Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

Hospital Inspection (Announced)

Ysbyty Enfys Carreg Las, Pembrokeshire and

Ysbyty Enfys Selwyn Samuel, Llanelli.

Hywel Dda University Health Board

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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 receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

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. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of two field hospitals within Hywel Dda University Health Board area on 20 October 2020. The following sites were visited during this inspection:

- Ysbyty Enfys Carreg Las, Pembrokeshire
- Ysbyty Enfys Selwyn Samuel, Llanelli.

Our team, for the inspection comprised of one HIW inspection manager and one HIW clinical peer reviewer. At the time of our inspection both sites were empty and in the final stages of preparation to receive patients.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspection

We found evidence of extensive planning by the service in preparation for the provision of safe and effective care to patients within unique environments. The transformation of both sites into clinical wards was well considered. We saw evidence of good leadership and staff who were engaged and passionate in their roles.

This is what we found the service did well:

- A great deal of planning and preparation had been invested in the transformation of the two sites into clinical ward areas
- Both sites presented as having excellent facilities and good equipment provision
- Excellent infection prevention and control planning and training for staff
- Evidence that patient dignity was at the forefront of the planning process
- Good procedure and process in place for transferring patients out of the field hospital as needed
- Impressive staff recruitment, induction process and staff development processes
- Good governance arrangements with an excellent leadership team who were well informed and knowledgeable in all aspects of the development of the field hospitals
- The inspection team had a positive experience with all health board staff fully engaged in the process.

This is what we recommend the service could improve:

- Better signage/directions to the Ysbyty Enfys Selwyn Samuel
- Improvements to the trip hazard identified at the entrance to the patient toilet facilities at Ysbyty Enfys Carreg Las
- Patients could gain access and remain unnoticed at several areas within Ysbyty Enfys Carreg Las site. In addition there was an external

door which could be opened from the inside which patients could access.

3. What we found

Background of the service

Hywel Dda University Health Board provides healthcare services to a total population of around 384,000 throughout Carmarthenshire, Ceredigion and Pembrokeshire.

In response to the COVID-19 pandemic, the health board has engaged in planning to commission a number of new field hospitals[1] across the region in support of acute hospital services by creating additional capacity for patient care. As a result of the pandemic, health boards are faced with the challenges of acute hospital bed reductions due to social distancing measures, winter flu and seasonal winter pressures. The way in which hospitals within the health board area operate has been changed to ensure that patients who have tested positive for COVID-19 are kept separate from patients who do not have COVID-19, to minimise the risk of infection. This has meant they do not have the same level of capacity to treat patients and deliver services in the same way. The use of field hospital capacity provides a means of easing pressures on the acute hospital sites.

Ysbyty Enfys Carreg Las and Ysbyty Enfys Selwyn Samuel will be used for low and medium risk patients who no longer need medical intervention in hospital, but who need some additional time to recuperate, or are waiting for a package of care in the community. Ysbyty Enfys Carreg Las will care for up to 70 patients at a time whilst Ysbyty Enfys Selwyn Samuel has the capacity for up to 64 patients. Patients who have tested negative for COVID-19 and patients who are post COVID-19[2] will be transferred and they will receive care from a multi-disciplinary team including nurses, doctors, and therapists. Ysbyty Enfys Selwyn Samuel became operational and started accepting patients on 16 November 2020 and Ysbyty Enfys Las was due to receive patients on 9 December 2020.

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[1] Field hospitals are temporary hospitals and are also referred to as acute surge facilities

[2] 14 day post positive test and asymptomatic patients

Quality of patient experience

The sites were not operational during our inspection which meant that we did not have an opportunity to engage with any patients. We did however consider the way in which care would be provided to patients in a dignified, individual and timely manner.

Dignified care

During the course of our inspection we considered how the arrangements and facilities at both sites promoted and ensured the comfort and dignity of all patients using the facilities. We also considered whether the environment would allow for dignified and private care to be delivered. We saw that, due to nature of the environment of the field hospitals, they were not conducive to the same level of privacy and dignity as an acute purpose built hospital.

However it must be recognised that the sites have been built and designed for use during a local and national emergency and pandemic. Through discussions with senior staff we found that, despite the challenges and barriers to dignity and privacy, the health board and local team had worked extremely hard to ensure they maximised patients' dignity. Every development and design feature was considered in relation to dignity and privacy while maintaining safety. This was a difficult balance for the health board to achieve, however it was evident they had worked very hard to achieve this balance.

We saw that each bed space could be completely enclosed by screens if bed based care was required. These screens could also be used to separate the bed spaces in the event that a patient required more privacy. Staff worked hard to ensure that patients could be cared for with dignity and respect. This included escorting them to toilet and shower facilities and using private areas away from the main clinical areas to hold sensitive conversations.

We considered how patient's relatives would be kept up to date with their treatment and care. We were told that each site has designated family liaison officers. These officers will assist patients with undertaking video calls and virtual visiting and supported patients with their communication needs. In addition the sites had developed a schedule for calling patient relatives to update them on a daily basis. This ensured that patients' relatives were supported and kept up to date in an extremely challenging and distressing time.

The health board had tested the viability of establishing and operating a field hospital by opening Ysbyty Enfys Caerfyrddin, as a pilot for eight weeks during

the summer of 2020. We were told that during the time of the pilot, visiting from family was discouraged. However; due to the layout of the field hospital, the health board were able to risk assess and facilitate some visits in an out-door area. It was explained to us this made a significant difference to the overall well-being of patients. We were told that staff were in the process of developing similar safe measures, to be able to offer the same service on the two sites inspected.

We looked at whether the facilities were appropriate for longer stay patients. We were told the facilities were designed for short stays only, and not suited to long stays for patients. The health board had also taken the decision that these sites were not suitable for the accommodation and care of certain patient groups. These included patients living with a history of self-harm, cognitive impairment and learning disabilities. This was in recognition of the specialised and unique needs of these patient groups and how the field hospital environment may not meet their needs.

Patient information

We reviewed a draft of a patient information leaflet relating to Ysbyty Enfys Carreg Las. The leaflet provided clear and concise information for patients and their families/carers. It included an explanation of the need for the health board to develop the field hospitals, the level of care patients could expect to receive, contact telephone numbers for the site and the family liaison team and photographs of the building and internal facilities at the site. We were told that individual leaflets would be developed for each field hospital site.

Whilst patients will be transferred from acute hospitals to the field hospitals, we considered how accessible the sites are to potential visitors. We found that signage and directions to Ysbyty Carreg Enfys Las were excellent. The site was easily accessible via a purpose built temporary road. However, the inspection team experienced difficulty in locating the Ysbyty Enfys Selwyn Samuel site, which was located within Llanelli town centre. This was because the destination was not accurate on vehicle satellite navigation systems. This was discussed with senior staff who agreed that additional road signs would be beneficial, to accurately direct traffic and visitors to the site.

Timely care

We were told that patient observations would be recorded in a recognised national chart to identify patients who may be becoming unwell or developing

sepsis[3]. We also reviewed documentation which reflected that a sepsis pathway and process had been developed in line with the field hospital setting. This demonstrated that a trigger system and escalation process for accessing senior medical care and escalation of care was in place.

We saw there was a procedure and process in place for transferring patients out of the field hospital as needed. This include liaison with the acute site management team and Welsh Ambulance Service. The health board had implemented a flow chart of escalation and transfer from the field hospital. This included scenarios such as clinical emergency and suspected infection. This process had been tested during the use of a field hospital earlier in 2020. Staff reported that the process worked well and engagement from the acute site and welsh ambulance service was good.

People’s rights

We considered whether patients were able to access spiritual and religious care and support. We were told by senior staff that spiritual and religious care and support was available when required. This could be provided virtually predominantly, however, onsite support could be provided in exceptional circumstances.

There were on site mortuary facilities to care and accommodate deceased patients if needed. The health board was working on a local agreement with funeral directors to collect deceased patients quickly. This was to allow relatives to spend time with their deceased relative, in a less clinical and more appropriate environment such as the funeral home viewing area.

The sites were not planned to be used to care for patients who were in their last days of life. However the team outlined examples where patients had deteriorated and requested to stay within the field hospital. Staff outlined how they had ensured that the patient’s wishes were recognised and met. These examples were from the period of the pilot of Ysbyty Enfys Caerfyrddin.

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[3] Sepsis is a life-threatening reaction to an infection. It happens when the immune system overreacts to an infection and starts to damage the body’s own tissues and organs.

We heard examples of highly compassionate care which ensured that patients experienced dignified and peaceful last days of life. This included facilitating a patient to go outside one last time and staff going above and beyond to provide compassionate and dignified care.

There were facilities at the sites for patients living with a physical disability and reduced mobility. These included ramps for wheelchairs, widened doorways and disabled bathrooms and toilets.

Due to the original purpose of both sites, we saw that some of the environments appeared quite bland and it was highlighted that if spending significant time in this environment there was potential for mental health impact. We were told that staff were ensuring that the wards would have artwork, televisions and orientation clocks alongside games and RITA (reminiscence therapy) units in order to make the area more conducive to positive mental health.

Listening and learning from feedback

We reviewed documents which reflected that, during the pilot of Ysbyty Enfys Caerfyrddin, patients were supported by the health board's family liaison team to complete experience questionnaires. We were told the questionnaires alongside written and verbal feedback, demonstrated the positive effects of the field hospital admissions. We also saw some of the positive quotes received by the health board form patients.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Safe care

Managing risk and promoting health and safety

Through discussions with senior staff and from our own observations, it was evident that a great deal of planning and preparation had been invested in the transformation of the two sites into clinical ward areas. The inspection team saw that the environments at both sites were clean and tidy, appropriately lit and well-maintained. Both sites had a feeling of calmness throughout the inspection and the environment appeared safe for potential patients with no blocked corridors or clutter present.

The leadership team were actively working with the estates team to assess all areas for ligature risks. Due to the nature of the buildings and the adaptation of non-clinical areas, this posed challenges in minimising the risk of ligatures. The health board were actively working to address this issue. We saw that some ligature risks had been assessed and mitigated. An example of this was the removal of hooks from a wall. We have asked the health board to forward their completed risk assessment prior to utilising the site.

During our inspection we assessed the facilities to ensure any fluids or products hazardous to health, were able to be locked away. We saw lockable areas available to store fluids and products hazardous to health. We also considered the facilities to ensure that any objects which could be used for self-harm were locked away. There were some areas which had not yet been fitted with locks or keypads to ensure authorised access only. We received assurance from the health board and local leadership team that this would be rectified prior to the sites being operational.

We reviewed the arrangements to ensure that unauthorised persons could not enter the facility and that patients with cognitive impairment could not leave unnoticed. The arrangements in place at the time of the inspection did not ensure that patients could not leave the clinical areas unnoticed.

In particular, at the Ysbyty Enfys Carreg Las site, there were several areas where patients, could gain access to areas outside of the immediate clinical area and remain unnoticed. In addition there was an external door which could be opened

from the inside which patients could access. This would pose a significant risk if not rectified prior to operationalisation.

The leadership team assured us that they were working hard to ensure, that all areas that could be accessed, would be locked where this was safe to do. Where this was not safe to do, for example in the case of fire doors, the health board were risk assessing this. A possible mitigation the team were considering was adding alarms to doors, to alert staff to anyone leaving the area. Another measure being considered was increased staffing levels to ensure close supervision and visibility of patients. The health board provided us with confirmation of this work and an updated risk assessment prior to the sites being used.

During an orientation tour of Ysbyty Enfys Carreg Las, we identified a potential trip hazard at the entrance to the patient toilet facilities, where the joins in the flooring were raised. This was discussed with senior staff who had already identified this as a potential risk. We were assured that action would be taken to remedy this prior to the site becoming operational.

Preventing pressure and tissue damage

We saw that there was a specific risk assessment in place for the assessment of patients within field hospitals. This was to ensure that patients are helped to look after their skin and every effort is made to prevent them developing pressure and tissue damage.

We reviewed an evaluation report which detailed a breakdown of patient outcomes and quality indicators, following the period when the temporary Ysbyty Enfys Caerfyrddin was operational. This reflected there were no cases of healthcare acquired pressure ulcers.

Falls prevention

The health board also had a separate risk assessment to assess those patients at risk of a fall, to ensure that every effort is made to prevent falls and reduce avoidable harm.

Infection prevention and control

There were several hand washing and sanitising stations spaced out throughout the clinical areas. The location and number of these stations had been carefully planned by the health board, with advice from the specialist infection prevention and control (IPC) team. There was one station per seven patients.

We did not observe any handwashing practice as the sites were not operational. However we observed guidance for staff on correct handwashing techniques and we were told that hand washing audits, will be undertaken by the leadership team when the site is operational.

In addition; there were clearly sign posted and allocated donning and doffing areas. These were used by staff to apply and take off personal protective equipment.

There were also staff changing facilities, where staff could safely change in and out of their uniforms and scrubs. These facilities were located close to the clinical area but separated clearly. They were equipped with showers and sinks for staff who wished to use these.

We considered how patients who develop COVID-19, Norovirus[4] or Vancomycin-resistant Enterococci (VRE)[5] whilst on the unit would be cared for. Senior staff we spoke to were clear that staff were trained in what symptoms patients may display if they developed COVID-19 or other infectious diseases. Arrangements were in place for patients to receive rapid swabs and specimen collection as needed.

The field hospital sites also all had point of care testing for some diagnostic tests. However, we were told that the analysing of COVID-19 swabs and other microbiological specimens was undertaken at the acute hospital sites. Staff explained that the results for these tests was timely in most cases. We established that the process for testing for COVID-19 was well established and including rapid access testing for staff. We were told that staff were actively encouraged to acknowledge and report any symptoms that they may experience in order that prompt isolation and test and trace processes could be followed.

We saw facilities and several areas available at both sites for the isolation of suspected or confirmed cases of infectious diseases including COVID-19. These areas were separated from the main nightingale style, bedded area. The areas were separated by doors and had areas for staff to don and doff PPE when

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[4] Norovirus is a stomach bug that causes vomiting and diarrhoea.

[5] VRE is a bacteria or bug found in the body which can cause infections which may require a patient to be isolated in their own room away from the main ward.

leaving and entering the areas. The health board had not decided which of the areas would be used for this purpose but were working on ensuring they were allocated prior to the sites becoming operational.

The health board's pandemic planning, designated the field hospitals as 'green' sites. This meant that they would not accommodate COVID-19 positive patients. Therefore the field hospitals had a process to follow if any patients developed symptoms of COVID-19 or tested positive. This process instructed staff to immediately isolate the patient, increasing their PPE requirements, undertaking testing and arrange for a transfer to a 'red' site, where COVID-19 patients would be accommodated.

We also considered how the clinical environment would be cleaned effectively to minimise infection control. The commissioning plan for each site outlined how the sites would be cleaned effectively when patients were present. This included the involvement of hotel services staff and on site domestic workers. Multiple cleaning checklists were in place to ensure the sites were maintained while awaiting operationalisation. These tasks were undertaken by staff on site. Staff worked together across disciplines to ensure that all areas of the site were cleaned to a very high standard. All areas were visibly clean with no dust or soiling present.

The facilities had been designed with infection control specialists and as a result all areas were able to be cleaned effectively. We observed staff actively cleaning areas during the inspection and found all areas to be cleaned to a very high standard. There was sufficient cleaning fluids and consumables required to maintain the cleanliness of all areas.

We also observed appropriate arrangements to minimise the risk of legionella in line with national guidelines and standards. These were undertaken daily consistently and recorded on appropriate paperwork.

We asked senior staff whether designated IPC staff were available to provide advice and guidance. We were told that the IPC team had been heavily involved at all stages of the development of the field hospitals. This included a designated lead within the team available for leaders and staff to access for advice and support. In addition the field hospitals were fully integrated into the health board's arrangements for on call specialist support. This meant that staff could access timely specialist support and advice on IPC.

Nutrition and hydration

We saw that facilites are available on both sites for the preparation of hot and cold food. We were also told that any patient with special dietary requirements would be accomodated.

Medicines management

We considered whether antibiotics and other treatments for infections could be safely delivered to patients. We observed adequate facilities and equipment available for the delivery of antibiotics and other intravenous medications and fluids. These would be delivered by nursing staff who were trained in their administration and use. The health board had developed a criteria panel to decide which patients could safely be cared for within the field hospital environment. We were told this involved discussion around each patient's suitability for transfer and also whether the patient's individual care needs could be supported at the field hospital. This added further safety to the process of identifying patients to be transferred to the hospital. We saw documentation which reflected that when the sites would become operational, patients admitted to Ysbyty Enfys Carreg Las were likely to be Level 0[6], and patients at Ysbyty Enfys Selwyn Samuel most likely to be Level 0-2[7].

We were informed by the health board's clinical lead for field hospitals of the proposed clinical oversight and doctor input, in line with the patient criteria at both sites. Ysbyty Enfys Selwyn Samuel was via an acute/geriatric led model whilst Ysbyty Enfys Carreg Las was General Practitioner (GP) led.

We considered whether medicines and medical gases at the sites were managed to keep patients, visitors and staff safe. At the time of inspection no medications

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[6] Patients who are deemed to be at Level 0 are described as people able to recover in their own home/care-home/nursing home.

[7] Patients at Level 1 are considered low risk whose needs would normally be met on an acute ward in an acute hospital setting. Patients will need low level observations. Patients may require additional support for example, cognitive impairment, minimal oral medication (55%). Patients at Level 2 are considered medium risk patients who require secondary care intervention and whose needs would normally be met on an acute ward in an acute hospital setting. Patients may require minimal supplementary oxygen, will require observations and likely to have additional comorbidities but no longer needing higher levels of care (15%).

were stored on site as the hospitals were not yet in use. However staff and leaders articulated how the sites would be supplied and stocked ahead of operationalisation. This included the involvement of dedicated pharmacists and technicians. The commissioning programme set out how this process would work including patients arriving with minimally four weeks of medications. We were told that additional medications would be stocked on an 'as required' basis. These included medication used to treat pain and nausea as well as medications needed in an emergency.

We also considered whether the sites had adequate facilities to store and dispense medications. During our inspection we saw that each site had lockable clean utility rooms. These rooms contained appropriate storage facilities for all types of medications to be stored on site. This included key coded refrigerators and metal cupboards. In addition both sites had cupboards secured to the wall with specialised locking mechanisms required for the storage of controlled drugs. Each patient bed area had a lockable cabinet to store the patient's own medication.

There were processes set out in the commissioning plan to ensure that designated pharmacy support would be allocated when the sites were operational. This included pharmacist attendance for three days a week and pharmacy technicians on the intervening days. We were told that pharmacy were involved in all communications and processes around the commissioning of the field hospitals.

We considered whether there are local microbiology protocols for the administration of antibiotics and whether prescribers would be using them. We found that field hospital used the same microbiological and antimicrobial prescribing guidelines as the wider health board.

Medical gases were minimal within the clinical environment as the hospitals did not accommodate patients with continuous oxygen needs. However there were two portable oxygen cylinders available for emergency use and these were to be stored in a designated area which we consdiered to be suitable for this purpose.

Medical devices, equipment and diagnostic systems

We were satisfied that there were adequate arrangements in place to ensure sufficient supplies of resuscitation and emergency equipment. Staff at the sites had worked with the health board's resuscitation team to ensure that the number and contents of these trolleys met health board and national standards.

Effective care

Safe and clinically effective care

We considered whether the ward environments at both sites were safe for staff, patients and visitors. We saw evidence within the documentation we reviewed of extensive operational considerations for the design and build of the health board's field hospitals. This included the segregation of 'clean' and 'dirty' areas, sluice, linen store, examination and basic treatment room, pharmacy storage and lockable filing cabinets for temporary records and hospital records. We also reviewed documents which evidenced wide consideration of bed configurations, equipment, transport, patient flow, facilities, information technology and finance.

We considered whether there were areas which could be visualised by staff more easily for patients with these conditions to ensure their safety? The clinical areas were highly visible but were large due to the nightingale style of the bed space areas.

As part of our inspection, we considered how patients with specific risks are identified and how the system supported staff to tailor their care accordingly. We established there was a bespoke field hospital documentation pack to be completed for all patients admitted to the field hospitals. This document pack was comprehensive and allowed staff to effectively assess clinical and environmental risks to patients. It was suitable for use in the setting and guided staff as to specific risks patients may face. The care planning process within this document allowed staff to tailor their care accordingly and ensure a personalised care planning approach.

In considering the arrangements and facilities to ensure the comfort and dignity of all patients using the facility, we looked at how patient's pain would be managed. We were told that, where possible, patient's pain management needs will be considered, identified and addressed prior to transfer. If patients required pain relief and did not have this prescribed, there were arrangements in place to meet this need. There was daily medical staff attendance on site enabling pain assessment and prescribe appropriate pain relief. Any patient in the field hospital would have access to specialist services provided at the acute site and this included specialised pain team. In addition the team were working with pharmacy to consider the use of patient group directives to allow nursing staff to administer simple analgesia if required.

Information governance and communications technology

Through dicsussions with senior managers, we identified that patients would be transferred with their full medical records as required and indicated by their

condition and clinical teams request. In addition there were arrangements to access records from the acute sites if required.

There were secure lockable trolleys available to store patient notes and records to ensure that medical records are stored safely and securely.This ensured that records were stored in a way which maintained privacy and legal requirements and kept patients safe.

It was explained to us that electronic records were linked up with the overall health board computer systems. This meant that staff could access up to date information as they needed this. This included access to diagnostic test results and images such as x-rays.

We also considered what systems were in place to ensure data and information relating to COVID-19 was accurate and reported on a timely basis. We established that daily reporting was widely available and utilised within the health board as a whole. This included site meetings and input into Wales wide data sets and reporting on bed capacity, cases and mortality. The field hospitals were directly linked into the health board's computer systems. This allowed easy access to test results.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Governance, leadership and accountability

We reviewed documentation which demonstrated that the health board had established a regional governance model to manage the programme of work involved in setting up its field hospitals due to the size and complexity inolved. This composed of a number of work streams at both a county and regional level, and included a number of representatives from across health, local government and partner agencies.

As previously referred to in this report, as part of the health board's overall COVID-19 response planning, it tested the viability of establishing and operating a clinical in-patient facility within an unconventional non-NHS premises by operating Ysbyty Enfys Caerfyrddin as a pilot. It was explained to us that his had been essential in order for the health board to test the environment, workforce, equipment, operations manual, policies and procedures, patient criteria, panel process and technology. We were told by senior staff that the operationalising of the site had been a success with a large amount of positive feedback.

We reviewed a report drafted by the field hospital manager and senior nurse manager following the closure of the site which had been operational for eight weeks during the summer of 2020. The site had accepted the transfer of up to 24 COVID-19 negative medically optimised patients from Glangwili General Hospital who had been assessed as having care needs that could be appropriately managed within a field hospital environment. The report provided a summary of the activity, patient outcomes, lessons learned, feedback and immediate recommendations relevant to the potential future commissioning of field hospital facilities. Senior staff told us the testing of the field hospital had been critical in learning new ways related to patient, pathway and discharge management and in future planning for the development of additional field hospitals.

Following the decommissioning of the site, a number of staff reflective sessions were hosted by the field hospital management team with the aim of providing an opportunity for staff to share experiences and perspectives with each other as a means of de-briefing and closure. It also provided an opportunity to gather

feedback in terms of staff perception and experience of work at the site, their thoughts regarding patient care and pathways and their understanding regarding what learning and ways of working could be adopted and applied to practice within an acute hospital site. Senior staff described to us how they were looking to capture the positive energy seen and felt within the team, and how this could be shared with staff across the health board.

We considered the arrangements in place to support the well-being of staff due to COVID-19. We were told that the health board had established support mechanisms which included opportunities for staff to attend team well-being sessions run by a clinical psychologist. This would provide staff with an opportunity to talk through any anxieties they may have. Staff could also receive support by self-referring to the health board's occupational health service, or by being referred by their manager. Additional support was also available to staff through the staff personal appraisal development reviews (PADR).

Staff and resources

Workforce

We reviewed documentation which reflected that the workforce model was considered and developed at an early stage of the health board's planning process for field hospitals. The model was based on the patient profile and pathways and the best estimate of the numbers of staff and skills needed to service each facility with access to the wider workforce across sectors. It had been subject to change as discussions developed and the situation changed.

We considered how the health board would ensure that there were sufficient numbers of appropriately trained staff available to work in both sites to provide patients wth safe and effective care. It was explained to us that the identification and availability of workforce was the biggest challenge the health board faced in relation to operationalising the field hospitals. Senoir staff had worked closely with colleagues from across the system in order to identify teams of staff to deliver safe and effective care to patients. We were told that their pilot site at Ysbyty Enfys Caerfyrddin demonstrated their ability to pull together a multidisciplinary team of staff comprising of medical, nursing, therapies, pharmacy, hotel services and administrative support. This had been achieved using a variety of methods including expressions of interest from existing workforce, identification of staff from services that were temporarily paused, targeted recruitment in response to the COVID-19 pandemic and the use of temporary workforce to backfill substantive staff in their contracted posts. Individuals were trained and rotated from their substantive roles. This resulted in a larger pool of individuals that they could have confidence in when required to backfill within the field hospital

establishment. We were told that the same process was being used to identify staff for the Ysbyty Enfys Carreg Las and Ysbyty Enfys Selwyn Samuel sites.

It was explained to us that the learning from the pilot at Ysbyty Enfys Caerfyrddin was being used to inform and develop the future workforce within the health board's other field hospital sites. We were told that staff would be given training and induction that was bespoke to the field hospital in which they had been allocated to work. This was supported by evidence we reviewed which included induction packs specific to health care support workers and registered nurses and a two day induction programme for staff. Alongside generic orientation, specific skills and competency training relating to the patient criteria and knowledge required were delivered to individual staff groups. Training was delivered on-site and the field hospital environment allowed training to be delivered face to face in a socially distanced manner. This allowed opportunity for staff engagement and for staff to familiarise themselves with the hospital prior to patient admission.

We were told that as a result of the unfamiliar environment and staffing constraints that were faced, staff from all disciplines were encouraged, trained and empowered to work more freely outside of their traditional role boundaries. This gave an opportunity for more generic working, particularly in relation to their hotel services and ancillary employees. Examples of this were domestic staff supporting the nursing workforce with cleaning items that would routinely be cleaned by nursing staff or porters acting as 'an extra pair of eyes' in the absence of a call bell system. Portering staff and hotel services were also trained with additional skills in cleaning of beds and assisting with mobilisation of patients. We were told that documented competencies in relation to these tasks were completed and evaluated. We considered this to be positive in providing staff with opportunities to develop within their roles.

The training plan and induction for staff working in the field hospitals included PPE training and also FIT testing processes for staff who needed to wear respirators type masks. Leaders assured us that all staff working in clinical areas within the health board had received recent training in PPE donning, doffing and levels required for differing scenarios.

We also considered the provision of appropriate infection prevention and control training for staff, and additional training for COVID-19. We established that training had already commenced ahead of the possible opening of the sites. There were training sessions in various subjects being provided at the field hospitals. This included infection control. In addition the health board expected all temporary staff working in the field hospitals to undertake the same training as substantive staff. This helped ensure that all staff working at these sites were

trained to the same level. Leaders reported strong relationships and good engagement with the specialist infection control and prevention team in relation to training.

We considered what training staff had been given to assess and manage patients changing needs to identify acute illness and to keep patients safe. All nursing staff working within the field hospitals were required to undertake a training course in resuscitation and recognition of acute illness. This was in addition to immediate life support training.

In addition to the workforce deployed within the pilot site, we were told that the health board were going to introduce more specific roles with delegated responsibilities, generic competencies, therapy led areas and external support from military colleagues at future field hospital sites.

We considered the staffing arrangements for both Ysbyty Enfys Carreg Las and Ysbyty Enfys Selwyn Samuel to ensure that there would be sufficient numbers of appropriately trained staff on the wards to provide safe and effective care. At the time of our inspection final nurse staffing levels had not been agreed and were still being negotiated with the senior management team. We discussed proposed patient to nurse ratios with senior staff, and expressed concerns over the suggested ratio. It was positve to note that the final nursing establishemt agreed by the health board took our comments into consideration and the health board have implemented a nursing establishment in line with our discussions.

Throughout our inspection we spoke to senior staff involved in the implementation of the field hospitals within the health board area. Through these discussions and from a reiew of documents received, it was evident that there was strong management and leadership. We were told that visible leadership had played a vital part in ensuring that staff felt confident working in the field hospital environment. A senior leader had been allocated daily at the pilot site site and a clear escalation plan for out of hours operational or medical need was in place and communicated widely.

We also had an opportunity to speak to skeleton staff who had already been deployed to work at both sites. All staff were welcoming, enthusiastic, expressed positivity and appeared passionate within their roles. It was apparent that staff and managers took great pride in the service they will provide to patients within unique environments.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Hospital: Ysbyty Enfys Carreg Las & Ysbyty Enfys Selwyn Samuel

Ward/department: Field hospitals

Date of inspection: 20 October 2020

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
There were no immediate assurance issues identified on this inspection.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Ysbyty Enfys Carreg Las & Ysbyty Enfys Selwyn Samuel

Ward/department: Field hospitals

Date of inspection: 20 October 2020

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board are not required to complete an improvement plan as a result of the inspection	1.1 Health promotion, protection and improvement			
	4.1 Dignified Care			
	4.2 Patient Information			
	3.2 Communicating effectively			

Improvement needed	Standard	Service action	Responsible officer	Timescale
	5.1 Timely access			
	6.1 Planning Care to promote independence			
	6.2 Peoples rights			
	6.3 Listening and Learning from feedback			
Delivery of safe and effective care				
	2.1 Managing risk and promoting health and safety			
	2.2 Preventing pressure and tissue damage			
	2.3 Falls Prevention			

Improvement needed	Standard	Service action	Responsible officer	Timescale
	2.4 Infection Prevention and Control (IPC) and Decontamination			
	2.5 Nutrition and Hydration			
	2.6 Medicines Management			
	2.7 Safeguarding children and adults at risk			
	2.8 Blood management			
	2.9 Medical devices, equipment and diagnostic systems			

Improvement needed	Standard	Service action	Responsible officer	Timescale
	3.1 Safe and Clinically Effective care			
	3.3 Quality Improvement, Research and Innovation			
	3.4 Information Governance and Communications Technology			
	3.5 Record keeping			
Quality of management and leadership				
	Governance, Leadership and Accountability			
	7.1 Workforce			

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):

Job role:

Date: