Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Llywodraeth Cymru
Welsh Government

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Healthcare Inspectorate Wales

Annual Report 2014–15

Contents

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Foreword

Last year was a challenging year for health services in Wales with the publication of 'Trusted to Care' in May 2014, continuing concerns about progress in Betsi Cadwaladr University Health Board, and health services continually in the spotlight in the period leading up to the UK Government elections.

Scrutiny of Healthcare Inspectorate Wales also continued following the publication of the Assembly's Health and Social Care Committee report in March 2014 and the subsequent independent review by Ruth Marks ***"The Way Ahead: to become an inspection and improvement body"***[1] which was published in January 2015.

The challenge for HIW was to retain a focus on addressing its organisational challenges such as recruitment and retention whilst demonstrating that it could fulfil its external responsibilities to provide assurance on the quality and safety of care.

Our response was to publish an ambitious work programme that increased inspection activity in both the NHS and independent healthcare compared to recent years and also introduced new programmes of inspection in general practice and dental practices.

It is a testament to the commitment of the people working at HIW, under huge external scrutiny, that the Operational Plan for 2014-15, was delivered so effectively.

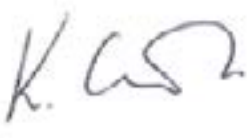
This report shows not only how HIW met its commitments but also the impact we have across the health landscape in Wales. It is not enough to just undertake inspections; we must ensure that our work is conducted in a way which enables and supports improvement too.

A key achievement for us in terms of governance was the establishment of the ***HIW Advisory Board***[2] which comprises of both key stakeholders but notably about half of the Board are service users, ensuring the voice of the patient and public is considered throughout our work programme.

We have reviewed many of our internal systems and processes to ensure HIW is robust as an inspectorate. We have been encouraged by the Ruth Marks report which highlighted not only the passion and commitment HIW staff have for their work, but also how far this organisation has progressed during 2014-15.

I am proud to present this year's annual report; it represents a significant improvement in performance for HIW which ultimately results in better care for patients.

Thank you for taking time to read this report.



Dr Kate Chamberlain
Chief Executive

[1] www.gov.wales/topics/health/nhswales/organisations/review/?lang=en
[2] www.hiw.org.uk/advisory-board-2

Introduction

Recently we reviewed HIW's outcomes and values and published these within our ***Strategic Plan for 2015–2018***[3]. We are clear that the interests of the public, patients, relatives and all users of health services should be at the core of our work. Our fundamental purpose is:

"To provide the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements."

We do this by aligning our work, and seeking to influence, four key outcomes.

- Provide independent assurance on the safety quality and availability of healthcare by effective regulation and reporting openly and clearly on inspections and investigations
- Encourage and support improvements in care through reporting and sharing good practice and areas where actions is require
- Place patient experience at the heart of our inspection and investigation processes
- Use our experience of service delivery to influence policy, standards and practice.

The following sections of this Annual Report describe how we have approached this in each of four overarching programmes of activity: our work in the NHS; our regulation and inspection of independent healthcare; our programme of activity relating to mental health and learning disability services and our role as the host organisation for the Local Supervising Authority for midwives. We have also outlined some of the actions that we have taken during the past year to develop ourselves as an organisation.

We have set out what work we have done, what we have found, and provide examples of where our work is helping to support service improvement.

This report can only provide an overview of our work. Throughout the report we have provided links to further detailed information wherever this is available.

[3] www.hiw.org.uk/strategic-plan

NHS

Hospital (Dignity and Essential Care) Inspections

During 2014-15 HIW focussed its inspection programme to create a greater volume of activity and broader coverage across the NHS. Dignity and Essential Care Inspections (DECI) provided the core of HIW's inspection approach in NHS Wales. We have significantly increased our presence and visibility in the NHS and ensured that our findings are reported in a timely and constructive fashion which supports improvement.

HIW conducted 46 DECI inspections and 6 follow up inspections within health boards throughout Wales. All the hospital inspections considered four domains and the following sections summarise the key themes that were identified in each domain from our inspections during 2014-15.

We also reviewed our approach to follow up to maximise the impact of our inspection activity. This ensured that issues raised were responded to. We did this in a variety of ways, including further targeted inspection activity.

Patient Experience

Overall, HIW found that people experienced health care that was delivered with dignity, respect, compassion and kindness. We received over 330 patient feedback questionnaires which indicated that patients were happy with the quality of care and treatment and found staff to be polite, conscientious, professional and respectful. Some statistics from the questionnaire responses are as follows:

- 95% of people felt that the ward was clean and tidy
- 95% of people said staff were polite to them, their friends and family
- 91% said staff listened to them, their friends and family
- 76% said staff helped them to understand their medical conditions
- 97% of people said staff were kind and sensitive to them when they carried out their care and treatment.

We are intending to produce a thematic analysis on the dignity and essential care inspections during the Summer 2015 which will include a full analysis of the patient experience questionnaire responses.

Fundamentals of Care

Generally, HIW found staff teams committed to delivering a high standard of health care. Noteworthy practice included:

- We saw the use of a variety of 1000+ Lives initiatives for the improvement of care and treatment across our inspections. For example, the meaningful use of ***patient safety briefings***[4] at staff handovers and the ***Drink A Drop***[5] campaign.
- During some inspections we saw initiatives which captured important information about patients and their preferences, thus supporting their dignity and making their treatment more personal. These included initiatives such as the ***This is me***[6] profile and the ***Dignity Pledge***[7].

Despite this, HIW could not always be assured that people were receiving effective and safe care. We identified particular issues around patient records, which were not always maintained in accordance with legislation and clinical standards guidance. This was an issue highlighted in all health boards, with examples of findings such as:

- Inconsistent approaches by staff to the completion of care and risk assessment documentation such that care interventions by staff were not always consistent with the written plan. Where there were care plans, they were generic and not person centred and there appeared to be some confusion amongst staff regarding the term 'person centred' care plans. We could not, therefore, be assured that there was written evidence of individualised care being promoted.
- Entries in the patient records were not being written in a timely way, and sometimes being left instead to the end of the shift.
- Patient records indicate that ward teams were not regularly assessing patients level of discomfort, pain or distress to provide effective and appropriate treatment or medication. Also, patients were not routinely undergoing mental health assessments alongside their general health assessments from the point of admission to hospital wards.

Management and Leadership

Generally, our findings around the management and leadership of teams within the NHS were positive. We saw evidence of strong cohesive teams working at ward level with a willingness from staff, of all grades, to work seamlessly to meet the needs of the patients.

[4] www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/T4I %283%29 SBAR.pdf
[5] www.cwmtafuhb.wales.nhs.uk/news/37847
[6] www.cwmtafuhb.wales.nhs.uk/opendoc/218999
[7] www.cwmtafuhb.wales.nhs.uk/opendoc/165833

Despite this, HIW could not always be assured that health services are consistently of a high quality and that a safe service is being provided. This is because there were not always enough staff with the right knowledge and skills available at the right time to meet people's needs. This was an issue identified in some areas of all health boards. Specific concerns related to the high dependency on bank and agency staff, staffing levels not adequate for the acuity of patients and limited opportunities and inconsistent approaches to training.

Quality and safety

Overall, we found evidence of systems in place to monitor, audit and manage patient safety and the quality of the environment, care and treatment. However, HIW could not always be assured that people's health, safety and welfare is actively promoted and protected. This is because risks are not always identified, monitored and where possible, reduced or prevented. Particular themes identified and recommendations made in this respect included:

- **Medicines management** – not all staff understanding the correct procedures to follow regarding the storage and administration of medication and to ensure compliance with local policy and Nursing and Midwifery Council (NMC) guidelines
- **Documentation** – improvements required to aspects of patients' care. Also, that all staff understand the principles and need for consistently high standards of record keeping
- **Audit and clinical effectiveness** – The need for effective and recognised quality improvement methodologies, activities and programmes, with the results being acted upon. Including sharing outcomes with patients, staff and the public.

Case Study 1

HIW undertook a ***follow-up inspection on the 24 March 2015***[8] at Penhow ward, St Woolos Hospital, Newport. The purpose of this visit was to establish the extent of the progress made by the health board to address the areas for improvement identified at the previous ***HIW inspection (3 and 4 December 2014)***[9].

- The standards of hygiene had improved considerably at this follow-up inspection. All areas occupied by patients were visibly clean and toilet and bathing areas were fresh. The ward cleaning schedule had been revised and improved and the care environment was free from clutter and trip hazards.
- The health board and ward team had introduced a variety of systems and procedures to ensure improvements were made to the quality of aspects of health and social care for patients within Penhow ward. This was in direct response to findings at our previous inspection and in accordance with the current Fundamentals of Care.

Penhow ward had not been in permanent use since 2012. This meant that the workforce in this area of the hospital had been transient and unstable. The health board however made a decision (September 2014) to keep Penhow ward open until October 2015 and appointed a new manager to the ward (on secondment) four weeks prior to our December 2014 inspection.

[8] www.hiw.org.uk/opendoc/269008
[9] www.hiw.org.uk/opendoc/259534

During the course of this follow-up inspection we found demonstrable improvement with regards to workforce skills, knowledge and stability of the ward team. Use of bank and agency staff had diminished and the health board had recruited five additional registered nurses at St Woolos Hospital, some of whom had been assigned to Penhow ward.

We found that improvements had been made in an effort to ensure that patients' health, safety and welfare was actively promoted and protected. More specifically, staff were in the process of being provided with training regarding the application of the Mental Capacity Act and Deprivation of Liberty Safeguards legislation. The ward team was also being supported and advised by representatives from the health board's Older Adult Mental Health services to ensure that no patients were being unlawfully deprived of their liberty.

Since our first inspection all staff at Penhow ward had been reminded of the importance of the safe administration of medicines and the health board medicines management policy. In addition, all registered nurses had completed a supervised practice drug round with the ward manager which had resulted in the consistent application of professional standards and health board policy.

Overall, we found evidence that the health board had made significant improvements to the service provided to patients within Penhow ward.

Dental Inspections

In 2014-15 HIW began a 3-year programme of inspections of all general dental practices in Wales. 77 dental practices were inspected.

During these visits a number of key themes arose.

- Some practices did not conduct regular checks of their sterilising equipment to ensure it was working correctly. We found a few practices where relevant dental equipment was not sterilised after each use.
- Several practices did not comply with the relevant regulations relating to the safe use of radiographic (x-ray) equipment. Practice staff did not always receive appropriate training, and just over a quarter of the practices we inspected did not conduct regular checks to confirm that radiographic equipment was working effectively.
- The complaints procedure in over half of the practices we visited did not comply with the NHS 'Putting Things Right' arrangements for NHS patients. In some practices owned by UK-wide corporate providers, policies were generic and had not been adapted for use in Wales.

We also saw some areas where good practice was observed.

- Patient records were of a satisfactory quality
- There were suitable procedures in place to respond to patient medical emergencies when they occur
- Patients across Wales told us they were generally satisfied with the service they receive from their dental practice.

We have seen that across Wales practices have taken action to improve the service they provide to patients as a direct result of our inspections.

We also supported improvement by attending Local Dental Committee meetings to present our inspection process and answer questions about how practices can improve to ensure they meet the required standards. We attended the All Wales Health Board Dental Operational Group meeting to build effective links with health boards to drive improvement.

In addition we liaised with the Wales Deanery for Postgraduate Dental Education to ensure our inspection findings feed into their training programmes for dental professionals.

GP Inspections

HIW completed a pilot programme of 34 inspections of General Practices (GP's) during 2014-15.

In these inspections, HIW chose to examine the particular themes of communication and continuity of care, record keeping, and dealing with complaints. These themes were informed by the Welsh Government's document *'Learning for the future – Taking forward and building on recommendations from the Robert Powell investigation'*[10].

A number of key themes arose from the pilot programme.

- Communication between hospitals and GPs when a patient is discharged from hospital is generally inadequate. We saw evidence of discharge notices from hospitals of very poor quality.
- Across Wales we found that access to appointments was an issue for patients.
- Communication with patients, especially those with additional needs, could be improved. The provision of information in a range of formats, addressing language and communication needs, had not been considered by most practices.
- GP practices we inspected did not usually record informal or verbal complaints so trends or themes were not identified and addressed.

[10] www.gov.wales/topics/health/publications/health/reports/powell/?lang=en

We also found some areas where good practice was followed:

- We saw that the referral process from a GP to hospital usually works well. We were told that efficiency has been improved since the introduction of an electronic system
- Patient records were generally easy to understand, contemporaneous and recorded in sufficient detail to provide continuity of care if a patient were seen by a different clinician
- Practices we inspected handled formal complaints in accordance with the national arrangements for NHS complaints (Putting Things Right)
- Patients were very satisfied with the care and treatment they receive from their GP practice and were very complimentary about the staff. Patients reported that they were generally happy with the opening times of their surgery.

We saw that across Wales practices took action to improve the service they provide to patients as a direct result of our inspections.

As a result of the success of this pilot, HIW has now added inspections of GP practices to its annual programme. We have also informed Welsh Government about the quality of discharge information available to GPs so that this can be addressed across Wales.

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)

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'.

Given the specialist nature of this area of work, HIW works with the Medical Exposures Group of 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.

During 2014-15 HIW undertook four IR(ME)R proactive compliance inspections of diagnostic imaging departments across four health boards in Wales.

From the 4 inspections undertaken in 2014-15 we found that there was significant variation in the extent to which the health boards and the specific hospital locations were compliant with IR(ME)R.

One of the key issues that emerged from our inspections was in relation to the variations and standards of policies and procedures. The regulations require the employer to have written procedures and protocols in place however the standard of these documents were variable.

The standard of training records we observed during our visits was extremely variable. In some health boards training records were available at all sites however they were often different in format, whilst at others comprehensive records were in place and up to date.

There was clear evidence that clinical audit was taking place at all of the sites we visited however as with such things as training records the approach and standard of audit varied considerably. In some areas most of the audits tended to be carried out by radiologists, in others there was no dedicated audit programme but there were audits being undertaken and in others there was effective and efficient coordination of audit which provided background details, context and clear outcomes followed by shared learning.

We will be publishing a detailed report on our IR(MER) work during the summer 2015 which provide a more in depth analysis as a basis for sharing good and noteworthy practice.

Death in Custody Reviews

HIW has completed 10 clinical reviews on behalf of the Prison and Probation Ombudsman (PPO) since April 2014. Of these, 7 deaths have been of natural causes, and 3 deaths were suicide.

There have been a series of issues highlighted in the individual clinical reviews carried out by HIW. However, the key themes are in regards to record management; chronic disease management; communication and cancelled appointments between the prisons and the local hospitals.

During 2014-15, we improved the links with policy leads for Offender Health in Welsh Government, in particular to ensure that issues emanating from our reviews are shared with them. We have also implemented a follow up system to ensure that health boards are being formally notified of any issues that arise for them to address from our clinical reviews.

HIW has shared the findings from our Death In Custody reviews with the *'Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds'*[11] being conducted by Lord Harris. We also routinely attend the Prison Healthcare Improvement Network meetings. This is another mechanism whereby HIW shares the learning from our clinical reviews to improve outcomes for others.

[11] www.iapdeathsincustody.independent.gov.uk/harris-review/

Betsi Cadwaladr University Health Board Governance Review

During 2014-15 HIW and the WAO published *'An Overview of Governance Arrangements; Betsi Cadwaladr University Health Board: A summary of progress against recommendations made in June 2013'*[12].

This was a follow-up review to the previous report published in 2013, with the aim of assessing progress made by the health board in respect of the recommendations.

While our follow-up identified evidence of progress, some of it significant, a number of the fundamental challenges that were identified during 2013 still existed and the health board still had considerable work to do before its governance and management arrangements could be regarded to be fully fit for purpose.

Subsequently, partly as a consequence of the lack of progress found in our review, at an *NHS Escalation and Intervention*[13] meeting held in October 2014 the Betsi Cadwaladr University Health Board was placed under 'targeted intervention'. This escalation status was elevated further at an extraordinary NHS Escalation and Intervention held in June 2015; here it was recommended the health board should be placed in Special Measures.

HIW and the WAO are therefore undertaking further follow-up during 2015-16 to assess what progress the Health Board has made in relation to several key areas, which include:

- Governance, leadership and oversight
- Mental health services
- Maternity services at Ysbyty Glan Clwyd
- GP and primary care services, including out-of-hours services
- Reconnecting with the public and regaining the public's confidence.

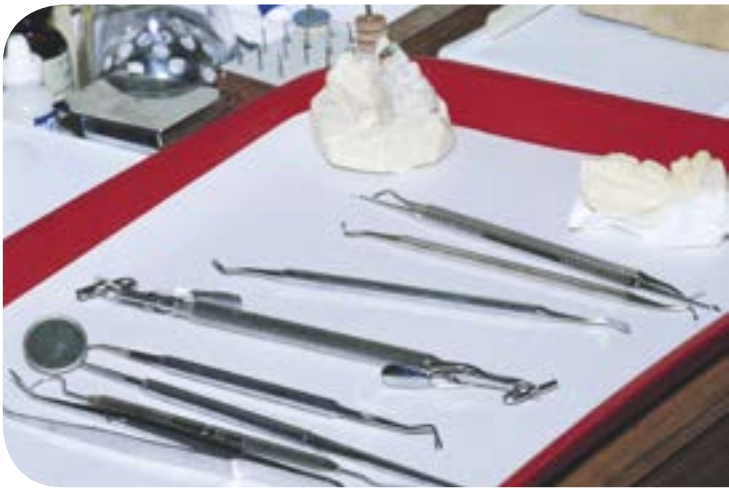
Further Information

Reports on all of our inspections are published on our website under *Find Our Reports and Reviews*[14]

[12] www.audit.wales/system/files/publications/Betsi_Cadwaladr_UniLHB_ Followup_English_2014.pdf
[13] www.gov.wales/topics/health/publications/health/guidance/escalation/?skip=1&lang=en
[14] www.hiw.org.uk/documentmap/

Regulation of Independent Healthcare

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.



In 2014-15 HIW registered 24 new settings, these ranged from mental health hospitals to laser and intense pulsed light services. These settings also included a child and adolescent mental health hospital, a religious circumcision clinic, a service carrying out clinical research and an agency providing telemedicine consultation and treatments for dermatological and allergy issues. In addition, HIW also registered 12 new managers of settings currently registered and 7 major variations to existing registrations. HIW also register individual private dentists, in 2014-15 we registered 127 new dentists who are now able to provide private dental services in Wales.

As part of the registration process HIW hold interviews with applicants, carry out a visit to the premises and scrutinise the services policies and procedures to ensure they are compliant with the relevant regulations and standards. HIW will only register a service if they can demonstrate they comply and can continue to comply with the regulations and standards. If the service is able to demonstrate this then registration will be granted. In doing this HIW can ensure that at the point of registration the service is safe for the people that use it.

HIW also carried out investigative work into information we received about settings providing services that were not registered, this work resulted in 10 unannounced visits to these settings. These visits were to establish whether registerable services were being provided and to advise that to do so is an offence for which they could be prosecuted.

Key themes

During 2014-15 HIW conducted 26 inspections and visits to independent healthcare services. Where significant concerns were identified we issued an immediate assurance letter. Immediate assurance letters were issued on 10 occasions.

On most inspections we do pick up a number of issues. During these visits a number of key themes arose.

Governance

Of those visited over three quarters of services required improvement to ensure on-going effective governance and management arrangements were in place. For example, we found updates were required to staff personnel files and revisions to policies and procedures. In some cases, we found staff lacked awareness and understanding of the organisations policies that guide their day-to-day work. We found staff appraisals, mandatory training and regular clinical supervision had been undertaken and not recorded, or not been conducted. These areas are important to assist and maintain the quality and safety of the care provided, and to ensure patients are treated by staff who have appropriate skills and up-to-date training.

Safe and Effective Care

At approximately three quarters of services we inspected, we found there were improvements needed to ensure safe and effective care was provided. For example, we found the arrangements and documentation around the supply of medication needed review. Improvements were needed to patient records to ensure contemporaneous assessment and care planning was undertaken and record keeping was carried out.

Good record keeping and medicines management is essential to ensure that people receive effective and safe care. We also found improvements were needed in some cases to infection control arrangements, including cleaning policies and schedules. This is important to ensure that patients are protected from cross-infection.

Premises and Environment

At over three quarters of services we inspected we found improvements were needed to the premises and environment. For example, we found fire risk assessments were not always completed and up-to-date and regular testing to fire alarms and emergency lighting were not always completed. This is important to ensure that suitable fire protection and prevention is in place to protect patients and staff from the risk of fire. We also found instances where checks of gas, electrical wiring and portable appliances were not regularly conducted. This ensures that equipment and facilities used at the service is safe for use.

Areas of Good Practice

We also saw some areas of good practice. For example, at a healthcare advice service we found that staff provided high levels of patient focused care and compassion, with a significant amount of time given to addressing individual patient needs. The privacy and dignity of patients was maintained at all times. We spoke to one patient who said she had been treated with sensitivity and compassion from beginning to end. From her first contact with the centre, she had found staff professional, helpful and been assured of confidentiality. The patient was confident that the quality of her care was of a high standard and that medical and nursing staff were competent, knowledgeable, and explained everything and were able to answer all her questions and concerns.

Another example of good practice we found was at a hospital specialising in paediatric treatment. Children, families and the staff caring for them were interviewed at each stage of the healthcare journey and we found a high standard of clinical and child

and family-centred emotional care was delivered by appropriately qualified and experienced staff. The staff communication and interaction with children was good with extra care being given to nervous or anxious children and parents. Exceptional practice was demonstrated in the anaesthetic room prior to and during a nervous child's anaesthetic induction process, the communication was effective, age appropriate and calming for the child and parent. The environment of care was excellent in relation to the range of age appropriate bedding available and the variety of play and distraction materials provided. The children and families interviewed were very pleased with the service delivered. All parents stated that the care and treatment of their child was either up to, or beyond, their expectations.

Case Study 1

Following an inspection to an independent hospital in 2014, we received positive feedback from the hospital manager which indicated how HIW inspections have helped to drive improvement at the service. As a result of several years of hard work from the staff and management to make improvements, in the last inspection by HIW in 2014, no regulatory breaches were identified.

"…a thorough inspection was more than valuable to me as it provided me with a base line whilst giving me a greater understanding of the required standards that I need to achieve or maintain."

"Prior to the inspections I rarely contacted HIW unless I had a problem I needed to share. Therefore, I do feel that my relationship with HIW has greatly improved as I am more likely to contact HIW for advice, support or reassurance and not just to share negative information."

"Overall, I have to say that following 4 recent inspections, we are pleased that our relationship with HIW has developed. I personally and we as a hospital have gained a lot of insight in to the required national minimum standards and found the inspections overall a positive and beneficial experience."

Case Study 2

During an initial inspection of a hospice, we identified several areas of improvement needed including the procedures for the administration and recording of controlled drugs, completion of mandatory training and areas of premises/facilities in order to ensure patients were protected and received safe care. Due to the issues identified, a follow-up inspection was made in which we saw that ongoing progress had been made and issues relating to premises had been actioned. Furthermore, a new member of staff had been specifically employed to review systems, such as policies and procedures, and implement and/or re-establish programmes including mandatory training updates.

Further Information

Reports on all of our inspections are published on our website under *Find Our Reports and Reviews*[15]

[15] www.hiw.org.uk/documentmap/

Mental Health and Learning Disabilities

Mental Health and Learning Disability Inspections

Our mental health and learning disability inspections cover both independent hospitals and mental health services provided by the NHS. Inspection visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services in Wales. The inspections also fulfil our legislative responsibility to monitor Parts 2 and 4 of the Mental Health Measure (2010) by reviewing individual patient care and treatment plans to ensure that patients have a Care Co-ordinator appointed and patients have a comprehensive mental health and physical health assessment.

During 2014-15 our workbooks have been reviewed. Firstly to ensure our focus remains appropriate and updates in legislation are reflected. Secondly, to streamline our workbooks as one suite of documents that enable all aspects of our work to be covered during monitoring and inspection visits. The ***full suite of workbooks***[16] were published on our website in June 2015 and we will continue to review and update them to ensure our work remains focused on services providing quality services that are patient centred.

The way we report our findings to hospitals changed from management letters to reports. Our reports provide more context to our visits and enable readers to have more in depth information regarding the setting, our findings, our recommendations and next steps. We ask all hospitals to provide an action plan outlining how and when they will achieve the recommendations and we monitor progress accordingly. All our reports, action plans and updated action plans are published on our website.

Throughout this inspection year we have issued 17 immediate assurance letters which have enabled us to have quicker assurance over some of the more urgent findings from our visits.

We identified a number of themes during our inspections last year relating to low staffing numbers, a lack of training in key areas including patient restraint, a lack of planned maintenance (this was a particular issue with the NHS), a lack of patient recreational and social activities, the lack of essential policies and procedures and a lack of robust governance and clinical audit processes.

[16] www.hiw.org.uk/mental-health-workbooks

Staffing

Across both NHS and independent sector hospitals we have noted a lack of appropriate numbers of staff for the number of patients being cared for. This has resulted in a number of issues for patients, specifically:

- some patients being unable to take ***section 17 leave***[17]
- some patients being fearful of their safety because of unsatisfactory staffing levels
- some patients not receiving regular one-to-one time with their named nurse
- some patients being unable to undertake activities because there is not enough staff available to facilitate
- staff unable to take their breaks because there is no cover available.

Training

We have identified gaps in staff training across NHS and independent hospitals, however compliance with mandatory training requirements is better in the independent sector than the NHS. Nearly all the NHS hospitals we have inspected were considered to have poor compliance against a number of training areas, including Mental Capacity Act, Mental Health Act 1983, restraint training and manual handling. The deficit in staff skills can have detrimental effects upon patient care.

Maintenance

Maintenance issues are a primary theme occurring across both NHS and some independent sector hospitals. The NHS hospitals we have inspected have had more significant maintenance issues, requiring more complex repairs which has had a marked effect upon the hospital, staff and patient group. Across NHS hospitals we have noted on a number of occasions that the lack of response to the reporting of maintenance issues has resulted in significant deterioration of the premises. Concerns we have raised and identified range from broken facilities including washing machines and doors, dirty and unkempt patient areas including patient gardens and courtyards to more significant areas including roof leaks, electric cabling issues and broken/missing ceiling tiles. In addition, with a number of health boards there is an issue with the decommissioning of large old psychiatric hospitals with dates for complete closure being revised for many years. For a number of years there has been a lack of adequate maintenance of these hospitals and now many wards are in a serious state of disrepair whilst patients still remain accommodated there.

Activities

A lack of recreational and social activities is a recurring theme with particular concern at weekends, when not all professions are working to provide and support patient activities.

[17] Section 17 leave - Formal permission for a patient who is detained in hospital to be absent for a period of time. Patient remains under the powers of the Act when they are on leave and can be recalled to hospital at anytime www.legislation.gov.uk/ukpga/1983/20/section/17

Policies and Procedures

During the review of a number of health boards with one in particular there has been issues with a lack of robust and clinically sound policies and procedures for staff to follow. This is unacceptable and does not give patients, staff and others the level of protection and confidence with the care that they receive.

Governance and Clinical Audit

During the review process of both NHS and private providers a number of very significant issues have been identified by HIW. We are concerned that both NHS and private providers are reliant on HIW inspections to identify areas of poor practice and concern but should instead have robust governance processes in place to identify the issues themselves and take appropriate action.

Areas of Noteworthy Practice:

Throughout our mental health and learning disability inspection visits we have noted a number of areas of noteworthy practice, including:

- the level of psychology input across the independent sector is noteworthy
- the increase of NHS hospitals working towards and obtaining external accreditation, including Accreditation for Inpatient Mental Health Services (AIMS), Star Wards and Safewards is to be commended
- some independent hospitals have and are investing financially into their services and undertaking vast improvement renovations of patient accommodation
- a multi disciplinary team working across both NHS and independent hospitals is generally effective and inclusive of all professional disciplines that attend with patient needs at the forefront of discussions and outcomes
- the openness of staff and patients to engage with the inspection process across both NHS and independent hospitals is generally very good.

Monitoring the Use of the Mental Health Act

HIW has specific responsibilities to monitor the Mental Health Act. Throughout 2014-15 we conducted 77 Mental Health Act monitoring visits. A total of 59 of these visits were undertaken as part of our in-depth mental health reviews. We did not find any consistent failings regarding the Act throughout Wales. Overall there is a very high compliance with the mental health Act in both the NHS and independent sector. If any issues are identified during our inspections actions are taken by the providers to promptly rectify any issues and inform patient when required.

Organisations using the Mental Health Act, use statutory documentation to help ensure compliance with the Act. Where statutory documentation has not been prescribed by Welsh Government, health boards and independent providers have established their own prescribed forms to ensure compliance with the Act and guidance on the Code of Practice is consistent across their organisations.

However, we noted the majority of individual Mental Health Act administration teams (established by the health boards and independent providers to ensure that patients' safeguards under the Act are upheld by the organisations) have their resources stretched to undertake their role in ensuring patient safeguards are upheld, i.e. appeals against detention, provision of rights monitoring, consent to treatment safeguards, etc. both for inpatients and patients in the community on CTOs (Community Treatment Orders).

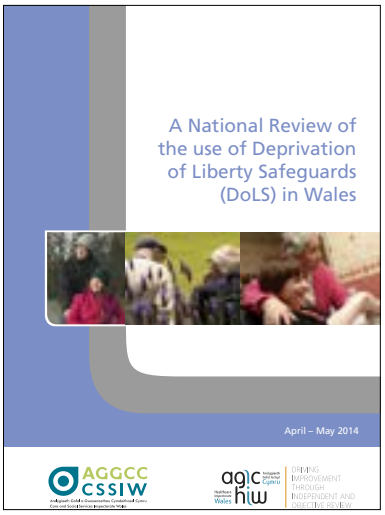
In addition, there is a lack of unified electronic systems across different health boards and external agencies such as Local Authorities, Ministry of Justice and the Police, who could all be involved with patient.

Other Activities

During the year we also supported improvements in a number of areas in a variety of ways. For example, we observed an inspection conducted buy the NHS Wales Quality Assurance Improvement Team in order to share methodologies and learn from each other's approaches. We have also undertaken a number of pieces of work with a range of local authorities, police and local health boards in terms of safeguarding the welfare of patients. These pieces of work included attending specific Protection of Vulnerable Adults meetings where there may have been potentially regulatory breaches by independent healthcare providers.

In addition, we attended five Local Intelligence Networks to share information regarding Controlled Drugs (CD). HIW also maintains a list of Accountable Officers regarding CDs for the health boards and independent providers. These individuals are the link individual who has statutory responsibility regarding these drugs.

Deprivation of Liberty Safeguards (DOLS)



Within the review process of the NHS and private providers the area of patients who maybe subject to DOLS is considered. The relevant paperwork including individual patient assessments is examined to ensure a robust process is in place to adequately protect patients.

We work jointly with the Care and Social Service Inspectorate (CSSIW) on this area of work and in addition to the ***Annual Monitoring Report***[18] published in March 2015 we also collaborated with CSSIW to undertake a ***'National Review of the use of the Deprivation of Liberty Safeguards'***[19] which was published in November 2014 to coincided with a national conference which provided delegates with updates on the legal position with DOLS, findings from the national review and a look forward to future plans and intentions.

HIW also attends the Mental Capacity Act and Deprivation of Liberty Safeguards leadership group to discuss legislative changes and good practice.

Homicide Reviews

HIW is responsible for undertaking external independent reviews of homicides when the perpetrator is a mental health service user. HIW do this so that the bodies responsible for and involved in the care, treatment and support of the individuals are identified and necessary improvements can be made.

During 2014-15, HIW published two reviews of homicides committed by individuals known to mental health services. Both of these reviews received significant attention when they were published.

Whilst they both highlighted issues specific to the individual cases there were some broadly common issues:

- Communication was a factor in both cases, whether it related to communication between services, it between those working within services
- In both cases, it was difficult to engage with the individuals
- Non adherence with medication/non compliance with treatment
- Both lacked insight into their condition
- No recorded threats to members of the public
- Poor discharge planning was a factor in both cases
- Organisational and systemic shortcomings identified.

[18] www.hiw.org.uk/opendoc/259900
[19] www.hiw.org.uk/opendoc/251546

In both cases it was difficult to determine the predictability of the tragic events that occurred. Neither case highlighted any significant previous risk to others and in both cases the care and treatment provided to these individuals could have been better, but there is no absolute guarantee that this would have prevented a tragic event from occurring.

In order to assist with ensuring that the learning from these tragic events is shared, HIW presented the key themes and findings from these reviews at a 'National Sharing Learning from Untoward Incidents in Mental Health Services' event held in March 2015. These events are facilitated by Public Health Wales and include senior professionals and incident teams within mental health services from across Wales. The meetings provide an environment where issues and lessons can be shared. HIW is a key contributor to these events and meetings.

Public Health Wales also aided HIW in developing a pilot 'closing the loop' project whereby actions identified following a homicide review, were followed through to ensure they were implemented. As a result HIW will be continuing with this approach and applying it to the two homicide reviews published in 2014-15 to ensure the recommendations of these reviews are fully addressed.

This work in sharing the learning was noted and highlighted by the Equality and Human Rights Commission as excellent examples of learning and sharing information from investigations in its report ***'Preventing Deaths in Detention of Adults with Mental Health Conditions; An Inquiry by the Equality and Human Rights Commission'***[20] which was published on 23 February 2015.

In order to fully understand the impact that the 13 homicide reviews published by HIW since 2007, HIW's Operational Plan states that during 2015-16 we will conduct a thematic report on lessons learned from previous homicide investigations. This work will assess the impact that HIW reports, and the recommendations issued since 2007, have had on services that are being provided to mental health service users.

[20] www.equalityhumanrights.com/sites/default/files/publication_pdf/Adult%20Deaths%20in%20Detention%20Inquiry%20Report.pdf

Supervision of Midwives

HIW fulfils the function of the Local Supervising Authority and therefore is responsible for ensuring that statutory supervision of all midwives is exercised to a satisfactory standard across Wales. 2014-15 saw significant changes to the way in which these responsibilities are discharged with a new model of supervision coming into being on the 4th August 2014. The overarching aim of the new model was to improve the quality of statutory supervision in Wales through the appointment of supervisors, to work full time as a Supervisors of Midwives (SoMs), for a rotational 18 month period. The SoMs are dedicated to the role of supervision thereby increasing their visibility and accessibility to midwives and service users.

One issue the new model was intended to tackle was to improve both the quality of and compliance with the Annual Supervisory Review (ASR) process. To do this we have introduced the concept of group supervision rather than a 1:1 meeting between SoM and Midwife. The introduction of this has been an unrivalled success winning over many midwives and some supervisors of midwives who were initially sceptical about the concept. Regular evaluation following each of the sessions has identified positive aspects such as learning from others and gaining insight into challenges faced by other staff groups. There is currently a small study evaluating the outcomes as a precursor to NMC Revalidation for midwives and nurses. In addition to the benefits for midwives and supervisors the group supervision concept has had a positive impact on the compliance with the ASR process. On the 31st March 2015 there was 100% compliance with the ASR process and at the time of reporting, 99.2% of midwives in Wales had an ASR uploaded to the LSA database. This a positive impact from the implementation of the new model showing an upward trend from the previous year of 97% reported to the NMC.

Building on the concept of group supervision, the model has also introduced record keeping group sessions to peer review records which provide a convivial environment to examine the very serious subject of shortcomings in the standards of record keeping. These active learning sessions have been well received and evaluated as shifting the power to the midwives to take ownership of the problem rather than a tick-box exercise which failed to make sustained improvements to date.

The new model also has benefits for student midwives and newly qualified midwives who are having three contacts with supervisors of midwives during the year rather than very ad hoc arrangement in the previous model. The team of supervisors are building on the support for newly qualified midwives by devising an All Wales preceptorship programme to support midwives to consolidate their practice in their first year as a newly appointed midwife.

Investigating incidents and complaints where midwifery practice may have been suboptimal was a particular challenge in the traditional model in meeting a 45 day timeframe and quality of the process and investigation report. The

LSA is pleased with the progress of achieving 75% of investigations with the timeframe with an expectation of further progress once the model becomes well embedded. Heads of Midwifery, Supervisor of Midwives, midwives and union representation are now very positive about the revised process in terms of timely reports and the benefits of external supervisors now available to undertake the investigation process.

The Nursing and Midwifery Council undertook the three year quality assurance visit in December 2014 and reported the new model of statutory supervision as innovative and effective. The NMC[21] described the model as an example of excellent change management. They reported that Directors of Nursing (DoNs) and Heads of Midwifery (HoMs) were impressed with the effective way that the LSA worked in collaboration with Welsh Government, health boards and service users. DoNs and HoMs shared with the NMC that they were now satisfied that the risks which had previously existed with the former approach to midwifery have been resolved with the new model of supervision.

The LSA lay reviewers are key to the LSA audit process as they are responsible for seeking the views of maternity service users and assessing their awareness of supervision from an independent perspective. The involvement of the lay reviewers in supervision of midwives during the year has been extensive by confirming that maternity service users particularly value the service provided by SoMs. The lay reviewers concluded from their audit process that group supervision is an effective mechanism to ensure that midwives practise is kept under review to enhance public protection, and allows the sharing of best practice and joint learning.

The Kirkup Report (March 2015)[22] has endorsed the need for the NMC and Department of Health to act upon the recommendations of the Kings Fund urgently. The LSA in Wales is in a stronger position as a result of seeking new and better way of providing supervision of midwives. The LSA has challenged the status quo and addressed many of the risks identified by Kirkup and Parliamentary Health Service Ombudsman report[23] for England. The Chief Nursing Officer is currently linking with CNOs from all four countries to use the evaluation of the model to consider the most effective elements of supervision, such as leadership, peer review/support and guidance and include them in the revalidation requirements for nurses and midwives.

[21] NMC (2015) HIW LSA-Monitoring review of performance in mitigating key risks identified in the NMC Quality Assurance framework for local supervising authorities for midwifery supervision. NMC London
[22] Kirkup (2015) The Report of the Morecambe Bay Investigation www.gov.uk/government/news/morecambe-bay-investigation-report-published
[23] Parliamentary & Health Service Ombudsman (2013) Midwifery supervision and regulation: recommendations for change.

Organisational Improvement

Dealing with Concerns

We have significantly improved and enhanced our internal processes for dealing with issues of concern. In particular we have introduced a ***Risk and Escalation Committee***[24] that meets on a monthly basis to:

- Consider the intelligence that we hold on health services and whether this indicates a risk of quality and safety standards not being met
- Reach a conclusion on whether action is required by HIW as a result of the assessment of risk.

The forum considers issues that emanate from concerns or enquiries made to HIW and determine, dependent upon level of risk, what the appropriate action may be.

We are also a member of the ***NHS Escalation and Intervention***[25] arrangements. These arrangements outline how the Welsh Government and external review bodies may seek to identify and respond to serious issues affecting NHS service delivery, quality and safety of care, and organisational effectiveness

Working with partners

During 2014-15, HIW revised the format of the annual Healthcare Summits. Changes including reducing the format of the summit from 10 individual meetings each lasting half a day; to one all day meeting where all 10 health boards and NHS trusts where discussed. The revised format ensured that the intelligence shared on the day was more focussed on the high level concerns and priorities of each organisation. It provided the opportunity to flag strategic national concerns.

In addition, HIW introduced a second Healthcare Summit day, so that information shared was more timely and relevant. This revised format, has ensured that HIW's contribution at the Escalation and Intervention tripartite meetings is informed by intelligence held by a wider network of partner bodies.

During 2014-15, the Concordat membership was expanded to include all statutory bodies that regulate health and social care professionals in the UK. As a result we are able to share relevant information more routinely with a increased range of partner organisation to support our and their work programmes. This was achieved by revising and refreshing 11 existing ***Memorandum of Understanding***[26] with partner organisations and the identification and establishment of new agreements with additional Professional Standards Authorities.

[24] www.hiw.org.uk/sitesplus/documents/1047/HIW Statement of Risk.pdf
[25] www.gov.wales/docs/dhss/publications/140320escalationnhsen.pdf
[26] www.hiw.org.uk/working-with-partners

HIW has attended and presented at the Welsh Independent Healthcare Association (WIHA) throughout 2014-15. The last meeting in June 2015 was an important information sharing session in which HIW and WHIA members engaged in discussions about HIW's approach to inspections of independent healthcare. HIW has noted the feedback from WHIA for the need for greater consistency around the report and inspection format, but also that it is positive HIW have moved away from previous report formats. Positive feedback from WHIA also included the following:

"2014-15 has seen improvements in HIW's interactions with hospitals".

During the year we also collaborated with The Palliative Care Implementation Board in the conduction of an end of life peer review project. The aim of the review was to develop and implement a peer review model that drew on the extensive clinical expertise we have across Wales. During 2014, peer reviews were conducted at two hospices. This was important in helping to identify the best ways to support patients, families and carers with end of life care needs.

Peer and Lay Reviewers

During 2014-15, HIW continued to work closely with both lay reviewers and clinical peer reviewers across the HIW work programme.

Lay reviewers listened to the voice of the patient to ensure that the patients' perspective was reflected in our work. Community Health Council members provided the lay perspective during the pilot of GP practice inspections.

HIW recruited large numbers of health professionals with a current health care registration to work with us as peer reviewers within the inspection teams. Our panel has increased from 33 to 202 and contains professionals from a range of specialities including nurses, doctors, dentists and pharmacists. Peer reviewers bring relevant and current clinical knowledge and advice to HIW inspection and review.

HIW supported the "Trusted to Care Ministerial Spot Checks" by securing peer reviewers to take part in these inspections.

In a short survey, HIW asked peer reviewers how their experience of working with us may have influenced changes in their organisation to improve patient experience or clinical practice. Here's what they said:

Dental Peer Reviewer

"One practice that I visited was excellent in that they had a board in the waiting room with different themes like: decontamination, complaints, training of staff etc and had pictures of how it is done in that practice, these were displayed in the waiting room with laminated posters for patients to view and be assured that they were following good standards in each theme. Talking to patients, they appreciated this transparency and I have taken this on board in my own practice."

Pharmacist Peer Reviewer

"I retired from full-time work in August 2014 and became an external pharmacy reviewer for HIW and the Care Quality Commission in England. I continue to work occasional locum days in hospital pharmacy to maintain my clinical expertise and I have found that organisations are very keen to ask my advice as to whether their current practices are in line with what HIW would expect to see. I have been able to provide input to these organisations to improve practice in Medicines Management and internal audit frequency and scope."

Nurse Peer Reviewer

"Having recently retired from the NHS where I worked as a Mental Health Act Manager, I am no longer able to influence change as such. However, I still deliver Approved Mental Health Professional training at a University on Mental Health Act prescribed forms and associated documentation. In doing so, it is important to specifically relate to the potential impact of the Mental Health Act on those affected by it as well as the necessity for lawful and quality completion of documentation and records. Working as a peer reviewer has given me the opportunity to assess Mental Health Act documentation and records in various settings to identify varying standards, the aim being to enhance future training and improve patient experience."

GP peer reviewer

"We have investigated a course for our senior nurses in the management of minor illness and 2 of our nurses are currently undertaking Independent Prescribing courses. I was alerted to these two possibilities during the course of a practice review."

We also asked peer reviewers about their experience of working with us. This is what they had to say:

Dental peer reviewer

"A very positive experience. I have enjoyed meeting the inspectors and feel the inspections are helping others to raise standards and improve patient care, whilst improving my practice at the same time. The meeting with other existing reviewers was very interesting and productive."

Nurse peer reviewer

"I have been very impressed with the level of communication and engagement that I have been involved with to date. I have colleagues who are involved at a similar level with other regulators who have not had such a positive experience as I have. I believe the induction day and prep was invaluable and I was immediately made to feel part of the team. It was a fantastic learning opportunity and also allowed me to build relationships with HIW."

We have also received valuable feedback from our reviewers on how we can continue to improve in areas such as clarity of objectives at the beginning of inspections, ensuring they are kept up to date with news about HIW and ensuring they receive feedback on their roles following inspection activity.

Learning and Development

Learning and development for both staff and reviewers was an important focus for HIW during 2014-15. We introduced an induction programme for staff which contained a comprehensive training plan including appropriate guidance from the Clinical Director. This enabled us to provide bespoke training for inspection managers, supporting their continuing professional development. Here is an example of feedback received from a peer reviewer which describes this improvement:

> "The inspection managers have been supportive and knowledgeable and have had excellent communication skills with the ability to deliver both positive and negative points of inspections in such a way that promotes integrated working with those being inspected."

The learning and development plan was developed as a result of working closely with staff, many of whom were new to HIW. Staff increased their knowledge and skills by having access to a variety of learning opportunities. We introduced a blended approach to learning and development which enabled staff to attend conferences, training days, information sessions and access e-learning packages.

Peer and lay reviewers attended induction and training days which equipped them with the skills required to take part in inspections. HIW introduced a comprehensive feedback process which inspection managers utilised to provide feedback to reviewers following their participation in an inspection. This process gave reviewers the opportunity to feedback on their experience of the inspection. This information was utilised to provide support, identify training requirements and make changes to inspection methodology.

Communications

In April 2014 we launched a new website which makes searching our library of reports easier and more accurate. We recognise that there are still improvements to be made and further developments will be progressed during 2015-16.

We have updated our ***Public Information leaflet***[27] and ***Complaints Documents***[28] ensuring they are providing up to date information for members of the public.

We launched our ***Twitter account***[29] in March 2015 which allows us to connect with the public and stakeholders through social media, increasing awareness and visibility of our role and the readership of our reports.

[27] www.hiw.org.uk/opendoc/267991
[28] www.hiw.org.uk/raise-a-concern
[29] www.twitter.com/hiw_wales www.twitter.com/AGIC_Cymru

One of our main communications targets for the year was to improve the timeliness of reporting and we set ourselves some very tough targets. These were:

- To report issues of immediate concern within 2 days
- To provide the inspected setting with a draft report within 3 weeks
- To publish the final report within 3 months.

We didn't meet them all but the following table shows that we published 67% of our reports within 3 months of the inspection taking place.

Immediate assurance letters issued within 2 days	68%
Provide the inspected setting with a draft report within 3 weeks	61%
Publish the final report within 3 months	67%

In addition to the key performance indicators above, we know that 83% of our reports were published within 100 days. We published 4 reports more than 150 days after the inspection visit, with our longest publication lag is 164 days. We have conducted a short internal investigation to understand what went wrong in these cases and have implemented the lessons learned.

Finance

The following table shows how we used the financial resources available to us to deliver our 2014-15 Operational Plan.

	£000's
HIW Total Budget	**3.007**
Expenditure:	
Staff costs	2.462
Non-staff costs	0.266
Reviewer costs	0.588
Total Expenditure:	**3.316**
Income:	
Independent healthcare	0.261
Dental registry	0.090
Total Income:	**0.351**
Total Net Expendutire:	**2.965**

What we said….	What we did….
DECI Inspections:	
A minimum of 50 wards or other settings covering all Local Health Boards in Wales with a mix of acute and community hospitals, and produce a summary of findings at the end of each group.	52 inspections (inclusive of 6 follow up visits). These reports have been published on the HIW website.
Produce an annual summary of the trends and themes identified as a result.	We have produced and an annual summary and this will be published in Summer 2015.
Develop the way we carry out the inspection prevention control arrangements and undertake a number of pilot inspections.	As a result of ongoing work with stakeholders to implement the new arrangements we have agreed a three year plan to assess infection prevention arrangements. These are set out in our *Operational Plan 2015-16.* [30]
Mental Health Act Reviews:	
Minimum of 60 reviews in settings where individuals are liable to be detained under the Act, and issue verbal feedback followed by management letters to each setting.	77 reviews undertaken.
Publish our findings in the Mental Health Act Annual Report 2013-14.	Report published: *Mental Health Act Report 2013-14.* [31]
SOAD:	
We will respond to approx 750 requests. Volume is driven by requests from the service.	In excess of 800 requests completed.

[30] www.hiw.org.uk/operational-plans
[31] www.hiw.org.uk/opendoc/265626

What we said….	What we did….
DoLS:	
Monitor the implementation of safeguards by NHS and registered independent hospitals when caring for such patients who are unable to make decisions about their care. We will publish a DoLs report jointly with CSSIW in the first quarter of 2015 relating to our findings from our routine data collection about the use of DoLs in Wales. Undertake a joint national review with CSSIW and publish a joint report of the findings. We will produce and publish the Mental Health Annual Report as soon as possible after the financial year which we are reporting on.	Report published: *Deprivation of Liberty Safeguards – Annual Monitoring Report for Health & Social Care – 2013-14.* [32] Report published: *A National Review of the use of Deprivation of Liberty Safeguards (DoLs) in Wales.* [33] We also jointly hosted a conference on DOLS in November 2014. The conference gave an update on the legal position, and findings from the joint review along with a look forward to future plans and intentions.
NPM:	
Continue to attend quarterly business meetings, contributing to UK National Report as appropriate.	We continued attending these meetings and were an active member of the Steering Group during 2014-15.
Homicide Investigations:	
We expect to undertake four investigations into circumstances where a service user known to Mental Health services is involved in a homicide. The volume undertaken is dictated by the number of investigations commissioned by the Welsh Government.	2 Investigations were undertaken. Reports published: *Report of a review in respect of The provision of mental health care and treatment provided to Mr M by Betsi Cadwaladr University Health Board (BCUHB), prior to committing a homicide in May 2011.* [34] *Report of a Review in respect of Mr L and the provision of Mental Health Services, following a Homicide committed in October 2012.* [35]

[32] www.hiw.org.uk/opendoc/259900
[33] www.hiw.org.uk/opendoc/251546
[34] www.hiw.org.uk/opendoc/251969
[35] www.hiw.org.uk/opendoc/248571

What we said….	What we did….
Mental Health Measure:	
We will incorporate care and treatment reviews as part of our Mental Health Act reviews in inpatient settings where appropriate, and develop an agreed approach with the Welsh Government in early 2014-15 to undertake similar assessments in community settings.	We continued to monitor compliance with the Mental Health Measure (parts 2 and 4) as part of our NHS and independent mental health inspections.
CTO's:	
We will consider undertaking a review of the use of Community Treatment Orders towards the end of 2014-15.	This work will now be conducted during 2015-16.
IR(ME)R:	
Provide training for our staff to lead and support this programme of work. secure the specialist reviewers necessary to deliver our inspections. maintain the effective operation of the panel review incident notifications. undertake a minimum of 4 inspections of clinical departments.	We conducted 4 IRMER inspections and have developed a more sustainable use of resource and external partners going forward. We sourced specialist reviewers and maintained a panel to process the notifications of new incidents.
Deaths in Custody Reviews:	
We expect to undertake up to 10 reviews of deaths in custody. The volume undertaken is dictated by the volume of cases referred to us by the Prison and Probation Ombudsman.	10 investigations undertaken.
We will improve the way in which the findings from our reviews of deaths in custody are shared with respective NHS Wales organisations, in order to ensure that the issues we find during these reviews relating to NHS care are addressed.	We continue to share our learning with national groups and have drafted a report summarising our findings from the reviews we have conducted. This report will be published in Summer 2015.
We will take part in a joint inspection of one youth offending team in Wales as the partners inspectorate for health.	Report published: *Full Joint Inspection of Youth Offending Work in Newport.* [36]

[36] www.hiw.org.uk/news/34000

What we said….	What we did….
GP's:	
Undertake and evaluate a minimum of 34 inspections of GP Practices (10 between April and August 2014 across all Local Health Boards in Wales.	34 inspections undertaken (11 of which were between April and August 2014). As this was a pilot the individual reports were not published.
Produce and publish a report summarising the findings from the inspection programme.	Report published: *General Practice Inspections – Pilot 2014-15 – Thematic Analysis.* [37]
Dental:	
Publish a report on the results of the 2013-14 QAS for practitioners delivering only private dentistry in Wales.	Report published: *Results of the QAS for practitioners.* [38]
Contribute to shaping effective regulations and National Minimum Standards for Private Dentistry in Wales.	We continue to work closely with Welsh Government to ensure that our expert view is taken into account when the new regulations and standards are being created. We provided advice and guidance on how private dentistry can meet the National Minimum Standards for Independent Healthcare so that standards for private dentistry are consistent with NHS services.
Inspect approximately 70 NHS Dental Practices in Wales in 2014-15 which will include one third of Private Dentists.	77 Dental inspections undertaken.
Integrated Care:	
Undertake a pilot exercise to establish a framework for co-ordinated regulation and inspection of integrated care.	A visit was undertaken to a joint health and social care facility in Powys. The learning from this has been captured and will be used to inform inspections of integrated health and social care services in the future.

[37] www.hiw.org.uk/opendoc/266556
[38] www.hiw.org.uk/opendoc/258308

What we said….	What we did….
Use the experience from this work to shape a forward programme of work focusing on evolving models of integrated care.	A visit was undertaken to a joint health and social care facility in Powys. The learning from this has been captured and will be used to inform inspections of integrated health and social care services in the future.
Independent Healthcare:	
Continue to process applications to register as an independent healthcare setting or if they look to change the service they are currently registered to provide, including individual private dentists, in a timely manner. Ensuring that they demonstrate, or continue to demonstrate that they meet the relevant regulations and minimum standards.	We processed 170 applications during 2014-15 which consisted of: 24 – Independent healthcare 12 – New manager 7 – Major variations to existing settings 127 – New dentists
Undertake a minimum of 16 visits to registered providers of class 3B or 4 laser or intense pulse light laser used for non surgical purposes, and to continue our programme of visits to suspected unregistered providers.	36 visits undertaken, inclusive of 10 suspected unregistered providers.
Undertake unannounced inspections of all of the 21 independent mental health and learning disability hospitals.	23 inspections undertaken. 6 NHS inspections also achieved.
Undertake a minimum of 30 inspection visits to other registered establishments and issue management letter to the registered providers within 4 weeks summarising the visit. (This will include acute and non acute hospitals, hospices for children and adults, independent clinics, in vitro fertilisation clinics/ centre, class 3B or 4 laser or intense pulse light laser used for non surgical purposes, for example).	Breakdown of inspections conducted: Children's hospice: 1 Adults hospice: 8 Independent clinic: 4 Class 3B or 4 Laser: 36 Slimming Clinic: 3

What we said….	What we did….
LSA	
Ensure that all midwives who practice in Wales have access to and receive appropriate levels of supervision in accordance with the standards and guidelines set by the Nursing and Midwifery Council (NMC).	As of 31 March 2015, 16 full time SoMs were in post, and 1,786 midwives had notified the LSA of their Intention to Practise (ItP) midwifery in Wales during 2014-15. During the year, an adjusted ratio calculation shows the average all Wales Midwife to SoM ratio has been 1:11 which is within the NMC required ratio of 1:15.
Continue to work with all relevant stakeholders to implement the Future Proofing Supervision model in Wales.	Directors of Nursing, Heads of Midwifery, Lead Midwife for Education, Royal College of Midwives and Nursing and Midwifery Council have continued to work with the LSA with the implementation and monitoring and evaluation of the new model of supervision. All relevant stakeholders have been part of the monitoring and evaluation group which has met on a bi-monthly basis. Directors of Nursing were updated with a briefing paper at the all Wales Executive Nurse meeting with the Chief Nursing Officer in February 2015. The NMC Quality Assurance Review undertaken in December 2014, reported the new model to be innovative and effective, recognising the implementation of the model as notable practice. The NMC reported the model as an example of excellent change management which involved relevant stakeholders within maternity services, HIW and service users representatives. The NMC confirmed professional standards for statutory supervision are being met in Wales.
Publish an Annual Report to reflect the progress made in supervision during 2013-14 within NMC requirements.	Report published: *2013-2014 – Local Supervising Authority Annual Report.* [39]

[39] www.hiw.org.uk/opendoc/251348

What we said….	What we did….
Consider an options appraisal for the most appropriate organisation to host the LSA function.	This is on hold given the outcome of the Kings Fund review of midwifery regulation which indicated that statutory supervision will be disbanded over the coming year to 18 months.
Contribute to a review of the governance arrangements that support the peer review programme.	The LSA have a strong governance arrangement with the peer review programme with an annual work plan. This has included specific audit on the user's perspective of the new model and how women felt about contacting a SoM.
Consider our ongoing role with regard to supporting peer review with peer review partner agencies and other stakeholders.	A lay reviewer sits on the all Wales Monitoring and Evaluation Group, which agreed to extend the evaluation of the model to include service user experience.
Publish on our website a public version of the reports and the action plans produced following each peer review.	The *2013-14 LSA Annual Reports* [40] and Audit reports have been published to our website. The 2014-2015 LSA Annual and Audit report will be published in August 2015. Our website feature a section to explain the changes with the implementation of the *new future proofing model of supervision model* [41] and publish the relevant documents to support the changes.
Operational Governance and Assurance:	
Actively support the review of healthcare standards led by Department for Health and Social Services within the Welsh Government, against which the Local Health Boards are expected to assess themselves.	HIW was represented on both the Project Board and Project Board for the review of the health care standards.

[40] www.hiw.org.uk/lsa-latest-reports
[41] www.hiw.org.uk/future-proofing-model-of-supervision

What we said….	What we did….
Validate the self assessments against our wider intelligence and provide feedback to each NHS organisation.	Self assessments were validated against intelligence at the summit, the WAO structured assessment and the evidence found in HIW inspection activity. These will be fed back to health boards through the inclusion in the annual reports due to be published during the Summer 2015.
Introduce a process of annual reporting to NHS Board Members highlighting the themes and issues arising from our work.	Relationship managers are presenting findings to health boards during Summer 2015 and reports will then be published August 2015.
Making a difference:	
Continue to participate in liaison groups across Europe, the UK and Wales in order to ensure we share with, and learn from, our colleagues in inspection, audit and regulation.	Active participation in European Partnership for Supervisory Organisations and the Five Nations Heads of Inspection. Within Wales we have played active roles in chairing the healthcare summits, the Wales Concordat and by hosting the Programme Manager for Inspection Wales.
Use healthcare summits to share and test information and intelligence held about NHS organisations in Wales to establish an overarching, cohesive assessment that drives our respective plans.	Improved summit structure to create more effective sharing of intelligence and evidence.
Implement our operating protocol with Community Health Councils (CHCs) across Wales to better share evidence to identify problem areas earlier, ensuring the experiences and views of patient help us to inform the risk assessment process.	Published CHC protocol: *Operational Protocol, CHC and HIW.* [42]
Review our Memoranda of Understanding, Operating Protocols and Information Sharing Protocols for completeness, appropriateness and consistency.	Our MOU have been reviewed during 2014-15, with many being re-drafted and republished.

[42] www.hiw.org.uk/opendoc/259199

What we said….	What we did….
Ensure that all Memoranda of Understanding and associated protocols are up to date and published on our website.	Review of MOU published: *Working with Partners.* [43]
Contribute to the effective implementation of the NHS Wales Escalation and Intervention Arrangements.	NHS Wales Escalation and Intervention Arrangements were implemented with the help of HIW during April 2014. HIW will continue to provide contribution to these arrangements through the Risk and Escalation Committee.
Update and implement our enforcement policy and guidance.	Enforcement policy has been updated and will be implemented and published during summer 2015.
Strengthening Communication:	
Launch a new website that is much easier to navigate and find out more information about individual health care settings.	New website launched during April 2014.
Develop a literature campaign that will make hard copy information about HIW available in different healthcare settings and consider how we can work more effectively with Community Health Councils to raise awareness of our respective roles.	HIW *information leaflet* [44] produced.
Publish quarterly newsletters.	This was reviewed and newsletters are now sent to external stakeholders twice a year, but all reports are circulated as they are published.
Review the format of our inspection reports and ensure that they are published promptly following the inspection visit.	Our inspection reports have been reviewed and updated to better reflect the themes we test during our visits. We have also moved publishing management letters for MH inspections to full reports. In addition we now issue immediate assurance letters for the most serious concerns immediately following a visit.

[43] www.hiw.org.uk/working-with-partners
[44] www.hiw.org.uk/opendoc/267991

What we said….	What we did….
Undertake an exercise to seek the views of stakeholders on our strategic priorities for the period 2015-2018.	The *HIW Strategic Plan 2015-2018* [45] is currently published for consultation, and responses are expected to be received by 31st July 2015. Upon receipt and consideration of all contributions, the report is aimed to be finalised during August 2015, however it is proposed that the plan will remain a live document and be updated as necessary.
Peer and Lay Reviewers:	
Continue our recruitment activities to put in place the reviewer capacity essential to deliver our inspection and investigation programmes.	Recruited over 150 extra reviewers during 2014-15.
Our Staff:	
Fully implement our strategic approach to learning and development. This will ensure continuous improvement in our approach to induction, management development, professional skills development and support staff in accessing the learning and development they need to perform and progress.	A learning and development strategy was produced and implemented.
Advice and Challenge:	
Refine the terms of reference for the Advisory Board and will have the Board operational before the end of March 2015.	Our *Advisory Board* [46] was created and met twice during 2014-15.
Records and Information Management:	
Review the structure of our records management system to make it more user friendly.	This action is ongoing as we continue to evolve.
Review the use of all databases holding personal or sensitive information to ensure accuracy and that data inputting processes are streamlined and robust.	As part of this objective we developed new systems which are more robust and provide more effective management information.

[45] www.hiw.org.uk/strategic-plan
[46] www.hiw.org.uk/advisory-board-2

What we said….	What we did….
Performance Standards:	
Delivery Objectives To deliver against the specific objectives set out in this plan and where objectives are missed, to be able to evidence the reason for variation and use this intelligence to adjust future year's planning assumptions.	This annual report responds to this objective in an open and transparent way.
Internal Processes Reporting: • to provide verbal feedback to the inspected body within 2 hours of inspection • to provide a management letter detailing any immediate actions within 2 days of inspection • to provide draft report for accuracy checking within a maximum 3 weeks of inspection • to publish agreed report and action plan on HIW website within a maximum 3 months of inspection.	This was a challenging target for us. The figures relating to each component are below, but further detail is contained within the main body of this report. 2 hours – 100% 2 days – 68% 3 weeks – 61% 3 months – 67%
User perspective To launch a new website during April 2014 and to continue to develop and enhance during the year. to consider ways to baseline awareness and perception of HIW and measure how this changes over time.	We conducted a stakeholder analysis and used this to feed into a communication strategy for 2014-15. Ruth Marks also conducted and reported on stakeholder views.
Organisation and people To have at least 70% of HIW staff survey respondents state that they have been able to access the right learning and development opportunities when they need to to hold at least 8 staff seminars during 2014-15.	Our staff survey reports that 77% of staff are able to access the right learning and development opportunities when needed. We conducted 14 seminars for staff.