Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Healthcare Inspectorate Wales

Annual Report 2010-2011

January 2012

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications and Facilities Manager
Healthcare Inspectorate Wales
Bevan House
Caerphilly Business Park
Van Road
CAERPHILLY
CF83 3ED

Or via

Phone: 029 20 928850
Email: hiw@wales.gsi.gov.uk
Fax: 029 20 928877
Website: www.hiw.org.uk

75% wedi'i ailgylchu recycled

ISBN 978 0 7504 6778 0

WG13852

Contents

Foreword

I have pleasure in presenting the seventh annual report of Healthcare Inspectorate Wales (HIW). On behalf of Welsh Ministers and the citizens of Wales, HIW provides independent and objective assurance on the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

This annual report looks back at our activities during 2010-11, as well as looking forward to the challenges ahead. Over the past year, the landscape within which healthcare services are planned and delivered across the UK has continued to develop and change.

Following on from the reforms that changed NHS structures in 2009, NHS leaders focused on developing their longer term strategies and plans and equipping their organisations to deliver high quality, safe and sustainable health services now and in the future. The publication in November 2011 of a new 5 year vision for the NHS in Wales: Together for Health outlines the challenges facing the health service and the actions necessary to ensure it is capable of world class performance.

Health services therefore need to continue to transform their ways of working and work effectively with their statutory and third sector partners if they are to realise the vision of a new model for health services that is based around community services with patients at the centre and places prevention, quality and transparency at the heart of healthcare.

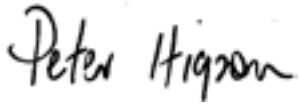
The independent sector too has prepared for changes to the regulatory framework with the introduction of new regulations and associated standards in Wales in April 2011. This brings with it particular challenges for providers operating across borders.

As well as changes in health services, the way in which wider public services are planned, organised and delivered is also changing rapidly with many new forms of joint services being provided. Delivering this level of change in the current economic climate remains a significant challenge for health services in Wales and public services generally.

Taking this into account, throughout 2010-2011 we looked to better equip ourselves to deliver for the future. The introduction of a new organisation structure in April 2010 enabled us to deploy our staff more flexibly across the range of our work in both the NHS and independent healthcare sectors; and the development of new ways of working enabled us to ensure that we are proportionate in the work we do and efficient in the way in which we do it.

Working collaboratively with other inspection, audit and review bodies in Wales and beyond, we are continuing to focus on ensuring we provide citizen focused and complementary assurance about health and social care services in Wales and in so doing, make the biggest impact in supporting improvement in the quality, safety, efficiency and effectiveness of health services in Wales.

Most importantly, we are grateful to all of you who took the time to share your views and experiences of health services with us; our objective assessment of healthcare services is informed by the information you provide to us.



Who we are, what we do and how we do it

Who we are:

- Healthcare Inspectorate Wales (HIW) is the leading regulator of all healthcare in Wales
- We carry out our functions on behalf of Welsh Ministers
- We are professionally independent
- We provide an objective and robust view of healthcare services that, taken as a whole, affect virtually everyone in Wales

What we do:

- We inspect NHS and independent healthcare organisations in Wales against a range of standards, policies, guidance and regulations
- We focus on how well those who may be in vulnerable situations are safeguarded
- We identify where services are doing well and highlight areas where services need to be improved
- We investigate where there may be systemic failures in delivering healthcare
- We take immediate action if we determine that the safety and quality of healthcare does not meet required standards
- We inform patients, service users and the public about the standards of healthcare in Wales
- We drive improvement through shared learning

Our responsibilities are wide ranging:

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
- Supporting and encouraging learning, development and improvement

In April 2010, we introduced our new Code of Ethics. It embodies our values by clearly defining the standards of behaviour we expect from our staff and all those who carry out work on our behalf.

How we do it

Our People

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

At the start of the year, we restructured our organisation so that our teams are 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 now better 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 continued to work with our pool of over 200 external reviewers - health and social care professionals and members of the public - who are trained to help us carry out our reviews, and who bring a wealth of up to date and specific skills, knowledge and experience to our work. During the year we started a review of our use of external reviewers, reflecting on our experiences to date as well as learning from others' approaches. We are currently considering our future needs taking into account the impact of our new ways of working, and will introduce new arrangements in 2012. Further information on how we appoint, train and work with external reviewers can be accessed on our website[1].

In 2010, we reviewed and further strengthened HIW's Advisory Board which has been set up to provide us with independent external advice on the conduct of our work. Its membership now includes representatives from the Board of Community Health Councils in Wales; NHS Wales Chairs and Chief Executives; our peer and lay reviewers; as well as experts from NHS bodies outside Wales. Our Advisory Board met 4 times during the year. You can find out more about its work on our website.

[1] www.hiw.org.uk

Working together with others

How we involved and engaged citizens in Wales

We continued to work closely with patients, service users, carers, their families and the public more generally. This helped us to understand people's needs and preferences, to learn from their experiences of health services and to promote openness and transparency about the quality of healthcare. Throughout the year we involved our citizens by:

- Consulting on our overall plans and work programmes
- Seeking views and perspectives on specific aspects of healthcare, or within particular communities and areas in Wales
- Working with patients, services users, carers, their families and representative groups to develop new approaches to our work
- Including members of the public as 'lay reviewers'
- Providing information on the quality and safety of healthcare through the publication of our reports. A full list of our publications is included at **Appendix A**

In 2011, we agreed with the Board of Community Health Councils in Wales to work more closely together to develop a co-ordinated approach to engaging citizens across Wales through the appointment of a Joint Public and Patient Engagement Manager. This role will focus on further developing our approach to capturing and using the experiences of health service users in our work and on the part we play in monitoring the quality and effectiveness of NHS bodies' own approaches to citizen engagement.

How we worked with healthcare services and staff

Through our attendance and involvement in a range of workshops, conferences, working groups and other development activities, we continued to work with colleagues from across the NHS and independent healthcare sectors to create a common understanding of what we can do collectively to improve health services in Wales.

We encouraged health service organisations to 'get things right first time' by working together with colleagues from across the NHS and the Wales Audit Office to develop new arrangements for self assessing how well they are doing and where they need to improve through the framework of Doing Well, Doing Better: Standards for Health Services in Wales.

We continued to appoint clinical staff working within NHS organisations in Wales as key members of our review teams. As well as fostering self improvement through assessment activity, our approach is also helping to share learning across organisational boundaries.

How we worked with other inspectors and regulators, professional bodies and improvement agencies

Across the UK and beyond

Through our continued commitment and active involvement in the work of the UK and Ireland Five Nations Group[2] of health and social care regulators; the UK Heads of Inspectorates Forum and the European Platform for Supervisory Organisations (EPSO)[3], we continued to ensure our work is both informed by and influences the development of effective inspection, investigation and regulatory practice in health and social care.

We continued to liaise with health professional bodies and regulators such as the Academy of Medical Royal Colleges in Wales[4], General Medical Council (GMC)[5] and Nursing and Midwifery Council (NMC)[6] both to access professional expertise to help us in the conduct of our work and to influence and be informed by the development of professional standards and clinical practice. In particular we supported the development of new arrangements established by the GMC for the revalidation of all doctors in the UK.

[2] The UK 'Five Nations' group of health and social care regulators comprises representation from the Care Quality Commission (CQC) for England; Healthcare Improvement Scotland (HIS); Healthcare Inspectorate Wales (HIW), the Regulation and Quality Improvement Authority (RQIA) for Northern Ireland and the Health Information and Quality Authority for Ireland.

[3] Established in 1996, EPSO is a European network of officials who have a duty to supervise and monitor the quality of health care in their countries. It aims for a better co-operation on quality of inspection, supervision and monitoring in health services and social care.

[4] Academy of Medical Royal Colleges in Wales - has a leading role in the areas of Doctors' revalidation, training and education and aims to speak with a clear and sure voice on generic health care issues for the benefit of patients and healthcare professionals

[5] General Medical Council (GMC) - an independent, statutory, UK wide body which registers and regulates doctors practising in the UK.

[6] Nursing and Midwifery Council (NMC) - an independent, statutory bode which registers and regulates nursing and midwifery practicing in the UK

In Wales

In March 2010, together with the Care and Social Services Inspectorate Wales (CSSIW), Estyn and the Wales Audit Office (WAO), we published a joint paper Developing our Work Together in a Climate of Change[7]. This set out how we were jointly responding to the public policy agenda in Wales and set the scene for the subsequent development and publication of our Strategic Agreement[8] in January 2011. These documents frame our approach to joint working and guide the activities of our joint project team who continue to support the development of joint working between our organisations to ensure more proportionate and co-ordinated approaches to the review and regulation of public services in Wales.

Further information on how we are working together with the other main inspectorates in Wales is available at our new joint website: **www.inspectionwales.com**

Throughout the year we continued to work together to carry out a range of cross sector reviews of health and social care, education and criminal justice in Wales, involving review bodies from across the UK. This included joint reviews of the Older People's National Service Framework; Youth Offending Services; Youth Alcohol Misuse and Offending; and Youth Crime Prevention. We also contributed to investigations carried out by others, for example those carried out by the Prison and Probation Ombudsman (PPO) into deaths in Welsh Prisons, and co-ordinated our work with others such as the monitoring activity carried out by HIW and CSSIW of the Deprivation of Liberty Safeguards (DOLS) in health and social care.

Wales Concordat Cymru[9]

We continued to support the work of the Wales Concordat between bodies that inspect, regulate, audit and improve health and social care services in Wales through our facilitation of three meetings focusing on terms of reference, information sharing and developing the Concordat website.

Memoranda of Understanding

We continued to work together and share information with our partner organisations in line with the framework established within our Memoranda of Understanding. During the year, we developed and introduced a new agreement with the Board of Community Health Councils and started work on the development of new agreements with the GMC and the NMC. Copies of all Memoranda are available on our website[10].

Developing our own ways of working

We continued with our comprehensive programme of organisational development designed to enhance the way we do our work. This ongoing programme is aimed at improving our overall effectiveness and efficiency. During the year we focussed on developing the way we work to strengthen both our planning and our delivery and in doing so we have continued to maximise opportunities to work collaboratively with other inspection and review bodies so that we are able to learn from each others approaches.

During the year we introduced new arrangements to strengthen the way in which we plan, co-ordinate and manage our work programme during the year; improve how we

[7] Developing our work together in a climate of change. Published March 2011 and available at www.inspectionwales.com
[8] Working Collaboratively to Support Improvement. A Strategic agreement between HIW, CSSIW, Estyn and WAO. Published January 2011 available at www.inspectionwales.com
[9] The Wales Concordat is a voluntary agreement between inspection, external review and improvement bodies working in health and social care in Wales www.walesconcordat.org.uk
[10] www.hiw.org.uk

handle and share information and intelligence about health services in Wales; further develop our staff through a comprehensive programme of induction and ongoing learning and development; and enhance and improve our 'toolkit' of approaches to the conduct of our review work.

How we learned from feedback and complaints about our work

Although we aim to be an exemplar Inspectorate, we recognise that we do not always get things right. As well as improving our ways of working by learning from our own experiences, we actively review and respond to all feedback we receive about how we carry out our work so that we can:

- acknowledge the contribution our staff make in achieving high standards of customer service
- monitor the types of problems people have with the way we work
- decide the best way to sort the problems out
- look at how long we are taking to deal with the matters raised

We investigate complaints about HIW by following the Welsh Government's Code of Practice on Complaints[11].

During the year, we received two complaints about our own work. One related to our handling of a meeting and another about our handling of a complaint we received about the actions of a health service provider. Also during the year Peter Tyndall, the Public Services Ombudsman for Wales investigated a complaint about the actions of HIW, CSSIW and the Welsh Government. Published in 2011[12], the Ombudsman upheld most aspects of the complaints against HIW and a complaint against the Welsh Government but did not uphold the complaint against CSSIW.

As a result of our own internal investigations and that of the Ombudsman, we made a number of improvements to our ways of working. This includes the introduction of revised arrangements for handling complaints made about HIW and how we in turn responds to concerns and complaints received about healthcare services. Our strengthened arrangements are described in two new booklets.

[11] Welsh Government Code of Practice on Complaints is available from any Welsh Government office or at www.wales.gov.uk or www.hiw.org.uk

[12] A report by the Public Services Ombudsman for Wales. The investigation of a complaint by Mr & Mrs A against Healthcare Inspectorate Wales, the Care and Social Services Inspectorate for Wales, and the Welsh Assembly Government. Case Ref: 2485/200901222. The report is available at www.hiw.org.uk or www.ombudsman-wales.org.uk

How we handled requests for information

One of our key roles as a provider of public assurance is to inform patients, service users and the public about the standards of healthcare in Wales. Therefore, the majority of the information we hold about health services is made available to the public on our website and through our published documents.

We also respond to specific requests for the release of information from members of the public. In doing so, we follow the Welsh Government's Code of Practice on Access to Information[13] and the provisions of relevant laws, including the Freedom of Information Act (FoIA) and the Environmental Information Regulations (EIR), both of which provide individuals with a right of access to official recorded information that we hold. The Data Protection Act (DPA) also provides individuals with the right to access any personal information we hold about them.

During 2010/11, HIW received three requests for information, all of which were considered and responded to within the deadlines set.

How we improved our customer service

We are committed to providing excellent standards of service. During the year we designed and started to roll out a dedicated customer service training programme for our staff. This provided us with the opportunity to work with staff to review our existing arrangements for dealing with enquiries and requests for advice and information from members of the public and others. As a result of this work we are consulting on a proposed new set of customer service standards. You can access these on our website.

How we improved our communications

During the year we developed a new Communications Strategy and Plan. As part of this strategy, we reviewed and made some improvements to our website. We updated sections, used clearer language and added news items more regularly. During the year, the home page[14] of our website was accessed 386,257 times in English and 2,194 times in Welsh and it is clearly a key source of up to date information about our work. In view of this, we have decided to design a new website that will help members of the public access the information they want, when they want it, faster and easier. We will launch our new website in early 2012.

We also introduced a new, quarterly HIW newsletter, designed to keep members of the public and others up to date with our work. We routinely distribute our newsletter to over 500 subscribers as well as publishing it on our website.

If you would like to become a subscriber, please contact us using the details on the inside cover of this report.

[13] Welsh Government Code of Practice on Access to Information. Published 2007. Also available at www.wales.gov.uk
[14] www.hiw.org.uk

How we manage our resources

Our comprehensive programme of organisational development is designed to improve our efficiency through our new ways of working and to deliver the benefits of collaborative working so that we make the best use of our collective resources and minimise any unnecessary burden on health service organisations. Our approach helped us to contribute to the Welsh Government's 'Managing with Less' initiative and helped ensure we operated within our allocated budget.

Targeting our work on what matters most

How is the Health and Wellbeing of the People in Wales?

According to the Chief Medical Officer (CMO)[15], the health of the population of Wales is continuing to improve, with increasing life expectancy and a corresponding reduction in the number of premature deaths (under 65 years) from cancer and circulatory disease. There remain significant differences in health between social groups and local authority areas in Wales and the pace of improvement is still not matching that of the best performing parts of the United Kingdom and Europe. The CMO considers that the key challenge in Wales is to reduce inequities and strive for fairer outcomes for all.

[15] Chief Medical Officer for Wales, annual report 2010. Published October 2011.

In his 2010 report, the CMO highlights a number of key issues, including:

- **There were decreases in the number of men and women that died because of cancers across all ages**

Our Action: Cancer remains a significant challenge. Over the past year, we have continued to focus on cancer services through our work with the Wales Cancer Co-ordinating Group to develop an approach to reviewing compliance with the Welsh Government's Cancer Standards through a new Peer Review programme. Our three year programme 2011-2014 also sets out our plans to review referral pathways for cancer services, focussing particularly on the role GPs play in early identification and referral

- **The improvement in reducing deaths from circulatory disease is not just as a result of effective treatment, it is also due to changes such as reduced levels of smoking and access to better standards of living and nutrition**

Our Action: As the NHS shifts its focus to health promotion, prevention and well-being, so too will aspects of our own work; for example, our new programme of Dignity and Essential Care reviews will routinely consider these aspects

- **One of the hidden non communicable diseases is depression and poor mental wellbeing. There remains a stigma around this and many do not consult with health professionals, friends or family about it**

Our Action: We use the information we collect from the work we carry out, including that provided by our Mental Health Review Service to monitor services in this area, and in particular to report upon the effectiveness of the relationship between mental health services and medical services

- **The health of ex-service personnel in Wales is a significant public issue. Veterans with health conditions related to their service are entitles to priority NHS treatment and care**

Our Action: We continue to support the Ministerial Expert Group for the Armed Forces Community in Wales and in 2011 we will carry out a review to capture the stories and experience of Armed Forces personnel, their families and veterans in accessing health services, and will use the information we gather to help develop and influence specific quality requirements and to improve our own assessment and reporting processes to that we maintain an ongoing focus in this area

The development of our work programme and our decisions on what we should look at, when and how, took account of the work of the Chief Medical Officer and others alongside a range of considerations:

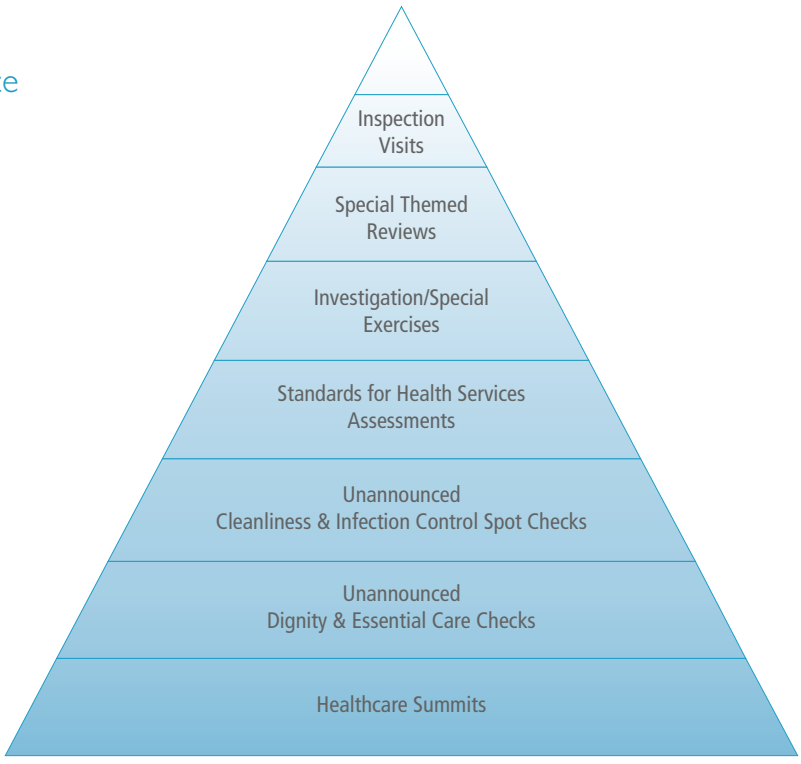
- The fact that some services, by their very nature, always carry risks, either because of the potential vulnerability of the client group or the complex nature of the service
- Our risk profile for a particular service or organisation indicated areas of concern or worrying trends, perhaps as a result of concerns or complaints received
- The outcomes from our previous work identified areas where further work was needed
- Intelligence we have received from other bodies, or the outcomes from other review work
- The service or issue may have been a recognised national priority for healthcare services
- There may have been new standards or quality requirements against which service provision could be assessed to identify improvements
- There may have been a recognised inequality in the provision of healthcare services, or a high proportion of the population may have been affected
- Performance data may have indicated variations in quality or areas of major risk affecting particular sections of the community or areas of Wales
- There may have been significant or increasing public concern
- The impact of our work may have been maximised through joint working with other inspection, audit or review bodies

Further information on all our review work, including the terms of reference for individual reviews together with background information and guidance on how to feed in your views is available on our website.

Health Service Delivery in Wales: what we found in 2010-2011

Our assessment approach

Over the last year we continued to develop and adopt a wide range of approaches to enable us to effectively assess the quality and safety of healthcare provision. In doing so we sought to take a human rights based approach to all our work and to embed active consideration of equality issues in our inspection and investigation tools and techniques.



Our work programme for 2010-2011 incorporated:

- A continuation of our routine regulation, inspection and assurance work designed to fulfil our statutory responsibilities and other priorities
- Continued progress in a number of all Wales assessments targeted at areas of special interest
- Informing and influencing healthcare policy and practice through our contribution to key areas of development
- Follow up work from earlier reviews and inspections

Driving care centred on the needs of patients and service users - ensuring healthcare organisations are fit for purpose

During the year, we maintained a key focus on ensuring that health service organisations are 'fit for purpose', that is that they are effectively governed and well equipped to deliver the health services they are responsible for.

We considered how health services organisations are performing against Doing Well Doing Better: Standards for Health Services in Wales

The Standards for Health Services in Wales[16] set out the Welsh Government's common framework of standards to support health services in providing safe, effective, timely and high quality services across all settings.

The Self Assessment against the standards is a key mechanism for ensuring health service organisations' fitness for purpose. It highlights the progress they have made; identifies where they have practice worth sharing with others and prioritises areas for further development and improvement.

All of the work we carry out during the year helps to inform our assessment of how well organisations are doing against the Standards.

We facilitated the introduction of a new approach to self assessment

During the year, HIW continued to encourage healthcare organisations to self assess their own performance more effectively and further strengthen their internal scrutiny so that they are better equipped to deliver high quality and safe services. We facilitated the development of a new approach to the self assessment of the Standards by working with colleagues from across the NHS in Wales, Welsh Government and other review bodies including the Wales Audit Office.

The new approach to self assessment is 'modular' in design. In 2010/11, NHS organisations carried out their first corporate level assessment of their performance against the Standards using the 'Governance and Accountability' self assessment module. The module provided a framework for health service leaders to consider and to demonstrate to others how well they were governing their organisation. Importantly, the framework provides a clear focus for organisations to identify and priorities areas requiring further development and improvement. Each organisation reported upon its findings as a key element of its 2010/2011 'Statement on Internal Control[17]'.

[16] Doing well Doing Better: Standards for Health Services in Wales. Published by the Welsh Government in April 2010
[17] The Statement on Internal Control (SIC) is a public accountability document that describes the effectiveness of internal controls in an organisation and is personally signed by the Accounting Officer.

The Standards underpin all our activity and we use the results of our overall programme of work during the year to inform our assessment of individual health service organisations.

Key themes arising from the Standards for Health Services assessment

Overall, NHS organisations' first self assessment of their performance against the new Standards for Health Services identified a good level of self awareness of their strengths and a clear focus on where they need to further develop and improve. Unsurprisingly, many of the areas identified as requiring further development related to a need to further embed corporate arrangements following on from the restructure in late 2009 and the formation of the new Health Boards.

The key themes arising from the work we carried out throughout the year largely mirror the areas for further development also identified by organisations themselves in relation to their overall leadership and governance. These include the need for NHS Boards to:

- Continue to work closely with health service staff to create a greater understanding and commitment to the overall strategic direction and vision they have set
- further develop the way in which they work together with the public and other stakeholders across their communities to inform the design and delivery of health services
- Ensure the way in which they organise their functions is clearer and simpler so that decision makers and those who are responsible for checking on performance can do so easily and effectively
- Improve their communication and ways of working so that the different parts of their organisation work well together and learn from each other.
- Ensure leaders, managers and clinical staff are working well together to drive their organisations in the same direction
- Continue to focus on strengthening the capacity, capability and deployment of their workforce so that they are better equipped to provide high quality, safe services at the same time as shifting their overall direction to deliver the strategic vision for the NHS in Wales
- Further embed their internal systems for identifying and addressing risks to the achievement of their objectives
- Continue to improve their arrangements for information and records handling so that leaders, managers and front line staff have access to the information they need when they need it to carry out their jobs effectively
- Further strengthen internal scrutiny and assurance arrangements so that they are better placed to assess their overall organisational performance; respond quickly and effectively to areas of concern and drive overall improvement
- Build on their existing arrangements to share good practice within organisations and beyond, and ensure wider organisational learning takes place in response to concerns and complaints
- Continue to deliver services that maintain patient safety and dignity, even in the older parts of the NHS estate in Wales

The development of HIW's work programme 2011-2014 has taken account of the above themes and our resulting priorities for the next three years enable us to keep these matters under active review.

In particular, the 2011 programme of Healthcare Summits, referred to in Chapter 3 of this report, has provided us with an opportunity, working alongside other inspection, audit, review and improvement bodies, to consider the extent to which organisations are making progress in tackling these issues. We will feed back to organisations the results of this work in early 2012.

We regulated the independent healthcare 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.

Table 1: Table of Independent Healthcare Registered Settings 2009-11

Type of setting	Number of registered providers at 31 March 2009	Number of registered providers at 31 March 2010	Number of registered providers at 31 March 2011
Acute hospitals	7	12	17
Mental health hospitals	22	24	24
Detoxification hospital	1	1	1
Dental hospitals using anaesthesia	3	3	3
Hospices for adults	5	5	6
Hospices for children	2	2	2
Class 3B and 4 lasers/ instense pulsed lights	39	43	45
Hyperbaric oxygen chambers	5	4	4
Independent GPs	1	1	1
Independent clinics	9	8	8
Private dentists	1	1012	1208
TOTAL	95	1115	1319

During the year, we registered 8 new providers, de-registered 15 providers and dealt with 6 variations to registrations. This represents a much more stable position compared to two years ago, where the introduction of registration for private dentists saw our registrations increase by over 1,000. Over the past two years we have also seen the number of Acute hospitals[18] registered more than double from 7 in 2009 to 17, as at March 2011.

[18] The Acute Hospital category includes Acute Hospital, Dental Hospital, Comestic Surgery Hospital, Hospice, IVF, Non Acute Hospital, Termination of pregancy Hospital.

Inspections

During the year we carried out 53 inspection visits of Independent Health Care settings (excluding dentists). We inspected against the requirements set out in regulations and the National Minimum Standards for Independent Health Care Services in Wales[19]. In assessing whether or not a registered setting meets a particular regulatory requirement, we consider if it meets each of the relevant, related standards.

Table 2: Table of Independent Healthcare Inspections undertaken during 2010-2011

Type of setting	Number of Inspections
Hyberbaric	3
Dental Hospitals	1
Acute	6
Independent Clinic	4
Mental Health	19
Laser/IPL	20
TOTAL	53

Reports of our findings in relation to each of these inspections are available on our website.

Overall, we found that the majority of standards were met by the organisations we inspected. However, we also identified a number of common themes arising from our visits:

- In 40% of inspections we found that better patient information should have been provided by the organisation
- In 79% of inspections of Mental Health Hospitals we found issues around care planning, with many settings not documenting whether patient views had been taken into account
- We found that in 37% of the Mental Health hospitals we inspected, and in 50% of Acute hospitals there was a lack of suitable training provided to staff in relation to the 'Protection of Vulnerable Adults' (POVA)
- In three of the four inspections of Independent Clinics we raised issues around the storage and documentation of medicines and found similar issues in two out of the six Acute hospitals inspected

We will be following up on these findings during 2011-2012.

[19]The National Minimum Standards for Independent Health Care Services in Wales - A statement of national minimum standards applicable to independent hospitals, independent clinics, and independent medical agencies made by the Minister for Health and Social Services of the Welsh Government under powers conferred by section 23(1) of the Care Standards Act 2000. The National Minimum Standards were revised in April 2011. The current Standards can be accessed at www.hiw.org.uk.

Inspections of dentists are undertaken on our behalf by the Dental Reference Service (DRS), the organisation that inspects NHS dentists in England in Wales. The Dental Reference Service monitors and makes recommendations on the quality of dental care in England and Wales through a risk-based monitoring system and practice visits. HIW's relationship with the DRS in relation to the inspection of private dentists in Wales is defined within a formal contractual arrangement.

Reviewing notifications of events or incidents that may directly affect the safety of patients

As with NHS organisations, we monitored independent healthcare providers throughout the year, taking into consideration the information and intelligence we received from a variety of sources. This included our own inspection findings and self assessments carried out by providers themselves as well as the valuable information we gained from patients, relatives and carers about their experience of health services.

One of the key elements of our ongoing monitoring activity was our review of events or incidents notified to us throughout the year. Registered persons[20] must formally notify us about a range of specified events or incidents that may directly affect the safety of patients[21].

During the year, we received notification of 102 incidents and 697 deaths. In each case we reviewed the information provided and where we considered it necessary, took further follow up action to ensure that the organisation's response to the individual incident was appropriate.

We continued to focus on the fundamental matters of dignity and respect

In 2009 and early in 2010 HIW carried out a number of unannounced 'Dignity and Respect' spot check visits to wards and departments in hospital across Wales which provided services to older people with a mental health condition.

During 2010-11, HIW received and reviewed the action plans submitted by all healthcare settings that had been subject to a spot check visit. All action plans were published on our website. We shared the findings from our work in this area with the Older People's Commissioner for Wales[22], to inform her report Dignified Care?[23], and we also used the findings to inform our joint review with CSSIW 'Growing old my way: review of the impact of the Older People's National Service Framework (NSF) in Wales' [24].

[20] A person who is the registered provider (a person who runs a service on their own) or the registered manager of an establishment or agency.

[21] Regulation 27 of the Independent Health Care (Wales) Regulations 2002 provided for the notification of events or incidents that may directly affect the safety of patients. The new Independent Health Care (Wales) Regulations 2011 came into force on 5th April 2011. They replaced the 2002 regulations and regulation 27 notifications are now known as regulation 30/31 notifications. Further information on the requirements on independent healthcare registered providers and managers in this respect may be accessed at www.hiw.org.uk

[22] The Older Peoples Commissioner for Wales is a source of information, advocacy and support for older people in Wales and their representatives

[23] «Dignified Care? Published by the Older Peoples Commissioner for Wales in March 2011. www.olderpeoplewales.com

[24] Growing old my way: review of the impact of the Older People's National Service Framework in Wales: a joint report published by CSSIW & HIW, January 2012.

Our findings from this work, together with the work carried out by a number of other organisations including the Older People's Commissioner for Wales, The Patients Association[25], Public Services Ombudsman for Wales and Wales Audit Office show that there are still many issues affecting older people when they are in hospital. This includes concerns around the quality of the patient environment; staff attitudes and behaviour; care planning and provision; fluids and nutrition; personal care and hygiene; medicines management and pain management; activities and stimulation; discharge planning and the management of patients with confusion.

We have therefore reviewed and extended our original spot check approach to ensure a strong focus on the areas of continuing concern. Our new programme of Dignity and Essential Care[26] spot checks began in December 2011 and includes unannounced visits to healthcare settings in the early morning, evening and at night.

We worked to ensure patients and service users in potentially vulnerable situations were safeguarded

We recognise the potential vulnerability of anyone accessing health services and ensure that our routine work programmes, inspection tools and work practices focus on the extent to which health service organisations provide appropriate support to individuals during their involvement with the service. In addition, we deliver a number of key programmes that focus on ensuring the well being and human rights of individuals from specific service user groups are safeguarded.

The functions previously performed in Wales by the Mental Health Act Commission (MHAC) were transferred to us in 2009. These new responsibilities enabled us to develop a sharper focus on these services through our ongoing monitoring of compliance with the Mental Health Act[27] and Deprivation of Liberty Safeguards[28] (part of the Mental Capacity Act[29])

During the year, the work of our Mental Health Review Service has included:

- Visits to patients subject to the powers of the Mental Health Act and
- The provision of a Second Opinion Appointed Doctor (SOAD) service

Our Mental Health Act Visits

Our reviewers undertook 85 visits covering 95 wards within 51 NHS and independent hospitals and units. During these visits, they spoke with patients and staff 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
- Given care and treatment appropriate to her or her needs
- Enabled to lead as fulfilling a life as possible

[25] The Patients Association is a healthcare charity which advocates for better access to accurate and independent information for patients and the public; equal access to high quality health care for patients; and the right for patients to be involved in all aspects of decision making regarding their health care.
[26] Up to date information on our spot checks is available on our website www.hiw.org.uk
[27] Mental Health Act 1983
[28] Deprivation of Liberty Safeguards 2009 The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
[29] Mental Capacity Act 2005 An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.

As in 2009-2010, generally we found that the correct legal processes had been followed when detaining patients. However, we also found many of the same concerns we identified in our previous year's work in relation to the consistent application of the Act and in the overall provision of care and treatment. In particular, we continued to highlight issues around the assessment of a patients capacity to consent to treatment; a need for better communication between GPs and community mental health teams; a tendency in some areas to adopt a 'tick box' approach to informing patients of their rights; and in some cases a lack of stimulating and appropriate therapeutic activities, including access to psychological therapies. We also highlighted a lack of clarity around the status or rights of voluntary patients, particularly based around 'leave' or a decision not to 'grant' leave (whether escorted or unescorted).

We identified that for children and young people, difficulties were sometimes encountered where, due to a crisis, they needed to access suitable services at evenings or weekends.

As a result of efforts to support patients in the community wherever possible, patients are increasingly only admitted to hospital when they are acutely ill. This has led to a more volatile patient mix and heightened pressures on staff. We found that staffing has not always been reviewed to take account of this change in patient profile.

The development of intensive community support services has previously seen occupancy levels within hospitals reducing. During 2010-2011 however, we noted an upwards trend in occupancy levels. This mainly appeared to be arising as a consequence of temporary or permanent closures of wards/units. In order to manage the situation, patients were often "sleeping out" on other wards or being sent on leave. In some areas the lack of beds had led to patients being cared for on wards that were not appropriate to their age or severity of condition, placing additional demands on staff and causing disruption for other patients.

We continue to monitor these issues, and each year we prepare an annual report that gives an account of the work we have undertaken to meet our Mental Health Act monitoring responsibilities. Our report for 2010-2011 will be published in early 2012 and will provide full details of our findings.

The Second Opinion Appointed Doctor Service

The Second Opinion Appointed Doctor (SOAD) service 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. The role of the SOAD is not to give a second clinical opinion in the conventionally understood medical form of the expression, but to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of a patient.

HIW is responsible for managing the SOAD service in Wales. Given the important role that the SOAD plays in ensuring that the treatment individuals (detained under the Act) are prescribed is ethical and in line with national guidelines and best practice, we have set very tight timescales for the visits. Upon receipt of a SOAD request we aim to ensure that a visit takes place within:

- Two working days for a Electro Compulsive Therapy (ECT)[30] request

[30] A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.

- Five working days for an inpatient medication request and
- 10 working days for a Community Treatment Order (CTO)[31] request

We reviewed 901 requests received for SOADs during the year. Of these, 823 were for medication reasons only, 61 were for ECT and 17 were for both. We experienced a number of problems meeting the target timescales particularly in certain areas of Wales and during certain months. As a result, we recruited a number of additional SOADs particularly to cover those areas of Wales, notably the West and North, where we have previously had difficulties identifying available SOADs. This has resulted in significant reductions in the time between receipt of a request and a visit taking place but we are continuing to monitor the situation.

Deprivation of Liberty Safeguards

The introduction of the Deprivation of Liberty Safeguards legislation in 2009 introduced a duty for governments to monitor their implementation and operation. In Wales this duty fell on Welsh Ministers, who delegated the responsibility to CSSIW for social care and HIW for health services.

CSSIW and HIW have worked together to develop a joint approach to monitoring the operation of the Safeguards and to collect and analyse the relevant data, and in March 2011 we published our first Annual Reports[32] setting out the findings of our monitoring activity during the previous year.

Building on our joint approach, we will be publishing early in 2012 a joint report with CSSIW setting out the results of our monitoring activity across health and social care in Wales during 2010-2011.

The outcomes from our monitoring work indicate that the picture across health services is similar to that in 2009-10, and we are continuing to see a variable picture across Wales in relation to the use of the Safeguards.

We are continuing to monitor the application of the Safeguards as a matter of routine and the information we gather will be used to inform the further development of our approach in future years.

Acting upon the findings from our review of arrangements in place across NHS Wales for 'Safeguarding and Protecting Vulnerable Adults'

Following on from the publication of our report 'Safeguarding and Protecting Vulnerable Adults' in March 2010, we wrote to all Health Boards and NHS Trusts about the actions they were taking to implement its recommendations.

We reviewed the information provided to us within individual action plans and concluded that whilst organisational policies were being translated into systems and procedures that delivered good practice to safeguard and protect patients who may be in vulnerable situations, some gaps were still identified. In all cases, action plans required further strengthening, and it is clear that more work was needed in this area.

We are continuing to monitor ongoing progress in this area through our routine work programmes and reviews into areas of special interest.

[31] Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment.

[32] Mental Capacity Act 2005 Deprivation of Liberty Safeguards Annual Monitoring Report for Health 1 April 2009 to 31 March 2010 Published March 2011. Available www.hiw.org.uk

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 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 the year we published our findings in respect of three separate reviews[33].

These findings mirrored many of the common themes and issues identified in earlier reviews. In particular, the implementation of the 'Care Programme Approach (CPA)[34]' remains inconsistent across Wales; there is a need for better communication and improved information sharing between statutory agencies; dedicated services provided by Community Mental Health Teams (CMHT)[35], Crisis Resolution/ Home Treatment(CRHT)[36] and Assertive Outreach Teams[37] require further development; and aftercare arrangements are sometimes inconsistent.

Overall, strong leadership is needed to ensure the arrangements in place to support true multi disciplinary/agency team working and provide appropriate staffing are working effectively.

The recommendations from our individual reports have informed the development of an overview report which will provide more detail around the common themes and concerns identified here. This report will be published early in 2012.

During 2011-2012 we will also be undertaking a review of the effectiveness of risk assessment in mental health through the targeted analysis and evaluation of the information obtained through our routine work.

Deaths in Custody while in Welsh Prisons

During the year we provided clinical advice to the Prisons and Probation Ombudsman (PPO) as part of 14 investigations into deaths in Welsh prisons, an increase from 10 in 2009-10 and six during 2008-9.

We identified a number of common issues arising from our work in 2010-11. These included concerns around the:

- Inadequate screening of prisoners upon arrival and a lack of further screening
- Arrangements for 'handover' when prisoners transfer between prisons
- Poor care planning, monitoring and record-keeping in relation to prisoners' health
- Lack of adequate information provided to prisoners about health matters
- Lack of accessible cells and occupational therapy for disabled prisoners
- Lack of follow-up of issues, e.g., cancellation of test results

[33] All 3 reports are available to the public using the details on the inside cover of this report or at www.hiw.org.uk

[34] Care Programme Approach (CPA) describes the approach used in mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for individuals.

[35] Community Mental Health Teams (CMHT). The team should have workers from different professions, who understand each other's different skills and ways of approaching problems. Most people recover from their mental health problems without coming into hospital, and so the team is usually called a community mental health team .

[36] Crisis Resolution/Home Treatment (CRHT) Crisis resolution and home treatment teams provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units.

[37] Assertive Outreach Teams, known also as 'assertive community treatment teams', provide intensive support for the severely mentally ill people who are 'difficult to engage' in more traditional services

We continue to share this information with relevant bodies with a view to raising standards of healthcare in prisons.

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.

Substance Misuse Services in Wales

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. Originally commissioned by the Welsh Government in 2009/10 to undertake this work, we have continued during the year to assess the adequacy and quality of services provided across Wales.

We held six regional multi-agency conferences to consider how services are currently designed and delivered across Wales. Over 150 people attended the conferences including representatives from all local authorities in Wales, Local Safeguarding Children's Boards, Police, Service Providers, Commissioners, Probation Services , Mental Health services, Social Services, Midwifery services, Protection of Vulnerable Adults (POVA) Teams, Youth Offending Services, Integrated Family Support Teams, Domestic Abuse and other agencies.

We will publish our findings from this review during 2012.

A Joint Review of Youth Offending Services

During the year we reported on our joint review of Youth Offending Services[38] (YOSs) with inspectors from CSSIW and Estyn. The review sought to identify how well education, health and children's services work with YOSs in Wales to improve outcomes for children and young people in the youth justice system. The review took place in parallel with the Core Case Inspection of the Youth Offending programme in Wales led by Her Majesty's Inspectorate of Probation (HMI Probation).

Overall, inspectors from all organisations concluded that YOSs have made good progress since they were last inspected. Leadership and management systems have improved, and education, health and children's services are working better together to deliver better services to children and young people. However, this improvement was inconsistent and further work is needed across services.

A Joint Inspection of Youth Alcohol Misuse and Offending

There is a known link between alcohol misuse and health problems, underachievement in school and offending behaviour. During the year, we reported upon the results of our joint inspection with Care Quality Commission, HMI Probation and Estyn to determine whether youth offending and health services were sufficiently engaged and involved in efforts to reduce the impact of alcohol misuse by children and young people who offend[39].

[38] Joint Review of Youth Offending Services. Published February 2011 available using the details on the inside cover of this report or at www.hiw.org.uk

[39] Message in a bottle. A joint inspection of Youth Alcohol Misuse and Offending Published June 2010 www.hiw.org.uk

We found that YOTs were offering significant and effective health resources where alcohol misuse is seen to relate directly to offending. However, we also found there were too many inconsistencies in the quality of assessments across England and Wales, suggesting children and young people who misuse alcohol are going without the appropriate help at times.

A Joint Inspection of Youth Crime Prevention

This thematic inspection[40] was one of several which, with the Core Case Inspections, form a three year 'Inspection of Youth Offending programme' coordinated by HMI Probation. Led by HMI Constabulary, the review team included inspectors from HMI Probation, the Care Quality Commission (CQC) and HIW.

The review team concluded that there was impressive partnership work in operation and that a common strategic ethos about youth crime was present. However, the challenges should not be underestimated; it was very clear that many children who have been identified as more likely to offend than others were subject to multiple 'risk factors' and their future lives were likely to be adversely affected.

"Growing old my way" A review of the impact of the National Service Framework (NSF) for older people in Wales

The Welsh Government made a commitment to commission a fundamental review of the NSF after two years to assess progress so that its future direction and development could be informed. The aim of our joint review was to answer one fundamental and simple question: What impact is the NSF having on the quality of life of older people in Wales?

We worked together with CSSIW over a period of two years to gather, assess and evaluate available information for this review. The work commenced in 2009-10 and continued through 2010-11. We produced a preliminary report to inform the second phase of the Older Peoples NSF during 2010.

The final report Growing Old my Way[41] published in January 2012 concluded that the NSF has had a positive impact in Wales. Together with the related strategies and the role of the Older People's Commissioner, it has raised the profile of services received by older people in Wales and highlighted the need for them to be treated as individuals and without discrimination.

Our review highlighted that across Wales a number of innovative and valuable services and support mechanisms for older people have been put in place. We were told that schemes and services that worked well were:

- Exercise and activity classes
- Lunch clubs
- Shop and drop internet services
- Television adverts such as the FAST advert for stroke

However, we also found that:

- Primary care practitioners and, in particular, GPs need to be better engaged in a team approach to care and support as their role is critically important in ensuring access to appropriate and timely assessment
- Older people with complex needs often end up in hospital when in reality for many it is the last place they should be

[40] A joint inspection of youth crime prevention Published Sept 2010. Available at www.hiw.org.uk
[41] Growing old my way, Review of the Impact of the National Service Framework (NSF) For Older People in Wales. Published January 2012.

- When older people get admitted to hospital they are there for too long and as a result their independence and confidence is impacted upon

Many of the concerns we identified centred around the fundamental aspects of care, dignity and respect that are essential for anyone accessing health and social care services.

We therefore concluded that the full implementation and consequent benefits of the NSF are a long way off, and health and social care still have a lot to do in terms of refocusing their approach and agenda to one of prevention and empowerment. What is needed is better collaboration between health, local authorities and third sector organisations to deliver the changes, rather than writing more policies, strategies and NSFs.

Our programme of unannounced visits focusing on 'Dignity and Essential Care' will enable us to continually monitor the extent to which health services are tackling this agenda across Wales.

We continued to drive improvement in the environment of care

During the year we continued to roll out our programme of unannounced visits to healthcare settings focusing on cleanliness and infection control. We visited every health board and one independent hospital, covering 22 wards and including a wide variety of services[42].

On the majority of the wards we visited we found an acceptable or good standard of cleanliness. We identified areas of noteworthy practice in many wards, in particular:

- The promotion of good infection prevention and control, with wards displaying the results of hand hygiene checks and providing good infection control information for patients, visitors and staff
- Clear evidence of regular 'preventative' checks being undertaken, e.g., in relation to legionella, or the need for curtain changes

However, we also identified a number of common themes, in particular:

- Commodes were not always being cleaned to an acceptable standard
- Storage space is a continuing issue, with a number of wards either lacking sufficient storage space or not utilising the space that they do have effectively
- Clinical waste bins were sometimes unlocked in areas that were accessible to both patients and the public

Our programme included a number of follow up visits to wards where we had previously identified areas of concern. We found that on our return a number of the issues we identified had been addressed and that staff had worked hard in order to achieve this.

Being treated by suitably qualified and trained staff

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 (LSA) for Wales, for exercising general supervision over all midwives practicing in Wales.

[42] Reports on each visit are available using the contact details on the inside cover of this report, or by visiting our website www.hiw.org.uk .

The LSA supports midwives through a model of supervision that aims to protect the public by pro-actively supporting midwives to provide a high standard of midwifery care with an informed choice for women.

The LSA oversees midwives practising across the seven health boards that provide NHS maternity services, as well as a small number of self-employed midwives who provide independent midwifery services in Wales. Health boards are diverse in the type of services they offer, ranging from acute obstetric units to birth centres, but midwife-led care and initiatives to promote birth to be as normal an event as possible, where medical intervention is minimised, remain prominent in each.

As at 31 March 2010 1678 midwives notified an intention to practice midwifery in Wales for the year ahead, and there were 149 Supervisors of Midwives in Wales.

Table 3: Ratio of Supervisors of Midwives (SoMs) to midwives in each maternity services provider as at 31 March 2010

Health Board	Number of midwives	Number of supervisors	Ratio supervisors to midwives
Abertawe Bro Morgannwg University	290	26	1:11
Aneurin Bevan	290	26	1:11
Betsi Cadwaladr University	372	24	1:15
Cardiff and Vale University	270	23	1:11
Cwm Taf	225	23	1:9
Hywell dda	176	22	1:8
Powys	41	5	1:5
TOTAL (All Wales)	1678	149	1:11

On an all-Wales basis the LSA met the NMC standard of one SoM to a maximum of 15 midwives; the actual ratio as at 31 March 2010 was 1:11. With the exception of Betsi Cadwaladr University Health Board all maternity providers were well within the NMC standard of 1:15, with five out of the seven health boards working at a ratio of 1:12 or below. During the year, the LSA has worked closely with Betsi Cadwaladr University Health Board to reduce the ratio and to support those SoMs with a higher caseload.

Each year NHS organisations are required to compile an annual report to the LSA setting out how they have met the requirements set annually by the NMC. This includes indentifying areas of good practice where SoMs have influenced service change as well as areas of challenge and how this will be managed locally. We used the local report submissions from NHS organisations when preparing our overall LSA Annual Report[43] to the NMC.

The review work carried out by our LSA team in 2010-11 confirmed that the standards for statutory supervision of midwives set by the Nursing and Midwifery Council were achieved.

As SoMs are often practising midwives, they are busy undertaking their 'day job' across wards and in the communities they serve. Taking on the additional responsibility as SoM is therefore a significant commitment. The work carried out by our LSA team during the year highlighted that there was a strong network of SoMs within all providers of maternity services 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 are maintained in times of financial stringency.

Throughout the year, SoMs in Wales have been instrumental in leading a number of initiatives aimed at enhancing midwifery practice and care for women. Individual providers of maternity services are proactive in taking measures to identify trends and make changes in practice to improve care and outcomes for women and babies and through their local organisational reports, identified the good practice in several areas.

The LSA team plan to further improve the sharing of good practice by producing a regular newsletter and arranging regional workshops so that SoMs from across Wales can share their experiences and learning with others. In addition, the team continues to address the challenges in securing a strong supervisory practice by raising awareness at health board level of the value of statutory supervision of midwives in the management of risk, and gaining the necessary support from Nurse Directors and Board members to ensure that tightening resources do not impede the effectiveness of supervision.

The LSA team are preparing for their triennial Nursing and Midwifery Council review in March 2012 and will aim to demonstrate ongoing innovation and improvement.

Overall, we noted a decrease in the number of home births in 2010-11 (1348) compared to 2009/10 (1547). Statistics[44] for the year also show a very slight increase of Caesarean sections in Wales 25% in 2010/11 compared to 24.8% in 2009/10. We will continue to monitor these trends especially in respect of the changes in NICE Guidelines[45] on caesarean sections which may result in a shift in these figures at a time where the Welsh Government is encouraging midwife led care.

[43] Local Supervising Authority (LSA) Annual Report to the Nursing and Midwifery Council 1 April 2010 - 31 March 2011. Published August 2011

[44] Key health statistics available at www.wales.gov.uk/statistics

[45] NICE Clinical guideline CG132 updated November 2011 www.nice.org.uk

The LSA is routinely notified of significant untoward clinical incidents in order to consider whether substandard midwifery practice contributed to the incident. All providers of maternity services in Wales have policies in place to ensure serious clinical incidents are reported, reviewed and corrective actions implemented as required. During the year the LSA team reviewed notifications of 71 clinical incidents, an increase from 57 in 2009-10. The team also reviewed information in relation to ten maternal deaths, again an increase from five in 2009-10, and concluded that in all cases (which were all from different health boards), poor midwifery care was not a factor.

Ionising Radiation (Medical Exposures) Regulations

Since 1st December 2009 HIW has been responsible for monitoring the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 (and its subsequent amendments) through a programme of assessment and inspection of clinical departments that use ionising radiation in their work.

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
- Ensure that patients receive no more exposure than is necessary to achieve the desired benefit within the limits of current technology
- Protect volunteers in medical or biomedical, diagnostic or therapeutic research programmes and those undergoing medico-legal exposures

Given the specialist nature of this area of work, we work with the Health Protection Agency (HPA)[46] to ensure we have access to expert advice to support both the inspection and investigation elements of our work in this area.

During the year, we reviewed the notifications received in respect of 26 incidents involving "exposure much greater than intended" from across six health boards, one NHS Trust and one independent Hospital. The majority of cases were caused by administrative errors leading to the incorrect patient undergoing an X ray or CT scan or the incorrect procedure being carried out. We considered whether these cases had been properly investigated and whether remedial action was taken as necessary by the organisation. Two of our incident reviews subsequently resulted in an inspection of the hospital. The results of our individual inspections have been published on our website.

In general, we had few immediate concerns from our review of the notifications we received. However, we will be undertaking further work with healthcare providers to improve the consistency of reporting of 'exposure greater than intended'. This will help to ensure that we hold an accurate all Wales picture of the incidents taking place.

[46] The Health Protection Agency's role is to provide an integrated approach to protecting UK public health through the provision of support and advice to the NHS, local authorities, emergency services, other arms length bodies, the Department of Health and the devolved administrations

Nurse Agencies

During 2010/11 Welsh Health Supplies awarded new contracts to supply agency nurses, healthcare assistants and operating department practitioners to the NHS in Wales. We are working together with CSSIW to develop an approach to assessing the delivery of work in this area and expect to introduce new arrangements in 2012.

Controlled drugs

The Controlled Drugs (Supervision of Management and Use) (Wales) regulations 2008 established clear requirements for the safe and effective handling of controlled drugs. During 2010/11 we continued to monitor these arrangements using a collaborative approach among a range of regulatory partners and national agencies. We also published a list of accountable officers[47].

Special Reviews

We may undertake special reviews of healthcare organisations or services in response to concerns that may arise from a particular incident or series of incidents. The scale and nature of any special review work depends upon the seriousness or frequency of these.

During the year, we started work on two special reviews, one focusing on the governance arrangements put in place by Cwm Taf Health Board and the other looking into mental health services provided at a hospital within Abertawe Bro Morgannwg University Health Board.

Work has continued throughout 2011 and we will publish reports of our findings from these reviews early in 2012.

[47] A copy of the list of accountable officers is available by contacting us at the address on the inside cover of this report or at www.hiw.org.uk

Driving improvement through our work

Making a difference

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

Reports on health providers and services	Leading and contributing to workshops and training events	Facilitation of healthcare summits	Input to conferences and exhibitions
Investigation reports	Our annual report	Reports into areas of special interest	Contributing to consultations
Agreements and protocols for inter-agency collaboration	Methods for inspection, investigation and review	Briefings for Ministers and Evidence to committees	Registers of healthcare providers

Encouraging change through our Publications

One of our key tools for driving improvement is our reports and other publications. By making them available to patients, service users, carers, their families and the public more generally, we aim to empower all those who access or who have an interest in health services to ask their own health service providers about their individual care and about the quality and safety of health services more generally in their local areas and communities.

By distributing our reports to all health service providers and delivery partners we aim to encourage them to use the findings to consider how well they are doing in relation to the services they provide and to use the results to drive further improvement.

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.

You can see a full list of the reports we published in 2010-2011 at Appendix B, or visit our website to access the full reports.

Following up on our findings

Publishing the reports is not the end of our work. We require organisations to produce action plans and we encourage change by working with organisations to support them to improve.

We work closely with officials in the Welsh Government's Department for Health, Social Services and Children so that progress with the implementation of our recommendations is monitored and managed through their performance management arrangements for the NHS in Wales. We may ourselves revisit organisations or services to ensure that suitable progress is being made.

We may also decide to undertake more focused or detailed work in future work programmes, as we have done so during the year in relation to matters of cleanliness; dignity and respect and safeguarding and protecting adults.

Influencing healthcare policy and practice

At an all Wales level, we continued to inform the development of healthcare policy and practice in Wales through a range of activities. As well as the publication of our reports during the year:

- We provided independent advice to Welsh Ministers through a range of briefings
- We provided oral and written evidence to four Welsh Committees and General Medical Council committees
- Between September 2010 and March 2011, we responded to 16 consultations from a range of organisations including the Welsh Government, General Medical Council, Health and Safety Executive, HMI Prisons, HMI Constabulary, Royal Colleges, the General Dental Council and the Office of the Health Professions Adjudicator
- We contributed to a wide range of conferences, seminars, exhibitions and working groups across Wales, the UK and beyond

We also continued to provide specific advice and input throughout the year to inform the Welsh Government's policy development in relation to health services and contributed to the development of relevant standards and quality requirements. In particular:

- We supported Baroness Findlay's work on behalf of the Minister for Health and Social Services to develop quality requirements for palliative care through the Palliative Care Implementation Board. The Quality Standards for End of Life Care[48] set out the minimum that anyone nearing the end of their life should be able to expect from a service, whatever their age, and those who are care for them
- We worked with the Wales Cancer Co-ordinating Group to develop a new Peer Review Programme to review compliance with the Cancer Standards. This work is continuing throughout 2011-2012
- We started work on a project to support the Expert Group on the Armed Forces Community in Wales by working together with service organisations and charities to capture the stories and experiences of Armed Forces personnel, their families and veterans in respect of the adequacy and availability of health provision; access to health services and the effectiveness of priority treatment provision for veterans; and overall experiences when using healthcare services. This work is continuing throughout 2011-2012
- We worked with Health Service regulators from across the UK in relation to the role of regulators in supporting the new arrangements established by the General Medical Council (GMC) for the revalidation of all doctors in the UK. This work is continuing throughout 2011-2012

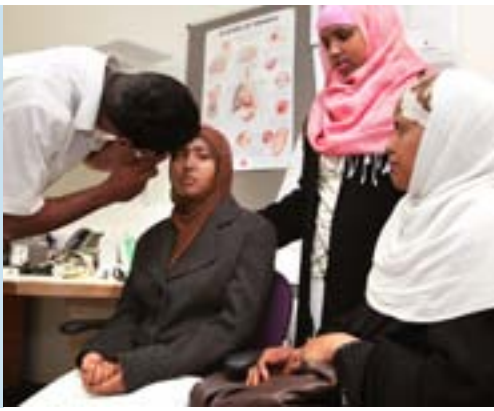
[48] More information can be found on this work at www.wales.nhs.uk/palliativecare

A stronger force for change through Healthcare summits

During the year, we further developed and facilitated an annual programme of healthcare summits, each one designed to focus on a particular NHS health board or Trust in Wales. The summits involved health and social care review bodies and improvement agencies working across Wales, and 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.

The summits provided us with a clear framework for the production of a more integrated plan for assurance and improvement. They enabled us to focus on the key areas of concern or challenge affecting NHS organisations in Wales with the aim of more effectively targeting and co-ordinating our respective work programmes to maximise our impact on driving improvement.

The number of participating organisations and levels of involvement in the Summit process is being extended in 2011-2012. For the first time, we will also be discussing the outcomes of our summit programme with NHS leaders.



Looking to the Future

The integrated systems of health boards and trusts in Wales aim to deliver partnerships that meet the health needs of people across communities, encouraging cooperation rather than competition in delivering public services. The different emphasis in England and future plans to grant budgetary control to GPs is likely to continue to have an effect, especially on cross border referrals for specialist health services.

The Department of Health are intending to transfer the functions of the Human Fertilisation and Embryology Authority (HFEA) and the Human Tissue Authority (HTA) by the end of this current Parliament (2014/15). The Department of Health are currently considering the practicalities and legal implications of dividing the functions between a new research regulator, the Care Quality Commission and the Health and Social Care information Centre. HIW continues to watch these changes with interest so that we can consider the implications for the services in Wales as well as our own operations.

For the independent healthcare sector in Wales, the introduction in April 2011 of new regulations and associated standards in Wales further establishes the divergence of the regulatory framework for independent healthcare across the UK, bringing with it particular challenges for providers operating across borders.

Further proposed legislative changes for the registration of private dentists in Wales will significantly impact on our work. A shift from the registration of individual dentists to the registration of dental practices will enable us to add more value through our inspection activity.

In early November 2011, the Minister for Health and Social Services launched the Welsh Government's new 5 year vision for the NHS in Wales: Together for Health. This vision is based around community services with patients at the centre, and places prevention, quality and transparency at the heart of healthcare. The document outlines the challenges facing the health service and the actions necessary to ensure it is capable of world-class performance.

This is a landmark document for the NHS in Wales and we will be ensuring that HIW's work programme over the coming years reflects and responds to the shifting pattern in how services are delivered.

Our work in 2011-12 and beyond

In August 2011 we published our Three-Year Work Programme 2011-14 which outlines our aims to respond to the key areas of concern facing patients, service users, the public and key stakeholders (including health service organisations) in these challenging times. In it we emphasise that the scope and approach to our work will be kept under review to ensure that we are focussed on those aspects that matter most to the citizens of Wales.

One example of this was the earlier introduction of our programme of unannounced visits to establishments providing services for those who may be in particularly vulnerable situations or who may be at particular risk. Responding to public concern arising from the airing of a BBC Panorama programme which identified abuse in a UK specialist hospital providing care and rehabilitation to adults with learning difficulties, we started our unannounced visits in July 2011. These will continue throughout the year.

We will continue to shift the balance of our own work so that we look at front line services delivered within primary and community care settings and not just hospitals - in line with the Welsh Government's own ambitions to focus strongly on health prevention, promotion and the provision of primary and community care. In doing so, we will consider how our own inspection approaches need to develop further to reflect healthcare provision across all settings, including healthcare provided 'at home'.

We will match the design and timing of our work programmes to enable us to consider the impact and effectiveness of key developments in healthcare policy and practice introduced by the Welsh Government, e.g., the Rural Health Plan[49], the Mental Health (Wales) Measure[50] and Carers Strategy (Wales) Measure[51], as well as key themes and priorities identified within the NHS Wales Annual Qualify Framework (AQF).[52]

[49] Rural Health Plan - a Rural Health Plan has been developed to ensure that the future health needs of rural communities are met in Wales. It can be accessed at http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth

[50] Mental Health (Wales) Measure 2010 makes a number of important changes to the current legislative arrangements in respect of the assessment and treatment of people with mental health problems..

[51] Carers Strategy (Wales) Measure places a duty on the NHS and Local Authorities in Wales to work jointly to prepare, publish and implement a strategy for carers.

[52] NHS Wales Annual Quality Framework

We will encourage healthcare organisations to self assess their own performance more effectively and further strengthen their internal scrutiny so that they are better equipped to 'get it right first time every time' or to identify and respond quickly and effectively to issues affecting the quality and safety of services. We will do this by using the framework established by Doing well, doing better: Standards for Health Services.

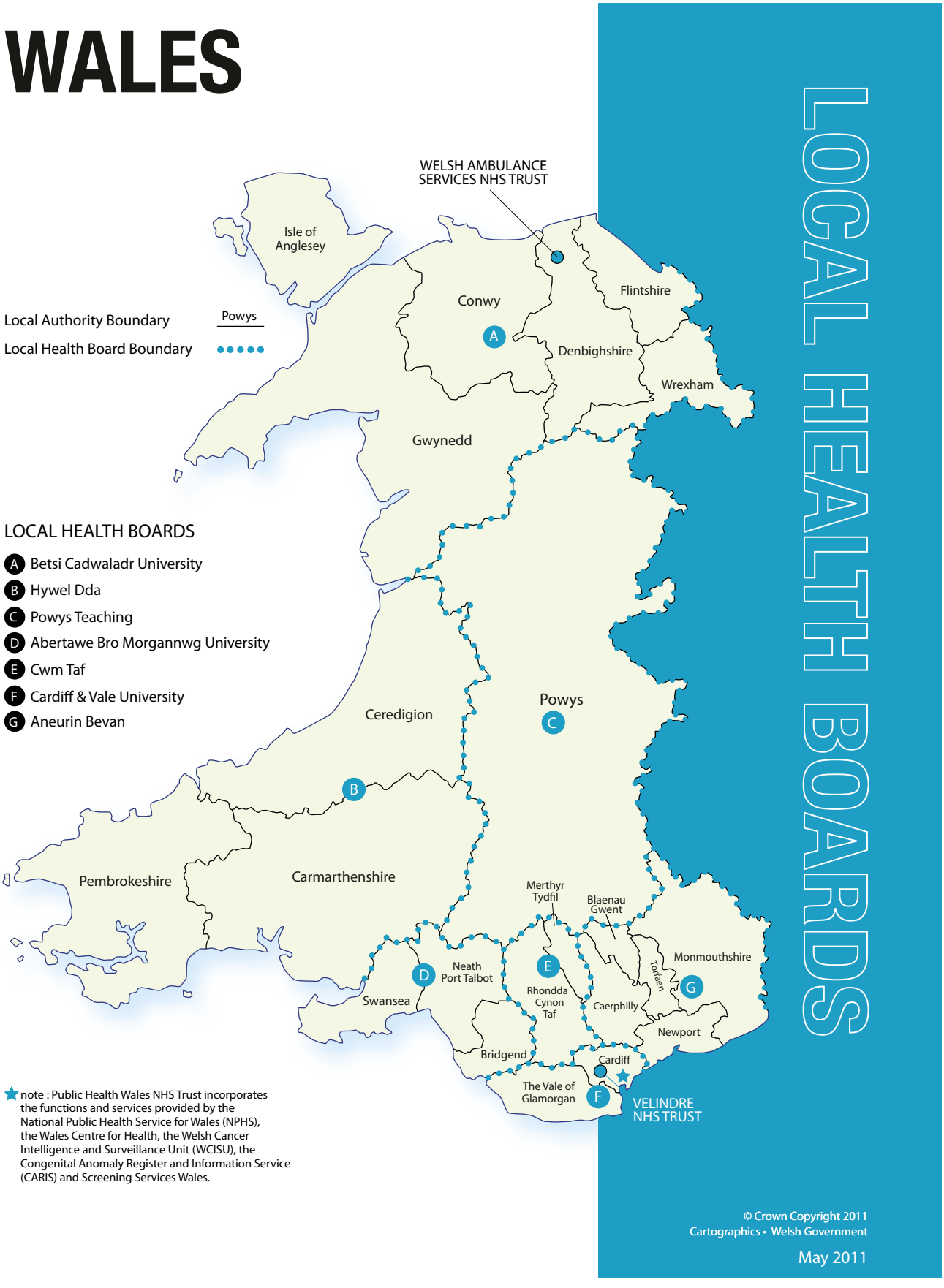
We will engage and involve healthcare professionals more in our work in order to foster an environment of sustained self improvement in the quality and safety of healthcare provision. We will do this by adopting a range of approaches including direct involvement of healthcare professionals in the design and delivery of our own review programmes so that they may also be used as self assessment tools.

We will further strengthen our collaborative approach - focusing particularly on the path from the 'diagnosis' of problems or weaknesses in service provision to 'improvement' action - developing stronger links with support and improvement agencies so that healthcare organisations are able to access the help and support they need to make the changes they need to.

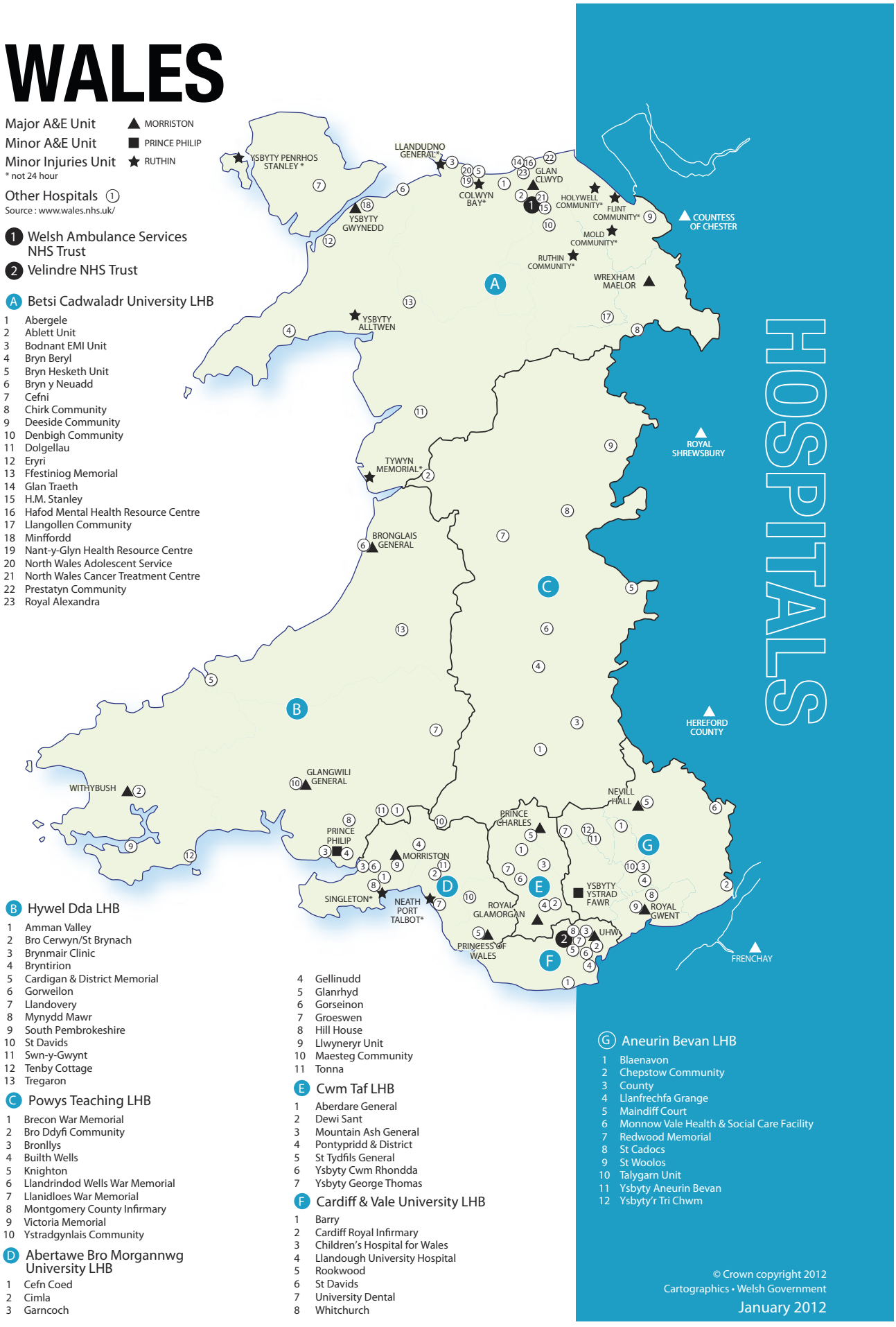
We will avoid 'over' diagnosis of problem areas. Where others have already identified issues affecting the quality and safety of healthcare, our focus will be to build on that work rather than repeating it. This may mean for example, carrying out a more detailed assessment into a particular aspect or following up at a later stage to determine if improvements have been made.

Our website provides further information on all our activities, including the terms of reference for individual reviews along with background information and guidance on how you can feed in your views.

Appendix A: Healthcare Maps



WALES



January 2012

Independent Healthcare

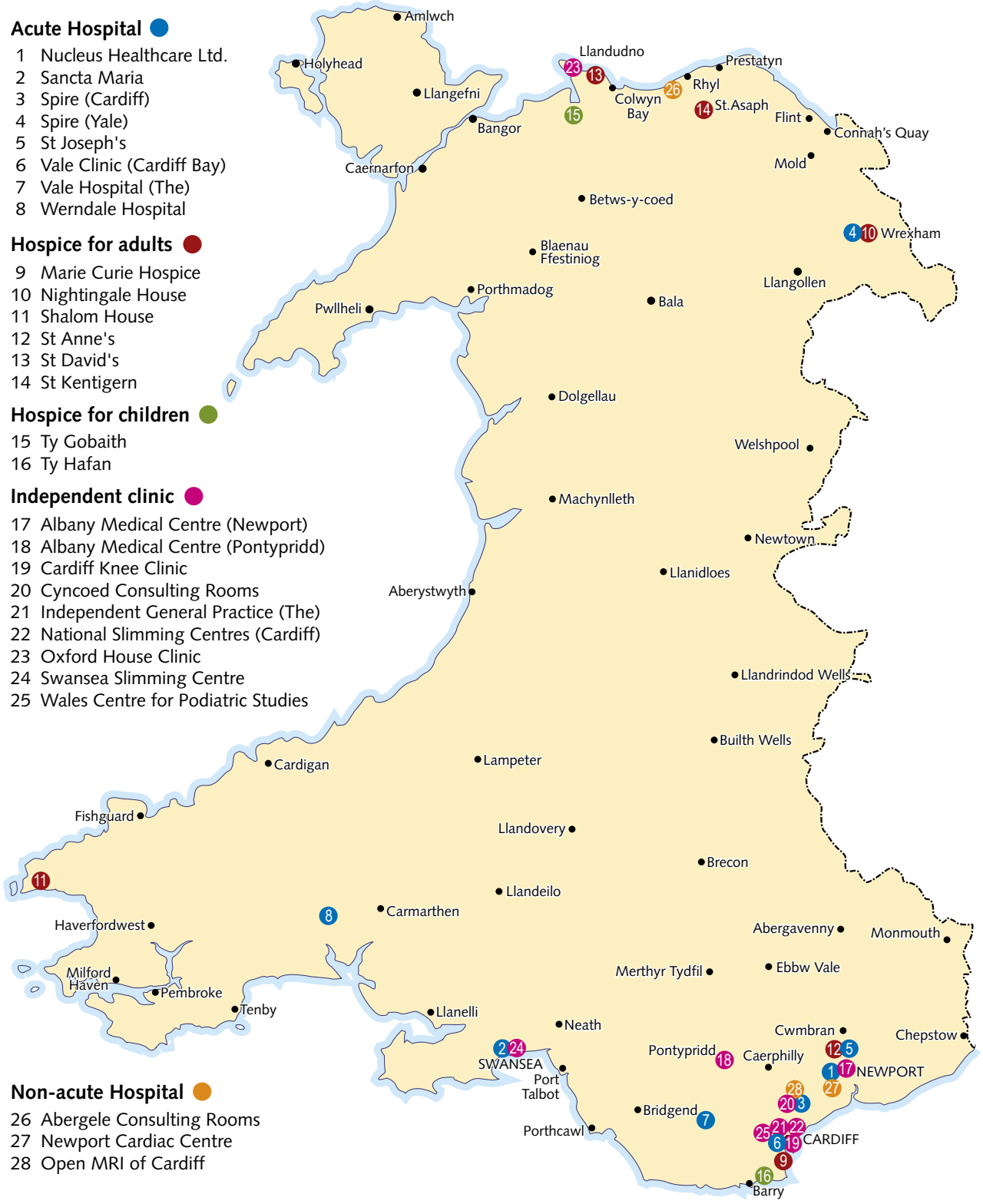
MAP 1

Acute Hospital
1 Nucleus Healthcare Ltd.
2 Sancta Maria
3 Spire (Cardiff)
4 Spire (Yale)
5 St Joseph's
6 Vale Clinic (Cardiff Bay)
7 Vale Hospital (The)
8 Werndale Hospital

Hospice for adults
9 Marie Curie Hospice
10 Nightingale House
11 Shalom House
12 St Anne's
13 St David's
14 St Kentigern

Hospice for children
15 Ty Gobaith
16 Ty Hafan

Independent clinic
17 Albany Medical Centre (Newport)
18 Albany Medical Centre (Pontypridd)
19 Cardiff Knee Clinic
20 Cyncoed Consulting Rooms
21 Independent General Practice (The)
22 National Slimming Centres (Cardiff)
23 Oxford House Clinic
24 Swansea Slimming Centre
25 Wales Centre for Podiatric Studies



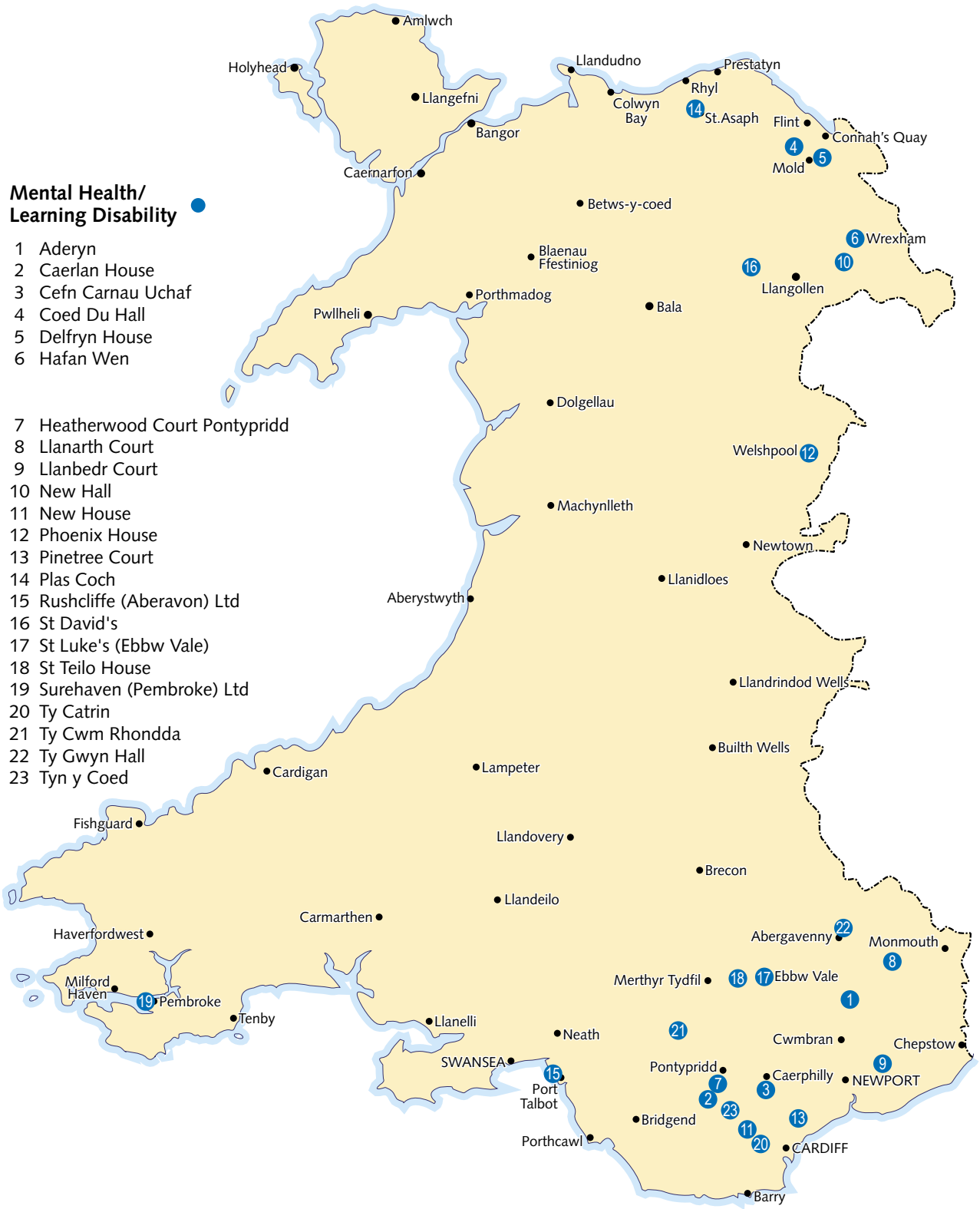
Non-acute Hospital
26 Abergele Consulting Rooms
27 Newport Cardiac Centre
28 Open MRI of Cardiff

Cartographics • Welsh Government
ML/10/11.12

July 2011

Independent Healthcare

MAP 2

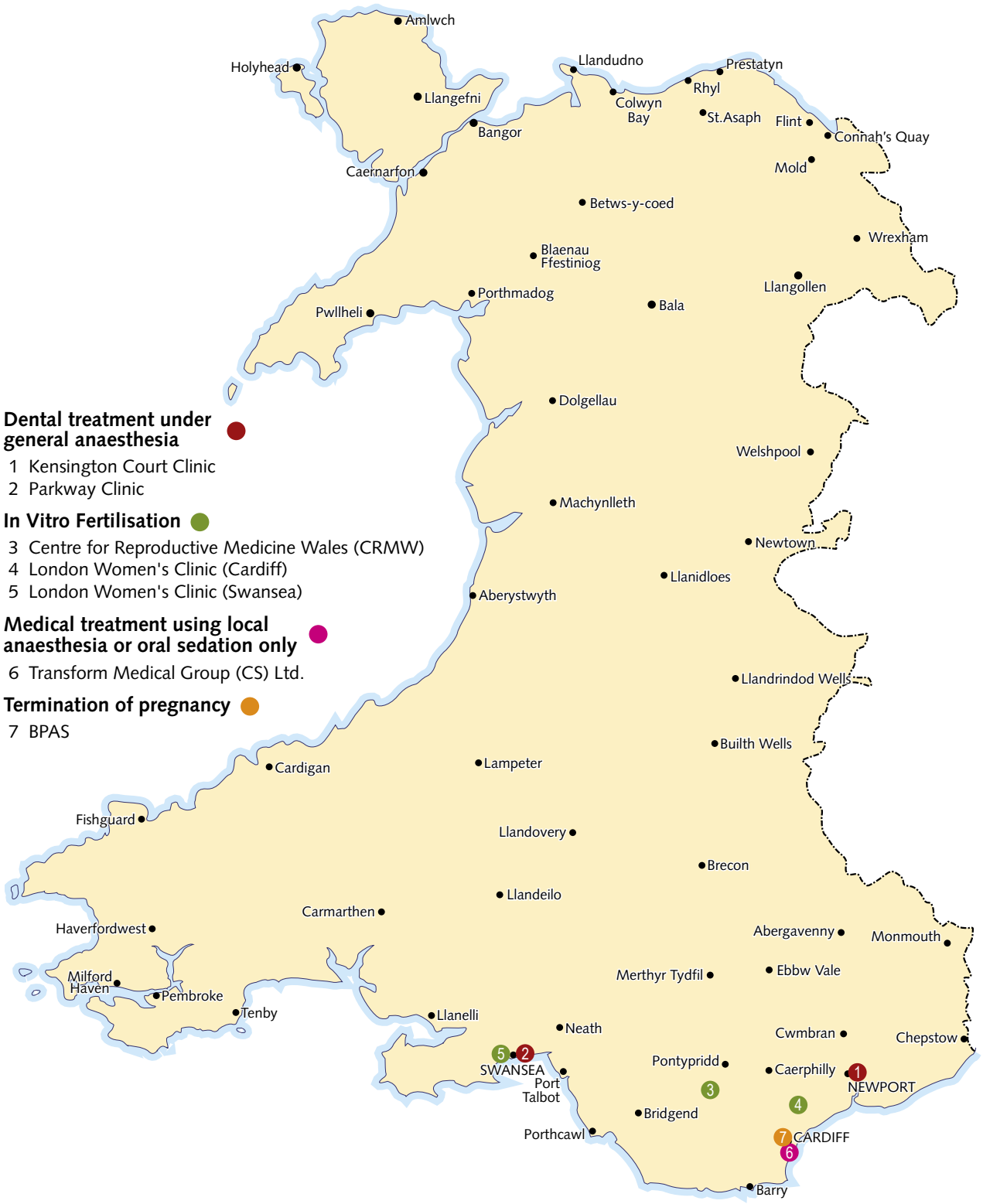


Mental Health/ Learning Disability

1 Aderyn
2 Caerlan House
3 Cefn Carnau Uchaf
4 Coed Du Hall
5 Delfryn House
6 Hafan Wen
7 Heatherwood Court Pontypridd
8 Llanarth Court
9 Llanbedr Court
10 New Hall
11 New House
12 Phoenix House
13 Pinetree Court
14 Plas Coch
15 Rushcliffe (Aberavon) Ltd
16 St David's
17 St Luke's (Ebbw Vale)
18 St Teilo House
19 Surehaven (Pembroke) Ltd
20 Ty Catrin
21 Ty Cwm Rhondda
22 Ty Gwyn Hall
23 Tyn y Coed

Independent Healthcare

MAP 3



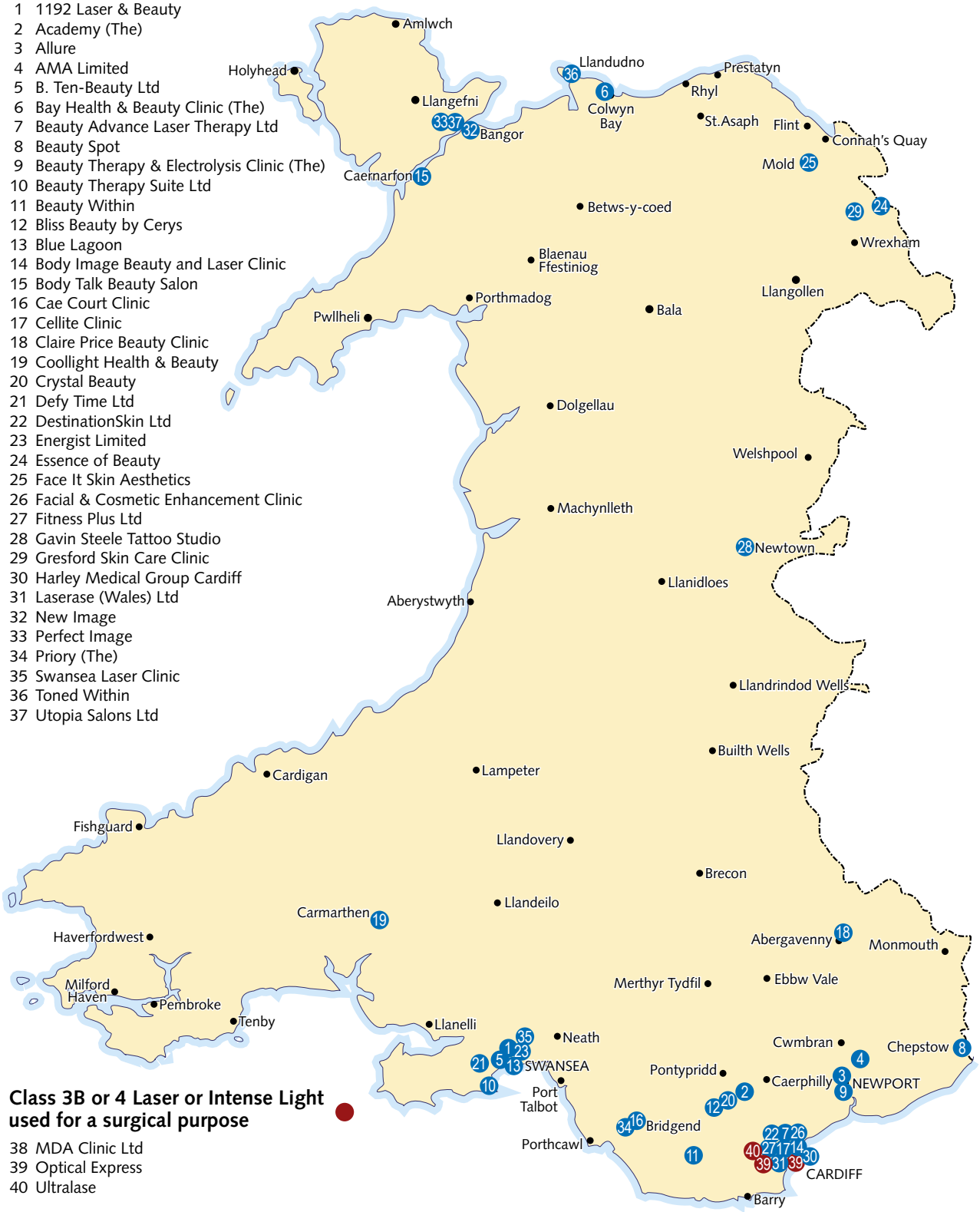
July 2011

Independent Healthcare

MAP 4

Class 3B or 4 Laser or Intense Light used for a non surgical purpose

1 1192 Laser & Beauty
2 Academy (The)
3 Allure
4 AMA Limited
5 B. Ten-Beauty Ltd
6 Bay Health & Beauty Clinic (The)
7 Beauty Advance Laser Therapy Ltd
8 Beauty Spot
9 Beauty Therapy & Electrolysis Clinic (The)
10 Beauty Therapy Suite Ltd
11 Beauty Within
12 Bliss Beauty by Cerys
13 Blue Lagoon
14 Body Image Beauty and Laser Clinic
15 Body Talk Beauty Salon
16 Cae Court Clinic
17 Cellite Clinic
18 Claire Price Beauty Clinic
19 Coollight Health & Beauty
20 Crystal Beauty
21 Defy Time Ltd
22 DestinationSkin Ltd
23 Energist Limited
24 Essence of Beauty
25 Face It Skin Aesthetics
26 Facial & Cosmetic Enhancement Clinic
27 Fitness Plus Ltd
28 Gavin Steele Tattoo Studio
29 Gresford Skin Care Clinic
30 Harley Medical Group Cardiff
31 Laserase (Wales) Ltd
32 New Image
33 Perfect Image
34 Priory (The)
35 Swansea Laser Clinic
36 Toned Within
37 Utopia Salons Ltd



Class 3B or 4 Laser or Intense Light used for a surgical purpose

38 MDA Clinic Ltd
39 Optical Express
40 Ultralase

Appendix B: List of publications[1] resulting from activity 2010-2011

Category	Publication Title
Cleanliness Spot Check	Abertawe Bro Morgannwg University Health Board Unannounced Cleanliness Spot Check Morriston Hospital
Cleanliness Spot Check	Aneurin Bevan Health Board Unannounced Cleanliness Spot Check Report The Royal Gwent Hospital
Cleanliness Spot Check	Betsi Cadwaladr University Health Board Unannounced Cleanliness Spot Check Report Ysbyty Gwynedd
Cleanliness Spot Check	Cardiff and Vale University Health Board Unannounced Cleanliness Spot Check University Hospital of Wales and Llandough Hospital
Cleanliness Spot Check	Cwm Taf Health Board Unannounced Cleanliness Spot Check The Royal Glamorgan Hospital
Cleanliness Spot Check	Hywel Dda Health Board Unannounced Cleanliness Spot Check West Wales General Hospital
Cleanliness Spot Check	Powys Teaching Health Board Unannounced Cleanliness Spot Check Report Machynlleth Community Hospital
Cleanliness Spot Check	Spire Cardiff Hospital Unannounced Cleanliness Spot Check
Homicide	Report of a review in respect of Mr G and the provision of Mental Health Services, following a Homicide committed in May 2009
Homicide	Report of a review in respect of Mr F and the provision of Mental Health Services, following a Homicide committed in December 2008
Mental Health	Protection for people with mental incapacity - first annual reviews published
Local Supervising Authority (LSA)	Annual Report 2009 -2010
Local Supervising Authority (LSA)	Annual Report to the Nursing and Midwifery Council 2010-2011
Joint Report	Joint review of Youth Offending Services (YOSs)
Joint Report	A Joint Inspection of Youth Crime Prevention

[1] All reports are available using the contact details on the inside cover of this report. An online version of this list is also available with links to each report at www.hiw.org.uk

Category	Publication Title
Joint Report	Message in a Bottle A Joint Inspection of Youth Alcohol Misuse and Offending
Joint Working	Developing Our Work Together in a Climate of Change - A paper on inspection, audit and regulation in Wales prepared by Care & Social Services Inspectorate Wales (CSSIW) Estyn HIW and Wales Audit Office
Joint Working	Working Collaboratively to Support Improvement - A Strategic Agreement between Care & Social Services Inspectorate Wales (CSSIW) Estyn, HIW and Wales Audit Office
Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)	Powys Teaching Health Board: Ionising Radiation (Medical Exposure) Regulations 2000 and the Ionising Radiation (Medical Exposure) Amendment Regulations 2006 (IR(ME)R)
Independent Clinic	Oxford House Clinic
Independent Clinic	Swansea Slimming Centre
Independent Clinic	Albany Medical Centre, Newport
Independent Clinic	Albany Medical Centre, Pontypridd
Hyperbaric Oxygen Treatment	Multiple Sclerosis Support Centre
Hyperbaric Oxygen Treatment	South Wales Multiple Sclerosis Therapy Centre
Hyperbaric Oxygen Treatment	Hope MS Therapy Centre
Dental Hospitals	Parkway Dental Hospital
Acute Hospitals	Yale Hospital
Acute Hospitals	Werndale Hospital
Acute Hospitals	Sancta Maria Hospital
Acute Hospitals	Abergele Consulting Rooms
Acute Hospitals	St Joseph's Independent Hospital
Mental Health Hospitals	St Luke's Independent Hospital

Category	Publication Title
Mental Health Hospitals	Llanarth Court Independent Hospital
Mental Health Hospitals	Ty Gwyn Hall
Mental Health Hospitals	Ty Catrin
Mental Health Hospitals	Heatherwood Court
Mental Health Hospitals	Coed Du Hall
Mental Health Hospitals	Delfryn House
Mental Health Hospitals	Plas Coch
Mental Health Hospitals	New Hall Independent Hospital
Mental Health Hospitals	Ty Cwm Rhondda
Mental Health Hospitals	Llanbedr Court
Mental Health Hospitals	Hafan Wen
Mental Health Hospitals	Phoenix House
Mental Health Hospitals	Rushcliffe Independent Hospitals (Aberavon)
Mental Health Hospitals	Caerlan House
Mental Health Hospitals	Aderyn
Mental Health Hospitals	St Davids Hospital
Mental Health Hospitals	Cefn Carnau Uchaf
Laser/IPL	Toned Within
Laser/IPL	Defy Time
Laser/IPL	Allure Skin and Beauty
Laser/IPL	FACE Advanced Facial and Cosmetic Enhancement Clinic
Laser/IPL	The Bay Health and Beauty Clinic

Category	Publication Title
Laser/IPL	Crystal Beauty
Laser/IPL	Utopia Salons Limited
Laser/IPL	The Beauty Therapy and Electrolysis Clinic
Laser/IPL	Beauty Advance Laser Therapy
Laser/IPL	B.ten Beauty Limited
Laser/IPL	Beauty Within Medi Spa
Laser/IPL	Destination Skin
Laser/IPL	Gavin Steele Tattoo Studio
Laser/IPL	Laserase (Wales) Limited
Laser/IPL	The Priory
Laser/IPL	West Wales Aesthetics and Laser Clinic
Laser/IPL	Essence of Beauty
Laser/IPL	Body Talk Ltd
Laser/IPL	Beauty Therapy Suite
Laser/IPL	Perfect Image
Newsletter	HIW Newsletter - October 2010
Newsletter	HIW Newsletter - June 2010
Newsletter	HIW Newsletter - January 2011