospital

The inspection concluded that despite staff efforts, patients were not consistently receiving safe care. We found staff were working extremely hard to provide good quality care for patients, at a time when the service was under considerable pressure. However, we identified that a number of improvements were needed, some of which required immediate action to be taken by the health board.

HIW calls for immediate improvement in the Angelton Clinic at Glanrhyd Psychiatric Hospital

Inspectors highlighted serious issues which required immediate action by Cwm Taf Morgannwg University Health Board, to prevent significant harm to patients and staff. The inspection identified a number of areas that required significant improvement including security issues, ligature risk assessments, adequate care planning and conducting regular audits.

Activity Update

Assurance and Inspection Activity

Ysbyty Glan Clwyd Emergency Department remains a 'Service Requiring Significant Improvement' following HIW inspection

The visit in November 2022 follows on from work which HIW carried out in March and May 2022 and is the third inspection report published by HIW in relation to this unit since March 2022. Our inspection in May 2022 resulted in the department being designated as a service requiring significant improvement (SRSI), a classification applied by HIW to those services where concerns about standards are the most significant. Whilst there were some improvements found in November, compared to earlier in the year, these were minimal and did not provide HIW with enough evidence to be able to remove the SRSI designation.

Immediate improvement is required to keep patients safe following an inspection at a Mental Health Unit in Llandough Hospital

Inspectors issued an immediate assurance letter to Cardiff and the Vale University Health Board, following evidence staff had participated in incidents of restraint, without the required levels of training. This meant that we were not assured that staff and patients are being fully protected and safeguarded against injury. The inspection did highlight staff within the wards were committed to providing safe and effective patient care.

Report praises staff but reveals improvement is required within a specialist mental health ward at Ystradgynlais Hospital

Inspectors found staff were motivated and committed to providing a high standard of care to patients, and there were adequate processes in place to manage risk, health and safety and infection control. However, improvements were required in relation to updating patient care plans, policies and risk assessments, the security of patient records and staff compliance with mandatory training.

Reviews

National Review of mental health services for children and young people

This spring, we will be commencing and leading on a joint national review with fellow inspectorates Estyn and Care Inspectorate Wales (CIW). The aim of the review is to establish whether children and young people in Wales are receiving effective support for their mental well-being, and where applicable, whether there is a timely and effective Child and Adolescent Mental Health Services (CAMHS) intervention to meet their needs.

The review will also consider whether services within the communities of each health board, education service and children's service across Wales:

- Consider and/or provide effective support to children and young people to help prevent early issues with mental well-being.
- Provide effective support to children and young people to prevent deterioration with existing mental health conditions.
- Work well together to ensure timely and effective care or support is offered to those who need it, when they need it."

Rapid review into child protection arrangements

We are working with Care Inspectorate Wales (CIW) and Estyn to look at how children in Wales are protected. The objective of the rapid review is to determine to what extent the current structures and processes in Wales ensure children are appropriately placed on, and removed from, the Child Protection Register when sufficient evidence indicates it is safe to do so.

We are working jointly with CIW to carry out fieldwork for the review, whilst Estyn undertake fieldwork in different local authorities. On completion of the fieldwork, we will each contribute towards the final report, which will be published in the summer.

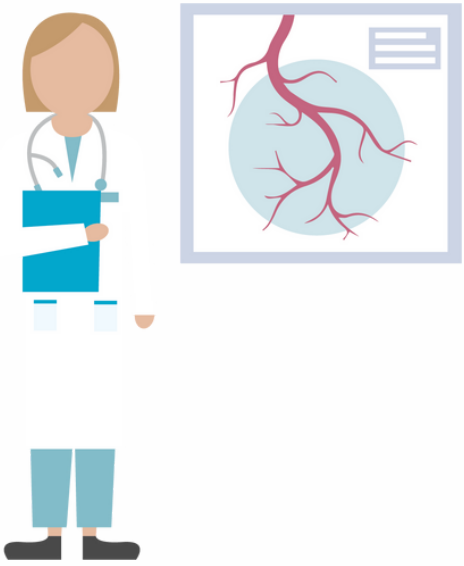
Reviews

Joint Inspection Review of Child Protection Arrangements: Denbighshire County Council, Betsi Cadwaladr University Health Board, North Wales Police

Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Care Inspectorate Wales (CIW) and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect of children in Denbighshire.

This report outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Denbighshire.

Local Review: 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 Summer.

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 Summer this year.

Learning and Insight

Back to basics

We recently refreshed our General Medical Practice (GP) methodology and enhanced the methodology to include key elements such as mental health support services and the wider primary care landscape including referrals and signposting to other services. We now include a practice nurse peer reviewer on our inspection team to reflect the importance of the role and the extent of work they contribute to the effective running of a GP practice. We have inspected nine GP practices with our refreshed methodology in 2022/23.

GP practices are under significant pressure and are facing unprecedented demand, impacted by long wait times at Emergency Departments and other areas of pressure on the NHS. This pressure has been reflected in our findings, which have varied significantly.

However, patient safety is paramount, and we have noted clear risks to patient safety in many of our inspections. We have issued Immediate Assurance letters on five occasions. For context, in 2019/20 inspection year, we completed 32 GP inspections and only required six Immediate Assurance letters.

Learning and Insight

Back to basics

The Immediate Assurance issues included (some of these have occurred more than once):

- **Incomplete safeguarding records and poor follow up of concerns**
- **Checks of emergency equipment and drugs not completed**
- **No DBS checks on staff including admin/reception staff**
- **Medicines not safely stored**
- **Medication fridge temperature checks not completed**
- **Poor compliance with mandatory training including safeguarding, CPR and infection prevention and control**
- **Out of date equipment including sterile sutures, sterile gloves, urine sample collection packs, minor surgical operations packs and needles, some of which were dated 2006.**

Learning and Insight

Back to basics

We consider mandatory training to be a vitally important part of maintaining patient safety at any healthcare setting. Topics that are deemed mandatory, for example infection prevention and control, safeguarding and CPR, are mandatory because of real risks to patients and how a setting manages a potential incident. In addition, the proper storage of medicines, and checks on emergency equipment, are again a requirement because of clear patient safety risks. While they all take time to complete, the resource investment is worthwhile as it helps to protect patients and staff.

Despite the service pressures, our patient experience surveys regularly conclude that staff treat patients with dignity and respect, but around a quarter of patients tell us they struggle to access an urgent appointment.

Informative / Guidance Patient Safety Alerts

Providers of healthcare services who are registered under The Independent Health Care (Wales) Regulations 2011 and The Private Dentistry (Wales) Regulations 2017 have a responsibility to be aware of any relevant safety alerts being issued.

Within these regulations the responsible person, must be aware of any guidance issued by the registration authority or appropriate expert body in relation to the safe handling and use of medicines and medical devices. This includes making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines and any medical devices used in or for the purposes of the associated establishment or agency.

Learning and Insight

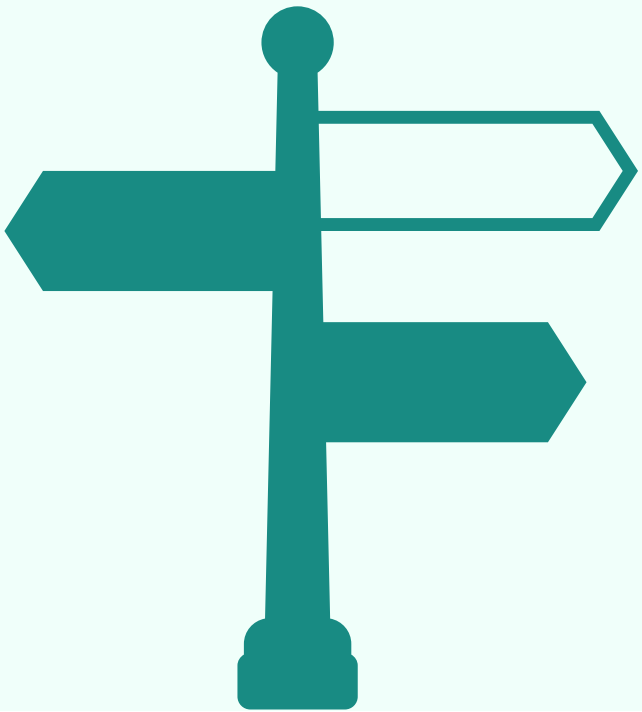
Informative / Guidance Patient Safety Alerts

Registered individuals must protect patients against the risks associated with the unsafe use and management of medicines and medical devices, and ensure patients and staff have access to advice and information on any medicines or medical devices used.

Subsequent to this all registered providers of healthcare services should ensure they are aware of the informative patient safety alerts issued from the Welsh Government, the NHS Wales Shared Services Partnership the Medicines and Healthcare Products Regulatory Agency and the Health and Safety Executive (HSE).These bulletins provide safety and security advice for healthcare professionals and your patients. The information alerts are for action and dissemination within your services . These often range from alerts, recalls and safety information in relation to medicines and medical devices.

Some of these can be accessed via the below links:

- **Pharmaceutical Public Health Links**
- **HSE - Working with Wales: HSE in Wales**
- **Medicines and Healthcare products Regulatory Agency - GOV.UK (www.gov.uk)**



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