Meeting Date	**23 May 2023**	**Agenda Item**	**4.3**
Report Title	**External Inspections Report**		
Report Author	Neil Thomas, Assistant Head of Risk & Assurance		
Report Sponsor	Hazel Lloyd, Director of Corporate Governance		
Presented by	Neil Thomas, Assistant Head of Risk & Assurance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to highlight matters arising in respect of Healthcare Inspectorate Wales (HIW) inspections and reviews, and to provide assurance regarding action to address issues raised. The report has being expanded to capture other external reviews.		
Key Issues	• Two final HIW inspection reports have been published – no immediate assurances were required. Another has been issued in final form but awaits publication in May 2023 – one immediate improvement was required and action was agreed with HIW to address it. • HIW has undertaken a review of Mental Health Discharge at Cwm Taf Morgannwg Health Board. SBU has self-assessed local arrangements against its recommendations and submitted to HIW. • One unannounced inspection has been undertaken (a Learning Disabilities service). No immediate assurances were required – the report is awaited. • A report has been received following an inspection of Wales Fertility Institute at Neath, by the Human Fertility & Embryology Authority. A task & finish group has been set up to address findings. • A final WRP review of Consent to Examination & Treatment has been received. Reasonable assurance was reported in respect of policies and their clinical application.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the update in relation to external reviews and the health board responses to issues raised. • **CONSIDER** any areas requiring further assurance.			

EXTERNAL INSPECTIONS REPORT

1. INTRODUCTION

The purpose of this report is to highlight matters arising in respect of Healthcare Inspectorate Wales (HIW) inspections and reviews, and to provide assurance regarding action to address issues raised. The report has been expanded to capture information on other external reviews.

2. BACKGROUND

The Healthcare Inspectorate Wales (HIW) looks at the quality, safety and effectiveness of the services that are being provided to people and communities, drawing attention to good practice where it is found and highlighting practices that could cause harm to those who are receiving it and areas for improvement. It inspects NHS services in Wales, and regulates and inspects the independent healthcare sector. HIW also works with other review and inspectorate bodies to consider the quality of healthcare delivered in non-healthcare settings such as prisons. In addition to inspections, HIW undertakes a programme of reviews to look in depth at national or more localised issues. As part of its work it makes recommendations to make improvements, immediate and longer term, where appropriate.

This report presents information in respect of reviews/inspections approaching or in progress, and those recently concluded and reported.

Where reviews/inspections identify areas for improvement, HIW presents recommendations against which improvement plans may be developed by the health board and shared. Progress against these actions is communicated periodically by service leads to the corporate Risk & Assurance team and the position summarised and reported to support corporate oversight and the provision of assurance to the Quality & Safety Committee.

This report presents the status of actions agreed following HIW reviews/inspections within the health board as informed by updates received to date from service areas.

Health board services are reviewed and inspected by other external bodies, in accordance with statutory arrangements, quality management accreditation systems, and commissioning arrangements. Steps are being taken to coordinate information on these so that it is clear how risks and assurances arising from these are captured and reported.

3. NEW REPORTS RECEIVED – HIW

3.1 HEALTH BOARD SERVICES – FINAL REPORTS & AGREED IMPROVEMENT PLANS

3.1.1 Learning Disabilities Service (Unannounced Inspection) – Final Report

Following an unannounced inspection at one the Health Board Learning Disabilities services on 24 & 25 January 2023, Healthcare Inspectorate Wales (HIW) published its final report on 27 April 2023. There were no immediate assurances required following the inspection. Findings are summarised below:

Quality of Patient Experience:
The environment had significantly improved since the last inspection and met all the needs of the patients. HIW observed that staff interacted and engaged with patients appropriately and treated patients with respect and dignity.

There was a range of suitable activities at the hospital and within the community for patients to access.

The range of information at the hospital could be improved for patients and families.

This is what HIW recommended the service can improve:
• Patient menus need to be reviewed and improved to ensure that the menu choices are meeting the nutritional requirements of the patients
• Food temperature checks need to be consistently taken and recorded
• Health information should be provided for patients and visitors.

This is what the service did well:
• Staff interacted and engaged with patients respectfully
• Good team working and motivated staff.

Delivery of Safe and Effective Care:
The hospital environment was equipped with suitable furniture, fixtures, and fittings for the patient group.

HIW found that staff were completing clinical processes and documentation as required. There were established processes and audits in place to manage risk, health and safety and infection control. This enabled staff to continue to provide safe and clinically effective care.

This is what HIW recommended the service can improve:
• COSHH equipment is stored correctly.
• Protect patient confidentiality.

This is what the service did well:
• Care plans were detailed, individualised, and easy to navigate
• Safe and effective medicine management.

Quality of Management and Leadership:
There was an established staff team with strong team-working ethos. The staff team had a good understanding of the needs of the patients at the hospital.

This is what HIW recommended the service can improve:
• Regular staff meetings should take place and be minuted
• Review rotas to ensure staff have sufficient rest days between shifts
• Review and update policies
• Improve DoLS training figures.

This is what the service did well:
• Motivated and patient focussed team
• Staff team were cohesive and were positive about the support and leadership they received.

The full report, incorporating the Health Board's improvement plan, is attached at **Annex 2**. Preliminary feedback from the service indicates several actions already completed. A formal update is expected for review this quarter within the Service Group.

3.1.2 Paediatric Services – Ward M & Oakwood Ward, Morriston – Final Report

An unannounced inspection of the above services (managed by the Neath Port Talbot Singleton Service Group) was undertaken on 17 & 18 January 2023. No immediate assurances were required following the inspection. The final report was published on 20 April 2023. Findings are summarised below:

Quality of Patient Experience:
HIW found that staff provided patients and their relatives with an overall positive experience during their admission. Patients and their relatives commented in an overall complementary manner of the way care and treatments had been delivered.

Staff had made efforts to maintain an environment which was suitable for children, young persons, and their relatives. However, this was limited by a tired environment and lack of suitable space which does not reflect a modern paediatric service.

This is what HIW recommended the service can improve:
• Provide HIW with a timeline for the proposed refurbishment works
• Consider how to effectively communicate the CAMHS process to patients and their relatives.

This is what the service did well:
• HIW observed staff providing kind and respectful interactions with patients and their relatives
• There were generally good mechanisms for patients and their relatives to provide feedback and for this feedback to be acted upon.

Delivery of Safe and Effective Care:
HIW found that staff provided patients with an overall responsive and timely level of care and treatment. Staff demonstrated a good knowledge in relation to providing appropriate care specific to the needs of children and young patients.

HIW made several recommendations for the service to fully improve the delivery of safe and effective care:
• Ensure that all ward areas are able to be effectively cleaned and that actions from infection prevention and control (IPC) related audits are acted upon in a timely manner
• Strengthen aspects of record keeping in relation to fluid monitoring, medication administration and individualised care
• Ensure that staff training and knowledge in relation to sepsis is strengthened, including giving consideration towards implementing a sepsis tool
• Reflect on processes for the recognition and escalation of an unwell patient to enhance existing methods.

This is what the service did well:
• Staff explained clinical matters to patients and their relatives in a clear and age appropriate manner
• Staff demonstrated a good knowledge in areas including IPC and medicines management
• There were robust governance processes in place for the management of safeguarding matters.

Quality of Management and Leadership:
HIW found effective ward management and leadership, and all staff engaged positively with the inspection process. Staff that HIW observed and interacted with demonstrated a clear patient focus and were keen to provide patients and their relatives with a positive experience.

This is what HIW recommended the service can improve:
• Reflect on the staff responses and comments provided in this report.

This is what the service did well:
• Staff overall were supportive of the managerial support provided.

The full report, incorporating the Health Board's improvement plan, is attached at **Annex 3**.

3.1.3 Diagnostic Imaging Department, Morriston Hospital – IR(ME)R Inspection – Final Report (awaiting publication)

An announced inspection of the above service was undertaken on site on 21 & 22 February 2023. The inspection was a positive experience overall, but one point was raised requiring immediate assurance: HIW required assurance of action being taken to improve mandatory staff training compliance in respect of both resuscitation training and safe moving and handling training, and to promote patient safety in the interim. An Immediate Improvement Plan was submitted on 2 March and accepted by HIW.

A wider improvement plan was submitted on 18 April 2023 in response to HIW's formal draft report following the inspection. HIW issued the final report to the Health Board on 4 May 2023 and it is scheduled for wider publication on 25 May 2023. A copy of the final report will be included following its publication, with our next report to this Committee.

HIW has requested that an update on progress be provided within three months of the improvement plan. Arrangements are in place to provide this in July 2023 – progress reported will be shared with the Committee also.

3.2 Health Board Services – Recent Inspections & Draft Reports

3.2.1 New Request: Mental Health Discharge Arrangements

On 7 March 2023, HIW published a report following a review undertaken to assess the quality of discharge arrangements in place within Cwm Taf Morgannwg University Health Board (CTM), for adult patients being discharged from inpatient mental health services to the community. On 24 March 2023, SBU Health Board received a letter from HIW highlighting the key findings of the report and the recommendations made in respect of CTM. HIW requested that each health board complete an equivalent action plan to provide assurance that the issues identified in the HIW review were not replicated within other mental health services across Wales.

The Health Board response was submitted on 5 May 2023. It comprises two documents: a self-assessment against the issues & recommendations of HIW's CTM report; and an action plan setting out actions to address areas where areas for improvement were identified in the self-assessment. Both documents are attached at **Annex 4**.

3.2.2 Unannounced Inspection: Hafod-y-Wennol Assessment and Treatment Unit

HIW undertook an unannounced inspection in the above service during week commencing 17 April 2023. Verbal was provided at the close of the on-site inspection and no immediate assurances required. The formal report and improvement recommendations are awaited.

3.2.3 Planned Inspections

The Health Board has received notice of an upcoming inspection at Pontardawe Health Centre scheduled for 4 July 2023. Details have been provided to the Primary Community & Therapies Service Group Director to support any preparations required.

3.3 Primary Care Contractors – HIW Reports issued

Responsibility for addressing concerns raised by HIW inspections within independent contractors rests with the independent contractors. Reviews & inspections of the health board's primary care contractors have been identified by review of publications on the HIW website and are provided below for information – reports are received by

the Primary Community & Therapies Service Group. The following has been published since the last QSC meeting:

- General Dental Practice Inspection Report (Announced)
  Russell Street Dental Clinic, Swansea
  (Activity date: 9 January 2023. Publication date: 11 April 2023)
  Six improvements identified (no Immediate Assurances required).

4. PROGRESS AGAINST ACTION PREVIOUSLY AGREED

4.1 Health Board Directly Managed Services

The below table summarised the overall status of actions agreed for those services with actions remaining open (more detail is provided at **Annex 1**):

Number of Recommendations	Number of Actions Agreed	Number of Actions Completed	Number of Actions Ongoing	Number of Actions Overdue
74	151	114	37	15

Legacy improvement plans relating to the services within the Emergency Department at Morriston and Paediatric Services have been superseded and replaced by more recent HIW inspections in these areas – these have been added to the supporting table at Annex 1 for monitoring. Progress against the three most recently published reports (Learning Disabilities, Paediatric Services and IR(ME)R Inspection of Diagnostic Imaging at Morriston) will be included in future updates.

5. OTHER HIW REVIEWS INCLUDING NATIONAL/JOINT REVIEWS

National reviews and those requiring a joint response with partners are not included in sections above, but set out below:

5.1.1 Local Review of Governance Arrangements at Swansea Bay UHB for the Provision of Healthcare services to Her Majesty's Prison [HMP] Swansea

The Primary Community & Therapies Service Group is scheduled to attend the June 2023 meeting of the Q&S Committee. The Service Group Director is arranging for an update on the HIW Improvement Plan relating to HMP Swansea to be presented at that meeting.

5.1.2 National Review of Patient Flow (Stroke Pathway)

There is no change in respect of this review. As part of the HIW national review of Patient Flow, focusing on the stroke pathway, HIW conducted an onsite visit at Morriston Hospital on 26-28th April 2022. As previously reported, no issues were raised at the time of the on-site inspection with the service lead. Publication of the report is awaited – the scheduled publication date for this report is Spring 2023/24.

5.1.3 National Review of Mental Health Crisis Prevention in the Community (March 2022)

At the last meeting it was reported that of the 19 recommendations made, two recommendations (three related actions) remained to be confirmed as addressed to close the response. Since that position, staff within the service indicate progress with staff appointments and the setup of clinics to assist address the need for physical health assessments and monitoring. A formal, updated plan will be considered via the Service Group governance process this quarter and for discussion at the local quality & safety meeting in June 2023. A further update will be provided following this.

5.1.4 National Review of Maternity Services (Nov 2020)

There is no change to report in respect of this review. Of the 101 actions agreed, 15 remain to be confirmed as closed.

5.1.5 Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover (Oct 2021)

Following publication of the above report in October 2021, the Emergency Ambulance Services Committee (EASC) developed a single action plan in response to the report, with input from NHS organisations across Wales. To inform an update on progress for HIW in 2022/23, EASC sought information from every partner organisation in respect of local action taken/in progress. The SBU response to this request was returned in November 2022, and a final consolidated national update was submitted to HIW by EASC that month. HIW confirmed that the update provided it with sufficient assurance, as the improvements HIW identified had either been addressed and/or progress was being made to ensure that patient safety is maintained and improved.

The progress update submitted by EASC is attached for the Committee's information at **Annex 5**.

5.1.6 Care Inspectorate Wales (CIW) – Child Protection Rapid Review (April 2023)

The Health Board received a letter on 17 March 2023 from HIW indicating that following the publication of a Child Practice Review in November 2022, the Deputy Minister for Social Services had requested Care Inspectorate Wales (CIW) to lead a rapid review of decision making in relation to child protection.

A report is being prepared for the Safeguarding Committee in May 2023 by the Head of Safeguarding.

6. LEARNING FROM INSPECTION

A thematic review of recommendations raised across inspections conducted during 2022/23 has been prepared and will be discussed at the next Patient Safety & Compliance Group meeting. An update will be brought to the next meeting of this Committee.

7. UPCOMING & RECENT REVIEWS BY OTHER EXTERNAL BODIES

The table of other external reviews & inspections is presented at **Annex 6**. Recent inspection outcomes include:

7.1.1 HFEA Inspection: Wales Fertility Institute

The Human Fertilization & Embryology Authority (HFEA) undertook an inspection at Wales Fertility Institute at Neath, on 18 January 2023. The purpose of the inspection was to assess whether this centre complies with essential requirements in providing safe and high quality care to patients and donors. The HFEA's Executive Licensing Panel (ELP) uses the centre's application and the inspection report to decide whether to grant a new licence and, if so, whether any additional conditions should be applied to the licence. The report identified eight areas of non-compliance, seven of which were classified as major:

Major areas of non-compliance:

- The *Person Responsible* should ensure that the centre's success rates are accurately assessed and monitored against relevant KPIs.
- The *Person Responsible* should ensure the quality management system (QMS) is effective in ensuring the quality of services provided.
- The *Person Responsible* should ensure that consenting practices and procedures are compliant with regulatory requirements.
- The *Person Responsible* should ensure that legal parenthood practice and audit methodology is compliant with regulatory requirements and HFEA guidance.
- The *Person Responsible* should ensure compliance with statutory storage regulations.
- The *Person Responsible* should ensure that the information provided to patients regarding the use of their embryos in training is accurate and compliant with standard licence conditions.
- The *Person Responsible* should ensure that record keeping practice and procedure is compliant with standard licence conditions.

Other areas of non-compliance:

- The *Person Responsible* should ensure that the screening of donors is compliant with standard licence conditions and professional body guidance.

An HFEA Inspection Report Task & Finish Group has been set up to progress improvements required, chaired by the Director of Therapies & Health Sciences. Progress will be reported to the Patient Safety & Compliance Group. The report is attached at **Annex 7**. The service awaits formal receipt of HFEA Executive Licence Panel meeting discussions.

7.1.2 Community Health Council Inspection Report – Hafod Y Wennol

In February 2023, the South Glamorgan Community Health Council (CHC) issued a report following a scrutiny visit undertaken at the Hafod Y Wennol Treatment & Assessment Unit. CHC reports and responses are coordinated by the Director of Insight Communication & Engagement and reported via the Patient Experience & Stakeholder Group.

7.1.3 Welsh Risk Pool (WRP) Safety & Learning Team Report: A National Review of Consent to Examination & Treatment Standards in NHS Wales

The WRP issued their final report on the above to the Health Board in March 2023 (the report is anticipated for wider publication in May 2023). The aim of the review was to assess policies and their clinical application in the Health Board against the All-Wales Consent to Examination or Treatment Model policy.

The report concluded that the Health Board could take reasonable assurance in respect of the processes relating to Consent to Examination & Treatment. It made eight recommendations, and captures Health Board actions within an Appendix to the report. The report is attached at **Annex 8**.

8. OTHER MATTERS

8.1.1 HIW Quarterly Insight Bulletin (Feb 2023)

The Health Board has received a HIW Quarterly Insight Bulletin. Amongst the content there is shared learning for all Health Boards in relation to NHS Physical Restraint Training. A copy of the letter and bulletin are attached at **Annex 9**.

8.1.1 HIW Chief Executive News Bulletin (May 2023)

HIW has issued the above bulletin, highlighting:

- The focus of HIW assurance and inspection work has always been centred on patient safety, risk and the quality of services being provided. This will not change, but it will be complemented by the intentions of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and the move in April 2023 to implement the Duties of Quality and Candour. Recommendations for improvement and the reports into HIW findings will now be underpinned by the Health and Care Quality Standards 2023.
- Changes to the Health Board's Engagement Partner within HIW.
- The appointment of a new HIW Director of Assurance.

The full letter is attached at **Annex 10**.

8.1.2 Other Correspondence since QSC Feb 2023:

- February 2023: Confirmation of closure or IR(ME)R incident (HIW ref CAS-INVES-06011) in respect to an unintended exposure. This followed consideration of SBU investigation report(s) and conclusion that the response was detailed enough to provide HIW with assurance that the action taken is sufficient to prevent, as far as is reasonably practicable, similar incidents from happening again.

- April 2023: HIW letter highlighting concerns received regarding staffing levels at NPT hospital, and seeking confirmation of safe staffing levels there. A response was provided by Executive Director of Nursing on 14 April 2023.

9. GOVERNANCE AND RISK

This report aims to provide assurance regarding action taken to address issues & risks highlighted by HIW inspections and to inform Committee members and the Board of approaching and ongoing inspection activity.

10. FINANCIAL IMPLICATIONS

It is possible that actions to address some issues raised in external reviews and inspections may require resources. However, this report does not make any recommendations with financial implications.

11. RECOMMENDATIONS

Members are asked to:

- **NOTE** the update in relation to external reviews and the health board responses to issues raised.

- **CONSIDER** any areas requiring further assurance.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
HIW inspections may identify issues impacting upon the quality or safety of services, or the experiences of those affected by them. This reports aims to provide assurance on actions taken to address issues.		
Financial Implications		
It is possible that actions to address some issues raised in HIW inspections may require resources. However, this report does not make any recommendations with financial implications.		
Legal Implications (including equality and diversity assessment)		
HIW inspections may identify areas of non-compliance with legislation. This reports aims to provide assurance on actions taken to address issues.		
Staffing Implications		
HIW inspections may identify issues related to the staffing of services eg staffing numbers, or staff training/competency, or the solutions to other issues raised may have implications in terms of staff resources. This reports aims to provide assurance on actions taken to address issues.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The work of HIW provides an independent view of issues and risks within services. In addressing matters arising from reviews and inspections, the health aims to understand the causes of issues in order to prevent them from re-occurring.		
Report History	This is report has been prepared directly for the Committee	
Appendices	Annex 1: Progress Against Action Previously Agreed Annex 2: HIW Report: Learning Disabilities service Annex 3: HIW Report: Paediatric services (Morriston Ward M & Oakwood) Annex 4a&b: SBU Self-Assessment again HIW Recommendations following Mental Health Discharge Review at Cwm Taf Morgannwg Health Board Annex 5: HIW Ambulance Handovers Review – EASC Update provided to HIW	

	Annex 6: External Inspections Schedule Annex 7: HFEA Report Annex 8: WRP Consent to Examination Treatment Report Annex 9a&b: HIW Spring Stakeholder Update (Feb 2023) & Insight Bulletin Annex 10: HIW CEO News Bulletin (May 2023)