Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Healthcare Inspectorate Wales Annual Report 2008-2009

January 2010

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Foreword

I have pleasure in presenting the fifth annual report of Healthcare Inspectorate Wales (HIW).

HIW's role is to regulate the quality and safety of healthcare in both the NHS and the independent sector. As always, the main purpose of this report is to describe and summarise the outcomes and findings of the work we have taken forward over the past 12 months.

The management and delivery of effective healthcare have always presented very considerable challenges. Public expectations and the potential of clinical innovation and technology continue to rise, as does the longevity of our population. The birth rate is also rising. These issues have been confronted head-on in the past decade, with the result that Wales has a more modern and responsive system of healthcare than that which existed even five years ago.

The pace of change and the breadth of the *Healthcare Standards for Wales*, published in 2005, have been major factors in HIW's own development. Our functions have progressively been added to, for example, through the regulation of independent healthcare and the statutory supervision of midwives since 2006. In April 2009 they were widened still further through the transfer of work from the former Mental Health Act Commission.

At the same time, there have been moves to streamline regulation and to ensure that review and inspection bodies are proportionate in their approach. We have always recognised the importance of these issues and have been in the vanguard of tackling them jointly with other review, audit and inspection bodies.

With major changes underway in the organisation of the NHS in Wales, it seemed timely to consider in this report what we have contributed to the driving improvement agenda since we were set up in 2004. We obviously want to maintain the momentum of the past few years so that we can continue to offer assurance to the public and to inform improvements in healthcare. This will mean, among other things, working ever more closely with patients, the public, managers, clinicians and all our other stakeholders and partners.

In the light of these challenges, in July 2009 we published our programme for the next three years. This annual report emphasises, among other things, our quest for continuity and, by reflecting on our work so far, helps to explain the context of our future plans.

Dr Peter Higson
Chief Executive
January 2010

1: WHO WE ARE AND WHAT WE DO

Healthcare Inspectorate Wales (HIW) is the leading regulator of healthcare in Wales. Our main job is to review the quality and safety of healthcare commissioned or provided by organisations in the NHS and the independent sector.

We carry out our functions on behalf of Welsh Ministers and are part of a directorate within the Welsh Assembly Government. However, our operational and professional independence is protected by a number of safeguards that enable us to provide an objective and robust view of services that, taken as a whole, affect virtually everyone in Wales.

Our Annual Report

In common with most other public bodies, we have a statutory responsibility to publish an annual report. This is an important part of our accounting to the Welsh Assembly, our stakeholders and the public in general for what we have achieved over the past year.

This year's report is our fifth since we were set up in 2004. It takes stock of progress made since then and, in particular, reviews our programme for 2008-09 in the light of, among other things:

- The rising expectations that patients and the public have of healthcare and the way they are treated.
- The state of healthcare in Wales.
- National policies and standards for health and healthcare.
- Major changes to the organisation of the NHS in Wales.

Our Aims

Our primary focus is on improving the experience of healthcare for the citizens of Wales whether as a patient, user of services, carer, relative or employee. We aim to:

- Make a significant contribution to improving the quality of healthcare services in Wales.
- Strengthen the voice of patients and the public in the way health services are reviewed.
- Ensure that timely, useful, accessible and relevant information about the quality and safety of healthcare in Wales is made available to all.
- Develop more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

Our Role

Our main role is to regulate and inspect NHS and independent healthcare organisations in Wales against a range of standards, policies, guidance and regulations and to highlight areas requiring improvement. We also undertake special reviews where there may be systemic failures in delivering healthcare so that improvement and learning are able to take place.

Our other responsibilities include:

- The statutory supervision of midwives in Wales.
- Working with the Prisons and Probation Ombudsman on investigations into deaths in Welsh prisons.
- Ensuring compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

- Working with Her Majesty's Inspectorate of Probation and others on inspections of Youth Offending Teams in Wales.
- Since January 2009:

    - Being the registering body for private dentistry in Wales.
    - Ensuring that the NHS and larger healthcare organisations in the private sector have safe and effective arrangements for handling controlled drugs.

- Under an agreement with the Nursing and Midwifery Council (NMC), monitoring higher educational institutions in Wales that offer approved NMC programmes and the approval/re-approval of programmes that lead to a recordable or registrable qualification.

During 2008-09 we prepared to take on, from 1 April 2009:

- The former Mental Health Act Commission's responsibilities in Wales for monitoring compliance with the Mental Health Act 2007.
- Responsibility for ensuring that healthcare organisations observe the safeguards relating to deprivation of liberty under the Mental Capacity Act 2005.

In these, as in other areas, we have been working closely with Care and Social Services Inspectorate Wales (CSSIW) on the links between health and social services. In particular we shall aim to ensure that individuals affected by the Mental Health Act:

- Are treated with dignity and respect.
- Have the right to ethical and lawful treatment.
- Receive care and treatment that meets their assessed needs.
- Are enabled to lead as fulfilling a life as possible.

More generally, we work closely with other bodies that inspect, regulate and audit health and social care in Wales. We have led the implementation of a concordat whose principles have been adopted by 17 regulatory and other bodies.

We have systematic links with the main regulators of healthcare elsewhere in Great Britain and Ireland. Until its closure at the end of 2008-09, we had a statutory duty to cooperate with the Healthcare Commission, which, in addition to its prime responsibilities in England, had a small set of functions in Wales. In future, our duty of co-operation will be with the Care Quality Commission (which, in England, has replaced the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission).

Our Values

Our values are central to everything that we do and are fundamental to ensuring that we deliver against our core aim of driving improvement through independent and objective review; they are:

- **Independence**: reaching our own conclusions and communicating what we find.

- **Openness and transparency**: promoting an understanding of our work; explaining the rationale for our recommendations and conclusions; communicating in language and formats that are easily accessible.

- **Focus on patients and the public**: promoting healthcare services that focus on patients and is responsive to the views of the public; recognising the needs, opinions and beliefs of individuals and organisations, and respecting and encouraging diversity.

- **Improvement and learning**: working with and supporting staff to improve the quality and safety of healthcare; promoting excellence in the delivery of healthcare and the design of services; encouraging continuous improvement in our own approaches to review and corporate processes.

- **Partnership**: involving patients, carers and the public in all parts of our work; cooperating with other organisations, such as external reviewing bodies, other statutory agencies and voluntary organisations to make the best use of available resources and avoid any duplication of effort.

The state of healthcare in Wales

In 2005, the year after HIW was established; the Assembly Government published the *Healthcare Standards for Wales.* These provide a common framework for improving healthcare and supporting the effectiveness and quality of services. However, even in a country of just under three million people, it can be misleading to make generalisations about the quality or more general state of healthcare or of trends in the health of its citizens.

For this reason, among others, we assess NHS and independent organisations individually, although we do identify each year common issues for special consideration. For the NHS in 2008-09 our assessment against the standards focused on the protection of children and vulnerable adults, as well as the dignity and respect shown to patients and service users. We also carried out spot checks of cleanliness in hospitals.

In addition, we undertake each year a number of national thematic reviews. These provide an all-Wales picture of particular services, but here too we have identified any local and regional variations.

National trends

National trends are helpful in identifying common issues that might benefit from in-depth study. They can also help the healthcare community generally to anticipate how services may need to be directed in future.

An example is the rising and more diverse population of Wales. When HIW was established, the number of people at or above the age of retirement was projected to rise by 11% over twenty years, compared to only 3% overall in the rest of the United Kingdom. At the same time, as our annual reports for the Nursing and Midwifery Council have highlighted, the number of live births is increasing, while births continue to exceed deaths. We have seen also over the past five years how the needs of immigrant communities have had an increasing impact on the commissioning and provision of healthcare in many parts of Wales, with implications too, for how organisations communicate with patients and the public.

Reporting and influencing improvements in health and healthcare

There have been progressive improvements in Wales in relation to the management of waiting times and infection control, as well as action to tackle variations in health and lifestyle between the most deprived and affluent parts of the country.

Over the past few years there have been some common issues or concerns across Wales and England and hence we have taken forward broadly parallel reviews with the former Healthcare Commission, with sharing of methodology and findings. Examples include thematic reviews of maternity and learning disability services.

We intend to highlight through our annual reports significant trends or features. In the past year, for example, the trust with the highest rate of hospital infections saw a decline in incidents, but norovirus and *clostridium difficile* continue to pose a significant challenge to the NHS as a whole and in some parts of Wales were on the increase. We shall be following up some of these issues in a thematic review planned for 2009-10.

Among the population of Wales as a whole, more than half is overweight (and a fifth clinically obese). Just under one in four adults smoke tobacco, although, since the ban on smoking in public places was introduced in 2007, there has been a decline in the number of adults reporting regular exposure to the smoke of others.

HIW can, of course, influence improvements in these and other areas through its findings and recommendations, but we need also to work closely with other regulators who hold or publish relevant data. In turn, we are able to assess how healthcare organisations take account of such information in determining the collective needs of their patients and service users and implementing the healthcare standards and other requirements, such as national service frameworks and guidance published by the National Institute for Health and Clinical Excellence (NICE).

Challenges for the future

During the past year the NHS in Wales has been preparing for a major reorganisation. In particular, as of 1 October 2009 eight [of the ten] trusts and 22 local health boards (LHBs), all of which have been subject to individual scrutiny by HIW, have been replaced by seven bodies that combine primary and secondary care.

This reconfiguration has major implications for those who commission or provide healthcare, as well as for the co-ordination of its delivery with that of social care and other services. Together with the responsibilities that we have taken on from the former Mental Health Act Commission, these changes will have considerable impact on the content and balance of our own programme of work from 2009-10 onwards and specialist trusts (Wales Ambulance Services, Velindre and Public Health Wales).

In November 2008, the Assembly Government published for consultation, a policy statement about the role of audit, inspection and regulation in delivering top quality public services. This set out a number of aims and principles, including a more “citizen focused” and proportionate approach to work, increasing joint working and better co-ordination of regulatory activities.

In the fields of health and social care, good progress to these ends has already been made through the *Concordat between Bodies Inspecting, Regulating and Auditing Health and Social Care in Wales*, which we and other partners signed in 2005. Work is continuing between reviewing bodies to develop and refine ways of making regulation more effective and stimulating further improvements in healthcare.

Examples of joint working and sharing of information between signatories to the concordat increased during the year, supported, by a scheduling tool, which was re-launched in June 2008. The latter is an online directory of data and initiatives aimed at reducing requests for information about regulatory activities and avoiding duplication of effort. With our partners, we are developing a website to share examples of good and innovative practice. Collectively the signatories are committed to further progress in implementing the Assembly Government's aims and principles for inspection, audit and regulation.

Engaging and involving patients and the public

We work closely with patients, service users, their families and carers, and the public generally. This helps us to understand people's needs and preferences, to learn from their experiences and to promote openness and transparency about the quality of healthcare. All of our review teams include service users or other lay people.

During the year we prepared, for publication in autumn 2009, a statement about how we intend in the future to engage and involve patients and the public. This recognises that individuals have their own ideas about how they wish to be involved, depending, among other things, on the extent to which they, or someone close to them, receive services or otherwise take an active interest in healthcare: for example as part of an interest or support group. We have also been developing joint initiatives with our concordat partners, for which purpose there has been patient and public representation on the relevant reference group.

We also aim to actively encourage the involvement of people whose needs, background or circumstances might otherwise be under-represented.

Developing our staff and organisation

HIW has a skilled and dedicated workforce. Since 2004 our responsibilities have expanded considerably, as has the number and range of bodies with which we work. Consequently our staff has increased in number, with approximately 50 people now based at our office in Caerphilly. They all participate in the Assembly Government's processes for performance appraisal and personal development, and are encouraged to pursue opportunities for further learning and development. We are supported by over 250 peer and lay reviewers, who bring to our work a range of discrete skills, knowledge and experience.

During 2008-09 we strengthened our senior management structure so that we are able to act flexibly and respond quickly and positively to new challenges and our staff are able to focus on ensuring that our practices, procedures and operational tasks are carried out to the highest possible standards.

2: OUR WORK IN 2008-09

Assessing standards of healthcare

The *Healthcare Standards for Wales* (2005) are a common framework designed to improve care and treatment and to support the provision of services that are effective, timely and of good quality. Between them, the 32 standards cover:

- The experience of patients.
- Clinical outcomes.
- The governance of healthcare.
- Public health.

Since 2007 NHS organisations have been required to carry out annual self-assessments against the standards and to make a public declaration about their performance. HIW then tests and validates these assessments, concentrating on the issues that we believe, and people tell us, matter most to the people of Wales.

Performance is tested in three distinct areas that relate to domains in the standards:

- The experience of users: what is this like and is it improving?
- Operational and clinical outcomes: how is compliance with the standards ensured within services and on hospital wards?
- Corporate issues: how well do the boards of NHS organisations ensure compliance with the standards?

In relation to each of these an annual assessment is made at one of five levels of maturity: *aware, responding, developing, practising* or *leading.*

Annual assessment of NHS organisations

During the year we reported on the performance of NHS trusts and local health boards (LHBs) against the standards in 2007-08. We also made unannounced visits to every NHS trust in Wales and a sample of general practices managed by LHBs as part of our assessment for 2008-09.

Reporting performance in 2007-08

PERFORMANCE OF NHS TRUSTS AND LOCAL HEALTH BOARDS: LEVELS OF MATURITY AGAINST STANDARDS	
Leading	Innovative practice shared beyond the organisation and approaches evident to ensure long term sustainability.
Practising	Implementation throughout the organisation that addresses the key issues and evidence of continuous improvement.
Developing	Steps are being taken to address the key issues with evidence of practical application across the organisation.
Responding	There is recognition of the key issues to be addressed but no options identified.
Aware	There is recognition of the key issues to be addressed but no options identified.

Our assessments for 2007-08 looked in particular at ten standards against which most NHS organisations had under performed the previous year. These standards related to the suitability of healthcare premises and environments, the provision of information to patients, service users, carers and relatives, ensuring individuals are involved in their care planning and treated with dignity and respect, the provision of food and fluids. We found that all trusts had made some progress in raising the maturity level of standards assessed as only “aware” or “responding” in 2006-07. Many were assessed at the level of “developing” or

above and of these; we were pleased to find that a number were operating at the higher levels ("practising" or "leading") for some of the standards.
The majority of LHBs also raised the maturity level of specific standards assessed as "aware" or "responding" in 2006-07.

Six trusts and one LHB continued to be assessed in 2007-08 at the lower levels ("responding" or "aware") for some of the ten standards. As a result, the regional offices of the Assembly Government's Department for Health and Social Services carried out further monitoring, through trusts' and LHBs' improvement plans, in relation to standards that appeared to be posing particular problems.

We found that the majority of trusts and LHBs had made sound progress towards embedding the standards in their governance arrangements and engaging their boards in the process of assessment. However, it was clear that some organisations needed to strengthen the means by which they gather and submit evidence to us. It is important, in particular, that internal audit departments have an effective overview of the process and its implications.

Assessments in 2008-09

Taking account of our findings in 2007-08 and other developments, our visits to NHS organisations in 2008-09 concentrated on:

- The **protection of children** following concerns highlighted in England by the Baby Peter case.
- The **protection of vulnerable adults** because previous reviews had identified this as an area requiring further work.
- The **dignity and respect** shown to patients, service users and carers because these are fundamentally important to the experience of healthcare.

To inform our assessments, we undertook visits to each of the former NHS trusts across Wales and a sample of GP practices. As part of these visits we undertook observational checks and spoke to patients and staff. We found many examples of good practice but also some widespread problems, such as inadequate storage facilities or avoidable clutter that hindered effective cleaning or control of infection. There were also examples of inadequate cleaning and potential for cross contamination (such as the communal use of toiletries).

There was significant variation in the age of the premises that we visited, both as part of the spot checks and the wider assessment of standards. Although many of the challenges for those providing healthcare were similar whether the buildings were old or new, some of the problems associated with some older, adapted premises (including those of access, privacy and storage) are not easy to rectify and can have an adverse impact on the environment for patients.

Our reports for 2008-09 will be important documents for each of the new local health boards. They will describe further general improvements in performance against the standards compared to previous years. However, we identified also some areas of continuing concern or where performance was patchy, in particular:

All organisations need to strengthen their processes and procedures to protect children and vulnerable adults.

- There were marked variations in organisations' approach to dignity and respect. In particular, staff need to be vigilant when discussing confidential information with patients or carers so that privacy is fully protected.

- In addition to meeting statutory obligations to Welsh speakers, information for patients and families must be provided in a range of formats and languages to meet the increasingly diverse needs of local populations. This includes more consistent and effective communication with those with sensory impairment.
- In line with national guidance, all organisations should ensure that they comply with the requirements for staff to undergo checks by the Criminal Records Bureau and that these are followed up regularly and consistently.

We published an overview report of children's safeguarding arrangements across the NHS in October and will be publishing our overview report on the protection of vulnerable adults early in 2010. Further, to ensure that dignity and respect issues are being properly addressed we have started to take forward a rolling programme of dignity and respect unannounced visits. As with our cleanliness spot checks we will be using various information sources including issues reported to us to inform our visit programme.

Regulation of independent healthcare

Since 2006 we have registered and inspected providers of independent healthcare in Wales in line with the Care Standards Act 2000 and the Private and Voluntary Health Care (Wales) Regulations 2002.

On 31 March 2009, there were 94 registered providers, compared to 85 a year ago and 70 in 2007. These include a number of establishments that use prescribed techniques and technologies, such as class 3B lasers or an intense pulsed light source. We registered 14 new services in 2008-09. There continues to be steady growth in the number of mental health hospitals and psychiatric beds designated as low secure. Overall, there were 560 registered places for people with mental health needs. The number of registered providers is likely to grow further since we took on responsibility for registering private dentists on 1 January 2009.

Type of setting	Number of registered providers at 31 March 2009	Number of registered providers at 31 March 2008
Acute hospitals	7	7
Mental health hospitals	22	21
Detoxification hospital	1	1
Dental hospitals using anaesthesia	3	3
Hospices for adults	5	5
Hospices for children	2	2
Class 3B and 4 lasers/ intense pulsed lights	39	36
Hyperbaric oxygen chambers	5	5
Independent GPs	1	2
Independent clinics	9	3
TOTAL	**94**	**85**

Developing our methods

During the year independent providers of acute and mental health services took part in a pilot involving self-assessment of their performance against the *Healthcare Standards for Wales*. The aim was to assist alignment of assessment in the public and private sectors. As a result, we shall be moving our approach further in this direction from 2009-10, pending revision of the current national minimum standards and regulations for the independent sector. More generally, we shall continue annually to update and streamline our methodology.

We also invited Quality Improvement Scotland (QIS) to undertake a review of the effectiveness of our Healthcare Standards assessment approach. Their report published in May 2008 set out a detailed account of the strengths and weaknesses of the approach providing a sound evidence base to support future improvement and development. We have already begun to make improvements to the assessment approach and will ensure that the QIS report forms the foundation stone of future developments.

Private dentistry

Since 1 January 2009 regulations have required dentists providing private treatment in Wales to be registered by HIW. These apply regardless of any NHS treatment they offer.

As a result, the small proportion of dentists in Wales who provide solely private treatment will now be assessed in line with NHS dentists. They will have to meet certain national minimum standards for private dentists, which will be aligned with the *Healthcare Standards for Wales*. If the standards are not met, we can take action to ensure that any necessary improvements are made.

Developing better guidance: statutory notifications and concerns

We have been developing, for publication in late 2009, clearer guidance for providers about how and when to submit statutory notifications about changes in organisation or premises, or events such as the death or serious injury of a patient. We want to make better use of information we receive in this way: for example, to help identify emerging issues or, through aggregated data, to inform our reports.

Although we do not have statutory powers to undertake reviews or investigations of individual complaints, we do, in exercising our wider regulatory role, take account of any concerns we receive about independent providers. In some cases these may arise from a failure to meet certain standards or to comply with regulations. In the past year we have revised our guidance for the public and providers to make clearer what we can or cannot look at and how we aim to deal with information referred to us.

Cleanliness Spot Checks

During 2008-09 we continued our programme of unannounced cleanliness spot checks that we started in 2006. We visited 19 hospitals across Wales and in determining where to visit and the focus for these spot checks we took into consideration many different sources of information including organisational reviews of progress against Healthcare Standards for Wales, concerns and surveillance data. This combined information shaped the direction of our spot check programme which is kept under review in light of any new information that comes to our attention.

The tool used for hospital cleanliness spot check is based on the Infection Control Nurses Association (ICNA) tool and the approach adopted for hospital cleanliness spot checks relies on direct observation and some staff questioning with the request of some key documents.

The reports of our visits can be found on our website and to fully illustrate our findings they contain photographs of what we found. Organisations are required to provide us with an action plan detailing how they intend to address any issues and areas of concern identified within two weeks of the publication of our report.

The reviews we undertook in 2008-09 identified that generally there are issues in relation to the availability of storage space for equipment and many ward areas were found to be cluttered. Some of the NHS estate is ageing and our reports highlighted a number of issues that have arisen as a result of the wear and tear of the fabric of buildings.

Thematic reviews

Each year we carry out a number of reviews into the quality and safety of specific areas of healthcare. These test whether the services in question:

- Meet the needs of the people of Wales.
- Are safe and of high quality.
- Are delivered efficiently and effectively.

In each area, we always work closely with the main stakeholders and fully involve patients, service users, relatives and carers.

Wherever possible we work in partnership with other regulators. We are thus able to make the necessary links between health, social and other services, to make the best use of our collective resources and to avoid overlaps or duplication.

Review of the Older Peoples NSF

The National Service Framework (NSF) for Older People in Wales, launched in 2006, is a key component of the Welsh Assembly Government's Strategy for Older People published in 2003 and sets out national, evidence based standards for the health and social care of older people in Wales.

There was a commitment at the time of its launch to undertake a fundamental review of the NSF following the first period of its implementation in order to inform its future development and assess its progress and success. We are taking this review forward jointly with the Care and Social Services Inspectorate Wales over a two year period and its key aim is to assess:

> **'What impact is the NSF having on the quality of life of older people in Wales?'**

Phase 1 commenced in 2008 with a comprehensive mapping of the Health Care Standards for Wales, the Care Homes and Domiciliary Care Regulations and National Minimum Standards against the NSF standards and a review of all relevant and available data. Some areas of concern highlighted by phase 1 were:

- Issues of dignity arising from some hospital practices, such as the use of shared 'pooled' clothing.
- Examples associated with practical matters such as the sharing of information in public places.
- Older people sometimes spoken to in a way that reduces the sense of control they have over their lives.
- Some in-patient settings for people with dementia lacked access to outside space and activities.

- Lack of sufficient advocacy for older vulnerable people, especially those lacking capacity for decision making.

In phase 2 that commenced in the summer we will assess in more detail how well organisations are embedding cultures and practices capable of delivering person centred services.

Older people with dementia were highlighted during phase 1 as representing a most vulnerable group of older people. Dementia is also a key theme in terms of policy development with close links to a number of the wider Welsh Assembly Government policy agendas such as Dignity in Care and the current work being undertaken on National Dementia Action Plan for Wales. In taking forward phase 2, therefore, we will seek to review all of the NSF standards through the "lens" of older people with dementia.

All Wales Review of Substance Misuse Prescribing Services

Healthcare Inspectorate Wales (HIW) has been commissioned by the Welsh Assembly Government Minister for Social Justice and Local Government to develop and implement a programme of thematic reviews of substance misuse treatment services. The purpose is to assess the progress made on delivering the national agenda by examining the adequacy and quality of services provided across Wales, identify good practice and make recommendations for future improvement.

Our first review undertaken in 2008 focused on the commissioning and provision of substitute drugs such as methadone which is used to help manage and reduce the use of illegal opiate drugs such as heroin. The review also established an overview of substance misuse services across Wales and a baseline of provision which will be used to inform future reviews.

While recognising significant advances in the availability of treatment and support and in the numbers of people accessing services, we found there was still variation in the availability of services locally. While waiting times for treatment are generally falling across Wales, waiting times were found to be a significant barrier to accessing services in some areas.

Services themselves were generally of a high standard, although this too varied. Some service premises were however found to be inadequate. Access to other services such as mental health support for substance misusers was also found to be inadequate in many areas.

We also identified variations in how well services were planned and commissioned, some areas being far more advanced than others in developing treatment systems to address local need. In some areas it was found that treatment systems were not effectively planned, activity was not monitored and there was little strategic oversight.

We made thirty four recommendations aimed at improving the quality of both treatment provision and the systems set in place to plan and commission treatment systems, these emphasised the need to:

- Improve strategic management of the delivery of the substance misuse agenda at the local level.
- Improve commissioning and planning processes in order to improve quality and ensure availability of services at a local level.
- Improve waiting times and access to services and develop a treatment system with identified care pathways at a local level.
- Ensure the implementation of a number of Welsh Assembly Government policy initiatives. These include access to services for those with co-existing substance misuse and mental health problems and the use of an integrated assessment tool.

- Improve arrangements for the safeguarding of children and vulnerable adults and the local dissemination of learning from reviews into drug related deaths.

During the coming year, we shall publish the reports of several reviews undertaken in 2008-09 including those of children and young people with emotional or mental health needs and the implementation of the national service framework for coronary heart disease (both reviews jointly with the Wales Audit Office), the protection of children, and the commissioning and provision of opiate substitute services.

In addition, we shall be reporting on special reviews of histopathology services at the former North East Wales NHS Trust and an outbreak of *clostridium difficile* at the former North Glamorgan NHS Trust, reviews of two separate homicides perpetrated by users of mental health services.

Controlled drugs

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 came into force in January 2009. NHS organisations and the larger independent hospitals must nominate an “accountable officer” of sufficient seniority to ensure robust arrangements for the safe and effective handling of controlled drugs. As an initial step, the organisations affected have been advising HIW of their nominee. In this area we have kept in close touch with regulators with similar responsibilities in other parts of the UK.

Reviews with our partners

Working with the Health Protection Agency - compliance with the Ionising Radiation (Medical Exposure) Regulations

On behalf of Welsh Ministers HIW assesses compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 [known as IR(ME)R] as amended in 2006.

The regulations are intended to:

- Protect patients from unintended excessive or incorrect exposure to radiation and ensure that, in each case, the risk from exposure is assessed against the clinical benefit.
- To ensure that patients receive no more exposure than is necessary to achieve the desired benefit within the limits of current technology.
- To protect volunteers in medical or biomedical, diagnostic or therapeutic research programmes and those undergoing medico-legal exposures.

Our inspections seek information from discussions with staff and observations within the clinical settings, supplemented by additional evidence provided by the organisation prior to the inspection, including the completion of a self-assessment return.

Youth Offending Teams – Working with Her Majesty's Inspectorate of Probation

Together with CSSIW and Estyn (Her Majesty's Inspectorate for Education and Training in Wales), we have assisted Her Majesty's Inspectorate of Probation with a rolling programme of inspecting Youth Offending Teams (YOTs) that began in 2005. Five inspections and re-inspections took place during the year.

The majority of YOTs in Wales are small in terms of population but large in terms of geographical area, which can impact on the delivery of services. There is wide variation across Wales in the way YOTs are constituted, funded and managed. A particular concern highlighted by the reviews is that due to a number of the YOTs not using a specific health assessment tool, the physical health needs of significant numbers of children and young people are being missed. Also, concerns in relation to the coordination of emotional and mental health services for those young people aged between 16 and 17 years of age and who fall between adult and children's services have been identified.

We have been developing with our partners a new approach to the inspection of YOTs. This will involve a fresh rolling programme of inspecting individual teams, as well as three thematic inspections per year that focus on specific issues affecting YOTs in England and Wales. The first thematic inspection which will take place in 2009-2010 will look at the effect of alcohol on offending behaviour in people under the age of 18.

Working with the Prisons and Probation Ombudsman

During the year we provided clinical advice to the Prisons and Probation Ombudsman (PPO) as part of six investigations into deaths in Welsh prisons. Issues arising from these included communication between the NHS and prison healthcare staff, the importance of clear, up to date records of healthcare received by prisoners, and awareness of prisoners' past medical and psychiatric history.

Reports of reviews are published by the PPO and may be viewed at www.ppo.gov.uk. Recommendations requiring action by the prison healthcare service are followed up by Her Majesty's Inspectorate of Prisons.

Special reviews and investigations

During the year we were contacted on 28 occasions with detailed concerns about healthcare funded by the NHS.

Of these, three were drawn to our attention for information only and we redirected a further ten to agencies that were better placed to consider them. In the remaining 15 cases, we questioned the organisation involved about the actions it had taken to deal with or improve the situation. In just under half (7) we decided that action had been insufficiently robust and so carried out a special review aimed at assisting learning and improvement. Reports of completed reviews are on our website.

Reviews of Homicides where Perpetrator was a Mental Health Service User

In circumstances where a patient known to Mental Health Services is involved in a homicide, the Welsh Assembly Government may commission an independent external review of the case to ensure that any lessons that might be learnt are identified and acted upon. As of January 2007 these independent external reviews have been conducted by Healthcare Inspectorate Wales.

During 2008-09 we undertook three such reviews the terms of reference for which are to:

- Consider the care provided to the perpetrator as far back as his/her first contact with health and social care services.
- Provide an understanding and background to the fatal incident that occurred.
- Review the decisions made in relation to the care of the perpetrator.
- Identify any change or changes in the perpetrator's behaviour and presentation.
- Evaluate the adequacy of any related risk assessments and actions taken leading up to the incident.
- Produce a report detailing relevant findings and setting out recommendations for improvement.
- Work with key stakeholders to develop an action plan (s) to ensure lessons are learnt from the case.

The reviews we have undertaken to date have highlighted common themes and concerns in relation to the sharing of information across statutory bodies, risk assessment, risk management and the availability of services for individuals with a personality disorder. We will be publishing an overview report of the findings from the reviews we have undertaken to date in early 2010.

Special Reviews of Maternity and Mental Health Services provided by the Former Gwent Healthcare NHS Trust

In February 2009 we published our reports of the special reviews we undertook, of maternity services and community and mental health services provided by Gwent Healthcare NHS Trust.

The decision to undertake a special review of maternity services in Gwent Healthcare NHS Trust followed on from six maternal deaths that occurred in the Trust between 2005 and November 2007. We took the decision to review services to ensure that they were safe and that the Trust was seeking to learn and share the lessons from these tragedies.

The initial inspection we undertook in April 2008 concluded there was no common link between the tragedies, but we found inadequacies in the management and staffing of maternity services. In two of the deaths, we concluded that earlier identification of deterioration, or better advance preparation to manage identified risk, may have averted the deaths.

As a result of our initial inspection, we placed the maternity services on special measures – where the Trust was required to produce an action plan to address the concerns identified by HIW. We monitored the Trust's progress over a period of 18 months and saw clear improvements in the service and were assured that standards of care for mothers and babies had improved significantly. We took the Trust off special measures in September of this year.

Our review of community and mental health services followed on from concerns being raised by the Health and Social Services Minister, Edwina Hart and the emerging findings of our review of maternity services. This review focussed on the leadership and management of services. While we found that staff were committed to delivering good quality care and there were examples of innovation

and improvements in care, we found there to be challenges in relation to the delivery of services across a large and diverse area in a number of settings. We also identified issues in relation to incident reporting and feedback from senior managers to frontline staff. We also highlighted the continued existence of ligature points – any equipment or parts of the buildings, such as large window handles or shower curtains - that could be used by patients to self-harm.

We have worked with the former Trust and the new Health Board to ensure that the necessary action to improve services has been taken and we have noted the good progress that has been made.

Ensuring that those who provide care are suitably trained and qualified

In addition to issues about training and professional status that arise through our annual assessments of the NHS and other reviews, we maintain a number of specific functions relating to nurses and midwives.

Statutory supervision of midwives

We are the Local Supervising Authority (LSA) for 1,597 midwives practising in Wales on 31 March 2009. We are required to publish an annual report on this work to the Nursing and Midwifery Council (NMC), the body that has responsibility for setting standards for LSAs. Particular challenges identified during 2008-09 included the need to maintain the ratio of Supervisors of Midwives to midwives at the level required by the NMC (1:15) Wales presently performs very well in this respect, managing areas of risk and supporting midwives during the current reorganisation of the NHS. Due to amalgamations, the number of providers of maternity services reduced to nine (eight trusts and one LHB) in 2008-09 and there will be a further reduction to seven providers (the new Health Boards) during 2009-10.

Quality assurance on behalf of the NMC

On behalf of the NMC, we approve and monitor in Wales nursing, midwifery and community public health educational programmes that lead to professional qualifications.

In 2008-09, a total of eleven NMC education programmes were recommended for approval by us. This is a significant reduction from 2007-08. The main reason for this was that in the previous time period a significant number of pre registration programmes were all coming up for re-approval at the same time. We anticipate a rise in the number of approvals and re-approvals in the next twelve months.

A total of ten programmes were monitored, to ensure that they are delivering the quality and level of education needed, across seven NMC approved Higher Education Institutions in Wales.

Nurse agencies

We assess annually the fitness for purpose of agencies that supply, under contract to NHS organisations, nurses, healthcare assistants and operating department practitioners. In 2008-09 we visited eight nurse agencies currently providing such services. We followed up issues raised during 2007-08, including the induction and appraisal of staff, and reviewed arrangements for ensuring that the immunisation and health checking of staff were up to date.

We shall be revisiting these agencies in 2009-10. In addition to following up issues raised in the past year, we shall review in-service training, especially in relation to confidentiality, privacy and the protection of vulnerable adults and children.

Issues from our annual assessment of the NHS

Our assessment of the NHS in 2008-09 raised a number of concerns about whether staff in particular hospitals or GP surgeries had received systematic training relating to the protection of children and vulnerable adults. In addition, some staff seemed unclear about requirements or procedures relating to confidentiality and privacy. We shall pursue these issues further during the assessment for 2009-10 to ensure in particular that the new health boards adopt a coherent approach to meeting the essential training needs of their staff. As noted above, we are also looking at these matters in relation to some other healthcare staff, such as agency nurses.

Following up and communicating our findings

We work closely with officials in the Assembly Government's Department for Health and Social Services so that our recommendations may be followed up as necessary through their arrangements for monitoring the performance of NHS organisations. In some cases we ourselves re-visit organisations or services to ensure that suitable progress is being made. In the coming year, for example, we shall be following up the findings and recommendations that we made in our reviews of medium secure units (2005) and maternity services (2007). More generally we aim to ensure broad continuity of our programme from one year to the next so that, among other things, we can track changes over time.

In the independent sector, we follow up specific aspects of non-compliance and take any necessary enforcement actions.

Publishing our reports and plans

As in previous years, the reports of our reviews have been published in both Welsh and English in line with our Welsh Language Scheme. They are also available on request in a number of other languages and formats such as audio or Braille.

Relevant reports were distributed free of charge to the NHS, independent and voluntary organisations, local government and other stakeholders, including patients and the public, and our regulatory partners.

Reports may be downloaded from our bilingual website (www.hiw.org.uk)**,** which contains also our corporate plans and those for specific action arising from our reports. There is an interactive part of the site, which enables members of the public to comment or ask questions.

The website that we share with our partners in the concordat (www.welshconcordat.org.uk) provides information about planned reviews and examples of joint working and more general initiatives to improve the effectiveness of regulation.

3: LOOKING AHEAD

Our overriding aim remains to ensure that healthcare provided for the people of Wales is safe and of good quality.

As described in this report, we undertake a number of reviews each year as a matter of routine. Their focus is primarily to ensure that healthcare organisations are fit for purpose and have the necessary arrangements for effective management and governance. Some reviews are aimed specifically at ensuring compliance with statutory responsibilities and we shall continue to supplement our range of periodic work with reviews of specific services. We shall aim to increase the attention we give to clinical quality and the outcomes of interventions for patients.

We shall keep our methods under continuous review. In the next few years there will be a range of developmental work aimed at improving the efficiency and effectiveness with which we exercise our responsibilities. We must, in any case, refine our approaches to take account of changes in the organisation and management of the NHS and to reflect our new responsibilities. We shall also seek to align as far as possible our approaches to the public and private sectors and to work with our various partners to ensure that regulation is both proportionate and valuable to those who use, plan and provide services.

Our plans

Our plans for the next three years are described in our *Three Year Programme 2009-2012.* The dates and details of visits linked to our routine work will be placed on our website.

Our routine work

As part of a rolling programme we shall:

- Continue annually to **validate and test how NHS organisations comply with the healthcare standards**. Following on from our assessment in 2008-09, we shall focus in the coming year on how organisations safeguard children, protect vulnerable adults and address issues of dignity and respect. Unannounced spot checks of cleanliness will be extended from hospitals to community and primary care services, such as GP practices. We shall also inform our assessments through unannounced visits relating to safety, dignity and respect. We shall work with the new health boards and other stakeholders to enhance the process of assessment against standards so that it remains suitable in changing circumstances. This developmental work will be undertaken in conjunction with that planned by the Assembly Government for the enhancement of the standards themselves. Both the revised standards and process of assessment are expected to be published by the end of 2009-10.
- Through registration and inspection, continue to **regulate independent healthcare** in Wales. The Assembly Government is reviewing the current regulations and our own regulatory functions in this area. Our programme, including our recently acquired work relating to private dentistry, will be adjusted as necessary to take account of any changes and, more generally, to align our approaches to assessment in the public and private sectors.
- **Safeguard the interests of those who use mental health services** by monitoring compliance with the Mental Health Act 2007 and other relevant provisions, such as the Mental Capacity Act 2005 and the safeguards relating to deprivation of liberty.

New work relating to mental health

The monitoring and other functions previously performed in Wales by the Mental Health Act Commission (MHAC) transferred to Welsh Ministers on 1 April 2009. In future these will be carried out by HIW's Review Service for Mental Health. Because services for people covered by the Act are multi-disciplinary and multi-agency, we shall work closely with CSSIW and other bodies.

The new review service was established by a project team whose work was overseen by a board with members from HIW, CSSIW, the Welsh Assembly Government and the MHAC. The project involved:

- Te transfer of Mental Health Act Commissioners and Second Opinion Appointed Doctors (SOADs) from the MHAC to HIW.
- Developing a visiting, inspection and enforcement model for Wales that, among other things, involves service users.
- Communicating information about the changes and holding a number of workshops to gather views.
- Developing an information and communications system to support the new service and transferring records from the MHAC.
- Recruiting staff and developing internal processes to run the service.

Deprivation of liberty safeguards (DOLs)

The Mental Health Act 2007 introduced safeguards into the Mental Capacity Act 2005 which aim to protect vulnerable people who are deprived of their liberty other than under the Mental Health Act. These came into effect on 1 April 2009. They cover patients in NHS hospitals and in hospitals and care homes registered under the Care Standards Act 2000. As such, they place duties on LHBs and social services authorities.

Our the past year, we have:

- Worked with CSSIW to ensure that our approaches to monitoring are complementary and enable comparisons to be made across health and social care.
- Provided training for staff.
- Considered how monitoring of DOLs can be incorporated into our reviews and communicated with providers and commissioners about the information we shall require.
- Established links with those in the field who are leading implementation of DOLs.

We shall continue to regulate activities in a number of specialised areas. These include our work relating to IR(ME)R, controlled drugs, the statutory supervision of midwives, the supply of agency nurses and programmes of education for nursing, midwifery and community public health nursing. As in previous years, we shall work with the criminal justice inspectorates and the Prison and Probation Ombudsman to ensure that reviews of Youth Offending Teams and Welsh prisons are informed by relevant clinical expertise and knowledge.

Our thematic work

We shall be developing or undertaking a number of new reviews in 2009-10. These are concerned with infection control (the management of patients with diarrhoea and vomiting), older people (the impact of the national service framework – jointly with CSSIW), procedures and mechanisms for safeguarding children, the protection of vulnerable adults, and care pathways for substance misuse services. Most of these will build on earlier work by HIW and have been the subject of preparatory work during 2008-09.

Our three-year programme identifies other areas in which we shall either be developing reviews for 2010-11 and 2011-12 or, as already noted, following up the findings and recommendations of earlier reviews.