Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Healthcare Inspectorate Wales Annual Report 2009-2010

January 2011

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Foreword

I have pleasure in presenting the sixth annual report of Healthcare Inspectorate Wales (HIW). HIW's role is to regulate the quality and safety of health services in both the NHS and the independent sector in Wales.

This annual report looks back at our activities during 2009-10, summarising the assurance we have provided to patients, the public and others. It also looks ahead at the challenges facing all of us involved in the design, delivery and review of health services across Wales.

The year brought with it significant changes. Not only have we have seen a major, radical restructuring of the NHS in Wales, designed to transform patient care in Wales, but HIW's own powers and responsibilities, which have kept on growing since our establishment in 2004 have also extended further:

The monitoring and other functions previously performed in Wales by the Mental Health Act Commission (MHAC) were transferred to us in April 2009. These new functions have brought opportunities for us to develop a sharper focus on these services.

We have also developed our approach to inspection and review work to enable us to monitor the effectiveness of Deprivation of Liberty Safeguards[1](DOLS), introduced on 1 April 2009, with the aim of further protecting vulnerable people who are deprived of their liberty.

Since taking on the role of registering private dentists in January 2009, we have seen the numbers of dentists registering with HIW increase from one in March 2009 to one thousand and twelve in March 2010.

We have also lost some functions, with the transfer of responsibility for approving and monitoring nursing, midwifery and community public health educational programmes out of HIW.

Responding to these developments, and in anticipation of further changes in the landscape of public service delivery, we are continuing to take forward an extensive programme of organisational development. This programme is designed to equip us to meet the needs of an exemplar inspectorate: enabling us to fulfil our widening statutory responsibilities and respond effectively to the key areas of concern facing patients, the public and other key stakeholders (including health services organisations) in these challenging times.

Dr Peter Higson
Chief Executive
January 2011

[1] Deprivation of Liberty safeguards were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007. The DOL safeguards apply to anyone aged over 18 who suffers from a mental disorder or disability of the mind (such as dementia or a profound learning disability) and who lacks the capacity to give informed consent to arrangements made for their care and/or treatment and for whom deprivation of liberty is considered after independent assessment to be necessary in their best interests to protect them from harm. The safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

1. WHO WE ARE AND WHAT WE DO

Healthcare Inspectorate Wales (HIW) is the leading regulator of all healthcare in Wales. We carry out our functions on behalf of Welsh Ministers and are part of a directorate within the Welsh Assembly Government. However, our 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 mission

To be an exemplar inspectorate whose actions are flexible, proportionate and well-targeted, so that patient safety and quality of experience are maximised.

Our purpose

On behalf of the citizens of Wales, to provide independent and objective assurance on the quality, safety and effectiveness of health services, making recommendations to healthcare organisations to promote improvements.

Our aims

Our primary focus is on improving health services for the citizens of Wales, including the experience of patients, other service users, carers, relatives and health service employees. We aim to:

- make a significant contribution to improving the safety and quality of health 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 safety and quality of health services in Wales is made available to all; and
- develop more proportionate and co-ordinated approaches to the review and regulation of health services in Wales, working closely with other bodies that have relevant responsibilities.

Our role

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

- monitoring compliance with the Mental Health Act 1983 and other relevant mental health legislation, such as the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards;
- the statutory supervision of midwives in Wales;
- working with the Prisons and Probation Ombudsman on investigations into deaths in Welsh prisons;
- monitoring 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;
- registering private dentists in Wales; and
- monitoring of The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations.

Our values

Central to everything we do, our values establish the fundamental principles that govern the way we carry out our work. They are embodied in the behaviours of all our staff and external reviewers who carry out work on our behalf. They are:

- openness;
- honesty;
- centred on patients, service users and citizens;
- collaboration, sharing our experiences amongst ourselves and with other review bodies;
- efficiency, effectiveness and proportionality in our approach; and
- Supporting and encouraging learning, development and improvement.

We take a human rights based approach to all our work, ensuring active consideration of equality issues is embedded in all our work programmes.

1.1 Our People

The successful delivery of our work programme depends on the professionalism, skill and dedication of our workforce. Approximately 50 people are based at our office in Caerphilly.

Responding to the major expansion in our statutory responsibilities, and taking a strategic view of our staffing requirements in the longer term, we have, in 2010, introduced a new staffing structure and design. Our new structure is designed on a principle of integrated service delivery, with our teams organised on the basis of the functions they perform across both the NHS and independent healthcare sectors. Supported by a ‘matrix management’ approach, we are able to be flexible and agile, quickly moving the right people onto the right projects and providing learning to enhance skills as and when needed.

To support our core staff, we also have a pool of over 250 peer and lay reviewers who bring a wealth of specific skills, knowledge and experience to our work.

We are currently undertaking a review of the services provided by all our external reviewers, including our panel of peer and lay reviewers. This review will reflect on our experiences to date and identify our future needs to inform our approach to the appointment and use of external reviewers once our existing arrangements come to an end in May 2011.

1.2 Engaging and Involving Patients and the Public

We work closely with patients, service users, their families, 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, and we actively encourage the involvement of people whose needs, background or circumstances might otherwise be under represented.

In October 2009, we published a framework document "Engaging and Involving Patients and the Public" which set out how we involve patients, service users and the public in our work. During 2010-11, we will continue our development of a more strategic approach to the engagement and involvement of patients and the public in our work.

2. TARGETING OUR WORK ON WHAT MATTERS MOST

2.1 Health Service Delivery in Wales: A New Landscape

On 1 October 2009, six new Health Boards (and the former Powys Local Health Board) became responsible for planning and delivering health services in their areas, along with three specialist Trusts (Welsh Ambulance Services, Public Health Wales and Velindre). These reforms have changed the landscape within which health services are planned and delivered across Wales. Also, the NHS will need to continue to develop and transform its ways of working with its statutory and third sector partners to achieve its ambition of developing an integrated care system through working across Health and Social Care.

The impact of the present economic situation in 2010 and beyond is a further very significant challenge for the NHS and public services generally.

We are responding to these challenges and to our own reduced resources by ensuring that we focus on what matters most in terms of the quality and safety of healthcare. While at the same time redoubling our efforts to work in collaboration with other inspectorates and audit bodies to ensure that we make the best use of our collective resources and minimise any unnecessary burden on NHS organisations.

2.2 How is the Health and Wellbeing of the People of Wales[2]?

According to the Chief Medical Officer (CMO) for Wales, the health and wellbeing of the people of Wales is improving overall, although there remain significant challenges to be addressed, and Wales continues to lag behind other parts of the UK in levels of healthy life expectancy.

In his 2009 Annual Report, the CMO highlights the following:

- Wales has a comparatively low infant mortality rate of 4.1 deaths per 1,000 live births;
- Life expectancy at birth in 2006-08 increased to 77 years for men and 81.4 years for women, the highest figures yet recorded;
- One in four people in Wales has at least one chronic condition, this means some 800,000 people in Wales live with one or more chronic condition and that number is expected to rise as the population lives longer;
- The proportion of deaths under the age of 75 continues to decline. There is also evidence of a significant reduction in the number of deaths from heart related conditions, and to a lesser extent, there are fewer cancer-related deaths; and
- The largest cause of death is disease of the circulatory system. Coronary heart disease is Wales' biggest killer; more than 11,000 deaths every year are attributable to diseases of the circulatory system. Second most common cause of death was cancer (there are some 17,700 new cases of cancer every year in Wales) followed by respiratory disease and then diseases of the digestive system.

[2] Source: Chief Medical Officer for Wales, Annual Report 2009, published on 6 October 2010

For children, immunisation rates are improving, while the numbers who are overweight or obese are of real concern, and respiratory diseases like asthma are a particular threat. Dental health is poor compared to the other home countries, and there is a direct correlation between poor oral health and deprivation.

For the elderly, Wales has a growing number of patients with dementia. It is estimated that around 37,000 people in Wales have a form of dementia with the largest burden among those aged over 75. Two thirds of Welsh people with dementia remain living in the community with around one third living in care and nursing homes.

Several significant health threats emerged during 2009, including the measles outbreak and the influenza pandemic, and a matter for significant concern has been the increasing number of excess winter deaths, especially in the older population. This is related to the colder than average winters in recent years.

There remain inequitable gaps in health and wellbeing, with significant differences between parts of the country and between social groups.

For the new Health Boards, their ability to collectively tackle these challenges will be key to their long term success.

2.3 Our Work Programme for 2009/10

HIW's work programme for 2009-10 included a mix of routine, thematic and development work that together brought a strong focus to many of these challenges. Our programme covered a wide range of healthcare provision. For example, we looked at services for older people; the protection of children and vulnerable adults; treating individuals with dignity and respect as well as development work, such as new arrangements for reviewing compliance with Wales' Cancer Standards. The following sections summarise what we did and found in 2009-10.

2.4 Assessing and Reporting on Standards of Healthcare

What we found in 2009-10

Driving care that's patient-centred

> *"What really matters is keeping people healthy and out of hospital – the important thing is whether the patient is kept healthy or made to feel better, and whether they are satisfied with their treatment – not how many times they have gone through the hospital doors".*
> *Chief Executive, NHS Wales, 2010.*

Our work in 2009-10 demonstrates that healthcare staff generally are committed to providing care that's patient centred. There is a strong understanding of the importance of meeting the individual needs of all their patients and providing care in a manner that maintains an individual's dignity and shows respect at all times. The following sections describe our work in this area during the year:

The Healthcare Standards for Wales

The *Healthcare Standards for Wales* published by the Welsh Assembly Government in 2005 is 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 covered:

- the experience of patients;
- clinical outcomes;
- the governance of healthcare; and
- public health.

Between 2007 and 2010, NHS organisations were required to carry out annual self-assessments against the standards and to make a public declaration about their performance. HIW's role was to test and validate these assessments, concentrating on the issues that we believed, and people told us, mattered most to the people of Wales.

Performance was 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?*

Each organisation was judged as reaching one of five levels of maturity: *aware, responding, developing, practising* or *leading.*

During the year we reported on the performance of NHS trusts and local health boards (LHBs) against the standards in 2008-09. Between March and April 2009, we made unannounced visits to every Welsh NHS Trust, concentrating on Accident and Emergency (A&E) Departments, Minor Injuries Units, Paediatric Wards, Elderly Mental Health Wards, Medical Wards and Medical Assessment units. We also visited a sample of eighty five GP practices across Wales:

Our assessment for 2008-09 focused on:

- **Child protection** - as the Baby Peter case had highlighted significant concerns about services in England;
- **Protection of Vulnerable Adults** - as our previous reviews had highlighted this as an area where more work is needed; and
- **Dignity and respect issues** - as these are fundamental to patients'/service users' experience and matter to us all

by looking in detail at 10 of the 32 Standards, concentrating on the user experience and the environment of care.

Our reports to individual organisations for 2008-09 served as important legacy documents for the NHS, helping the new health boards to establish what was working well and where they needed to direct their attention on improvement across all their new areas of responsibility.

Taken as a whole, our work in this area highlighted the following:

Care Planning

Care planning is essentially about addressing an individual's full range of needs, taking into account their health, personal, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognises that

there are other issues in addition to medical needs that can impact on a person's total health and wellbeing. Effective care planning is therefore vital if patients' experience of healthcare is to be a positive one.

We found that care planning does take place throughout a patient's journey from admission to discharge, and often in a manner that includes the involvement of patients themselves, service users, their relatives and carers. However, this was not always consistent across Wales and more work needs to be done. For example, within the former Trusts we found that:

- the attention given to written care plans varied;
- plans often did not take into account the psychological, spiritual and equality needs of patients and service users;
- where specific needs had been identified, it was not always evident that any resulting actions were being taken to meet those needs; although
- measures are being taken in most areas through effective monitoring to identify personal information in order to help ensure service users are not discriminated against.

Meeting Individuals' Spiritual Needs

When asked, the majority of healthcare staff we spoke to understood the importance attached to the spiritual wellbeing of patients, and on a practical level, knew how to contact appropriate spiritual and religious leaders.

However, we identified this as an area that could benefit from clearer guidance at an all Wales level. In parallel, the Minister for Health and Social Services introduced new Standards for Spiritual Care in the NHS in Wales in May 2010 linked to the *Standards for Health Services.* The new spiritual standards are designed to help ensure equality across services and to develop an integrated approach to the delivery of religious and spiritual care.

Keeping People Informed

Patients and service users are able to access information in relation to health services more generally and their condition, care and treatment specifically. However, this information is not always available to patients in an appropriate language or format, especially for minority groups. There are gaps in the provision of support for patients and service users who have sensory impairment.

Nutrition

We found that nutritional assessments were routinely carried out, assistance was appropriately provided and the variety of food available was generally good. However, practice did vary slightly across Wales, with some patients reporting some anxiety around assessments, particularly where they had a specific dietary need.

Responding to Feedback

Patients and service users were routinely given the opportunity to provide feedback on their experiences, although there was a variable picture across Wales in some key aspects:

- Information leaflets on how to complain or comment were usually available but were not always clearly visible;
- the extent to which staff are made aware of these comments was unclear; and
- importantly, the extent to which the comments received actually influence changes or improvements was variable.

In October 2009, the Welsh Assembly Government issued new interim arrangements for the handling of concerns in the NHS in Wales, in advance of the introduction of new regulations which will set out the common arrangements and duties that apply to NHS organisations in Wales in respect of the investigation and handling of situations where something has gone wrong.

Using Ambulance Services

We were satisfied that, on the whole, a good standard of care is delivered to people using the ambulance services. There was evidence of the commitment of staff to providing a good quality service and a significant majority of the service users we talked to were complimentary of the way they were treated by staff. In general, we found that ambulance staff do everything possible to ensure that patients' dignity and respect is maintained. It was also evident that the Trust has made significant progress in putting systems in place to ensure the protection of children (POCA) and vulnerable adults (POVA).

Our Assessment Approach for 2009-10

Recognising the introduction of the new health boards in October 2009, and looking ahead to the replacement of the Healthcare Standards in April 2010, we took a different approach to assessment for 2009-10. Instead of conducting a specific 'once a year' exercise, we are instead using the results of our overall programme of work carried out during the six months from October 2009 to March 2010 to inform our assessment of how well the new health boards performed against the Standards.

Our detailed findings will be reported during 2010-11.

Following a major review by the Welsh Assembly Government of the Healthcare Standards for Wales in 2009-10, revised standards - *Doing Well, Doing Better, Standards for Health Services in* Wales - were launched on 1 April 2010.

Regulating the Independent Healthcare Sector in Wales

Through registration and inspection, we continued to regulate the independent healthcare sector in Wales, in line with the requirements of the Care Standards Act 2000 and associated Regulations.

As at 31 March 2010, there were 1,115 registered independent healthcare providers, compared to 95 a year ago. This significant increase is largely accounted for by the registration during 2009-10 of 1,011 private dentists, as a result of the introduction of new regulations which came into effect on 1 January 2009. The number of acute hospitals registered with us also increased significantly, rising from 7 to 12, albeit the overall number remains relatively small.

Type of setting	Number of registered providers at 31 March 2010	Number of registered providers at 31 March 2009
Acute hospitals	12	7
Mental health hospitals	24	22
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	43	39
Hyperbaric oxygen chambers	4	5
Independent GPs	1	1
Independent clinics	8	9
Private dentists	1012	1
TOTAL	**1115**	**95**

During the year, HIW worked with the Dental Reference Service[3] to assess dentists registered in Wales in line with the national minimum standards for private dentists (which are themselves aligned with the new Standards for Health Services).

Driving improvement in the environment of care

The provision of high quality health services depend on an environment of care and the availability of facilities that are 'fit for purpose', specific to the particular needs of the patients and service users accessing services.

[3] The Dental Reference Service (DRS) is the organisation that inspects NHS dentistry in England and Wales. HIW's relationship with the DRS is defined within a formal contractual arrangement.

Our work during the year in relation to the *Healthcare Standards for Wales,* together with our programmes of unannounced spot checks, focusing on *Dignity and Respect* and *Cleanliness*, largely informed our findings in this area.

Overall, we found that the majority of wards and clinical areas visited were safe and generally facilitated the treatment of patients and service users with dignity and respect. However, we were concerned that the:

- layout of wards does not always support privacy and confidentiality, eg., whilst the use of curtains around beds ensures privacy is maintained it is still possible for people to overhear what might be sensitive conversations;
- availability and access to single rooms, segregated washing and toileting facilities and single sex bays varied; and
- the right balance was not always struck between the need to ensure an appropriate 'clinical' environment whilst also improving patient experience through the provision of a more 'homely' environment. This was a particular issue on Elderly Mentally Infirm (EMI) wards.

In January 2010, the Welsh Assembly Government asked Local Health Boards to assess the extent to which their organisation was meeting the requirements of its policy on single-sex hospital accommodation. In response, additional guidance was issued to the NHS in August 2010, and at the same time health boards were required to introduce clear action plans to meet the full requirements of the hospital accommodation policy by 31 March 2011.

Unannounced Cleanliness Spot Checks

Healthcare Associated Infections (HCAIs) result in significant costs for the NHS in Wales. The cost to patients in terms of avoidable illness and death is significant. In 2008, MRSA was recorded as an underlying cause of death in 27 cases and *clostridium difficile*[4] in a further 203 cases. On average, a patient who subsequently contracts *clostridium difficile* stays in hospital 9-11 days longer than anticipated. It is estimated that HCAIs cost about £3,154 per case: in Wales this would amount to around £50 million per annum. Many of these infections are preventable but they result in ward closures, increased average lengths of stay and increased hospital waiting times.

Throughout the year, we continued with our programme of unannounced cleanliness spot checks. We carried out six unannounced cleanliness spot checks, visiting a range of wards and operating theatres, and following up on concerns identified as part of previous visits.

Fundamental to our drive for improvement, these visits focused on the standards of infection control in health service organisations, in doing so considering whether patients experience when accessing health services was positively affected by the cleanliness of their environment.

We found that:

- many organisations are meeting the challenge of maintaining standards of cleanliness even within environments that are ageing and not designed for modern healthcare services;

[4] *Clostridium difficile* is a bacterium that is present naturally in the gut of around 3% of adults and 66% of children under the age of two years. The bacterium does not cause long term harm to otherwise healthy people but causes problems when patients are prescribed antibiotics. The occurrence and severity of *clostridium difficile* infections is rising internationally.

- a lack of adequate storage space means that in many cases clinical areas or other spaces such as bathrooms are being used to store inappropriate items; and
- staff knowledge and understanding of infection control practice was generally acceptable, although there remains a tendency for staff to over use gloves for all patient contact. However, not all staff that needed it had received necessary training.

Monitoring the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R)

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 apply to both the NHS and independent healthcare providers, and 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;
- ensure that patients receive no more exposure than is necessary to achieve the desired benefit within the limits of current technology; and
- protect volunteers in medical or biomedical, diagnostic or therapeutic research programmes and those undergoing medico-legal exposures.

Given the specialist nature of this aspect of our work, we secure expert advice to assist us through a contract arrangement with the Health Protection Agency (HPA).

During 2009-10 we undertook five inspections.

We had no immediate concerns arising from our assessments of the Diagnostic Imaging, Nuclear Medicine and Radiotherapy Departments at the former Abertawe Bro Morgannwg University NHS Trust (now known as Abertawe Bro Morgannwg University Local Health Board); the Radiotherapy Department at Velindre NHS Trust; or the Diagnostic Imaging Department at Withybush Hospital, part of Hywel Dda Health Board. However, we still had a number of concerns in our re-visit inspection to Bronglais General Hospital. Further work was required on regulatory policies and procedures to ensure they were 'fit for purpose' and compliant; issues in relation to responsible individuals had still not been adequately addressed; and greater clarity was required in relation to the responsibilities and the scope of practice of individuals involved in medical exposures.

Safeguarding the most Vulnerable

Promoting the rights of children, young people and vulnerable adults and helping to keep them safe from harm is a key priority for us. Our overall work programme reflects this, and, with the introduction of new responsibilities for mental health services we were able to bring a sharper focus to this aspect of our work during 2009-10.

For health service providers tackling this area is challenging and can be complex, requiring close working across the NHS, voluntary and independent sectors as well as support from families, communities and the wider public.

Overall, we identified a strong desire and considerable commitment amongst healthcare staff to meeting their safeguarding responsibilities effectively. However, further work is needed to help staff translate this commitment into a clear, unambiguous understanding of what and when action is needed. This includes knowing when and what information should be shared responsibly in order to protect those who are vulnerable.

Safeguarding the interests of all those who access Mental Health Services

The monitoring and other functions previously performed in Wales by the Mental Health Act Commission (MHAC) were transferred to us in April 2009. These new functions have brought opportunities for us to develop a sharper focus on these services. In 2009-10 we monitored compliance on an ongoing basis with the Mental Health Act 2007 and other relevant mental health legislation, such as the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards. Through the establishment of a Review Service for Mental Health, our work included:

- visits to patients subject to the powers of the Mental Health Act; and
- the provision of a Second Opinion Appointed Doctor (SOAD) service, which appoints independent doctors to give a second opinion as a safeguard for patients who either refuse to give consent for certain treatments or are incapable of giving such consent.

What we did

Our reviewers undertook 91 visits to 51 NHS and independent hospitals and units. During these visits, they spoke with over 200 patients and carried out an extensive review of patient documents to assess the extent to which those receiving care and treatment in Wales which was subject to the provisions of the Mental Health Act 1983 were:

- treated lawfully;
- treated with dignity and respect;
- received care and treatment appropriate to his or her needs; and
- enabled to lead as fulfilling a life as possible.

What we found

Our monitoring of the application of the Mental Health Act 1983 and related legislation demonstrated that legal due process is followed in most cases.

Our concerns are around understanding and following the requirements around capacity and consent; ensuring patients understand the implications of being subject to the Act and their rights; and access for staff to appropriate training to help them understand their roles and responsibilities.

Other areas of concern relate to:

- the environment of care and privacy and dignity;
- provision of physical healthcare to patients on mental health wards;
- lack of meaningful activities and access to therapy and psychology services;
- care planning and risk management; and
- patient mix and models of care.

On older people's wards we are still finding a mix of people with illnesses such as depression and schizophrenia (known as functional illnesses) alongside those with dementias (known as organic illnesses) despite guidance and reports dating back to 2001-2.

Where assertive outreach and crisis resolution/home treatment teams are in place there is a noticeable impact on the number and length of admissions and the levels of bed occupancy on wards. When patients do need admission it is because they cannot be managed in the community, often because of their very acute presentation/challenging behaviour. As a consequence wards are seeing a higher percentage of their patients with acute symptoms and behaviours, but staffing levels have not necessarily been reviewed to meet this change.

Our early findings indicate that on the whole the health sector had made suitable preparations to raise awareness and manage actions in accordance with the requirements established by the Deprivation of Liberty Safeguards. However, statistics indicate that activity levels in this first year does not match forecasts. This is consistent across health and social care in Wales and is similar to activity levels reported in England. It is unclear why this has occurred, but could be indicative of a wider issue across these sectors where the understanding and implementation of the Mental Capacity Act does not appear to be as well embedded as it should be.

All Wales Special Reviews

Each year we carry out and report upon reviews into the quality and safety of specific areas of health service provision. Each of these reviews has the same, high level aims and objectives, specifically to ensure that services:

- meet the needs of the citizens of Wales;
- are safe and of high quality; and
- are being delivered in the most efficient and effective manner.

Each review:

- is tailored to focus on the key issues;
- appropriately involves key stakeholders, including patients, service users, relatives and carers; and
- is designed to take advantage of opportunities to work in partnership with other regulation, audit and inspection bodies, especially where health services link with others, eg., Social Services, Education Services, etc.

During the year, we carried out review work or reported upon the following:

Services for Children and Young People with Emotional and Mental Health Needs

The Assembly Government's ***One Wales*** agreement placed a new priority on mental health, including child and adolescent mental health services. Children and young people with emotional and mental health problems often have complex and wide ranging needs that require a co-ordinated response from different professionals and services in the fields of health, social care and education.

In response to concerns identified through audit and inspection work and from issues raised by a wide range of stakeholders, HIW, together with the Wales Audit Office, Estyn and CSSIW worked together to carry out a major review of child and adolescent mental health services. Working together for the first time in such a major review of services, we sought to answer the question 'Are services adequately meeting the mental health needs of children and young people?'

We found that services were still failing many children and young people with emotional and mental health needs, despite improvements in recent years, in particular new funding streams to develop parenting and family intervention services; expanding school based counselling and the introduction of primary mental health workers who support professionals, such as GPs and school nurses.

There was too much variation across Wales in the availability and quality of services:

- specialist community services, including services for young people with eating disorders were too variable;
- transition arrangements for the transfer of young people to adult services when they get older were not good enough; and
- unlike other parts of the UK there were no specialist mental health services in the community for children under five.

Joint working between the health, local authority and voluntary sectors was also variable, resulting in some children and young people receiving services that were poorly co-ordinated.

We published our findings in a single report in November 2009.

Safeguarding and Protecting Children

Following the investigation into the death of baby Peter Connelly in Haringey, the Welsh Assembly Government set out its response in a Ministerial Statement 'Safeguarding Vulnerable Children in Wales' made in November 2008. Following this, HIW and CSSIW undertook three reviews in tandem, each focusing on safeguarding and protecting children in Wales:

- Safeguarding and Protecting Children in Wales: A review of Local Authority Social Services and Local Safeguarding Children Boards (CSSIW);
- Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews (CSSIW);
- Safeguarding and Protecting Children in Wales: A Review of the Arrangements in Place across the Welsh National Health Service (HIW).

Our review focussed on the Welsh NHS's safeguarding and protection arrangements, and set out to answer two key questions:

- Are all those working in healthcare organisations aware of their responsibilities in relation to child protection and safeguarding and do they know how to properly deal with suspected child protection/safeguarding issues?; and
- Are children and young people safe when accessing health services or visiting healthcare premises?

We found that staff were generally alert to child protection issues and demonstrated a sound awareness of the appropriate reporting and escalation procedures. However, there were variations in the consistency of information sharing within organisations, as well as with other agencies and sectors. NHS organisations need to be clearer about when and how information should be shared in order to ensure that matters around patient confidentiality do not serve as a barrier to protecting and safeguarding children and young people.

The reports were published in October 2009, and brought together the findings from each strand of work undertaken by our two inspectorates.

Protection of Vulnerable Adults (POVA)

Aligned with work being taken forward by CSSIW, and informed by the results of our routine work programme, we reported during the year on how the NHS in Wales safeguards vulnerable adults. In doing so, we sought to answer two key questions:

- Are those working in healthcare organisations aware of their responsibilities in relation to the protection of vulnerable adults and do they know how to properly deal with suspected adult protection/safeguarding issues?; and
- Are vulnerable adults safe when accessing healthcare services?

We found that health boards demonstrated a strong commitment to the protection of vulnerable adults through their nomination of a designated lead for POVA, and their involvement as a named partner in all local arrangements for adult protection.

Nevertheless, adult safeguarding systems were under developed:

- the NHS in Wales faces a major issue around staff awareness of what constitutes ‘abuse’; and
- the training provided across Wales was inconsistent and did not always encompass all staff groups (e.g. medical staff/primary care/non-clinical staff).

Overall, we concluded that further significant work was needed in the development of future policy and guidance in order to recognise the important role the NHS has to play in safeguarding, and to empower staff across the NHS in Wales to grasp and progress this agenda.

We published our findings in March 2010, alongside CSSIW's report 'National Inspection of Adult Protection All Wales Overview'.

Review of the Impact of the National Service Framework (NSF) for Older People in Wales - Phase 1 2008-2009

Launched in 2006, The National Service Framework (NSF) for Older People in Wales, is a key component of the Welsh Assembly Government's Strategy for Older People (published in 2003). It sets out national evidence based standards for the health and social care of older people in Wales. At the time of its launch, a commitment was given to undertake a fundamental review of the NSF following the first period of its implementation in order to assess its progress and identify its successes in order to inform its future development.

Working together with CSSIW, we are carrying out this review over a two year period. Our work is being taken forward through a range of different work streams which, together, will enable us to assess what impact the NSF is having on the quality of life of older people in Wales. Our work in 2009-10 formed part of the second phase of our review, and sought to consider the NSF standards through the lens of older people with dementia. We will report jointly on our findings early in 2011.

Substance Misuse

Substance misuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. It also includes the use of prescription medicines, over the counter preparations and household products such as lighter fuel and other aerosols.

Commissioned by the Welsh Assembly Government, HIW has developed and is implementing, a programme of reviews of substance misuse treatment services to assess the adequacy and quality of services provided across Wales, identify good practice and make recommendations for future improvement.

In 2009-10 our review work focused on the commissioning and provision of substitute prescribing services for drugs such as methadone. Our approach involved close working with the Community Safety Division (CSD) of the Assembly Government, other regulation/inspectorate bodies and the then National Public Health Service (NPHS) to identify and prioritise the high-risk issues associated with substance misuse services in Wales.

We also engaged with service providers through workshops and one-to-one meetings. We held focus group and drop-in sessions for service users to help us establish an overview of substance misuse services across Wales.

We found that the strategic vision and objectives of the Welsh Assembly Government in relation to substance misuse services were not being consistently attended to or delivered across Wales. Strategic commissioning processes are underdeveloped in many areas, leading to the delivery of ad hoc and fragmented treatment. In particular, we identified:

- some high quality services across Wales within both statutory and voluntary sectors, although the quality and availability of services depended on where people lived; and
- further concern regarding the safeguarding of children and the protection of vulnerable adults.

Building on this work, we will focus in 2010-11 on the service user ‘journey’ from the point of accessing services right through different treatment options and support services.

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

HIW, together with Estyn and CSSIW, have continued to assist Her Majesty's Inspectorate of Probation (HMIP) with a rolling programme of joint inspections of Youth Offending Services in Wales. Reports are published by HMIP and may be viewed at www.justice.gov.uk/inspectorates/hmi-prisons.

In addition to the rolling programme, we also introduced a new approach to the joint inspection of YOTs in 2009-10. Our first 'thematic' inspection looked into the effect of alcohol on offending behaviour by young people (under 18 years) and considered whether youth offending and health services are sufficiently engaged and involved in efforts to reduce the impact of alcohol misuse by children and young people who offend.

Across England and Wales, Youth Offending Teams have made good progress in identifying and addressing alcohol misuse in children and young people, recognising the link between alcohol misuse and health problems, underachievement in school and offending behaviour. YOTs are offering significant and effective health resources where alcohol misuse is seen to relate directly to offending, but there were too many inconsistencies found in the quality of assessments, suggesting children and young people who misuse alcohol are sometimes going without the appropriate help.

Details of the findings and recommendations are contained in the report "Message in a Bottle" (published in June 2010).

Being treated by suitably trained and qualified staff

Linked to the structural changes in the NHS, 2009/10 saw major changes in the NHS Workforce across Wales. Further developing the capacity and capability of the workforce will be crucial to enable the NHS to meet its challenges and ensure patients are treated by the right person at the right time and in the right place. Our work programme this year has confirmed that health services in Wales benefit from a skilled and dedicated workforce overall. We have identified ongoing challenges around the consistent access to and provision of training across Wales in key areas such as infection control and safeguarding children, young people and vulnerable adults. A strong focus will be needed to ensure consistent progress is made in these areas

In addition to our programme of routine, thematic and special reviews, our specific functions relating to nurses and midwives also bring a strong focus to matters of training and qualification:

Statutory Supervision of Midwives in Wales

On behalf of Welsh Ministers and the Nursing and Midwifery Council (NMC), we are responsible, as the Local Supervising Authority for Wales, for exercising general supervision over all midwives practicing in Wales. As at 31 March 2010, 1,678 midwives notified an intention to practice midwifery in Wales for the year 2010-11. Throughout the year, the LSA supported midwives through a model of supervision that aimed to protect the public by proactively supporting midwives to provide a high standard of midwifery care with informed choice for women.

What we found

There were strong networks of Supervisors of Midwives within all maternity services providers in Wales and a firm commitment to an all-Wales approach. There was evidence of effective networking and sharing of good practice, particularly valuable in ensuring that high standards of practice are maintained amid changes in the NHS in Wales.

Midwives in Wales continued to promote normality and midwife-led care and strived to provide choice for women.

Ongoing challenges include maintaining the ratio of Supervisors of Midwives to midwives to the level required by the NMC, albeit Wales continues to be ahead of the recommended ratios; identifying and managing risk areas as well as supporting midwives and Supervisors of Midwives during implementation of new structures in the NHS in Wales.

A continuing increase in the birth rate in Wales has implications for future provision of maternity services, general workforce planning and workforce planning for midwife numbers in particular, to ensure choice and best care for women and the most appropriate use of resources.

A detailed report on the work of the LSA during 2009-10 was published in September 2010.

Quality assurance on behalf of the NMC

In 2009-10, on behalf of the NMC, we continued to approve and monitor nursing, midwifery and community public health educational programmes in Wales that lead to professional qualifications.

A total of eleven education programmes were recommended by us for approval - the same number approved the previous year. We also monitored a total of twelve programmes to ensure that they were delivering the quality and level of education needed, across seven NMC approved Higher Education Institutions in Wales.

Our monitoring of nursing and midwifery education, together with the quality of the programmes submitted for approval indicated that the provision in Wales was of a high standard.

Since April 2010, HIW has no longer carried out this function, as the NMC have made new arrangements covering the whole of the UK.

Nurse Agencies

NHS organisations may source nurses, healthcare assistants and operating department practitioners from specialist agencies. We carry out an annual assessment of any such agencies to ensure they are 'fit for purpose'. In 2009-10 we visited six nurse agencies to follow up any issues that had been identified in the previous years' assessments, as well as to review the arrangements in place to ensure staff contracted to the agencies had received relevant immunisations and health checks, and were appropriately trained in relation to the protection of children and vulnerable adults.

Our work during the year highlighted that some NHS organisations were going outside the contract to procure specialist nurses, and smaller agencies were having difficulty in procuring occupational health services.

Welsh Health Supplies have awarded new Agency contracts from 2010-11. We will be carrying out a baseline review in 2010-11 to assess 11 agencies that have been awarded a contract for the first time.

Controlled drugs

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 came into force in January 2009. These regulations establish clear requirements for the safe and effective handling of controlled drugs. During the year, we worked with NHS organisations and larger independent hospitals to make sure that they notified us of their nominated “accountable officer”. This officer must be of sufficient seniority to ensure that their organisation meets all requirements in relation to controlled drugs. We have published a list of these Accountable Officers on our website.

Learning when things go wrong

Mistakes happen in the provision of any service, and the health service is no exception. Key to the ongoing development of safe, sustainable health services in Wales is a culture that is not blame oriented; that recognises that mistakes happen and that seeks to learn and share its learning from those mistakes in an open and transparent manner.

Special reviews and investigations

HIW may undertake a special review of healthcare organisations or services where concerns have been expressed in relation to a particular incident or incidents. The level and extent of the work we might undertake depends upon the seriousness and/or frequency with which an incident has occurred.

Investigations may arise as a result of an NHS Organisation(s) self referral, issues brought to light during screening of data/information or inspection work, or following a request for an investigation from, for example, a member of the public, another inspectorate, the police or the Welsh Assembly Government.

The results of our investigations are publicised widely to ensure learning extends beyond the individual incident or health board that gave rise to the investigation.

During the year, we carried out or reported upon the following:

Special Review of the outbreak of Clostridium difficile at the former North Glamorgan NHS Trust (now part of Cwm Taf Health Board)

Following general media interest in *Clostridium difficile* infections and cleanliness in hospitals across Wales, the outbreak at the former Trust received a great deal of coverage by local and national media. The Minister for Health and Social Services commissioned HIW to undertake a special review of the arrangements put in place to manage the outbreak of *Clostridium difficile* at the Trust. The Review also sought to identify and share any lessons in respect of how best to prevent, control and manage *Clostridium difficile* infections and outbreaks.

Our review found that a number of factors contributed to the outbreak. Once identified, the Trust treated the outbreak as a priority and staff worked together to minimise its impact, although additional steps could have been taken by the Trust to further reduce the impact of the outbreak.

The findings of this special review informed our All Wales Review of the Management of Patients with Diarrhoea and Vomiting.

All Wales Review of the Management of Patients with Diarrhoea and Vomiting

Despite the progress that has been made over the years in relation to public health, hospital care and treatments, Hospital Acquired Infections[5] continue to be of major concern to the NHS, its patients and the general public.

Of particular concern is the number of outbreaks of highly contagious and debilitating diarrhoea and vomiting infections that occur each year across the NHS in Wales. Such outbreaks have the potential to affect not only patients but staff and visitors, and if not quickly identified and carefully managed can have a major impact on the wellbeing of patients.

In addition, these outbreaks of infection have a considerable operational impact on the running of a hospital with wards having to be closed to new patient admissions, which in turn impacts on the organisations ability to properly care for emergency admissions.

Our review set out to establish how well the NHS in Wales manages and cares for patients exhibiting symptoms of infectious D&V. Specifically, we set out to test the adequacy of the arrangements in place for:

- the management of the admission, transfer, movement and isolation of patients with diarrhoea and vomiting;
- the surveillance of infections and the management of outbreaks;
- laboratory testing of samples;
- the monitoring and management of antibiotic prescribing;
- ensuring sound infection prevention and cleanliness practices; and
- ensuring the appropriateness of the environment of care.

[5] A Hospital Acquired Infection is an infection acquired in hospital by a patient who was admitted for a reason other than the infection.

We visited over 20 sites across Wales. Overall, we found that patients who present with diarrhoea and vomiting in hospitals across Wales were identified and isolated so as to prevent other patients and staff from contracting the infection. Organisations also recognised the importance of keeping wards affected with *Norovirus* and *Clostridium difficile* closed for 48-72 hours after patients become symptom free.

However, achieving this was a difficult challenge for many hospitals in Wales who are providing healthcare within ageing environments that are not well designed to prevent the spread of infection, or at very busy times when demand for beds is high.

Further improvement was also needed in many organisations to ensure the most effective use of antibiotics and to avoid over prescribing.

We reported specifically on our findings to each of the individual organisations we visited.

Report on Maternity Services at the former Gwent Healthcare NHS Trust (now part of Aneurin Bevan Health Board): Follow up review

A review carried out in April 2008, and reported upon in February 2009, had highlighted a number of significant concerns in relation to the provision of Maternity Services by Gwent Healthcare NHS Trust affecting the continuing safety of women and their babies. As a result, we had placed the Maternity Services of Gwent Healthcare NHS Trust under 'Special Measures'. This required the Trust to take immediate action to address two key factors, inadequacies in the management and leadership of Maternity Services, and 'less than optimal' staffing arrangements.

In addition to closely monitoring the Trust's action plan, during 2009, we carried out a follow up review to determine the extent to which maternity services had improved at Gwent Healthcare NHS Trust. We concluded that sufficient progress and improvements had been made to justify the removal of 'Special Measures' in September 2009.

Special Review of Histopathology Services Provided by the Former North East Wales NHS Trust

Histopathology is the branch of pathology concerned with the examination and understanding of tissues. During the year, we reported upon our independent review which was carried out in response to a request from the Trust following their identification, in autumn 2007, of a sample of histopathology results that had been incorrectly reported upon as being negative. The review centred on:

- investigation of the circumstances in which erroneous reporting of results from tissue samples occurred between October 2004 and September 2007;
- examination of current policies, procedures, systems and practices in place in the Trust to deliver histopathology services; and
- consideration of any other matters relevant to the purposes of the review.

We highlighted a number of factors that contributed to incorrect reporting of histopathology results, and identified some key learning points. These largely centred around a range of 'people' related issues, including the capacity and capability of staff; leadership and management and team working. In addition, the premises provided for histopathology services did not provide an optimal environment for service delivery.

Reviews of Homicides where the 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 learned are identified and acted upon. HIW have carried out all such reviews since January 2007.

During 2009-10 we published our findings in respect of two separate reviews. The findings mirrored many of the common themes and findings emerging from the independent external reviews examined in previous years, notably:

- issues relating to the implementation of Care Programme Approach;
- risk management and assessment, and
- the sharing and communication of information.

Although neither homicide could have been predicted, in both cases, had the perpetrator been engaged with more assertively and treated adequately, then the risk of committing an act of violence or homicide might have been reduced. In addition, there was a lack of engagement with and support to families in both cases.

More broadly, this case also highlighted a lack of formalised health or social care arrangements in place in relation to the wider community in response to traumatic incidents of this kind, other than through self referral of those affected to health and social care professionals.

The recommendations from these reports have informed the development of an overview report, designed to identify the common themes and concerns identified across all our individual homicide reviews. This report will be published in 2011.

Deaths in Welsh Prisons - Working with the Prison & Probation Ombudsman

During the year we provided clinical advice to the Prisons and Probation Ombudsman (PPO) as part of ten investigations into deaths in Welsh prisons, an increase from six in the previous year. We are seeing further increases in 2010, and are actively engaging with PPO to further develop our approach to these reviews.

We identified a number of common issues arising from this work in 2009-10. These included concerns around the:

- prescribing and administration of medication;
- health assessments on admission to prison, ongoing and upon transfer to another prison;
- use of recognised symptom assessments including pain assessments; and
- completeness, accuracy and legibility of clinical records.

Reports of reviews into deaths in prisons 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.

3. DRIVING IMPROVEMENT THROUGH OUR WORK

We adopt a range of approaches to influence healthcare in Wales for the better:

Reports on healthcare providers	Our three year and annual plans	HIW-organised healthcare summits	HIW input to conferences and exhibitions
Investigation reports	Our annual report	Thematic reports	Contributing to consultations
Agreements and protocols for inter-agency collaboration	Methods for inspection, investigation and review	Professional input into media coverage of healthcare	Registers of healthcare providers
Briefings for Ministers	Unannounced spot check reports	Demonstrable compliance with legislation	Input to committees

3.1 Our Publications

Our main tool is the material which we put in the public domain and which we share with service providers and our delivery partners – these publications are the levers we use to move healthcare forward. Our publications are available bilingually (in line with our Welsh Language Scheme), free of charge, and on request in a number of other languages and formats, such as audio or Braille. They may also be downloaded from our website (www.hiw.org.uk).

3.2 Following up on our findings

We work closely with officials in the Assembly Government's Health & Social Services Directorate so that our recommendations may be followed up through their performance management arrangements for the NHS in Wales. We may ourselves re-visit organisations or services to ensure that suitable progress is being made.

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

3.3 Influencing policy and practice

At an all Wales level, we inform the development of healthcare policy and practice through a wide range of activities. As well as the publication of our reports, we also regularly provide professional advice and input to specific projects; briefings to Ministers; oral and written evidence to the work of Assembly Government and other Committees: responses to public consultations; as well as contributions at conferences and exhibitions.

During the year, we contributed to the following development work:

Sensory Impairment: We worked with the Royal Society for the Blind (RNIB) and the Royal Society for the Deaf (RNID) to support the development of quality requirements designed to address the needs of those individuals who have a sensory impairment.

Doing Well, Doing Better: Standards for Health Services: As well as contributing to the development of the new Standards themselves, we also focused on facilitating the development of a self assessment process designed to

enable health service organisations to assess and assure themselves, as well as others, of how well they are performing against the new Standards for Health Services.

Cancer Services: Working together with the Wales Cancer Co-ordinating Group, we focused on developing a 'peer review' approach to the review of compliance with the cancer standards.

Palliative Care: We supported Baroness Finlay's work on behalf of the Minister for Health and Social Services on the development of quality requirements for palliative care.

The Development of a Review Service for Mental Health: We worked with CSSIW to develop a review service for Mental Health that is holistic, properly integrated and places the service user at the centre of the review process.

Supporting Revalidation of Doctors: We worked with other health service regulators from across the UK to support new arrangements being established by the General Medical Council (GMC) for the revalidation of doctors in the UK.

3.4 Working with our partners

It is essential that our work is focussed on the things that matter most to patients and the citizens of Wales and that we work together with other inspectorates and regulators to ensure that we are as efficient and effective as possible. Our work programme for 2009-10 clearly demonstrates the collaborative approach we have taken to much of our work, working with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

Added to this, HIW has for the past three years facilitated a programme of annual Healthcare Summits involving health and social care review bodies working across Wales. This summit programme has provided us all with a valuable opportunity to share the information and intelligence we hold about NHS organisations to establish an overarching, cohesive assessment that drives our respective plans.

To help drive the ongoing development of a sustainable approach to collaboration across the welsh public sector HIW, the WAO, CSSIW and Estyn are currently working together on the development of a new 'strategic narrative' that establishes a clear focus and future direction for inspection and review bodies working together in Wales. At an operational level, we have also appointed a new Joint Inspectorate Project Manager working across our respective organisations. This post is helping us to further enhance the way in which we plan our work activity and share and use information.

Wales Concordat Cymru

The Wales Concordat between bodies, including HIW, that inspect, regulate, audit and improve health and social care services in Wales was signed in May 2005. We continued in 2009-10 to play a leading role in ensuring that the principles and practices of the Concordat apply to the work of all the signatories. For example, the Concordat has been the platform upon which we have developed the Healthcare Summits approach to information sharing in Wales.

Memoranda of Understanding

In addition to the Concordat, we have Memoranda of Understanding with many of our partner organisations which define the circumstances in which, and the processes through which we will co-operate in carrying out our respective duties. Copies of all the Memoranda are available on our website.

4. LOOKING TO THE FUTURE

4.1 Our work in 2010-11

Our plans for the next three years are set out in our Three Year Work Programme for 2010 – 2013. All of our work will contribute to our overall assessment of how well services across Wales meet the new Standards for Health Services. Our work programme will involve:

- a continuation of our routine regulation, inspection and assurance work designed to fulfil our statutory responsibilities and other agreed priorities;
- a programme of all Wales reviews targeted at areas of special interest;
- completion of a number of special reviews already underway and new ones as the need arises; and
- follow up work from earlier reviews and inspections we have undertaken.

4.2 Developing our own methods and ways of working

We will continue with our extensive programme of organisational development, focusing on transforming the way we carry out our work by further developing our systems, processes and our people.

We will enhance our approach to informing people about our work through the introduction of a new communication strategy. We will strengthen the way we make information available electronically through the redevelopment of our website and the publication of regular e-Newsletters. We will improve the guidance we make available to service users and their families as well as service providers.

We will continue to develop the capacity and capability of our workforce and the professional development of our Inspectorate through the introduction of new Standards for Professional Practice, supported by a Professional Skills Framework.

We will further develop our methods for registration, inspection and investigation, and in doing so ensure a continuing strong focus on equality, diversity and human rights in everything we do.

We will also look to make the best use of the resources and information available to us through improvements in our arrangements for programme management and knowledge management, and the further strengthening of our arrangements for information sharing and collaborative working with our partners involved in the inspection, audit and review of health services.