AGENDA ITEM
3.2.7

QUALITY & SAFETY COMMITTEE

REGULATORY REVIEW RECOMMENDATIONS AND PROGRESS UPDATE RELATING TO HEALTHCARE INSPECTORATE WALES (HIW) AND CWM TAF MORGANNWG LlAIS (formally known as the Community Health Council-CHC) VISITS AND REPORTS

Date of meeting	24th May 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Allison Thomas, Business Manager Patient Care & Safety
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
HIW	Healthcare Inspectorate Wales
GP	General Practitioner
CMHT	Community Mental Health Team
CIW	Care Inspectorate Wales

ED	Emergency Department
CHC	Community Health Council (since 1st April now Llais-Citizen Voice Body)
AMaT	Audit Management and Tracking

1. SITUATION/BACKGROUND

1.1 This report is based on Healthcare Inspectorate Wales activity and correspondence since the last report for committee in March 2023. Due to the bi-monthly nature of these meetings, this report will cover the 2 month period from the previous report.

An overview table has been included below in 2.1 to provide a 'summarised snapshot' of most recent activity.

All HIW Inspection activity can be accessed via the following link: https://hiw.org.uk/

This report includes updates and key messages from the former Community Health Council (CHC) now Llais, the new Citizen Voice Body.

On the 1st April 2023, CHC's in Wales were abolished and replaced by Llais, the new Citizen Voice Body for Health & Social Care.

Llais, Regional Director has an introductory meeting set up for early May 2023, to meet with the Health Board Chief Executive Paul Mears and the newly appointed UHB Chair Jonathan Morgan to provide an overview of, and introduction to, Llais.

1.2 **Llais – formally the Community Health Council (CHC) Update:**
No activity to report for this time frame as no site visits by Llais (CHC) have taken place since the last report.

2.0 HIW activity 17th February-30th April 2023

HIW activity across Cwm Taf Morgannwg University Health Board:

Number of Unannounced	**0**
Number of Announced	**0**
Number of patient/staffs concerns via HIW	**1**
Number of concerns raised through Fieldwork	**0**
Number of HIW & CIW joint Reviews	**1**

2.1 **Unannounced Inspections:**

There has been no (zero) unannounced inspections since the last report to the committee in March 2023.

2.2 **Update following unannounced Inspections:**

Princess of Wales Ward 5 Stroke Ward:

HIW published the final report with the supporting improvement plan on their website as of 28th April 2023:

The report can be found by the following weblink: https://www.hiw.org.uk/sites/default/files/2023-04/20230428POWEN.pdf

2.3 **Update following Announced Inspections**

The final report following the announced inspection to an Independent Contractor GP practice in January 2023 has been published on HIW website as of 25th April 2023 and can be accessed by the following link: https://www.hiw.org.uk/llynfi-surgery on the HIW website.

Community Mental Health Team (CMHT) - Maesteg Hospital

Following the joint CMHT inspection visit by HIW and Care Inspectorate Wales (CIW) which took place with both the Health Board and Bridgend County Council on 13th and 14th December 2022, the final report and supporting improvement plan was published on 16th March 2023 and can be accessed by the following link: Maesteg Community Hospital | Healthcare Inspectorate Wales (hiw.org.uk)

2.4 **Whistle-blower Concern raised via HIW**

Healthcare Inspectorate Wales were contacted by a whistle-blower in relation to concerns over patient safety. HIW strongly encouraged the whistle-blower to contact the health board directly through the whistleblowing policy to raise their concerns directly.

The concerns raised were promptly and fully responded to within the timeframe set by HIW.

2.5 **Local Reviews:**

Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board.

Following the HIW local review of the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within CTM UHB the draft report was received for factual accuracy together with the improvement plan template. The populated improvement plan, supporting documents and a programme of improvement activity was submitted to HIW as a result of the local review. All the recommendations have been aligned to workstreams as part of the Mental Health and Learning Disability in-patient improvement programme and/or other standard workstreams as part of the revised governance arrangements in the new Care Group. As well as the oversight from the workstreams the monitoring of HIW action plans is a standing agenda item on the Care Group Quality Safety Risk and Experience Group

The final report and supporting improvement plan was published by HIW on their website as of 7th March and this can be accessed by the following link: https://www.hiw.org.uk/sites/default/files/2023-03/20230307-CwmTafLocalReview-FINAL-ENGLISH.pdf

2.6 National **Reviews:**

i. ***National Review Patient Flow (Stroke Pathway)***

As part of the National Review work plan of HIW, they decided to undertake a national review of Patient Flow. In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, HIW elected to focus their review on the stroke pathway. HIW wanted to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway. An overarching report of findings from all health boards across Wales will be published by HIW. The health board will not receive an individual feedback report.

It is expected that the report will be published on the HIW website during the Spring 2023

ii. National Review of DNACPR Practices/ Processes

Following the update to the last Quality & Safety meeting regarding the HIW review to examine the use of DNACPR orders across Wales which commenced in January 2023, HIW have written to the health board Chief Executive and Chair to inform them that during the early stages of HIWs scoping and planning, HIW were made aware that plans were already in place for a national thematic review to be carried out by the Mortality Review (MR) Group, co-ordinated by Julie Rix, Patient Safety Manager within the NHS Wales Delivery Unit. Consequently, HIW made a decision to temporarily pause their DNACPR review whilst they take time to understand the full scope of the MR thematic review, to ensure any work undertaken by HIW will be complementary.

HIW informed the health board that they will in time recommence the review, and in doing so will share a Terms of Reference to all stakeholders, outlining their proposed plans for this work. In the meantime, HIW will review all the evidence which was submitted to them following their request in January as part of the initial information request for this review. This information, along with HIWs understanding of the MR thematic review, and the survey responses to date, will help them to refine the scope and future planning of this important piece of work.

HIW thanked the health board and its teams for our contribution and support with their work during its early stages and advised that they will be in touch again in due course.

Child Protection Rapid Review – April 2023

Following the publication of a Child Practice Review in November 2022, the Deputy Minister for Social Services, Julie Morgan MS requested Care Inspectorate Wales (CIW) to lead a rapid review of decision making in relation to child protection.

The overarching objective was 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.

Following receipt of the request from HIW regarding the joint review work with Care Inspectorate Wales and other agencies, a number of documents were provided to HIW in order to support their review, these were submitted in line with the timeframe set by HIW.

Initial verbal feedback has been shared with the Head of Safeguarding with the formal response awaited; it is noted that the survey link which has been shared with relevant staff members working within the field of child protection, such as school nurses, health visitors, midwives, paediatricians, CAMHS staff and safeguarding leads does not close until 5th May 2023.

An overall report on the findings will be prepared and published noting that there will not be individual health board reports published.

Further updates will be provided to future meetings and shared with the Safeguarding Executive Committee and Safeguarding Board.

Audit Management and Tracking system (AMaT)

Further work is being scoped to use the AMaT system to capture the actions arising from HIW activity to allow themes and trends to be identified and allow one dedicated space to capture oversight of HIW actions/ recommendations across the Health Board. Following all HIW inspections, the subsequent improvement plans are being closely monitored on a monthly basis via a centrally held tracker, which is in addition to all HIW inspection activity being included as a standing agenda item on the care groups quality, safety & patient experience governance meetings

3.0 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

For assurance the governance, monitoring, scrutiny and oversight of improvement plans in relation to HIW inspections and all service reviews are maintained without interruption within the new Care Group Model.

4.0 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Subject to the findings and outcomes of the HIW reviews.
Related Health and Care standard(s)	Staff and Resources
	All of the Healthcare Standards Governance, Leadership & Accountability Staff & Resources Staying Healthy Safe Care Individual Care Timely Care Dignified Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.

	Report for information on HIW activity No service or staff impact in direct response from report, this is considered through the improvement action plans Report not requesting proposal for any changes to services or staff
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Subject to the findings and outcomes of the HIW reviews
Link to Strategic Goals	Improving Care

5.0 RECOMMENDATION

The Committee is requested to **NOTE** the report.