Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Healthcare Inspectorate Wales

Annual Report

2013-2014

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Digital ISBN 978 1 4734 1759 5

WG22503

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Foreword

I am pleased to introduce our annual report for 2013-14. The NHS in Wales continues to face a challenging financial climate, continuing high level of demand for services and an unprecedented degree of scrutiny from within Wales and across the UK.

The 2013-14 National Survey for Wales showed that 92% of people were satisfied with the care they received at their last GP visit and 91% were satisfied with the care received during their last appointment at an NHS hospital.

However, it is important not to become complacent as clearly a proportion of patients have encountered difficulties. The findings of the 'Trusted to Care' report published recently clearly demonstrated that quality of care can vary between wards within hospitals and between hospitals within Health Boards. It is essential that patients and relatives feel able to raise concerns and feel that these are listened to. It is also essential that we use the information that we receive in HIW to focus our work on the areas where we can make most difference.

This year was a period of reflection for HIW. The inquiry by the Health and Social Care Committee of the National Assembly took place over the period August to November 2013 and reported in March 2014. The inquiry provided a valuable opportunity to take stock of the views of stakeholders and brought into sharp focus the challenges that the organisation had been facing in terms of capacity, capability and delivery.

We have made significant progress since the inquiry: we have undertaken significant recruitment exercises for permanent staff and to strengthen our panels of external reviewers; we have refreshed and tested new approaches to the review of dignity and essential care; we have introduced a new post of Clinical Director to ensure a robust professional underpinning to everything we do; we have significantly strengthened the flows and analysis of intelligence that we use to inform our work; and we have reviewed our processes to ensure that our reporting will be much more timely.

These changes are already having a demonstrable impact and they provide us with a stable platform on which we can build in future years.

Looking ahead to next year I am pleased to say that we published our operational plan 2014-15 before the start of the financial year. This plan demonstrates that in the coming year we will:

- Significantly increase our volume of inspection activity.
- Set explicit standards for the timeliness of reporting.
- Launch our new website early in the new year.
- Introduce annual reporting for each NHS body.
- Enhance the consistency and rigour in the way in which we respond to, and escalate, issues and concerns.
- Establish a new and strengthened Advisory Board.

Dr Kate Chamberlain
Chief Executive

1 About Healthcare Inspectorate Wales

Who we are:

Healthcare Inspectorate Wales (HIW) is the lead inspectorate for healthcare in Wales.

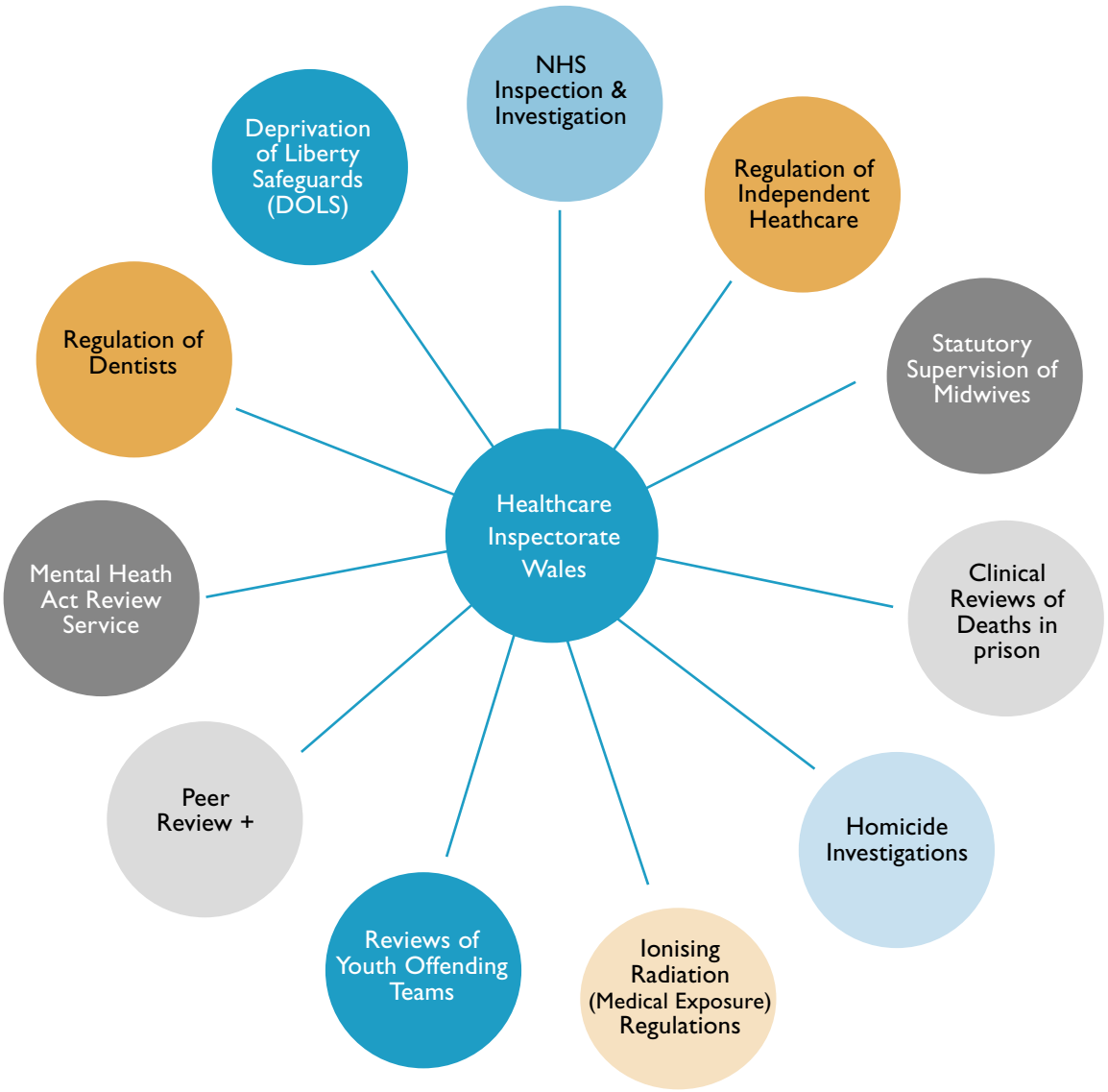
Our purpose is to provide independent and objective assurance on the quality, safety and effectiveness of healthcare services making recommendations to healthcare organisations to promote improvements.

What we do:

- We inspect and report on the quality and safety of the provision of healthcare by National Health Service (NHS) bodies 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 quality and safety of healthcare does not meet required standards.
- We inform patients, service users and the public about the standards of healthcare in Wales.

How We Do It

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 about 60, located in our Inspection, Investigation, Regulation, Local Supervising Authority (LSA) and Corporate Teams.

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

During the year we worked to develop the capacity and capability of our workforce through an extensive programme of recruitment so that we were 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

Following the publication of the *Report of the Mid Staffordshire Inquiry*, we identified a need to carry out a fundamental review of our governance arrangements, including the operation of our Advisory Board. New arrangements for the oversight and independent scrutiny of HIW's work were developed during the year recognising the need to take into account 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].

During 2014-15 we will be inviting expressions of interest for members of a strengthened Advisory Board. This will have between 15 and 20 members with about 50% representation from service users, carers, relatives, and volunteers working in healthcare services, voluntary organisations representing people, families and carers who use healthcare services and people with recent experience of working in healthcare services.

[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 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.

2 Our delivery principles

During 2013-14 we have developed a set of delivery principles which provided a framework within which we operate. These emerged from discussions with our partners and stakeholders and also take account of the requirements for a robust, proportionate, efficient and effective inspectorate as set out in the Report of the Mid-Staffordshire Inquiry[3]. They have continued to evolve during the year, but provided the underpinning for our 2013-14 operational plan[4].

Principle 1	HIW will undertake an annual programme of *NHS inspections* for each Local Health Board/Trust body which incorporates elements of: – defined baseline frequency of planned (announced and unannounced) inspections in specified settings with additional inspections in light of issues and concerns – testing of overarching arrangements for ensuring quality and safety – testing of organisational response to recommendations.
Principle 2	HIW will undertake a programme of regulation activity for each *independent* healthcare setting which ensures that: – All settings that are required to be registered with HIW **are** registered – The registration process ensures that independent healthcare providers meet the relevant regulations and minimum standards All settings are subject to baseline random visits to a minimum frequency with additional inspections undertaken in response to issues and concerns.

[3] Robert Francis QC – Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry published on 6 February 2013.
[4] www.hiw.org.uk/opendoc/238436

Principle 3

HIW will take a professional and measured approach to delivering its specific functions and will seek to use the information gathered in delivering these functions as far as possible to contribute to fulfilling its responsibilities under Principles 2 and 3. These functions include:

- The Local Supervisory Authority for statutory supervision of midwives
- Regulation and Inspection of Dental Services
- Responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005
- Second Opinion Appointed Doctor (SOAD) service
- Deprivation of Liberty Safeguards
- Contribution to National Prevention Mechanism
- Ionising Radiation (Medical Exposure) Regulations
- Controlled Drugs
- Homicide Investigations
- Regulation 30/31 Incidents (The Independent Health Care (Wales) Regulations 2011)
- Joint Reviews with HMI Probation and HMI Prisons
- Peer Review +

Principle 4

HIW will respond in an appropriate and timely manner to concerns and issues through:

- Escalation of concerns and issues in an NHS context
- Appropriate enforcement action where regulations are not being met by independent healthcare providers.

Principle 5

HIW will report clearly, openly and publicly on the work that we undertake in order that citizens are able to access independent and objective information on the quality, safety and effectiveness of healthcare in Wales.

Principle 6

HIW will keep patients and users at the heart of our work by:

- maintaining a panel of lay reviewers to take an active part in the inspection process
- continuing direct observation and discussions with patients, relatives and staff within our inspections
- extending our use of unannounced, out-of-hours and weekend inspections
- developing our overarching framework for public and patient engagement.

Principle 7

HIW will ensure a professional approach to regulation and inspection by:

- maintaining a panel of specialist peer reviewers who can be called upon to provide a professional input to inspection activity
- supporting our own staff in their professional and personal development
- utilising specialist reference groups to advise on effectiveness of, and developments in, inspection methodologies
- establishing a strong Advisory Board to challenge and scrutinise the overall work of the organisation.

Principle 8

HIW will maintain an overview of the risks, emerging issues and current issues for each inspected body in order to:

- be able to speak authoritatively in public about emerging concerns and issues, and
- to use this information to inform our programme of work.

Principle 9

HIW will – as far as is reasonable and appropriate – take a collaborative approach to its work in which it will seek to:

- share intelligence on concerns and issues
- work in partnership with other external review bodies; and
- place reliance on the work of others in deriving assurance.

Principle 10

HIW will base its review activity on recognised standards as defined by the Welsh Government and in associated guidance, recognised best practice, and requirements defined in legislation and regulation. We will use our experience of the delivery of these standards in order to inform their further development.

3 Our work in 2013-14

3.1. Our core NHS inspection programme

Dignity and Essential Care

Dignity and Essential Care Inspections (DECI) continue to provide the core of HIW's inspection approach in NHS Wales. In 2013-14 these visits continued to focus on the essential care, safety, dignity and respect that patients received in hospital.

Methodology and development of our approach

HIW's *'Dignity and Essential Care Inspections'* review the way patients' dignity is maintained within a hospital ward/unit/Department and the fundamental, basic nursing care that patients receive. We review documentation and information from a number of sources including, for example:

- Information held by HIW.
- Conversations with patients, relatives and interviews with staff.
- Discussions with senior management within the Health Board.
- Examination of a sample of patient medical records.
- Scrutiny of policies and procedures which underpin patient care.
- General observation of the environment of care and care practice.

These HIW inspections capture a snapshot of the standards of care patients receive and consider whether these may point to wider issues about the quality and safety of essential care and dignity within the hospital or Health Board.

In the first part of 2013-14 we undertook three inspections using our established methodology. The learning from these inspections was used to inform development. A further five inspections were undertaken during early 2014 to test the new tools. This has resulted in a specific focus being introduced on management and leadership and on systems in place for managing quality and safety.

A key development with regard to the content and reporting of our DECI inspections in 2013-14 has been the transition to inspecting and reporting against four domains:

- Quality of Patient Experience

  We continued to listen to the voice of the patient (adult and child) to ensure that the patients' perspective was reflected in our work.

- Delivery of the Fundamentals of Care

  Our inspections continued to focus on delivery of fundamental aspects of care and patient outcomes in all healthcare settings. We will keep this under review and work with the Welsh Government during its review of the Standards for Health Services in Wales – which incorporate the fundamental aspects of care, to ensure that we continue to align our approach with expectations for the NHS in Wales.

- Quality of Staffing Management and Leadership

  During our inspections we enhanced our review of management and leadership to test cultures in services and organisations and to review how NHS organisations monitor their internal performance against fundamental standards of dignity and essential care.

- **Delivery of a safe and effective service**

  We recognise the potential vulnerability of anyone accessing healthcare services and ensured that our routine work programmes, inspection tools and work practices focus on the extent to which healthcare service organisations provide appropriate support to ensure patients and service users in potentially vulnerable situations are safeguarded.

What we found:

During the year we carried out eight DECI inspections. Areas of good practice and some areas that require improvement were identified at each inspection. Examples of some of our key findings in this respect are set out below within their respective domains:

	Good Practice	Areas that require improvement
Quality of Patient Experience	• Patients told us they felt safe and cared for • Patients spoke positively about the attitude and behaviour of staff • Patients told us that their privacy and dignity was maintained • We observed many examples of friendly and respectful interactions between staff and patients.	• Limited activities for patients • A range of environmental issues with the potential to impact on the quality of the patient experience, such as poor directional signage to help guide patients.
Delivery of the Fundamentals of care	• Overall, the wards visited were run with due care and attention given to professional standards of care • There were some good examples of patients accessing therapies such as occupational or physiotherapy in a timely way to aid their recovery.	• A range of issues concerning the thoroughness of documentation relating to the delivery of patient care.
Quality of Staffing, Management and Leadership	• We observed some good examples of team work and ward leadership.	• Staff training in areas such as the care of patients with dementia; learning disabilities and adult protection.
Delivery of a safe and effective service	• Overall the wards and departments visited had well established professional accountability structures in place • Care was provided through safe systems informed by clinically effective policies and procedures based on National Guidance • Many areas had implemented "intentional rounding regimes" to ensure that patients received regular observation and care provision, especially the elderly.	• We identified some issues concerning the accuracy of documentation relating to medication • We identified a range of issues concerning the cleanliness of wards and the effectiveness of infection, prevention and control procedures.

Each Health Board has submitted an Improvement Plan in response to the findings that require improvement and these have been published on our website, alongside the respective inspection report.

Where we conducted follow-up against the action plans from our earlier inspections we found that progress had been made by the service and staff teams against the specific findings and recommendations made. The follow-up visits were announced visits and we recognise that our findings were made at a point in time. In relation to this we reinforced the need to the service areas to ensure national standards are maintained in service provision.

Assuring quality of care in GP practices

In October 2012 the Welsh Government published 'Learning for the future – Taking forward and building on recommendations from the Robert Powell investigation'. Amongst the action points included in this report was a requirement for LHBs to undertake a review of their governance arrangements for assuring the quality of primary care, and for HIW to test the effectiveness of these arrangements through a rolling programme of reviews. Information relating to these reviews was shared with HIW.

During 2013-14 we assessed the information provided by the LHBs, using this information to inform the development of programme of inspections at general practice level. Our development work has included:

- Establishing a reference group to obtain the views of a range of stakeholders including General Practitioners (GPs), Nurses, Practice Managers and Health Boards, Welsh Government, Public Health Wales and Community Health Councils.
- Designing an approach to the inspection of GP practices which will independently test the service actually provided to patients.
- Developing a pilot inspection programme which will commence in June 2014.
- Engagement with the Community Health Councils (CHCs) to explore the ways in which the inspection programme can be carried out in a collaborative and complimentary way where CHCs already conduct site visits to GP practices.

Contribute to the review of the effectiveness of commissioning arrangements for social care (including the interface between health and social care)

The Care and Social Services Inspectorate for Wales (CSSIW) conducted a national review of commissioning in adult social care between July 2013 and January 2014. The review was conducted in partnership with HIW and Auditor General for Wales (AGW) and was conducted in two phases. The first phase involved the completion of a self-assessment by local authorities, evaluating the quality of their overall commissioning with their partners in relation to their strategic priorities. This was followed by meetings between CSSIW and local authorities to verify the evidence within their self-assessment. The self-assessment focused on the commissioning of adult social care, and how far local authorities are compliant with the standards and best practice in the statutory guidance. The second phase comprised field work which focused on the commissioning of services for people with dementia.

The field work was conducted in Blaenau Gwent, Vale of Glamorgan, Swansea, Merthyr Tydfil and Flintshire. The review team scrutinised case

files, local authority documents and financial information. Inspectors spoke to service users, carers and their representatives, local authority staff, managers, commissioning teams, directors of social services, chief executives and council members.

A review report was published in April 2014. It found that local authorities and health boards need to make major changes to the way they plan and commission services for people with dementia.

The full report can be found at: http://cssiw.org.uk/our-reports/national-thematic-report/2014/review-of-commissioning-for-social-care-13-14/?lang=en

Follow up review of Child and Adolescent Mental Health Services (CAMHS)

In December 2013 we undertook a follow-up joint review with Wales Audit Office (WAO) to establish whether the Welsh Government and Health Boards have fully addressed the issues that were published a joint report on Child and Adolescent Mental Health Services (CAMHS)[5] in November 2009.

The joint review examined a broad range of services for children and young people with emotional and mental health problems and covered health, social services and education. The joint review set out to establish whether services were adequately meeting the mental health needs of children and young people in Wales. Our findings in 2009 found that despite some improvements, services were still failing many children and young people, reflecting a number of key barriers to improvement.

[5] Services for children and young people with emotional and mental health needs, Wales Audit Office, Healthcare Inspectorate Wales, Estyn, Care and Social Services Inspectorate Wales, November 2009.

Our overall conclusion in 2013 was that, whilst there has been some progress in addressing the safety issues highlighted in our 2009 report, children and young people continue to be put at risk due to inappropriate admissions to adult mental health wards, problems with sharing information and acting upon safeguarding duties, and unsafe discharge practices.

The full report can be found at: http://www.wao.gov.uk/publication/children-and-adolescent-mental-health-services-follow-review-safey-issues

We will continue to monitor these issues during the course of our Mental Health Act monitoring visits.

Special Reviews

We 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.

In the last year HIW has published the following reviews:

27 June 2013

An Overview of Governance Arrangements: Betsi Cadwaladr University Health Board; Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office
http://www.hiw.org.uk/opendoc/234590

31 March 2014

Report of a review in respect of arrangements put in place by Aneurin Bevan Health Board (ABHB) following the death of Miss A in 2010
http://www.hiw.org.uk/opendoc/239453

2 April 2014
A Review Of Abertawe Bro Morgannwg University Health Board's (AMBU) Response to the ESBL E.coli Cross Infection in the Maternity/Neonatal Unit at Singleton Hospital in November 2011
http://www.hiw.org.uk/opendoc/238441

Assessment against Doing Well Doing Better: Standards for Health Services in Wales and the earlier Healthcare Standards for Wales

The approach to assessment of the standards places accountability for driving improvement with the Boards of NHS organisations. At a corporate level, the self assessment requires Boards to collectively consider and assess their organisational fitness for purpose and report on the outcome of their assessment as part of the organisation's Annual Governance Statement.

Our annual inspection programme, special reviews and investigative work are used to inform our assessment of how well organisations are doing against the standards. Discussions at Healthcare Summits test and probe each NHS organisation's self assessment identifying areas where the Board's view of their organisational maturity differs from that of the audit, review and regulatory bodies present.

Members of HIW play an active role on both the project board and project teams that are reviewing the standards as part of the Welsh Government response to the Francis inquiry.

3.2 Regulating and inspecting independent healthcare

Registration activities

Through registration and inspection we regulate the independent healthcare sector in Wales in line with the requirements of the Care Standards Act 2000 and associated Regulations and the National Minimum Standards for Independent Health Care Services in Wales[6].

The table below shows the number of registration visits undertaken and includes follow-up visits where the registered provider could not satisfy the registration criteria during the initial visit. In addition, meetings were also held with providers and commissioners of care. Two national provider workshops were held with representatives of the mental health and learning disability hospitals.

[6] 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

Type of activity	2013-2014
New registrations	136
Changes to registrations	123
De-registrations	122
Number of registration visits	36

Inspect independent healthcare settings

During 2013-14 we inspected independent healthcare settings using a range of our routine inspection programmes. These included dignity and essential care inspections (DECI) and cleanliness spot checks, as well as a specific programme targeted at independent settings who provide services for people with learning difficulties and mental health services.

We actively 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.

Table of Independent Healthcare Inspections undertaken during 2013-2014

Type of setting	Number of settings	Number of Inspections
Dental Hospitals	2	2
Hospices (Adult)	6	2
Hospices (Children)	2	1
Acute	11	8
Independent Clinic	8	4
Mental Health/Learning Disability	20	24
Laser/IPL	66	7
IVF	3	0
Termination of Pregnancy	2	0
Medical Agency	1	0
TOTAL	121	48

Detailed reports of the individual findings for each of these inspections are available on our website.

What we found

Over half of the settings inspected had an environmental issue highlighted. These issues ranged from the standards of decoration to the need to replace furniture. The environmental issues also covered standards of cleanliness.

Over half of the inspections had a lack of patient activities taking place. If a patient did not have Section 17 leave[7] then very few activities were available for them. Some settings required a review of the activities on offer and patients frequently complained of boredom.

Nearly all our visits highlighted issues with care plans/records. Issues included lack of risk assessments and missing information or lack of detail from care plans e.g. measurements of wounds, descriptions.

Over half of our visits highlighted appropriateness of patient admissions as an issue. Hospitals were asked to review admissions in line with the care and treatment that the hospital can provide.

We commonly highlighted a number of issues relating to staffing at settings inspected:

- Where a hospital used agency staff to cover shifts, very few had a written, documented induction checklist in place.
- Over half of the hospitals inspected did not have regular staff supervision taking place.
- Mandatory training for staff was poor in many hospitals. Mandatory training was out of date on numerous occasions.

[7] Formal permission for a patient who is detained under the Mental Health Act in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others.

3.3 Delivery of specific functions

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 informed choice for women.

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

As of 31 March 2014, 101 SoMs were in post, with 1,742 midwives having notified the LSA of their intention to practise midwifery in Wales during 2013-14. A number of SoMs in Health Boards with ratios above 1:15 were supported with additional SoM hours and an adjusted ratio was calculated. Taking into account the additional hours, the average all-Wales ratio of SoMs to midwives as at 31 March 2014 was 1:12 which is in line with guidelines set by the NMC which recommends a ratio of 1:15.

Table of Ratio of SoMs to midwives in each maternity services provider as at 31 March 2014

Health Board	Number of midwives	Number of supervisors	Ratio supervisors to midwives	Adjusted ratio with additional hours
Abertawe Bro Morgannwg University	311	21	1:15	
Aneurin Bevan	293	14	1:21	1:13
Betsi Cadwaladr University	400	13	1:31	1:15
Cardiff and Vale University	287	16	1:18	1:15
Cwm Taf	209	16	1:13	
Hywel dda	197	16	1:12	
Powys	45	4	1:11	
Independent	0			
TOTAL (all-Wales)	1742	100	1:17	1:14

The review work carried out by our LSA team in 2013-14 confirmed that the standards for statutory supervision of midwives, set by the NMC, were achieved. Full details of the work of the LSA during 2013-14 will be set out in its Annual Report to the NMC[8].

The LSA is routinely notified of significant untoward clinical incidents in order to consider whether substandard midwifery practice contributed to the incident. Where sub standard midwifery practice may have been a factor, a supervisory investigation will be undertaken. During 2013-14 the LSA team received 48 notifications of clinical incidents, a reduction from the previous year's figure of 56. Twenty five of the 48 incidents notified to the LSA were subject to a supervisory investigation, conducted in accordance with UK LSA forum Guideline L[9] for investigation process.

During the year the LSA for Wales has continued to work with Nurse Executives and Heads of Midwifery from across Wales to agree a new model of supervision that will be fit for purpose and stand the test of changing demands and pressures. For 2014-15, there is a commitment to implementing a model that makes roles and accountabilities clearer and enables protected time to be dedicated to the SoM role.

[8] The regulatory body set up to ensure nurses and midwives are properly qualified and competent to work in the UK.

[9] LSA Midwifery Officers Forum UK (2009) Guideline and process for investigation into a midwife's fitness to practise by a Supervisor of Midwives on behalf of the Local Supervising Authority.

Regulation and Inspection of Dental Services

Dental Practitioners who provide private dentistry are required to register with HIW under the Private Dentistry (Wales) Regulations 2008 and 2011 Amendment Regulations. Under these regulations HIW is responsible for assessing the quality and safety of private dental care and treatment.

During 2013-14 HIW wrote to all dental practitioners delivering only private dentistry in Wales to require that they complete an online Quality Assurance Self-assessment questionnaire (QAS).

We launched the QAS with two key aims:

- **to engage with private dentists in order to get them to work constructively with us as we develop more robust regulation and inspection procedures**
- **to get a better sense of the quality of private dental care and treatment currently being delivered in Wales.**

The questionnaire provided an opportunity for dental practitioners to reflect and assess their quality assurance mechanisms, risk assessment and risk management processes and how they facilitate safe and effective clinical practice to ensure patient health and welfare.

To ensure that the requirements made of dental practitioners delivering exclusively private dentistry were proportionate and reasonable, we used the same questionnaire that dental practitioners delivering NHS dentistry are required to complete. We achieved a 100% response rate from the 101 private dental practitioners in Wales.

The questionnaire responses were assessed by dentists within the Dental Team of Public Health Wales on behalf of HIW with a view to identifying any issues for individual dentists and to identifying common themes. Using this analysis, HIW wrote to every dentist to alert them to concerns arising from their response to the questionnaire and to request that they set out how they would address concerns and by when. We then analysed the responses of the dentists with the assistance of two dental professionals.

We were pleased to note that the vast majority of dentists were prompted by completing the QAS to make improvements in the way they work such as updating their training and that of practice staff; testing and updating equipment; and updating health and safety risk assessments of the practice. We were also pleased to note that where concerns were raised in the majority of cases it was a result of the quality of the information provided in the QAS as opposed to actual issues within the practice.

The QAS exercise resulted in one emergency inspection.

Mental Health Act review service

Since 2009, HIW has been responsible for monitoring the implementation and application of the Mental Health Act 1983 (the Act) on behalf of Welsh Ministers. The role is fundamental to our commitment to protecting those who are most vulnerable. The main purpose of the Mental Health Act 1983 (the Act) 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 and when an individual is subject to a detention or restrictions. The Act, together with the accompanying Code of Practice sets out safeguards that are intended to ensure that individuals are not inappropriately detained or treated without their consent.

Our overall aim is to ensure that those detained under the Mental Health Act have a voice and are supported and empowered as far as possible to make decisions over their care and treatment.

We have a panel of experienced Mental Health Act reviewers who transferred in from the Mental Health Act Commission. They undertake a rolling programme of both announced and unannounced visits to mental health providers.

The focus of the reviewers is on ensuring 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 visit and talk to individuals who are subject to restrictions made under the powers of the Act. These discussions are held in private and only take place when the individual consents. The reviewer explores the 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, reviewers will 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. Any concerns are escalated immediately and are followed up in writing.

Visits are in the main unannounced. There is 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.

During 2013-14, 55 Mental Health Act monitoring visits took place. Findings from these visits are reported through a management letter to the healthcare provider. These management letters have not previously been published due to the inclusion of personal information that may lead to the identification of individual patients. The Annual Mental Health Monitoring Report has been used as the way in which aggregate findings can be placed in the public domain[10].

During the coming year we will be reviewing our publication arrangements to consider how the results of individual visits might be published without breaching patient confidentiality.

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

[10] Monitoring the use of the Mental Health Act in 2011-2013: http://www.hiw.org.uk/opendoc/239672

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

- Two working days for a Electroconvulsive Therapy (ECT)[11] request
- Five working days for an inpatient medication request and
- 10 working days for a Community Treatment Order (CTO)[12] request

Historically, HIW has experienced some difficulties allocating SOAD requests in accordance with our timescales in West Wales, and so in September 2013 we recruited a new Lead SOAD and have plans to recruit further SOADs to cover the west of Wales. Recruitment of SOADs has begun and we will significantly strengthen our pool of SOADs by the end of Summer 2014.

Section 299 of the Health and Social Care Act 2012 came into force on 1 June 2012 in both England and Wales. This means that patients who are subject to a Community Treatment Order (CTO) will no longer require a SOAD to authorise treatment, with the responsibility instead becoming that of the patient's Responsible Clinician[13]. This has reduced some of the pressure on the SOAD service.

During 2013-14, 690 SOAD requests were received by HIW.

[11] 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.

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

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

Deprivation of Liberty Safeguards

In 2009 the Deprivation of Liberty Safeguards[14] 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.

CSSIW and HIW have worked together to collect and analyse relevant data in order to monitor the operation of the safeguards in Wales.

Each year since the introduction of the Safeguards HIW has published a joint report with CSSIW, setting out the results of our monitoring activity across health and social care in Wales. http://cssiw.org.uk/our-reports/national-thematic-report/2014/dols-report-2014/?lang=en

The annual monitoring report highlighted that there is a variation in the number of DOLs applications across Wales. HIW and CSSIW committed to undertake further work to examine the application and effectiveness

[14] 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.

of DOLs due to variation in the number of applications across Wales. It was agreed HIW and CSSIW would undertake a joint National Review to achieve this. As part of the National Review HIW and CSSIW held three regional workshops in the Autumn of 2013 and invited stakeholders to share their views and experiences of DOLs. HIW and CSSIW then undertook a survey of all Health Boards and Local Authorities in Wales to establish the arrangements that are in place in each in relation to DOLs. This information has fed into the final phase of the National Review, the fieldwork. Inspection visits were undertaken in each of the seven Health Boards in Wales by HIW and in seven local authorities by CSSIW in May 2014. The findings from the visits will be published in a joint National Review report in late Autumn 2014.

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 20 independent bodies, and its work is co-ordinated by HM Inspectorate of Prisons (HMIP). HIW is one of these 20 members.

Each year since 2011 HIW has contributed to an Annual Report published by the NPM. These reports summarised the activities of the 20 members and provided an overview of the state of detention in prisons, police custody, children's secure accommodation, immigration, military and mental health detention. http://www.justiceinspectorates.gov.uk/hmiprisons/national-preventative-mechanism/

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 Public Health England to ensure we have access to expert advice to support both the inspection and investigation elements of our work in this area.

Throughout 2013-14 we received 52 notifications of *'exposure much greater than intended'* from across 6 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. We did this by gathering in depth information relating to the exposures from the Health Boards and assessing the notifications as a Panel. Overall, we noted that in the majority of cases, appropriate identification procedures had not been followed resulting in the wrong patient receiving the exposure.

During 2013-14 HIW lost capacity to deliver its proactive inspection programme in this area due to the specialist nature of the work involved. This difficulty is being addressed through the recruitment of specialist peer reviewers and inspections in this area will be prioritised in 2014-15.

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. HIW continued to maintain and publish a list of accountable officers in Wales.

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. During 2013-14 HIW published the following reviews:

12 September 2013

Report of a review in respect of Mr J and the provision of Mental Health Services, following a Homicide committed in March 2010

4 April 2014

Report of a review in respect of Mr K and the provision of Mental Health Services following a Homicide committee in March 2011

The key themes to have emerged from undertaking these reviews related to:

- Poor communication within services, and between organisations.
- Deficiencies with information sharing arrangements, particularly in relation to communicating and understanding risk.
- Inconsistencies with the assessment, recognition and management of risk.
- Weaknesses in the referral process from primary care to community mental health services.
- Challenges in engaging with homeless individuals.

Regulation 30/31 Incidents (The Independent Health Care (Wales) Regulations 2011)

We monitored independent healthcare providers, taking into consideration the information and intelligence received from a variety of sources.

One of the key elements of our on-going monitoring activity was our review of notifiable events or serious untoward incidents required to be notified to us throughout the year. Registered persons[15] must by law notify us about specified events or incidents that may directly affect the safety of patients[16].

[15] 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.

[16] 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

The number and type of notifiable events received and monitored by HIW since **1 April 2013** are set out below.

Type of event	Total
Death of a patient in a hospice	821
Death of a patient (excluding hospices)	8
Unauthorised Absence	75
Serious Injury	92
Outbreak of an Infectious Disease	2
Allegation of staff misconduct resulting in actual or potential harm	35

Joint Reviews with HMI Probation and HMI Prisons

Deaths in Custody while in Welsh Prisons

HIW undertakes clinical reviews of deaths in custody on behalf of the Prisons and Probation Ombudsman (PPO) as part of their investigations into deaths in Welsh prisons. Reports of reviews into deaths in prisons are published by the PPO.

During 2013-14 HIW completed 11 clinical reviews. The final reports published by the PPO can be found here: http://www.ppo.gov.uk/prison-investigations.html

There have been a series of issues highlighted in the individual clinical reviews carried out by HIW during 2013-14. The key themes were in regards to:

- Records management.
- Obtaining medical records and information of new prisoners.
- Chronic disease management.
- Communication between Prison and the Local District Hospitals.
- Cancelled appointments at the local Hospitals.

Joint work undertaken with Criminal Justice Inspectorates

HIW has assisted Her Majesty's Inspectorate of Probation (HMIP) with a programme of joint core case inspections of Youth Offending Services in Wales. These inspections look at the effectiveness of work with children and young people who have offended.

HMI Probation leads a Full Joint Inspection (FJI) programme in partnership with other inspectorates covering health, children's social care, education and training and police. The FJI is a targeted inspection carried out at a small number of YOTs each year, including at least one in Wales. We are involved in this Welsh FJI as the partner inspectorate for health.

The FJI is a two week fieldwork inspection. During the first week inspectors from HMI Probation assess the quality of a representative sample of statutory cases currently open with the YOT. In the second week, an inspector from HIW, together with inspectors from Estyn (Her Majesty's Inspectorate for Education and Training in Wales) and CSSIW will join the HMI Probation team to explore and further understand the findings from the first week and assess the quality of partnership work. We will

then contribute to the final inspection report of HMI Probation.

During 2013-14 HIW contributed to a full joint review of Youth Offending Work in Wrexham, with the inspection undertaken in September 2013 and the report Published on 22 January 2014, which can be found on HMI probation website: http://www.justiceinspectorates.gov.uk/hmiprobation/

Peer Review +

The peer review programme is a collaboration between HIW, the South Wales Cancer Network (SWCN), the North Wales Cancer Network (NWCN) and the Palliative Care Implementation Board (PCIB).

The Cancer Networks/PCIB have overall responsibility for:

- Planning each peer review.
- Coordinating the self assessment element of the peer review.
- Assisting cancer leads within Health Boards to complete the self assessment where necessary.
- Externally verifying the Health Board self assessment documents.
- Training, recruiting and selecting the peer review team members.
- Taking a formal record of each Peer Review visit.
- Produce a report – following each review visit – a draft of which is reviewed by the appropriate Health Board/Hospice prior to publication.

HIW supports the peer review process by:

- Helping to plan and organise each review.
- Formally writing to Health Boards when each review commences.
- Making arrangements for Health Boards to submit their self assessment documentation electronically.
- Observing the peer review process to ensure that it is fair and impartial and that the outcome of the review is communicated openly and transparently.

It is expected that the Health Board/Hospice will produce an action plan addressing any areas of concern raised in this report. HIW has agreed to host these reports in order to support the open and transparent reporting of conclusions. A public version of the report and the action plan is, therefore, published on HIW's website. This information should also be available on the website of the Health Board to which the report relates.

HIW takes note of this and other intelligence when considering its risk based approach to inspection and escalation.

HIW supported the following peer reviews in 2013-14:

Lung

Betsi Cadwaladr University Health Board

Upper GI

Betsi Cadwaladr University Health Board

Hywel Dda Health Board

Abertawe Bro Morgannwg University Health Board

Aneurin Bevan Health Board

Cardiff and Vale University Health Board

Urology

Abertawe Bro Morgannwg University Health Board

Aneurin Bevan Health Board

Cardiff and Vale University Health Board

Betsi Cadwaladr University Health Board

Penile
Abertawe Bro Morgannwg University Health Board
Cwm Taf Health Board

3.4 Responding to concerns and issues

We receive concerns regularly from members of the public through letters, email or telephone calls. It is not HIW's role to routinely investigate concerns about an individual's care and treatment; these are dealt with by the NHS Wales **Putting Things Right** complaints process.

However, we do consider all information we receive and use it to focus our work – particularly if we identify an emerging pattern of concern about an individual healthcare setting or service. This information may trigger an unannounced inspection visits or in certain circumstances a special review.

We review and consider each concern we receive 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.

A decision to undertake an investigation may also be determined or influenced by intelligence either collected by HIW or by other audit, regulation and inspection bodies. A NHS body may also refer itself to HIW and request that it undertakes a review of an issue or service, although this would need to be considered alongside other priorities.

Ensure appropriate action is taken when NHS services fail to meet the standards and requirements set for them

NHS Wales seeks to provide the very best care for patients at all times. However, issues do sometimes arise affecting service delivery, organisational effectiveness and the quality and safety of care. In most cases an appropriate response is made by the organisation concerned. However on occasions there is a requirement for co-ordinated action involving those with responsibility for the supervision, inspection and regulation of the healthcare system.

The **NHS Escalation and Intervention Arrangements** were introduced in March 2014. These set out when the Welsh Government, Auditor General for Wales and HIW will work together to share information and respond when issues of concern become apparent in NHS bodies in Wales. These arrangements may result in HIW undertaking an investigation either unilaterally or jointly with the Wales Audit Office.

Regular and effective information sharing will enable potentially serious concerns to be identified early on. We will work together and with relevant NHS bodies to ensure appropriate responsive action is taken.

Ensure appropriate action is taken when Independent Healthcare services fail to meet the standards and requirements set for them

HIW is responsible for ensuring that all providers registered to deliver Independent Healthcare comply with the requirements set out in the Care Standards Act 2000 and associated regulations and standards. Compliance with these statutory provisions helps ensure services provided to patients meet essential safety and quality standards.

HIW's view is that providers are responsible for the quality of services they provide and for achieving compliance with regulations and standards.

During 2013-14 we initiated a review of our enforcement process with the aim of clearly setting out our response to the non compliance of independent healthcare providers with regulations and standards.

This work continues and we are aiming to publish the revised enforcement process in Autumn 2014.

3.5 Reporting clearly, openly and publicly

Strengthening our communication

We have fundamentally reviewed our existing communication arrangements during 2013-14 and in the autumn were successful in recruiting a full-time communication officer.

This has enabled us to progress important development work including managing the development of our new website to enable the new version to be launched early in 2014-15. This is part of an ongoing programme of work to improve our internet communication with stakeholders.

To assist service users in identifying whether independent providers are registered with HIW we maintain and publish a complete and current list of registered independent healthcare providers.

Improving the timeliness of reporting

During 2013-14 we reported on our findings from inspections in a number of ways including:

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

Concerns have rightly been raised previously about the timeliness of HIW reporting. By reviewing our processes during 2013-14 we have been able to publish clear reporting standards for the coming year which will ensure that finalised reports are published on-line no later than three months after the date of inspection.

This approach is already having an impact: during 2013-14 we published the operational plan for that year in December 2013. Publication of the operational plan for 2014-15 was achieved nine months earlier and the plan was therefore available before the start of that financial year.

The publication of this Annual Report has also been achieved within four months of the end of the financial year: an improvement of six months.

Further reports

During 2013-14 we have published:

- Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care.
- Dignity and Essential Care Inspection for Morriston Hospital.
- An unannounced Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) Inspection at Wrexham Maelor Hospital (BCUHB Health board).
- Joint inspection of youth offending work in Powys.
- A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs (joint report between HM inspectorates of constabulary and prisons, CQC and HIW).

- An overview of Governance Arrangements in Betsi Cadwaladr University Health Board: Joint Review undertaken by WAO and HIW.
- LSA Annual Report 2012-2013.
- A report of a review in respect of Mr J and the provision of Mental Health Services, following a Homicide committed in March 2010.
- Dignity and Essential Care Inspection for Powys Teaching Health Board.
- Child and Adolescent Mental Health Services: Follow-up Review of Safety Issues.
- Healthcare Inspectorate Wales Annual Report 2012-2013.
- Review of Abertawe Bro Morgannwg University Health Board's (ABMU) Response to the ESBL E.Coli Cross Infection in the Maternity/Neonatal Unit at Singleton Hospital in November 2011.
- Healthcare Inspectorate Wales Operational Plan for 2014-2015.
- A report of a review in respect of arrangements put in place by Aneurin Bevan Health Board (ABHB)following the death of Miss A in 2010.
- 3 reports on Dignity and Essential Care inspections.
- 17 management letters relating to inspections of mental health/learning disability inspections.
- 23 management letters relating to inspections of independent healthcare providers.

We have also issued 40 management letters relating to our Mental Health Act Monitoring Visits which have not been published individually for reasons of patient confidentiality which are discussed earlier in this report.

We have also contributed to a number of other reports which are currently hosted on other websites as discussed earlier:

- Deaths in custody
- Youth offending teams
- National preventative mechanism.

During 2014-15 we will be exploring the way in which these reports are signposted through our website to make them easier to access by our stakeholders.

4 Equipping our organisation to deliver

4.1 Ensuring access to the skills and experience we need

Peer reviewer project

During 2013-14 we developed a mixed model approach to identifying and recruiting external reviewers. This provided us with responsiveness and flexibility to access the kind of expertise needed to meet our specific requirements set out within our current and future plans.

This approach was finalised in Autumn 2013 and early in the new year 2014 we began an extensive recruitment campaign designed to identify and recruit reviewers who will not only support the delivery of HIW's programme of work but will offer maximum flexibility.

The recruitment campaign activity was focused to reach a range of clinical experts to fill the following reviewer roles:

Second Opinion Appointed Doctors (SOADs) Peer reviewer – an independent doctor appointed by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.

Mental Health Act (MHA). A Peer Reviewer with knowledge and experience of the Mental Health Act who is able to undertake evidence based assessments of healthcare settings and Mental Health Act documentation to safeguard patients detained under the Mental Health Act.

Cleanliness & Infection control. Peer reviewers – those currently used are employed in healthcare in this specialist field in the following roles – head of nursing; infection control nurse/lead nurse/senior nurse and clinical nurse specialist.

Dignity & Essential Care Inspection (DECI). Peer reviewers – those currently used are employed in healthcare. It was also made clear that it would also be desirable if a proportion of the DECI reviewers were fluent Welsh Language speakers.

Substance Misuse Service (SMS) These reviews involve both peer and lay reviewers. The peer reviewers have specialist experience in the substance misuse field.

Investigation/Homicide work. A mix of peer and lay reviewers are utilised. The selection will depend on the nature and context of each particular case eg for Homicides it is highly likely they will require a psychiatrist or Mental Health nurse and they will often seek someone who is a member of the Royal College and is not based in Wales.

Local Health Boards, Communities of Practice and other bodies have shown their support in promoting the campaign. Early indications suggest significant interest from people working across all areas of expertise who are passionate about improving outcomes for patients, are committed to quality improvement and are interested in making a difference by working HIW. A final update will feature in our next report.

Keeping patients and users at the heart of what we do

We also employ lay reviewers who are members of the public who bring a public, patient or service user perspective to our work to ensure that the perspective and experience of patients is properly reflected in our work. During 2013-14 we undertook a limited exercise to strengthen our panel of lay reviewers for the LSA function as shown below.

> Local Supervising Authority (LSA) – Maternity reviewers. Lay reviewers – all are maternity service users.

During 2014-15 we will be recruiting to strengthen our panel of lay reviewers for other aspects of our work.

4.2 Supporting a professional approach to regulation and inspection

Develop the capacity and capability of our core workforce

During 2013-14 we undertook a recruitment campaign to replace the notable attrition of staff occurring during the period. This recruitment continues into 2014-15 to develop both our capacity and capability.

Type	Filled posts 1 April 2013	Staff leaving HIW	Staff joining HIW	Filled posts 30 March 2014
Permanent	42	15	14	41
Fixed term	9	2	3	10

A number of existing staff have also been promoted or moved to new roles within the organisation. As a result we have placed a high priority on updating our organisational approaches to staff development. This has included:

- reviewing and updating the HIW L&D Strategy to more accurately reflect current priorities and strategic direction
- producing a plan for the agreed priority L&D activities to be undertaken from January 2014 to March 2015
- evaluating HIW's current and future L&D needs, through staff workshops, staff conference, completion of a skills audit, meetings with senior leaders and collaboration between cross inspectorate colleagues
- introducing a new induction process and ensuring that existing staff are trained and equipped to deliver
- agreeing a plan to support the development of a Professional Skills Framework, to enable HIW staff to progress their professional and specialist skills
- examining all external reviewer learning and training needs and develop induction and training packages appropriate for both HIW staff and for external reviewers.

Each year the Welsh Government undertakes a survey of all staff to assess their views on how effectively the organisation operates. Results are available for each individual departments.

The results for HIW reflected the unsettled nature of the year stemming from staff churn and the relocation of HIW main office from Caerphilly to Merthyr Tydfil. To respond to this we held a series of engagement events for

internal staff. Learning from this will be used to develop future all-staff events to include external reviewers. These events were particularly valuable to the new staff who had joined HIW during the year.

Develop the professional practice of inspection and investigation

We introduced the role of Clinical Service Advisor in December 2013. This is a key role which provides clinical and service advice and provides an interface between HIW and wider professional groups and organisations.

The Clinical Service Advisor role has provided input into training of Peer Reviewers and HIW staff. Ongoing work with all members of the Inspection team includes all areas of professional approach and best practice within clinical areas, plus the development of the skills of all inspection managers in leading teams with a number of different lay reviewers and professional peer reviewers.

HIW has established a Professional Nursing and Midwifery Forum which enables those staff who are maintaining their professional registration to network, gain professional supervision and keep up to date. A number of guest speakers have attended to deliver updates on policy and practice with significance to HIWs operational plan.

Developing ourselves

During 2013-14 HIW worked with external stakeholders and staff to develop a programme of prioritised activities aimed at improving its own efficiency and effectiveness. HIW listened to its own staff through development events, also taking account of the findings from the 2013 staff survey. An organisational development programme board was launched, with external and independent representation. The board has provided challenge to HIW's plans as well as tracking progress against key objectives and deliverables.

This has been supported by recruitment to a number of key posts during the past year which have significantly enhanced our capability and corporate support:

Our Communications Officer has been instrumental in driving our new website, improving internal communication, and advising on how we can strengthen our communication with external stakeholders.

Our Programme Officer has enhanced our programme and project management capability and is developing the staff skills, systems and management information which are helping to drive delivery as evidenced by the efficient production of the operational plan 2014-15.

Our Learning and Development Officer has had an immediate and significant impact on strengthening training and support for HIW staff and for our external reviewers.

During the year we have also appointed to the post of Head of Corporate Services. With his team he is now working systematically through our corporate policies and procedures to ensure that the way in which we operate is efficient, streamlined and fit for purpose.

4.3 Maintaining an overview of risks, emerging and current issues

Further improve our intelligence base through the development of our knowledge management function

During 2013-14 we substantiality increased the flow of information into HIW to develop our corporate intelligence function. We improved the way we stored and used this information to

ensure our inspection team were better briefed in advance of inspections.

We have undertaken a mapping of different source of evidence including hard data and softer intelligence, using this opportunity to establish information flows with key partners. For example, we have significantly improved our use of the Fundamentals of Care audit data to aid the pre-inspection knowledge for the DECI visits. In addition, the CHCs share with us valuable intelligence from the visits and local knowledge.

We have reviewed the organisational profiles produced to support the relationship managers within HIW. These collate a variety of intelligence to help form a rounded and balanced picture of the organisation concerned. These are then used to feed into the healthcare summits.

The model for relationship management was reviewed. Relationship managers have been identified for each organisation. The process for implementing this model will be further developed in 2014-15.

Pre-inspection packs are produced in advance of visits and inspections. These will gather together a variety of intelligence relevant to the inspection type to provide the review team with a holistic view prior to the start of the process. It will also influence the focus of certain areas of the inspection.

Share the information and intelligence we hold about NHS organisations and services to establish an overarching, cohesive risk profile that can support the development of an integrated plan of assurance for NHS Wales

We have continued to improve the way intelligence about NHS organisations is stored to maximise its re-use within HIW.

During 2013-14 we started to review the Memorandum Of Understandings (MOUs) we held with other organisations with a view to refreshing and signing these off during 2014-15. This has enabled the effective sharing of information in a more efficient way. For example, HIW now accesses data relating to the notification of serious incidents in a more reliable manner. We have held discussions with other national professional regulators to ensure we have a wider and more comprehensive source of intelligence, such as the General Pharmaceutical Council and others.

As highlighted above the holistic views gained from analysing and interpreting evidence about and organisation is fed into the healthcare summits convened by HIW. This in turn feeds into the Escalation and Intervention Framework discussed earlier.

4.4 Base activity on recognised standards

During 2013-14, we have paid considerable attention to ensure that our inspection approaches are clearly and explicitly based upon recognised standards.

This has taken place across a number of work areas:

- As a result of our work to update our DECI inspections we have explicitly referenced the standards, guidance and best practice that provide the foundation for our work.
- We are actively contributing to the National Review of the Healthcare Standards for Wales and the Fundamentals of Care standards that is being undertaken by the Welsh Government.
- As we develop our inspection approach to dentists we are also working closely with

the Welsh Government in the update of Regulations relating to private dentistry.

- Our developing methodology for the inspection of general practice is based on recognised best practice underpinning the self-assessment approach previously promoted by Public Health Wales.
- We continue to be engaged in development of legislative proposals for the Regulation and Inspection of Care and Support in Wales.

5 Working with others

Across the UK and beyond

We continue to be involved in the work of the *'UK and Ireland Five Nations Group*[17]*'* of health and social care regulators, the '*UK Heads of Inspectorates Forum and the European Platform for Supervisory Organisations (EPSO)*[18]*,'* to ensure our work is both informed by and influences the development of effective inspection, investigation and regulatory practice in health and social care.

During 2013-14 the previous HIW Deputy Chief Executive was a member of an EPSO Peer Review Team undertaking a Peer Review of the Danish Health and Medicines Authority.

We liaise with health professional bodies and regulators such as the Academy of Medical Royal Colleges in Wales, General Medical Council (GMC) and Nursing and Midwifery Council (NMC) and other professional bodies both to access professional expertise to help us in the conduct of our work and to influence and be informed by the development of professional standards and clinical practice.

During 2013-14 HIW attended the annual conference of the Professional Standards Authority. The Chief Executive also spoke at the GMC Annual Conference in December 2013 and at the conference of the Royal College of Psychiatrists in Cardiff in December 2013.

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[19], we work closely together to ensure that we all play an active role in improving public services in Wales.

We have agreed an operating protocol with the Board of Community Health Councils and are continuing to develop Memoranda of Understanding with other key partners.

Wales Concordat Cymru[20]

The Wales Concordat is a collaboration between bodies that inspect, regulate, audit and improve health and social care services in Wales. We are currently act as Chair meetings of the Concordat Forum. We have been working with the GMC during 2013-14 to update the Concordat Agreement and review membership to ensure that all key bodies are represented. This work is due to be complete during the coming year.

[17] 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.

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

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

[20] 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/

Healthcare summits

During the autumn of 2013 we facilitated our usual programme of healthcare summits designed to facilitate information-sharing relating to Health Board and NHS Trusts in Wales. The summits involve bodies working across Wales who are responsible for healthcare inspection, audit, regulation and improvement and are a valuable opportunity to share and test the information and intelligence we hold about NHS organisations to establish an overarching, cohesive assessment that drives our respective plans. They will form a key part of intelligence gathering to support the new framework for NHS escalation and intervention during the coming year.