Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Healthcare Inspectorate Wales

Annual Report

2012-2013

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Foreword

I have pleasure in presenting this 2012-2013 annual report of Healthcare Inspectorate Wales (HIW), my first such report as Chief Executive. 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 2012-2013 as well as looking forward to the challenges ahead. In so doing, it reports upon a period when HIW was led by its former Chief Executive, Dr Peter Higson, OBE. I would like to thank Dr Higson for his stewardship of HIW from its introduction in 2004 as an NHS inspectorate through to its wide ranging role today as the independent regulator and inspectorate for all healthcare in Wales.

Throughout 2012-2013 the environment within which HIW operates underwent significant and rapid change. The NHS in Wales continued to respond to significant pressures brought about by an ageing population, the financial climate and service reconfiguration, all of which have the potential to increase the level of risk to the quality and safety of services.

HIW itself faced its own challenges in sustaining delivery through a period of reduced capacity at a time of unprecedented scrutiny of healthcare provision and increasing expectations on regulators and inspectorates.

The publication of the Francis Inquiry report in February 2013 and the Keogh review in July 2013 reminded us all that we cannot afford to take for granted the very basic requirements of good quality care. These reports raised some fundamental questions about the way in which all bodies involved in the commissioning, provision, regulation and inspection of healthcare carry out our work, and made clear that the scale of change needed is not just about changing our systems and processes alone – it must also focus on cultural and behavioural change.

All parts of the healthcare system in Wales must continue to learn from these tragic events and redouble their efforts to ensure that the right systems, behaviours and safeguards are in place at every level so that each individual and organisation takes full responsibility and are held to public account for their actions. HIW, as an integral part of the framework of public assurance in Wales must play its full part in this ongoing learning and improvement.

This is not just the challenge for the next year or so but it is the enduring and arguably most important thing to get right each and every year.

Dr Kate Chamberlain
Chief Executive

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

Who we are:

On behalf of Welsh Ministers and the citizens of Wales, Healthcare Inspectorate Wales (HIW) is the lead Inspectorate for healthcare in Wales

Our purpose is to provide independent and objective assurance on the quality, safety and effectiveness of healthcare services making recommendations to healthcare organisations to promote improvements.

What we do:

- We inspect and report on National Health Service (NHS) organisations in Wales
- We inspect and regulate independent healthcare providers in Wales
- 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:

The outcomes we seek to influence:

- Citizen experience of healthcare is improved.
- Citizens are able to access clear, timely, honest information on the quality, safety and effectiveness of healthcare services in Wales.
- Citizens are confident that inspection and regulation of the healthcare sector in Wales is sufficient, proportionate, professional, co-ordinated and adds value.

Our Values

Our values establish the fundamental behaviours that govern the way we carry out our work.

Our People

We have a staff complement of 58 most of whom are located in our Inspection, Investigation, Regulation, Local Supervising Authority (LSA), and Knowledge Management Teams.

To support our core workforce, we work with a panel of external reviewers, health and social care professionals and members of the public.

Under these arrangements, people who have specialist experience of providing health services from Wales and beyond and those who have experience of accessing healthcare services, whether as patients, service users or carers take part in our activities.

Our external reviewers may be sourced through:

- Targeted appointment of peer healthcare staff direct from Local Health Boards and Trusts
- Nomination and appointment of suitable specialist expertise via the Academy of Royal Colleges, individual Royal colleges and professional regulatory bodies
- Contracted arrangements for the provision of specialist expertise to advise upon or carry out review work
- Other Welsh and UK Inspection, Audit and Review bodies' arrangements;
- Our own targeted recruitment in certain key specialist areas
- Partnership arrangements with Third Sector and other representative bodies to access people who use services and their carers and families
- Working with the Board of Community Health Councils or individual CHCs.

During the year we worked to develop the capacity and capability of our workforce through an extensive programme of recruitment so that we are able to continue to deliver and develop our organisation to meet increasing expectations in the longer term and in accordance with our overall aims, values and delivery principles.

Our Advisory Board

HIW's Advisory Board was set up to provide us with independent external advice and challenge on the conduct of our work. Its membership included representatives from the Board of Community Health Councils in Wales; NHS Wales Chairs and Chief Executives; our external reviewers; as well as experts from NHS bodies in Scotland.

Following the publication of the Report of the Mid Staffordshire Inquiry, HIW identified a need to carry out a fundamental review of its governance arrangements, including the operation of its Advisory Board. New arrangements for the oversight and independent scrutiny of HIWs work will be developed in 2014, and will take account of the report of the short inquiry into the work of HIW[1] carried out by the National Assembly for Wales's Health and Social Care Committee[2].

[1] In July 2013 the Health and Social Care Committee of the National Assembly for Wales commenced a short inquiry into the work of Healthcare Inspectorate Wales. Details of this inquiry can be accessed at http://www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=7373

[2] The Health and Social Care Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the physical, mental and public health of the people of Wales, including the social care system.

Working Together

1. How we Involved and Engaged with Citizens of 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 citizens by:

- Engaging 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.

We worked together with third sector and representative organisations to help ensure that the views of specific service user groups, in particular those who may be seldom reached, inform and influence what we do and how we do it.

2. How we worked with healthcare policy-makers and service providers

We actively participated in conferences, working groups and development activities in order to create a common understanding of what we can do collectively to improve healthcare in Wales.

We actively encouraged secondments and placements of healthcare staff to work as part of our inspection teams in order to support their own professional development and to support sharing of practice across health providers.

3. How we worked with Other Inspectors and Regulators, Professional Bodies and Improvement Agencies

3.1 Across the UK and Beyond

Through our continued commitment and active involvement in the work of the '*UK and Ireland Five Nations Group*[3]' of health and social care regulators, the 'UK Heads of Inspectorates Forum and the *European Platform for Supervisory Organisations (EPSO)*[4]', 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 build relationships with health professional bodies and regulators such as the Academy of Medical Royal Colleges in Wales[5], General Medical Council (GMC)[6] and Nursing and Midwifery Council (NMC)[7] both to access

[3] The UK and Ireland '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.

[4] Established in 1996, the European Partnership for Supervisory Organisations in Health Services and Social Care (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.

[5] 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.

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

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.

During the year we worked with the GMC and members of the Welsh Revalidation Delivery Board to support and facilitate the development of new arrangements established by the GMC for the revalidation[8] of all doctors in the UK. HIW has also worked with the Deanery to pilot the development and implementation of an assurance framework for appraisal

3.2 In Wales

HIW, Care and Social Services Inspectorate Wales (CSSIW), Estyn (Her Majesty's Inspectorate for Education and Training in Wales) and the Wales Audit Office (WAO) are the four main inspection, audit and review bodies in Wales. Within the framework of a Strategic Agreement[9], we worked closely together to ensure that we all play an active role in improving public services in Wales.

Within this wider strategic framework, in November 2012 HIW and the WAO published a joint operational protocol[10] to provide further impetus to the joint and collaborative working that already exists between our organisations at an operational level. This is providing us with a clearer framework for taking forward work on information sharing, co–ordination of programme development and cross referral of concerns.

We continued to demonstrate our commitment to closer working with the Board of Community Health Councils in Wales through a two year jointly–funded post. The appointee worked across our two organisations to consider how greater collaboration could be achieved between our two organisations. We will be taking further actions in the year ahead to implement the opportunities identified.

For further information on how we work together with the other main inspectorates in Wales and the topics that we have agreed to work on together can be found on our joint website: www.inspectionwales.com

3.3 Wales Concordat Cymru[11]

HIW continued to drive and support the work of the Wales Concordat between bodies that inspect, regulate, audit and improve health and social care services in Wales. It did this by holding the Chair and facilitating regular meetings. During the year Concordat members agreed to fundamentally review the role and future operation of the Concordat. The GMC is leading this review which will also inform our current work to clearly describe the external assurance framework for the NHS.

[7] Nursing and Midwifery Council (NMC) – an independent, statutory body which registers and regulates nursing and midwifery practicing in the UK.

[8] Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC.

[9] The four main inspection, audit and regulation bodies in Wales signed an agreement in 2011 to boost joint working.

[10] The Operational Protocol between Healthcare Inspectorate Wales and the Wales Audit Office was signed in October 2013 http://www.hiw.org.uk/news.cfm?orgid=477&contentid=25026 .

[11] The Wales Concordat is a voluntary agreement between inspection, external review and improvement bodies working in health and social care in Wales http://www.walesconcordat.org.uk/

3.4 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. Alongside the agreements already in place, new Memoranda of Understanding between HIW and Her Majesty's Inspectorates of Probation and Prisons were published in December 2012, outlining the collaboration and co–operation in relation to the inspection of health services in places of detention and youth offending services in Wales.

HIW also signed up to the *Wales Accord on the Sharing of Personal Information (WASPI)*[12]. This provides a framework within which HIW and our partners can further develop arrangements governing the sharing of personal information for particular purposes

In 2014, through the work of the Concordat, HIW aims to support a more fundamental review of our partnership and information sharing agreements taking account of the learning from the *Report of the Mid Staffordshire Public Inquiry.*

4. Developing Our Own Ways of Working

4.1 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 seek feedback 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 the length of time we take to deal with the issues raised.

We investigate complaints about HIW by following the Welsh Government's Policy on Complaints[13]. During the year we investigated two formal complaints about our own work. One of these related to a concern about the failure to provide a substantive response on issues raised about a healthcare provider. The complaint was upheld in full with a substantive response and apology subsequently sent. The other related to a long standing and wide ranging concern about the exercise of the Local Supervisory Authority function in respect of an individual midwife. The investigation into this matter continued into 2013–2014 and will be reported in detail in the LSA's Annual Report 2013–2014.

A review of HIW's overall arrangements for dealing with concerns and complaints about our own work has identified scope to further develop our approach to ensure the lessons we learn as an organisation lead to sustained improvements in the way we work. This will be taken forward in 2014.

[12] The Wales Accord on the Sharing of Personal Information (WASPI) and its supporting documentation provides to the public sector, third sector and private service providers, a framework for development of protocols to govern the sharing of personal information for particular purposes. The Accord provides a single basis for protocols that underpin effective collaboration across organisations to make sure their staff can share information safely and legally..

[13] Welsh Government Policy on Complaints is available from any Welsh Government office or at www.wales.gov.uk or www.hiw.org.uk .

5. 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. A lot 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 information from members of the public. In doing so, we follow the Welsh Government's Code of Practice on Access to Information[14] and the provision 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 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 2012–2013, we received nine requests for information under the provisions of the DPA and the FoIA[15]. All requests were considered and responded to effectively within the deadlines set.

5.1 How we developed our Customer Service and Communications

During the year we worked to ensure that our staff, especially those new to HIW, dealt quickly, politely and effectively with enquiries and requests for advice.

Our website is a key source of up to date information about our work, but its design and layout is no longer suitable to meet the needs of those who want to find out more about our work. During the year, we made some progress in the design and development of a new website that will help members of the public access the information they want, when they want it faster and easier.

However, shortages in capacity within our Corporate Services function meant we were not able to launch our new website during the year as originally planned. We will now launch our new site in 2014.

We continued to publish regular newsletters in May, August, and December.

In 2014, we will review and refresh our communication arrangements to inform the development of an overarching approach to communicating with patients, the public and our wider stakeholders more effectively, including the use of social and other media.

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

[15] Welsh Government FOI response log can be found at http://wales.gov.uk/about/foi/responses/?lang=en

In the meantime, please contact us if you would like to receive copies of our regular newsletters by email. Our contact details can be found on the inside cover of this report.

6. How we Managed our Resources

Our commitment to collaborative working helped us to make the best use of our collective resources by working with others to provide a stronger, more integrated public assurance overall. However, our ability to further develop our efficiency through new ways of working within HIW was more limited during the year and continued into 2013–2014 as we faced a considerable challenge in successfully recruiting to our vacant roles.

In 2014, as our recruitment programme leads to a strengthening in our overall capacity and capability we will ensure a renewed focus on our organisational development through a planned programme of development activity.

2 Targeting our work on what matters most

The development of our work programme and our decisions on what we should look at when and how depends on 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 intelligence for a particular service or organisation may indicate areas of concern or worrying trends, perhaps as a result of concerns or complaints received
- The outcomes from our previous work may have identified areas where further work is needed Intelligence we receive from other bodies, or the outcomes from other review work may indicate areas where further review is needed
- The service or issue may be a recognised national priority for healthcare services
- There may be new standards or quality requirements against which service provision may be assessed to identify improvements
- There may be a recognised inequality in the provision of healthcare services, or a high proportion of the population may be affected
- Performance data may indicate variations in quality or areas of major risk affecting particular sections of the community or areas of Wales
- There may be significant or increasing public concern
- The impact of our work may be maximised through joint working with other inspection, audit or review bodies.

Taking this into account, in 2012–2013 the main focus of our work centred on:

- The delivery and ongoing development of our routine regulation, inspection and assurance work programme designed to enable us to meet our statutory responsibilities and in so doing drive improvement in the fundamental aspects of good quality healthcare – dignity and essential care, cleanliness and infection control
- The ongoing delivery of key programmes of work that focus on ensuring the well being and human rights of individuals from specific service user groups are safeguarded, particularly those who may be in the most vulnerable situations. In addition to our routine statutory programmes of work, we continued with our collaborative review programmes as well as our key programme of unannounced reviews of independent hospitals providing learning difficulty services
- An increasing number of commissioned investigations and special reviews of healthcare organisations or services (in response to concerns that arose from a particular incident or series of incidents).

What we found is set out in Chapter 3.

Our work programme also incorporated a range of activities designed to:

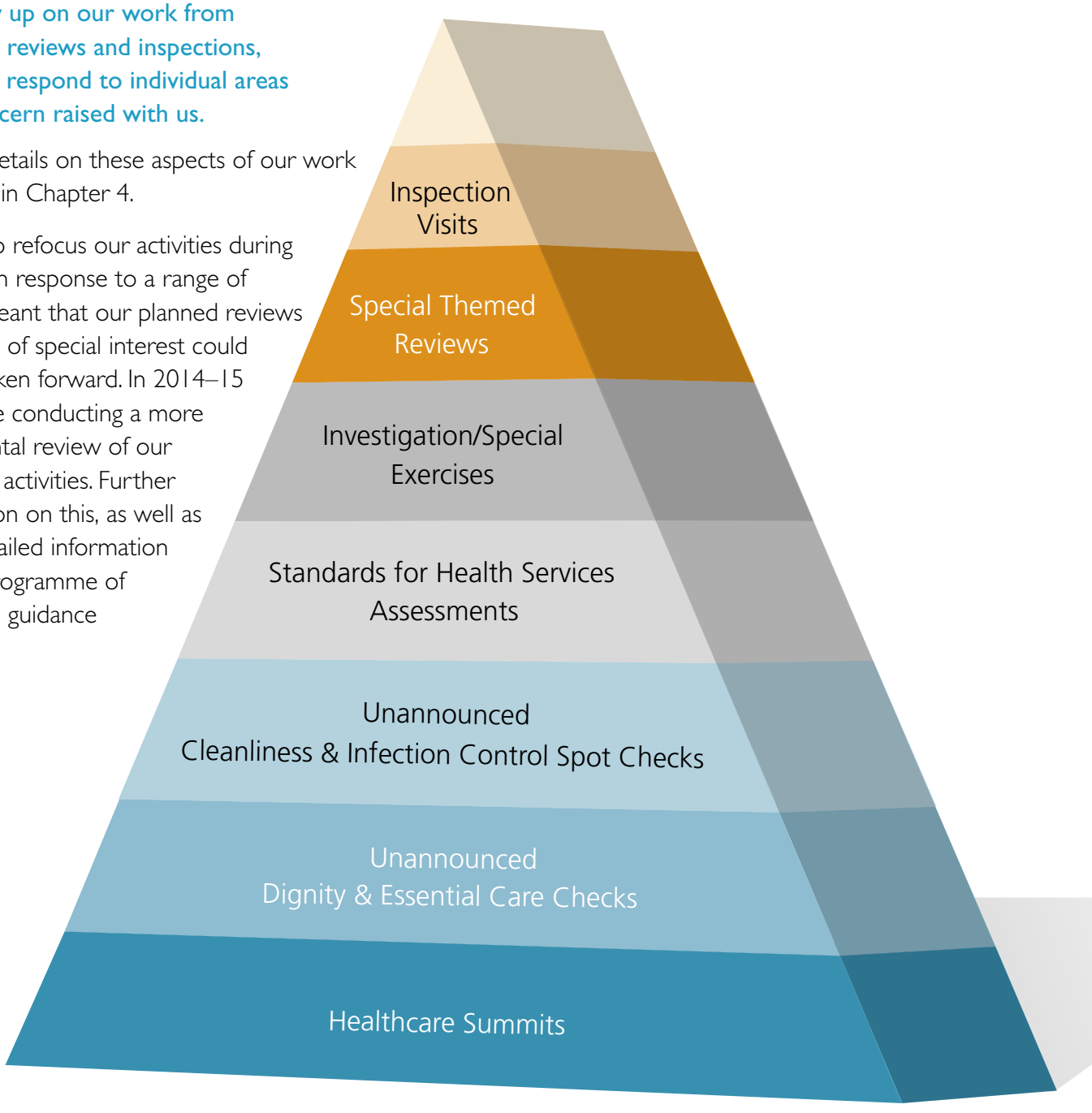
- Inform and influence healthcare policy and practice through our contribution to key areas of development
- Engender a broader, collaborative understanding through our assurance activity on the quality and safety of healthcare services in Wales
- Follow up on our work from earlier reviews and inspections, and to respond to individual areas of concern raised with us.

Further details on these aspects of our work is set out in Chapter 4.

A need to refocus our activities during the year in response to a range of factors meant that our planned reviews into areas of special interest could not be taken forward. In 2014–15 we will be conducting a more fundamental review of our plans and activities. Further information on this, as well as more detailed information on our programme of work, and guidance on how to supply your views will be available on our website.

Our Toolkit of Approaches

During the year we continued to develop and deploy a wide range of approaches to enable us to effectively assess the quality and safety of healthcare provision:



3 What we found 2012-13

Are Health Service Organisations in Wales fit for purpose?

We considered how Health Service 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. NHS organisations must report how well they are doing against the standards as part of their Annual Governance Statements.

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

Key Themes Arising from the 2012–2013 Standards for Health Services Assessment

NHS organisations' third self assessment of their performance against the Standards for Health Services demonstrated a mixed picture in tackling the governance challenges identified in earlier years. Overall, the majority of NHS Boards considered their organisation to be at the same level of organisational maturity as in the previous two years, and most displayed a good level of self awareness and a realistic assessment of the challenges they face.

Most organisations considered themselves to be strongest overall at looking ahead and setting their organisations vision, values and longer term strategic direction. Incremental improvement was noted in some other key areas, notably in relation to better understanding their own organisational performance and responsiveness to change.

However, organisations also identified a continuing challenge in maintaining a strong, sustainable organisational infrastructure; consistent ways of working and the effective deployment and development of their workforce to support the day to day delivery of services. In these areas, Boards indicated a decline in maturity in some cases alongside incremental improvements in others.

In the main, the key themes arising from our work during the year continued to mirror the areas for further development identified by organisations themselves with regard to their overall leadership and governance. These include the need for NHS organisations to continue to:

- build upon new approaches to work together more consistently with the public, partners and other stakeholders across their communities to inform the design and delivery of health services that effectively aligns local needs with the national strategy for health services in Wales

[16] *Doing well Doing Better: Standards for Health Services in Wales.* Published by the Welsh Government in April 2010.

- focus on ensuring all work carried out across their organisation is instilled with a strong sense of values, supported by clear standards of ethical behaviour
- develop their organisational infrastructure so that the different services and parts of their organisation work well together; decisions are taken by those best placed to do so and are well informed, timely and effectively communicated
- take action to strengthen the capacity, capability and deployment of their workforce so that they are better equipped to provide high quality, safe services now and through the delivery of service changes
- tackle the challenge of delivering services where and how they are needed through maintenance and development of facilities that enable the consistent delivery of safe, high quality and dignified care and treatment across all the communities served, even in the older parts of the NHS estate
- further develop their arrangements and infrastructure for information and secure 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

In addition, although organisations overall identified a continuing maturity in the following areas, we consider further ongoing attention is needed to:

- Build on their arrangements to share noteworthy practice within organisations and beyond, and ensure wider organisational learning takes place in response to feedback and concerns from patients, the public and their representatives
- Continue to strengthen internal scrutiny and assurance through better performance management and reporting arrangements so that they may respond quickly and effectively to areas of concern and drive overall improvement.

HIW's work programme takes account of the above themes and aims to keep these matters under active review. The publication of HIW's report in March 2012 of the review of the governance arrangements at Cwm Taf Health Board[17], together with the publication of the Francis Inquiry Report in February 2013 and the conduct also in 2013 of a joint overview by HIW and the WAO of the governance of Betsi Cadwaladr Health Board[18] provides a clear opportunity for NHS organisations to review the learning points from these reports which are relevant to NHS and wider public service organisations across Wales.

The annual programme of Healthcare Summits[19] provides a further opportunity, working alongside other inspection, audit, regulatory and improvement bodies to consider the extent to which organisations make sufficient progress in tackling these issues.

[17] A review of governance arrangements at Cwm Taf Health Board, March 2012 available at http://www.hiw.org.uk/news.cfm?orgid=477&contentid=22089

[18] An overview of governance arrangements at Betsi Cadwaladr University Health Board, June 2013, available at http://www.hiw.org.uk/news.cfm?orgid=477&contentid=27842

[19] For the past five years HIW has facilitated a programme of annual healthcare summits. The 2012 summit meetings took place between November and January.

We Regulated the Independent Healthcare Sector in Wales

Through registration and inspection we continued to regulate the independent healthcare sector in Wales in line with the requirements of the Care Standards Act 2000, associated Regulations and the National Minimum Standards for Independent Health Care Services in Wales.[20]

Table 1: Table of Independent Healthcare Registered Settings 2012-13, by Type

Type of setting	Number of registered providers at 31 March 2013
Acute hospitals	14
Class 3B and 4 lasers/intense pulsed light	53
Dental hospitals using anaesthesia	2
Detoxification hospital	1
Hospices for adults	6
Hospices for children	2
Independent clinic	9
Independent GPs	1
Mental health hospital	20
Private dentist	1232
Termination of Pregnancy	1
TOTAL	1341

[20] 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 http://www.hiw.org.uk/docopen.cfm?orgid=477&id=170738

During the year we registered 130 new providers and de registered 95. We also registered five new managers and applied seven changes to registrations. We carried out 18 visits to Independent Health Care settings (excluding private dentists) and published 13 reports or management letters setting out our findings.

Table 2: Table of Independent Healthcare Inspections resulting in Reports or Management Letters published during 2012-2013

Type of setting	Number of inspections resulting in reports or management letters
Acute	2
Dental Hospitals	0
Hospice	1
Independent Clinic	0
Laser/Intense Pulsed Light (IPL)	0
Mental Health	10
TOTAL	13

We inspected independent healthcare settings using a range of our routine inspection programmes. This included a specific programme targeted at independent settings who provide services for people with learning difficulties and mental health services. Our overall findings in relation to these specific areas of our work are commented upon later in this report. Detailed reports of the individual findings for each of these inspections are available on our website.

As with NHS organisations, we monitored independent healthcare providers, taking into consideration the information and intelligence we received from a variety of sources. We carried out follow–up visits where concerns warranted such action. In addition, as part of follow up, action meetings were also held with providers and commissioners where appropriate.

Unregistered service providers

We are sometimes made aware of services which may be operating but are not registered with HIW. The majority of these relate to the provision of non–surgical cosmetic treatments using a Class 3B or 4 Laser or Intense pulsed light systems. Where we are made aware of such services, our Regulation team takes action to investigate the matter further. In 2013–2014 we will carry out a targeted programme of unannounced visits to settings where we consider services may be carried out by unregistered providers.

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, self assessments for all laser settings, carried out by providers themselves, as well as the valuable information we gained from patients, relatives and carers about their experience of healthcare services.

One of the key elements of our ongoing monitoring activity was our review of notifiable events or serious untoward incidents required to be notified to us throughout the year. Registered persons[21] must by law notify us about specified events or incidents that may directly affect the safety of patients[22].

The number and type of notifiable events received and monitored by HIW between 1 April 2012 and 31 March 2013 are set out below.

Type of event	Total
Death of a patient in a hospice	636
Death of a patient (excluding hospices)	9
Unauthorised absence	46
Serious injury	34
Outbreak of an infectious disease	2
Allegation of staff misconduct resulting in actual or potential harm	29

[21] 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.

[22] 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 5 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

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 considered how well Health Service Organisations focused on matters of Dignity and Essential Care

Our Dignity and Essential Care unannounced spot check visits continued to form an essential element of HIW's routine inspection programme. In 2011 we introduced an updated programme of unannounced spot checks and extended our visit programme to include weekends as well as weekdays.

In 2012–2013 these visits continued to focus on the essential care, safety, dignity and respect that patients received in hospital and for the first time we included evening and night time visits. We continued to focus our attention on older patients, as research showed this group may feel particularly vulnerable during a hospital stay. During the year we extended our focus to include Emergency and Assessment Departments.

Our visits specifically focused on the following aspects of care and treatment:

Patient environment	Staff attitude/behaviour/ability to carryout dignified care
Care planning and provision	Pressure Sores
Fluid and nutrition	Personal care and hygiene
Toilet needs	Buzzers
Communication	Medicine management and pain management
Records management	Management of patients with confusion
Activities and stimulation	Discharge planning

Our approach to these reviews relied on direct observation, staff questioning and the review of key documents. Our reviewers provided immediate feedback to senior management at the end of each visit and organisations were required to provide us with an action plan detailing how they intended to address any issues and areas of concern identified within two weeks of the publication of our reports.

During the year we carried out eight DECI inspections, and published 8 reports of our inspection visits (this included reports of visits carried out prior to 2012–2013). Whilst we identified many areas of noteworthy practice, our visits also identified a number of emerging themes where improvement is needed:

- Standards of patient documentation were variable

  A vital part of the care and treatment process, the standard of patient documentation was variable. In some cases:

- although patient assessments were available, the level of detail varied, and it was not always clear that assessments reflected specific patient needs
- care plans were often generic in nature and did not record specific patient progress or the level of support required
- patient documentation had been completed retrospectively by staff.
- Access to medication was not always properly restricted

  In many cases we identified a risk of unauthorised access to medication by staff or patients. In some cases medication room doors were left open on wards; fridges holding drugs were found unlocked; and we observed staff leaving medication trolleys open and unattended in the main corridors during medication rounds.

- The environment of care was not always acceptable

We identified environmental issues at some of the hospitals we visited. Examples included the storage of medical equipment and clutter blocking access to fire doors and ward exits; insufficient toilet facilities; and the privacy and dignity of patients using toilet/bathroom facilities being compromised.

Our visits to Emergency and Assessment departments identified a number of specific themes:

- The length of time patients kept on trolleys in one case we observed an elderly patient with a suspected fractured neck of femur who had been kept on a trolley for 22 hours
- Inadequate staffing levels and skills mix on some units taking account of the patient mix. Some staff described feeling 'rushed' and unable to spend sufficient time with patients to provide the care needed
- Poor communication, in some cases due to a lack of staff discretion when providing patient sensitive information; and in others due to a lack of equipment such as communication aids for patients with sensory loss
- Poor ward design and layout making it more difficult to maintain patient observations.

We will continue to monitor progress in these areas.

In 2014 we will further develop our approach to the conduct of our DECI inspections including:

- The introduction of revised ward based tools mapped to the issues arising from the Francis Inquiry
- The development of additional modules including diabetes and general cleanliness

- More explicit referencing within our review approach and reports to the relevant standards and requirements for each aspect of review, e.g., patient safety alerts
- Enhancing our risk based selection process.

We Considered How Well Health Service Organisations were Driving Improvement in the Environment of Care

HIW first introduced a programme of unannounced infection control inspections in 2006–07 in response to growing public concern about MRSA, C. difficile and norovirus.

This type of unannounced inspection uses pictorial evidence to support our findings, and our inspection tools are based on the Infection Control Nurses Association (ICNA) tool. As with our DECI inspections, our approach relies on direct observation, staff questioning and the review of key documents. Our review teams include an infection control nurse and lay reviewer.

All visits are unannounced, and we provide immediate feedback to senior management at the end of the visit and organisations are required to provide us with an action plan detailing how they intend to address any issues and areas of concern identified within two weeks of the publication of our report.

During the year we carried out a limited programme of two inspection visits and published seven reports of our inspection visits (this included reports of visits carried out prior to 2012–2013).

Our reports recognised that the majority of wards visited were of a good or acceptable standard of cleanliness. We identified some areas where improvement was needed, in particular:

- Although in general the staff we spoke to had received training in infection control, we did identify some inconsistencies in the level of staff knowledge about appropriate hand hygiene procedures
- Domestic rooms were often found to be in a poor state of repair with inappropriate items being stored in these rooms
- A number of hazardous substances were inappropriately stored, and at some visits drug fridges were found to be unlocked
- Documented cleaning schedules were not always evident.

We also started to further develop our approach to this important area of our work to ensure a strong focus on infection prevention and control.

Our new approach will include:

- The introduction of revised ward based tools mapped to the issues arising from the Francis Inquiry
- The introduction of tools that focus on areas such as MRSA, C. difficile and theatres
- More explicit referencing within our review approach and reports to the fundamentals of care areas and other standards and requirements including patient safety alerts
- A streamlined approach to the collation of evidence and documentation.

We Worked to Ensure Patients and Service Users in Potentially Vulnerable Situations were Safeguarded

We recognise the potential vulnerability of anyone accessing health services so we 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 wellbeing and human rights of individuals from specific service user groups are safeguarded:

Our Learning Difficulty Visits

In May 2011, the BBC's investigative television series 'Panorama' broadcast a programme that highlighted abuse and ill–treatment of individuals with learning difficulties, residing at an independent hospital in Bristol.

The programme understandably gave rise to great public concern. As a result, HIW introduced in 2011 a focused programme of reviews of independent hospitals providing learning difficulty and mental health services.

The focus of the reviews was to ensure that individuals accessing such services were:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plans
- Supported to be as independent as possible
- Allowed and encouraged to make choices
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

Since 2011 unannounced visits have been undertaken to all registered independent mental health hospitals in Wales. These visits were undertaken at various times of the day, including over the weekend, at night and in the early mornings so that our inspectors' view of the care provided was as objective and holistic as possible.

Following each visit we met with the Registered Manager and key staff to provide immediate, initial feedback and highlight significant issues requiring action. Where necessary, we followed these meetings with an urgent action letter detailing any regulatory breaches and clearly setting out what action was needed to ensure patient safety and regulatory compliance. We required all organisations we visited to submit an action plan setting out how, when and by whom action would be taken. Where there were key concerns we undertook follow up visits to check progress.

During the year we undertook 13 visits and published 10 reports of our visits (some of which related to visits carried out prior to 2012–2013).

Our reviews did not highlight the issues of bullying and cruelty identified by the Panorama programme, but a number of areas for improvement were identified. These included:

- Care plans not being kept up to date and not reflecting risk assessments undertaken. Many of the care plans reviewed included reference to identified risks, but actions to manage those risks had not been set out
- Poor staffing levels and an over reliance on agency staff
- A blanket approach to the management of risks which resulted in a lack of individualised care and over control in many areas that impacted on patient choice and dignity.
- Poor record keeping, specifically medication records, where some entries were not signed and/or errors and changes not clearly identified
- A lack of regular staff supervision and appraisal

- Poor environments of care. Refurbishment and redecoration was highlighted as a major issue.

We shared our findings with those who commission services from the independent providers we visited so that we could work together to drive improvement with the key aim of ensuring individuals receive safe, high quality care.

In 2014 we will continue to undertake unannounced visits to our independent providers and will roll the programme of learning difficulty visits out across the NHS in Wales.

Our Mental Health Review Service

The functions previously performed in Wales by the Mental Health Act Commission (MHAC) were transferred to us in 2009. These responsibilities enabled us to develop a sharper focus on services through our ongoing monitoring of compliance with the Mental Health Act[23] and Deprivation of Liberty Safeguards[24] (part of the Mental Capacity Act[25]).

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

- Visiting patients subject to the powers of the Mental Health Act
- Providing the Second Opinion Appointed Doctor (SOAD) service.

Our Mental Health Act Visits

The main function of the Mental Health Act 1983[26] is to allow for compulsory care, treatment and action to be taken, where necessary, to ensure that an individual with a mental disorder gets the care and treatment they need for their own health and safety or for the protection of other people.

Under the Act individuals can be detained in hospital or be required to live in the community, subject to certain conditions as set out in a Community Treatment Order (CTO) or under guardianship. In some circumstances they can be given treatment to which they have not consented or do not have the capacity to consent. For some people detention under the Act can last for significant periods of time.

The Act has serious consequences for the human rights of individuals who are subject to its powers. It is therefore clear what processes must be followed when consideration is being given to detaining an individual and for when an individual is subject to a detention or restrictions. The Act, together with the accompanying Code of Practice[27] sets out safeguards that are intended to ensure that individuals are not inappropriately detained or treated without their consent.

When an individual is detained under the Mental Health Act they are very ill and by the very nature of their illness, extremely vulnerable. It is a very distressing time for the individual subject to the detention and their family. In recognition of this our Mental Health Act reviewers undertake

[23] Mental Health Act 1983.

[24] 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.

[25] 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.

[26] 2007 amendments to the 1983 Act, http://www.legislation.gov.uk/ukpga/2007/12/contents

[27] Mental Health Act 1983 Code of Practice for Wales.http://www.wales.nhs.uk/sites3/docopen.cfm?orgId=816&id=104742

visits to hospitals and wards where someone may be detained to ensure that the Act is being administered and used appropriately and the human rights of patients are protected. Further, in line with the requirements of the Code of Practice they ensure that the Act is operated with a view to promoting recovery by maximising the mental and physical wellbeing of patients and protecting them and others from harm, while keeping restrictions on independence to a minimum.

Our reviewers carry out both announced and unannounced visits to any setting in Wales where a person is liable to be detained under the Mental Health Act. In 2012–2013 our reviewers undertook 16 visits covering 25 wards within NHS hospitals and units. In addition, our learning difficulty review visits scrutinised arrangements in Independent Hospitals and looked at the application of the Mental Health Act in those settings.

The focus of our Mental Health Act visits is to ensure that everyone receiving care and treatment in Wales who is subject to the provisions of the Mental Health Act 1983:

- Is treated with dignity and respect
- Receives ethical and lawful treatment
- Receives the care and treatment that is appropriate to his or her needs
- Is enabled to lead as fulfilled a life as possible.

Our reviewers monitor that the correct legal processes are being adhered to, that patients understand their rights and receive the care and treatment that is appropriate to their needs. They do so by talking to individuals who are subject to restrictions made under the powers of the Act. These discussions are held in private and only take place with the consent of an individual. Our reviewers explore an individual's views on their care and treatment and will ensure that they understand their rights and the reasons for the restrictions placed on them. In addition, our reviewers check all records and paperwork related to the restrictions placed on the individual and ensure that the requirements set out in the Act and the Code have been met.

Our reviewers also explore other pertinent issues related to an individual detained under the Act including the environment of care in which a patient is detained; their privacy and dignity, food and nutrition, access to general healthcare and their care and treatment planning. Any concerns are escalated immediately and are followed up in writing.

Overall, we found that in general detained patients were cared for and treated by staff that have the necessary knowledge and skills. However, there were gaps in provision, in particular:

- staffing levels on some wards had resulted in a lack of access to therapies, (including occupational therapists and psychologists) and difficulties in the provision of escorted section 17 leave by some patients. Such interventions can greatly enhance a patients recovery and therefore reduce their length of detention
- the standards of record keeping, including statutory documentation concerning the Act was variable. In many cases the correct documentation had been completed appropriately but this was not evidenced by patient notes held on the ward and could therefore lead to confusion over a patients legal status.

We continue to monitor these issues. We prepare an annual report that gives an account of the work we have undertaken each year to meet our Mental Health Act monitoring responsibilities. In 2014 we will publish the findings from our work in this area since 2011 in our Mental Health Act monitoring report.

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 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 the patient.

HIW is responsible for managing the SOAD service in Wales. We set very tight timescales for our SOAD visits in view of the important role that SOADs play in ensuring that individuals detained under the Act are prescribed ethical treatment in line with national guidelines and best practice.

Upon receipt of a SOAD request we aim to ensure that a visit takes place within:

- Two working days for a Electroconvulsive Therapy (ECT)[28] request
- Five working days for an inpatient medication request and
- 10 working days for a Community Treatment Order (CTO)[29] request.

During the year, we received 758 requests for SOADs, a slight decrease from 944 in 2011–2012. Of these, 691 requests were for medication reasons only, 59 were for ECT and 8 were for both. We met all of the timescales required.

This decrease in the number of visits reversed an earlier year on year increase in SOAD requests and resulted from a change in the law. Section 299 of the Health and Social Care Act 2012 came into force on 1 June 2012 in both England and Wales. Since then, patients who are subject to a Community Treatment Order (CTO) no longer require a SOAD to authorise treatment, with the responsibility instead becoming that of a patient's Responsible Clinician[30].

Deprivation of Liberty Safeguards

In 2009 the Deprivation of Liberty Safeguards[31] legislation 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. The Safeguards are important because they provide a legal framework around the deprivation of liberty which should prevent breaches of the European Convention on Human Rights (ECHR). Any one of us might temporarily or permanently lose the capacity to make decisions about how we wish to be cared for, whether as a consequence of a sudden injury, a degenerative condition or a life–long impairment. While the number of people to whom the Safeguards have been applied remains small, the potential numbers of people lacking capacity whose well-being and welfare requires robust and well-informed discussion is much larger.

[28] 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.

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

[30] A Responsible Clinician is the approved clinician with overall responsibility for the patient's case.

[31] Deprivation of Liberty Safeguards apply to people who lack the capacity specifically to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the Mental Health Act 1983 is not appropriate. The aim of the Safeguards is to ensure people are given the care they need in the least restrictive regimes.

CSSIW and HIW work together to collect and analyse relevant data in order to monitor the operation of the safeguards in Wales. In April 2013 HIW published a joint report with CSSIW setting out the results of our monitoring activity across health and social care in Wales during 2011–2012.

Overall, we concluded that the Safeguards were still not being used consistently across Wales, although 2011–2012 saw the highest numbers of standard authorisations being granted since the safeguards were introduced.

We found that some individual local authority and health board supervisory bodies[32] have established effective models for the receipt, assessment and authorisation of applications.

However, we also identified that two supervisory bodies received no applications during 2011–2012. More effective awareness raising and staff training is needed on both the Mental Capacity Act and the Safeguards in those bodies where few or no applications were received.

Undoubtedly there are managing authorities[33] who work hard to care for people with impaired capacity without depriving them of their liberty. However, there will be occasions when a managing authority has no alternative but to lawfully deprive people of their liberty in order to give them the care they need.

We are concerned that there is no clear indication of what level of utilisation of the Safeguards equals good practice. Quantitative data has allowed us to draw some broad conclusions, but we need more qualitative data to make clearer judgements about the effectiveness of the Safeguards in promoting better outcomes for the relevant person.

HIW and CSSIW are working collaboratively again on the third report and the results of our monitoring activity during 2012–2013 will be published in spring 2014.

In light of the continued variations in the use of Safeguards in Wales, HIW and CSSIW are undertaking a focused awareness raising programme with key partners and stakeholders, and in the spring of 2014 will carry out a national review of the use of DoLs with fieldwork due to begin in the spring of 2014.

Our Contribution to the National Preventative Mechanism

The National Preventative Mechanism (NPM) was established in 2009 by the UK government to meet its United Nations (UN) treaty obligations regarding the treatment of anyone held in any form of custody. The NPM should have the right to regularly inspect all places of detention for the purpose of monitoring the treatment and conditions of detainees, with the clear purpose of preventing ill treatment of anyone deprived of their liberty.

The NPM is made up of 18 independent bodies, and its work is co–ordinated by HM Inspectorate of Prisons (HMIP). HIW is one of these 18 members.

[32] A local authority or local health board that is responsible for considering a deprivation of liberty request received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.

[33] The person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty.

In February 2013, the NPM published its third annual report. This report focussed on key issues arising from the NPM's work during the year, and made several recommendations with the aim of preventing ill–treatment in detention and ensuring the effective implementation of OPCAT in the UK. In particular :

- The use of force and restraint – the report reiterated the key components of a lawful, safe and effective system of force and restraint
- Escorting of detainees, particularly within the criminal justice system and on overseas escorts where detainees were removed from the UK. The reports recommendations in this area were aimed at ensuring an appropriate balance is struck between transporting detainees securely, and doing so safely and humanely, without resorting to disproportionate security measures.

Further information on the work of the NPM may be accessed at www.justice.gov.uk

Our Special Reviews

We may undertake special reviews of healthcare organisations or services in response to concerns that may arise perhaps 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 commenced or completed a number of such reviews examining several aspects of healthcare across Wales:

- In April 2012 we published a report following a review that examined the care and safety of patients cared for at Cefn Coed hospital, part of Abertawe Bro Morgannwg University Health Board[34]. The review looked into concerns arising from incidents that took place in 2010 and which were subject to investigation by South Wales Police. Our review took place following the Health Board's own internal review
- We reviewed the Urology service provided by Hywel Dda Health Board, again as a response to concerns raised by the Public Service Ombudsman for Wales (PSOW) about the Health Board's Outpatient Booking system. We expect to publish the findings of this work during 2014
- We examined the response of Abertawe Bro Morgannwg University Health Board following the outbreak of E.Coli at the Neo Natal Unit within Singleton Hospital in November 2011 which tragically resulted in the death of two babies. We expect to publish the findings of this work during 2014.

Our review of patient care at Ysbyty Glan Clwyd

In 2011 HIW was invited by the then Chief Executive of Betsi Cadwaladr University Health Board (BCUHB) to undertake an independent review of care provided at Ysbyty Glan Clwyd[35], part of BCUHB following concerns raised by the Public Services Ombudsman for Wales (PSOW) about the standard of patient care at the hospital.

HIW's review started in February 2012 and we published our report in December 2012. Our review highlighted that Ysbyty Glan Clwyd was a hospital working to capacity, with committed staff who were working under intense pressure. Staff were observed to be professional in their dealings with patients and care was being delivered in a way that was compassionate and maintained patients' dignity.

[34] *Review of the Care & Safety of Patients Cared for at Cefn Coed Hospital*, published April 2012 and available at http://www.hiw.org.uk/news.cfm?orgid=477&contentid=22467.

[35] http://www.hiw.org.uk/news.cfm?orgid=477&contentid=25266

However, we concluded that the Health Board had more to do, especially in relation to unscheduled care, there were clear challenges facing Ysbyty Glan Clwyd in ensuring that the patient pathway through the hospital is efficient, of high quality and safe.

The Health Board's performance in relation to the handling and management of concerns was poor. There were issues not only in relation to issuing responses in a timely manner, but also in ensuring the comprehensiveness of eventual responses and most importantly, that complainants were communicated with in a sensitive and compassionate manner.

The report made 23 recommendations aimed at addressing the issues identified and to support continuing improvement in the services provided at Ysbyty Glan Clwyd.

The findings from our review of patient care at Ysbyty Glan Clwyd resulted in the conduct of a wider quality and safety review which began in late 2012. The preliminary findings of that review were reported to the Health Board in March 2013 and, taken together with our earlier findings served to underline growing concerns about the effectiveness of the Board's collective leadership and its ability to address the challenges it faced.

This led to a decision by HIW and the WAO to conduct a joint overview of the governance arrangements at the Health Board, the report of which was published in June 2013. Further details of this review will be included in our 2013–2014 Annual Report.

Healthcare and the Armed Forces Community in Wales

In May 2012 HIW published our report on Healthcare and the Armed Forces Community in Wales[36]. The report followed a survey conducted between December 2011 and February 2012 which looked at the adequacy, availability and accessibility of NHS provision for Armed Forces personnel, their families and veterans in Wales. It drew primarily on the personal experiences of members of the Armed Forces community, but also included input from the main service organisations and charities.

Our report identified some specific issues raised by the survey about the arrangements for accessing healthcare, liaison between the Ministry of Defence (MoD) and the NHS and the overall provision and organisation of healthcare for the Armed Forces community.

A significant proportion of the survey responses expressed concern about the services available to those veterans with mental health problems resulting from their experiences during service. It was clear that more work was needed in developing a coherent and accessible range of appropriate services to meet these needs.

Overall the report made six recommendations for consideration by the NHS in Wales, the Welsh Government, service organisations and charities and the Armed Forces community itself. These mainly related to required improvements in relation to information, coordination, awareness and education.

[36] http://www.hiw.org.uk/news.cfm?orgid=477&contentid=22809

Homicide Reviews

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 has carried out all such reviews since January 2007.

In 2012–2013 we progressed our review of a homicide carried out by a mental health service user in the Thornhill area of Cardiff between 28 February and 2 March 2010.

Further information on our work in this area is available on our website.

Deaths in Custody while in Welsh Prisons

During the year we provided clinical advice to the Prisons and Probation Ombudsman (PPO) as part of 3 investigations into deaths in Welsh prisons.

We continue to make recommendations to the Welsh Prison Service. Common themes include:

- All prisoners should be appropriately examined during health screens, and that secondary health screens are completed in a timely manner
- Community GP records should be routinely requested to ensure continuity of healthcare.

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 http://www.ppo.gov.uk/prison–investigations.html. Recommendations requiring action by the prison healthcare service are followed up by HMIP.

Transitions: a joint inspection of the transition arrangements from youth to adult services in the criminal justice system

In October 2012 HM Inspectorate of Probation, the lead inspectorate, published on behalf of all involved inspectorates a report of a joint inspection carried out by HMIPr; HMIP; CQC; Estyn; HIW and Ofted of the transition arrangements from youth to adult services in the criminal justice system.

Reviewers carried out inspections in six locations across England and Wales. They looked at the work that takes place to help young people as they move from working with youth–based to adult–based services to find out what front line practitioners were doing to promote an effective transition between the various services and how it could be improved.

Although reviewers found examples of individual good practice, the report also found that work to promote effective transition did not always receive sufficient attention.

The detailed findings from this review may be accessed via HIW's website[37].

Examining Multi–Agency Responses to Children and Young People who sexually offend

In February 2013 HM Inspectorate of Probation, the lead inspectorate, published on behalf of all involved inspectorates a report of a joint inspection carried out by HMIPr; HMIP; CQC; Estyn; HIW and Ofted of multi–agency responses to children and young people who sexually offend.

The focus of the review was on the quality of the work undertaken with these children and young people and its outcomes – how the different agencies worked together and what had been

[37] http://www.hiw.org.uk/docopen.cfm?orgid=477&ID=198760&6BEC5A8B-D5EB-0CF3-8E5D36458BB7D0F0

achieved. Reviewers visited six Youth Offending Teams and examined a total of 24 cases in depth including one final warning case and four custody cases where the child or young person had now been released into the community. Reviewers followed each child or young person's journey from disclosure of the offence through to supervision in the community.

The review found that reoffending by children and young people who commit sexual offences can be prevented, but opportunities to intervene early were often missed by professionals.

Once these children and young people had been identified and picked up by the justice system, their chances for rehabilitation dramatically improved, although the process was disturbingly slow, with cases taking on average eight months between disclosure and sentence.

Although reviewers identified many examples of good practice in direct work with young people, too often the case management process supporting that work was characterised by poor communication between the relevant agencies, with inadequate assessment and joint planning.

The detailed findings from this review may be accessed via HIW's website[38].

Other joint work taken forward during 2012-2013

During the year HIW also contributed to the conduct of a range of joint inspection and review activity with other Wales and UK inspectorates, including:

- A Joint Inspection of Youth Offending Work in Powys
- Child and Adolescent Mental Health Services (CAMHS): a Follow up review
- A Criminal use of police cells? the use of police custody as a place of safety for people with mental health needs.

We will report on the findings from this joint work in our 2013–2014 Annual Report.

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), HIW is responsible, as the Local Supervising Authority (LSA) for Wales, for exercising general supervision over all midwives practicing in Wales. 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.

On 31 March 2013 1,748 midwives had notified HIW of their intention to practice midwifery in Wales for the year ahead and there were 121 Supervisors of Midwives (SoM)[39].

[38] http://www.hiw.org.uk/news.cfm?orgid=477&contentid=25911

[39] Supervisors of Midwives are experienced practicing midwives who have undertaken additional education and training to support, guide and supervise midwives.

Table 3: Ratio of Supervisors of Midwives (SoMs) to midwives in each maternity services provider as at 31 March 2013

Health Board	Number of midwives	Number of supervisors	Ratio supervisors to midwives
Abertawe Bro Morgannwg University	308	20	1:15.4
Aneurin Bevan	291	18	1:16.1
Betsi Cadwaladr University	393	21	1:18.7
Cardiff and Vale University	293	19	1:15.4
Cwm Taf	223	18	1:12.4
Hywell dda	197	19	1:10.4
Powys	43	6	1:7.2
Independent			
TOTAL (All Wales)	1748	121	1:13.7

The review work carried out by our LSA team in 2012–2013 confirmed that the standards for statutory supervision of midwives, set by the Nursing and Midwifery Council, were achieved. Full details of the work of the LSA during 2012-2013 are set out in its Annual Report to the Nursing and Midwifery Council

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 56 notifications of clinical incidents, a reduction from the previous year's figure of 74.

The team also reviewed information in relation to five maternal deaths reported to the LSA in 2012–13, in comparison to four in 2011–12 and concluded that in all cases, sub optimal midwifery care was a factor.

During the year the LSA concluded that the way in which supervision is provided across Wales must evolve and change if the requirements set by the NMC are to be properly met in the years to come, and most importantly midwives properly supported. Increasing midwifery numbers, a reduction in those applying to become supervisors and a growing number of senior midwives resigning from the Supervisor of Midwives role means that the current model of supervision is unsustainable. The LSA is continuing to work with Nurse Executives and Heads of Midwifery from across Wales to develop a new model that will be fit for purpose

and take account of a wider consideration of the future of statutory supervision led by the NMC. The resulting new arrangements will be introduced from April 2014.

Ionising Radiation (Medical Exposures) Regulations

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 (and its subsequent amendments 2006 and 2011). We achieve this through a programme of assessment and inspection of clinical departments that use ionising radiation. We also review incidents notified to us involving 'exposures much greater than intended'.

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 exposure.

Given the specialist nature of this area of work, we work with the Health Protection Agency (HPA)[40] to ensure we have access to expert advice to support both the inspection and investigation elements of our work in this area.

Throughout 2012–2013 we received 29 notifications of '*exposure much greater than intended*' (EMGTI) from across 5 health boards and 1 NHS Trust. We considered whether these cases had been properly investigated and whether appropriate remedial action was taken as necessary by the organisation. Overall, we noted that in the majority of cases, appropriate identification procedures had not been followed resulting in the wrong patient receiving the exposure.

We also carried out four inspection visits, and published two IR(ME)R reports.

We found that generally the sites reported upon were in the main compliant with IR(ME)R, and we identified a number of areas of noteworthy practice. In addition Health Boards ensured representation from staff working within other settings across the Health Board area attended the inspection visits to that lessons learned could be shared and actioned across the whole Health Board on a timely basis.

We did identify some common areas for improvement, in particular relating to a need to improve the entitlement process to ensure that duty holders are appropriately entitled for the tasks they undertake; and to strengthen IR(ME) R training of practitioners and operators and the recording of training activity in documented training records, including continuous professional development.

Controlled Drugs

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 establishes clear requirements for the safe and effective handling of controlled drugs.

[40] 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.

During the year we maintained and published a list of accountable officers[41] in Wales. Further details may be found on our website.

HIW's handling of concerns about healthcare services

It is not HIW's role to routinely investigate concerns about an individual's care and treatment, although we do consider all information we receive and use it to inform our future work plans – particularly if we identify an emerging pattern of concerns about an individual healthcare setting or service. This information may trigger an unannounced inspection visit or in certain circumstances a Special Review.

During the year we reviewed and considered each concern we received in order to determine the most appropriate response:

- We may signpost the individual to other bodies who can help them take forward their concern such as the health board itself; the advocacy service of the local Community Health Council or the Public Services Ombudsman for Wales
- Depending on the matters raised, HIW may also escalate the concern immediately to the Health Board or Trust; offer to meet the complainant or, with the persons consent, offer to write to the Health Board or Trust requesting that the organisation address their concern and keep HIW informed of the outcome
- There may be circumstances when the information provided to us indicates that a patient may be in danger of imminent harm or has been harmed. In this situation we will take immediate action to ensure their safety and also share this information with other agencies such as the Police.

On average, HIW responds to around 100 concerns each year from members of the public and current or past health service workers.

In September 2012 HIW published a new booklet explaining how healthcare workers can raise concerns with HIW about healthcare in Wales.

Further guidance for members of the public and others on how to raise concerns is available on our website.

[41] 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

4 Making a difference

Driving Improvement through Our Work

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

Encouraging Change through Our Publications

Our reports and other publications are a key tool for driving improvement. 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 2012–2013 at appendix B, or visit our website to access the full reports.

Following Up On Our Findings

We report on our findings in a number of ways:

- Immediate verbal feedback on the final day of an inspection visit
- Management letters requiring urgent action
- General management letters summarising areas for attention
- Traditional Reports.

Publishing our findings 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 may take a variety of approaches to our follow–up of issues identified depending on the seriousness and urgency of the issue.

Historically, we have worked closely with officials in the Welsh Government's Department for Health and Social Services 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. For example, we have further developed our approach to our dignity and essential care inspections to follow up on concerns regarding diabetes care and monitoring identified from both our own inspection activity and the work of the PSOW. We have also enhanced our mental health services to ensure a greater focus on care planning, risk assessment and the provision of meaningful activities.

Further, where it is more appropriate or where others are better placed to take forward follow up work, we share the necessary information with them and provide ongoing support to enable this to happen.

In 2014, we will increase our focus on following up on our earlier reported findings so that we can assess whether the required changes have been made and that this has resulted in a sustainable improvement to services.

Influencing Healthcare Policy and Practice

At an all Wales level, we continued to inform the development of healthcare policy and practice 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
- Responded to consultations about a wide range of healthcare related developments
- Contributed to 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 healthcare services and contributed to the development of relevant standards and quality requirements. In particular:

- We worked in partnership with Cancer Networks and the Palliative Care Implementation Board to research, develop and test peer review approaches with a view to introducing a rolling programme of reviews across Wales
- We continued to work with Health Service regulators across the UK on 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.

A Stronger Force for Change through Healthcare Summits

We continued to facilitate an annual programme of healthcare summits, each one designed to focus on a particular NHS health board or Trust in Wales.

The summits involved bodies working across Wales who are responsible for healthcare inspection, audit, regulation and improvement. They 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.

In 2014 we will further review the Healthcare Summit programme as part of a wider programme of work designed to develop a more integrated framework of assurance for healthcare services in Wales. This will enable HIW alongside other inspection, audit and regulatory bodies to collectively 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 activity to maximise our impact on driving improvement.

5 Looking to the future

The NHS in Wales continues to respond to significant pressures brought about by an ageing population, the financial climate and service reconfiguration, all of which increase the level of risk to quality and safety of services. Independent healthcare is also changing with the consideration of additional regulation in the field of cosmetic surgery.

The publication of the Francis Inquiry report in February 2013 and the Keogh review in July 2013 reminded us all that we could not afford to take for granted the very basic requirements of good quality care and our own roles in ensuring these requirements are met. Alongside others, HIW continues to test the scope and approach of our work against the findings and recommendations of the inquiry so that we can be sure what we focus our attention on, and how we carry out our work in the future takes, full account of the things that matter most.

Within Wales there are continued plans to review and scrutinise the role and effectiveness of external assurance bodies such as ourselves and consider how the landscape of regulation and inspection in Wales may need to evolve to ensure it is proportionate and effective. The recent inquiry by the National Assembly for Wales's Health and Social Care Committee into the work of HIW will bring a specific focus to our future development and plans.

Given this rapidly evolving context HIW's detailed plans are focused on the short term. Our recently published Operational Plan sets out in detail where HIW is focusing its activities during 2013–14 to ensure that a fundamental level of assurance is sustained by:

- continuing to focus our work on our routine programmes designed to enable us to meet our statutory responsibilities and in so doing drive improvement in the fundamental aspects of good quality healthcare – dignity and essential care, cleanliness and infection control
- recognising the potential vulnerability of anyone accessing healthcare services and focusing on the extent to which health service organisations provide appropriate support to individuals during their involvement with the service. In addition, we will maintain the ongoing delivery of key programmes of work that focus on ensuring that the well being and human rights of individuals from specific service user groups are safeguarded
- focusing on how we can shift the balance of our 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 ambition to focus strongly on ill health prevention, health promotion and the provision of primary and community care
- further strengthening our collaborative approach – in particular sharing intelligence and information on healthcare services with other inspection, audit, regulatory and improvement bodies and those responsible for managing the performance of the NHS in Wales so that any early warning signs are identified and acted upon quickly and effectively to ensure people are properly safeguarded whenever and wherever they access healthcare services in Wales

- Ensuring we are able to respond to concerns that may arise perhaps from a particular incident or series of incidents
- Strengthening our focus on further developing and improving how we engage, work with and inform patients and the public about our activities, our findings and the impact of our work
- recognising our need to further develop the capacity and capability of our workforce – including our panel of peer and lay reviewers – so that we are able to continue to deliver and develop our organisation to meet increasing expectations in the longer term and in accordance with our overall aims, values and delivery principles.

We will continue to use our professional knowledge to help shape and inform healthcare developments and influence the future of inspection and regulation by contributing to the Welsh Government's consideration and development of changes in the policy and regulatory framework relating to healthcare in Wales.

In the coming months we will publish an operational plan for 2014–15 which makes explicit our delivery proposals for the coming year and invites stakeholders and the wider public to comment on whether our plans are addressing the most important issues, in the right way, to ensure we are having a positive influence on sustainable improvement in the quality and safety of healthcare provision.

Appendix A: Healthcare Maps

Independent Healthcare

MAP 1

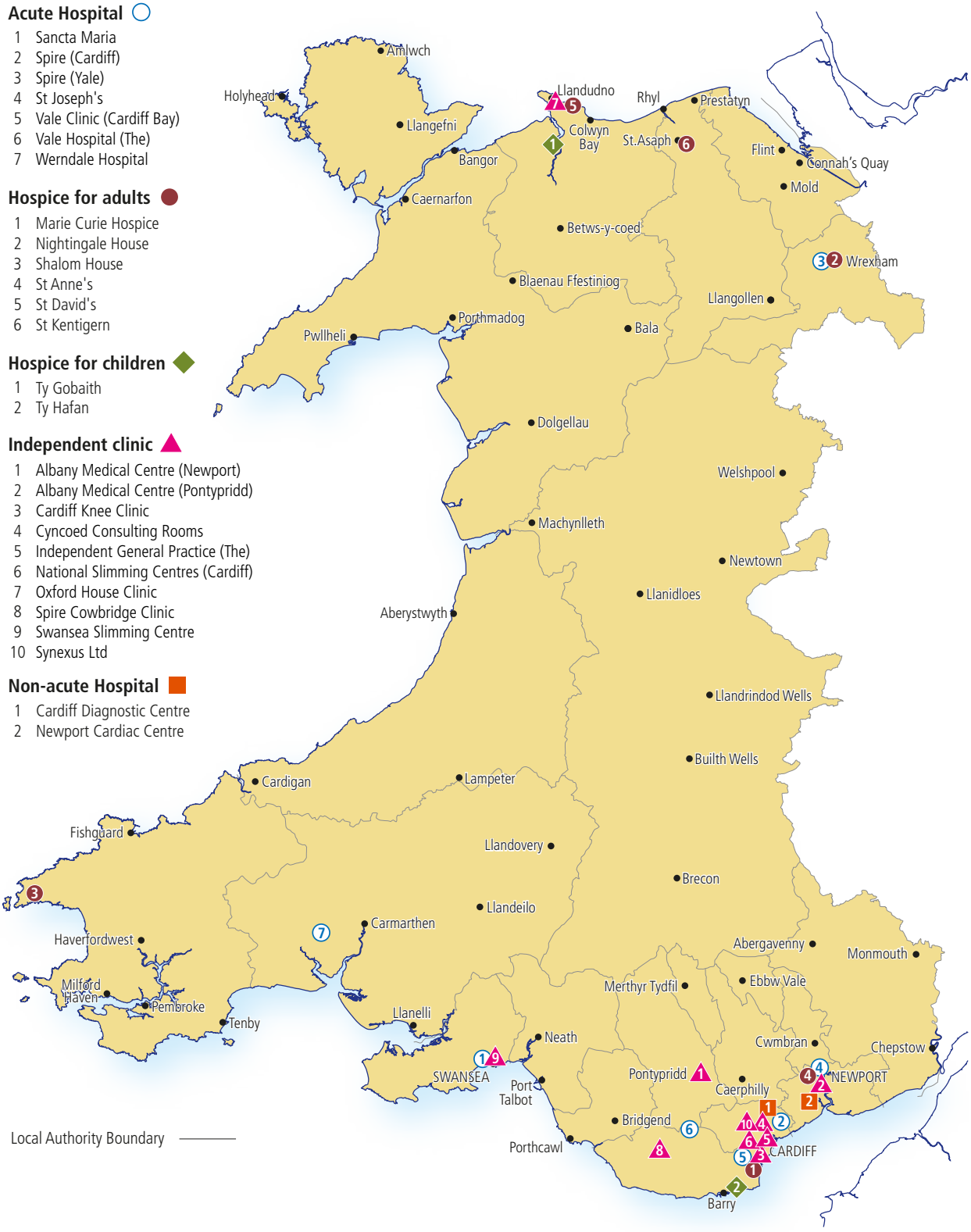
Acute Hospital
1 Sancta Maria
2 Spire (Cardiff)
3 Spire (Yale)
4 St Joseph's
5 Vale Clinic (Cardiff Bay)
6 Vale Hospital (The)
7 Werndale Hospital

Hospice for adults
1 Marie Curie Hospice
2 Nightingale House
3 Shalom House
4 St Anne's
5 St David's
6 St Kentigern

Hospice for children
1 Ty Gobaith
2 Ty Hafan

Independent clinic
1 Albany Medical Centre (Newport)
2 Albany Medical Centre (Pontypridd)
3 Cardiff Knee Clinic
4 Cyncoed Consulting Rooms
5 Independent General Practice (The)
6 National Slimming Centres (Cardiff)
7 Oxford House Clinic
8 Spire Cowbridge Clinic
9 Swansea Slimming Centre
10 Synexus Ltd

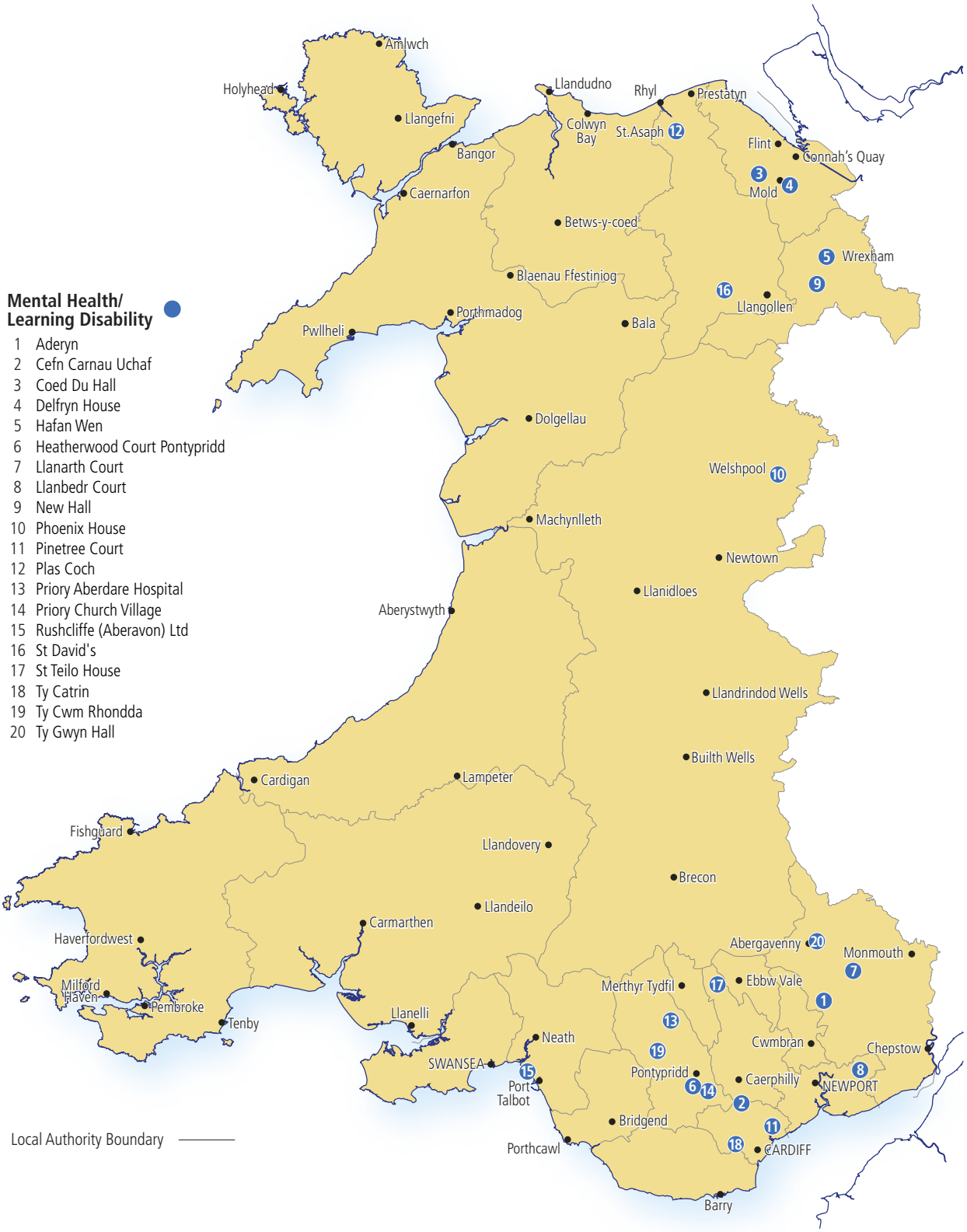
Non-acute Hospital
1 Cardiff Diagnostic Centre
2 Newport Cardiac Centre



November 2013

Independent Healthcare

MAP 2



Mental Health/ Learning Disability

1 Aderyn
2 Cefn Carnau Uchaf
3 Coed Du Hall
4 Delfryn House
5 Hafan Wen
6 Heatherwood Court Pontypridd
7 Llanarth Court
8 Llanbedr Court
9 New Hall
10 Phoenix House
11 Pinetree Court
12 Plas Coch
13 Priory Aberdare Hospital
14 Priory Church Village
15 Rushcliffe (Aberavon) Ltd
16 St David's
17 St Teilo House
18 Ty Catrin
19 Ty Cwm Rhondda
20 Ty Gwyn Hall

Local Authority Boundary

ML/189/13.14

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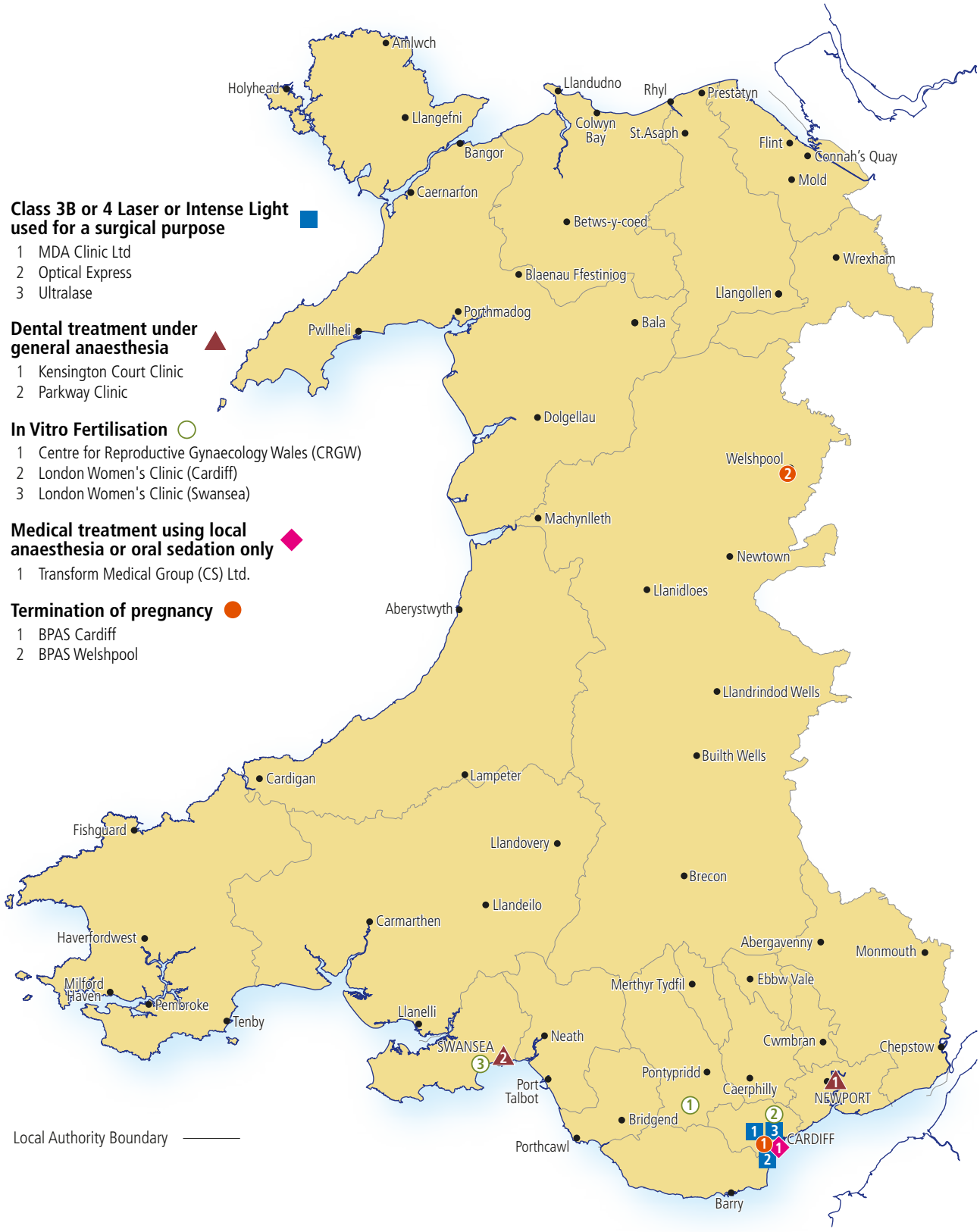
Independent Healthcare

MAP 3



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Cartographics • Welsh Government

November 2013

Independent Healthcare

MAP 4

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

1 1192 Laser & Beauty
2 Abergele Consulting Rooms
3 AMA Limited
4 B. Ten-Beauty Ltd
5 Bay Health & Beauty Clinic (The)
6 Beauty Advance Laser Therapy Ltd
7 Beauty Spot
8 Beauty Therapy & Electrolysis Clinic (The)
9 Beauty Therapy Suite Ltd
10 Beauty Within
11 Belle Clinic
12 Biothecare Estetika
13 Bliss Beauty by Cerys
14 Blush Hairdressing Limited
15 Body Image Beauty and Laser Clinic
16 Body Talk Beauty Salon
17 Cae Court Clinic
18 Cellite Clinic
19 Chepstow Cosmetic Clinic
20 Claire Price Beauty Clinic
21 Clear Skin Dermatology Treatment Clinic
22 Coollight Health & Beauty
23 Cosmeticlinic
24 Crystal Beauty
25 Cyfoes Healthcare
26 Defy Time Ltd
27 DestinationSkin Ltd
28 Energist Limited
29 Essence of Beauty
30 Face It Skin Aesthetics
31 Fitness Plus Ltd
32 Gavin Steele Tattoo Studio
33 Gresford Skin Care Clinic
34 Harley Medical Group Cardiff
35 Hickman Laser Clinic
36 Inkzane

Local Authority Boundary

37 Laser Clinic North Wales
38 Laser Heaven
39 Laserase (Wales) Ltd
40 ME:ME Maesteg Beauty Salon
41 New Image
42 Priory (The)
43 Reforme Medical Clinic
44 Refresh Skin Studio
45 Skin Deep Beauty & Laser Clinic
46 Swansea Laser Clinic
47 The Jasmine Rooms
48 Toned Within
49 Utopia Salons Ltd
50 Visible Changes
51 Wellbeing
52 West Wales Aesthetics and Laser Clinic

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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 Date of visit 27 October 2011
Cleanliness Spot Check	Betsi Cadwaladr University Health Board Unannounced Cleanliness Spot Check Date of visit 14 December 2011
Cleanliness Spot Check	Cwm Taf Health Board Unannounced Cleanliness Spot Check Date of visit 17 January 2012
Cleanliness Spot Check	Hywel Dda Health Board Unannounced Cleanliness Spot Check Date of visit 21 March 2012
Cleanliness Spot Check	Powys Teaching Health Board Unannounced Cleanliness Spot Check Date of visit 19 December 2011
Cleanliness Spot Check	Welsh Ambulance Services NHS Trust Unannounced Cleanliness Spot Check Date of visit 27 & 28 March 2012
Cleanliness Spot Check	Werndale Hospital Unannounced Cleanliness Spot Check Date of visit 22 February 2012
Acute Hospitals	Sancta Maria letter following inspection 20 March 2012
Acute Hospitals	Werndale Hospital Unannounced Cleanliness Spot Check Date of visit 22 February 2012
Hospice	Ty Hafan Children's Hospice (Date of Inspection 19&20/03/2012)
Dignity and Essential Care	Abertawe Bro Morgannwg University Health Board Unannounced Dignity and Essential Care Inspection 3 and 4 July 2012
Dignity and Essential Care	Aneurin Bevan Health Board Unannounced Dignity and Essential Care Inspection 1 and 2 February 2012
Dignity and Essential Care	Betsi Cadwaladr University Health Board Unannounced Dignity and Essential Care Inspection 14 and 15 December 2011
Dignity and Essential Care	Cardiff and Vale University Health Board Unannounced Dignity and Essential Care Inspection 29 and 30 May 2012
Dignity and Essential Care	Cwm Taf Health Board Unannounced Dignity and Essential Care Inspection Date of inspection 29 and 30 October 2012
Dignity and Essential Care	Cwm Taf Health Board Unannounced Dignity and Essential Care Inspection 26 and 27 March 2012
Dignity and Essential Care	Hywel Dda Health Board Unannounced Dignity and Essential Care Inspection Date of inspection 24 and 25 June 2012

Category	Publication Title
Dignity and Essential Care	Powys Teaching Health Board Unannounced Dignity and Essential Care Inspection Date of inspection 16 and 17 January 2012
Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)	Aneurin Bevan Local Health Board Announced Inspection Compliance with Ionising Radiation (Medical Exposure) Regulations 2000 and amendments 2006 and 2011 (IR(ME)R) Date of Inspection 4 and 5 October 2012
Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)	Cwm Taf Health Board Announced Inspection Compliance with Ionising Radiation (Medical Exposure) Regulations 2000 and Amendments 2006 and 2011 (IR(ME)R) 18 and 19 July 2012
Mental Health/ Learning Disability	A Review of Care provided to patients with a learning difficulty or mental health issue at Ty Catrin – 22 July 2011, 20 September 2011 and 6 February 2012
Mental Health/ Learning Disability	A Review of Care provided to patients with a learning difficulty or mental health issue at Ty Cwm Rhondda Date of visit 17 August 2011
Mental Health/ Learning Disability	A review of care provided to patients with a learning difficulty or mental health issue at Llanarth Court Independent Mental Health Hospital – 16 & 17 August & 19 September 2011
Mental Health/ Learning Disability	A Review of Care Provided to patients with a learning difficulty or mental health issue at New Hall Independent Mental Health Hospital – 2, 3 & 4 November 2011
Mental Health/ Learning Disability	A Review of Care Provided to patients with a learning difficulty or mental health issue at Phoenix House Independent Mental Health Hospital Date of visit: 1 October 2012 Letter
Mental Health/ Learning Disability	A Review of Care Provided to patients with a learning difficulty or mental health issue at Pinetree Court Independent Mental Health Hospital Date of visit: 15 & 16 November 2012 Management Letter
Mental Health/ Learning Disability	A Review of Care provided to patients with a learning difficulty or mental health issue at Plas Coch Independent Mental Health Hospital – 9 & 10 August 2011
Mental Health/ Learning Disability	Letter to Plas Coch management following an unannounced inspection on 2 & 3 October 2012

Category	Publication Title
Mental Health/ Learning Disability	A Review of Care provided to patients with a learning difficulty or mental health issue at Rushcliffe (Aberavon) Ltd 16 & 30 August 2011, 11 October 2011, 8, 14 & 16 March 2012
Mental Health/ Learning Disability	A Review of Care provided to patients with a learning difficulty or mental health issue at Llanbedr Court Hospital, Independent Mental Health Hospital Date of visits: 11 & 19 August 2011
Local Supervising Authority (LSA)	Annual LSA Audit Abertawe Bro Morgannwg University Health Board 2011-2012
Local Supervising Authority (LSA)	Annual LSA Audit Aneurin Bevan Local Health Board 2011 – 2012
Local Supervising Authority (LSA)	Annual LSA Audit Cardiff and Vale University Health Board 2011 – 2012
Local Supervising Authority (LSA)	Annual LSA Audit Cwm Taf Local Health Board 2011 – 2012
Local Supervising Authority (LSA)	Annual LSA Audit Hywel Dda Local Health Board 2011 – 2012
Local Supervising Authority (LSA)	Annual LSA Audit Powys Teaching Local Health Board 2011
Special Reviews	Review of the Care and Safety of Patients Cared for at Cefn Coed Hospital
Special Review	An Independent Review of Patient Care at Ysbyty Glan Clwyd 2012
Special Review	Healthcare and the Armed Forces Community in Wales
Youth Offending Services	Transitions: An inspection of the transitions arrangements from youth to adult services in the criminal justice system
	Examining Multi-Agency Responses to Children and Young People who sexually offend

Appendix C: Glossary of Terms

Access	The extent to which people are able to receive the information, services or the care they need.
Annual Quality Framework	The Annual Quality Framework is part of the planning framework for the NHS in Wales. It sets out a number of key action areas that NHS organisations need to address annually. The Framework has moved away from the use of process targets to setting clinical and patient outcome measures. Such measures include more protection and improvement in health for everyone; better joint working between services and a NHS that delivers and sustains excellent services to meet the needs of patients.
Carer	Carers provide unpaid care by looking after an ill, disabled or older family member, friend or partner.
CSSIW	Care and Social Services Inspectorate Wales is the body responsible for making professional assessments and judgements about social care, early years and social services and to encourage improvement by the service providers.
Community Health Councils	Community Health Councils (CHCs) are independent bodies, set up by law, who listen to what individuals and the community have to say about healthcare with regard to quality, quantity, access to and appropriateness of the services provided for them.
Community Treatment Order	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment.
Concordat	A voluntary agreement between autonomous bodies inspecting, regulating and auditing health and social care in Wales.
Criteria	Criteria are ways of demonstrating compliance with and performance relevant to, a standard. They establish specific, objective expectations, drawing on such evidence and indicators as the Welsh Government will publish and Healthcare Inspectorate Wales will use to inform its inspections and investigations.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	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.
Diagnosis	Identifying a medical condition by its pattern of symptoms (and sometimes also its cause and course).

Estyn	An independent inspection body in Wales. Their purpose is to inspect quality and standards in education and training in Wales.
General Medical Council (GMC)	An independent, statutory, UK wide body which registers and regulates doctors practising in the UK.
General Practitioner (GP)	A family doctor.
Governance	A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives.
Healthcare	Services provided for, or in connection with, the prevention, diagnosis or treatment of illness and the promotion and protection of public health.
Health inequalities	Differences in people's health between geographical areas and between different groups of people.
Healthcare organisation	Welsh NHS bodies, independent contractors and other organisations and individuals including the independent and voluntary sectors, which provide or commission health care for individual patients, service users and the public.
Healthcare professional	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Homicide	The killing of one human being by another human being.
Involvement	The participation of the public, patients, carers and their representatives in the development and improvement of healthcare organisations and services.
Local Health Boards (LHB)	There are seven (7) Local Health Boards in Wales, each of which are responsible for planning, designing, developing and securing the delivery of primary, community, in-hospital care services and where appropriate specialised services for the citizens in their respective areas to meet identified local needs within the national policy and standards framework set out by the Minister.
Mental Health Act 1983	The Act which provides the legal framework within which Mental Health Services maybe provided without the consent of the patient.
Mental Health Measure	This Measure aims to provide mental health services at an earlier stage for individuals who are experiencing mental health problems and to reduce the risk of further decline in their mental health. The Measure will also make provisions for care and treatment plans for those in secondary mental health care and extends mental health advocacy provision beyond that which is currently required.

Mental Health Services	Specialist provision of mental health and social care services provided at hospitals, outpatient clinics, or by community-based teams of health professionals using a multi-disciplinary approach whenever possible.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
National Health Service (NHS) Trust	NHS Trusts are self-governing units within the NHS established to provide goods and services for the purposes of the health service. There are three NHS Trusts in Wales - Public Health Wales, Velindre NHS Trust and the Welsh Ambulance Services NHS Trust.
National Service Framework	National standards of care published for a variety of conditions which are designed to improve the quality of care and reduce variations in standards of care.
Patient	A person who requires health care or is receiving care or treatment.
Peer review	A peer review is a process used for checking the work carried out by an equal (peer) to ensure it meets specific criteria. Generally, the goal of all peer review processes is to verify whether the work satisfies the specifications for review, identify any deviations from the standards and provide suggestions for improvements.
Primary Care	Primary care is the first point of contact health services directly accessible to the public. In Wales this is provided by GPs, dentists, pharmacists, opticians and others such as community nurses, physiotherapists, etc.
Public Health	Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients.
Quality assurance	A systematic process of verifying that a product or service being developed is meeting specific requirements.
Quality requirements	Quality requirements may be established through National Service Frameworks. They are benchmark standards which professional health and social care staff and their partners use to inform and guide their practice. Inspectorate bodies may use quality requirements to measure improvement in service provision.
Risk management	Covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them and monitoring and reviewing progress.

Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by Healthcare Inspectorate Wales to consider the appropriateness of certain types of medical treatment for mental disorder and authorise its administration. Most cases involve patients who are unable to, or refuse to, give consent to the treatment.
Service User	An individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.
Standards	Standards are a means of describing the level of quality that health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality.
Targets	Targets refer to a defined level of performance that is being aimed for, often with a numerical and time dimension. The purpose of a target is to incentivise improvement in the specific area covered by the target over a particular timeframe.
Third Sector	Third Sector organisations include community associations, self-help groups, voluntary organisations, charities, faith-based organisations, social enterprises, community businesses, housing associations, cooperatives and mutual organisations as well as many others. They all have some important characteristics in common, being: • **independent, non-governmental bodies;** • **established voluntarily by people who choose to organise;** • **'value-driven' and motivated by the desire to further social, cultural or environmental objectives, rather than simply to make a profit; and** • **Committed to reinvesting their surpluses to further their social, cultural or environmental objectives.**
Wales Audit Office	The Wales Audit Office is an independent public body responsible for auditing on behalf of the Auditor General for Wales across all sectors of government in Wales to ensure Welsh citizens benefit from accountable, well managed public services.
Welsh NHS body	NHS Trusts and Local Health Boards in Wales.
Youth Offending Teams	A multi-agency team of professionals including a range of health staff dealing with a variety of issues such as physical health, emotional and mental health and substance misuse issues whose purpose is to reduce the likelihood of a child or young person offending.