Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Healthcare Inspectorate Wales

Annual Report 2015–16

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

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.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Openness and honesty: in the way we report and in all our dealings with stakeholders**
- **Collaboration: building effective partnerships internally and externally**
- **Professionalism: maintaining high standards of delivery and constantly seeking to improve**
- **Proportionality: ensuring efficiency, effectiveness and proportionality in our approach.**

Our Outcomes

Through our work we aim to:

Provide assurance:	**Provide independent assurance on the quality, safety, and effectiveness of healthcare by reporting openly and clearly on our inspections and investigations.**
Promote improvement:	**Encourage and support improvements in care through reporting and sharing good practice and areas where action is required.**
Strengthen the voice of patients:	**Place patient experience at the heart of our inspection and investigation processes.**
Influence policy and standards:	**Use our experience of service delivery to influence policy, standards and practice.**

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Introduction

By placing the interests of the public, patients, relatives and all users of the health service at the core of our work, we aim to encourage all patients to understand and recognise good quality care and to provide feedback on their experiences whether good or not so good, to help local services develop.

In planning our work we seek 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.

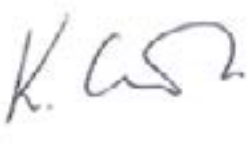
This report summarises our work during 2015-16 in each of four overarching programmes of activity: our work in the NHS; our regulation and inspection of independent healthcare; our programme of activity relating to mental health and learning disability services; and our role as the host organisation for the Local Supervising Authority for Midwives.

We have set out what we have done, what we have found, and provided some examples of how we are trying to support service improvement.

This report does not stand alone. Throughout the report we have provided links to further detailed information wherever this is available and in association with this report we will be publishing more detailed thematic analysis of some of our core inspection programmes.

We have continued to take opportunities to share what we find through presentations, conferences, reports and evidence to National Assembly for Wales Committees.

If you have any comments on our work, your experience, or on healthcare services in general I would encourage you to contact us.



Dr Kate Chamberlain
Chief Executive

Delivering our responsibilities: Inspecting the NHS

Hospital Inspections

During 2015-16 we changed our approach from single ward inspections to broader, multi ward and multi-site hospital inspections. This has provided us with a greater opportunity to explore the wider patient safety, governance and management arrangements in place within health boards across Wales.

HIW conducted 8 of these broader hospital inspections within six of the health boards throughout Wales visiting 15 hospitals and 43 wards in total. Each inspection considered three domains: the quality of the patient experience, the delivery of safe and effective care and the quality of management and leadership. The table below summarises the key themes and service delivery issues that were identified in each domain from our 2015-16 inspections.

In addition, we generally found that all health boards are facing increasing challenges in their attempts to recruit a sufficient number and mix of staff. As a result, all health boards are actively pursuing a number of available avenues to recruit and retain more permanent staff. We noted that whilst the recruitment for permanent staff is ongoing, health boards use temporary staff, where possible, to help them maintain the appropriate staffing levels for safe delivery of care.

The table below is not an exhaustive list of our findings, but seeks to highlight the main themes we identified in 2015-16. In all cases, we aim to work with health boards and have found that staff at all levels within those organisations were responsive to our findings and keen to make improvements.

Quality of patient experience

What services do well	What services need to improve
Dignified care: Overall, we found that staff teams were treating patients with great respect and compassion. We found that staff made every effort to protect the dignity and privacy of the patients they were looking after.	**Dignified care:** We found a small number of isolated occasions when staff did not treat patients with dignity and respect. HIW dealt with these instances swiftly, referring them for consideration under adult safeguarding procedures. Some older ward environments made the provision of dignified care more challenging.
Patient information: Many patients told us that staff had taken time to speak to them about their medical conditions which had helped their understanding.	
Listening and learning from feedback: We were able to report some positive practice regarding the arrangements in place for seeking and using patient feedback as a means of improving services. This was particularly evident in Abertawe Bro Morgannwg University Health Board and in Cwm Taf University Health Board. We would recommend other health boards take note of their approach.	**Listening and learning from feedback:** Whilst arrangements to seek feedback were in place we identified that three health boards needed to strengthen those arrangements and for acting on patient feedback.

Delivery of safe and effective care

What services do well	What services need to improve
Infection prevention and control: Most wards and departments were clean and tidy. The practice of conducting hand hygiene and other infection prevention and control audits was very well embedded across all clinical areas and health boards inspected this from a nursing perspective. This had a positive impact on patients in receipt of care.	**Infection prevention and control:** Not all members of the multidisciplinary ward teams (for example doctors and visiting therapy staff) were vigilant at following correct infection prevention and control procedures. This increases the risk of cross infection and contamination between patients and ward areas.
Record keeping: We found some evidence of strong multidisciplinary team working which had a beneficial effect on patient care and treatment outcomes.	**Record keeping:** We found that patient records were not always maintained in accordance with clinical standards guidance. This meant that staff did not always have a sufficient guide to assist them in providing safe, effective and tailored care to patients. **Medicines management:** A number of inspections identified that the storage of medicines and the completion of medication administration records needed to be improved. In some areas the management of controlled drugs was not adequate. Some patients were not wearing identification wristbands which could increase the risk of medication and/or patient identification errors. Many staff could not easily access a copy of their health board medicines management policy. This meant that they could not readily find relevant information to assist them in their day to day work.

Quality of management and leadership

What services do well	What services need to improve
Governance, leadership and accountability: We found that there were senior management structures in place which have the potential to help staff understand the wider responsibilities of health board and their senior staff.	**Governance, leadership and accountability:** We found that staff at ward level did not always understand the senior management structures in their workplace. This may result in the inability of staff to seek help and support in relation to the delivery of patient care.
Workforce issues: We encountered many effective ward managers who made every effort to support their staff to deliver high standards of care. In general, staff had attended mandatory training courses.	**Workforce issues:** However, we found a small number of instances where the skills of ward managers were less well developed resulting in staff teams not being led effectively. Where we identified this issue we highlighted it to senior managers and recommended that additional support be provided.

Our work with health boards is not limited to the inspection visits we make. Whilst these are often a catalyst for the ongoing work that we do, we have mechanisms in place such as intelligence shared with us through our Memoranda of Understanding and healthcare summits, concerns reported to us and our observations of health board governance arrangements which assist us to take account of the effectiveness of governance arrangements in each health board throughout the year.

During the summer we will be publishing an annual report for the Hospital Inspection Programme which will provide a more in depth analysis of the key themes from our inspections and recommendations.

Case Study

HIW undertook a multi ward, multi site inspection to the unscheduled care directorate at Hywel Dda University Health Board in August 2015.

The purpose of this visit was to assess the directorate against the Health and Care Standards, identifying themes and issues which the health board were asked to rectify. If we identify a potentially high risk issue during our inspection we request that it is rectified within a short (can be immediate) timescale. We give a longer timescale if the issues we find do not carry such potentially high risk.

During this inspection we noted that some patients were not wearing identification (ID) wristbands. We were concerned as this was a safety issue which had the potential to increase the likelihood of medication administration errors for these patients. Many other clinical procedures also depend on correct patient identification in order to be safe and effective. This was considered to be a potentially high risk finding and we took immediate action which ensured the patients in question were given ID wristbands.

Hywel Dda University Health Board were highly responsive to our findings; they undertook their own audit, across all four of their main hospital sites (Bronglais, Glangwili, Prince Philip and Withybush hospitals) to determine the scale of the problem, addressing the issues they found. The health board shared the results of this with us. They had undertaken a comprehensive one-off piece of work but also committed to establish a monthly audit within each inpatient area, to check for ongoing compliance with this standard. This is with the aim of ensuring that they continue to promote best practice and remain abreast of standards within their own clinical areas.

Dental Inspections

In 2015-16 HIW continued its programme of inspections of all general dental practices in Wales. 133 dental practices were inspected.

During these visits HIW explored how dental practices met the standards of care set out in relevant legislation and guidance, including the Health and Care Standards and the Private Dentistry (Wales) Regulations.

We found that patients were positive about the care they received from dental teams. We saw patients receiving dignified and timely care. Overall, we found that most practices provided safe and effective care to patients.

However we noted some areas for improvement, including:

- Practices were not always fully compliant with their obligations under the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000. We visited practices where relevant staff had not undertaken the required training; and where the arrangements for radiation protection were not adequate.
- We identified urgent improvements required in relation to decontamination procedures in sixteen practices, and we made recommendations for improvements in many others.
- We found that many practices had no mechanism for patients to provide feedback on the service they received.
- We found improvements were required to patient records. For example, patient medical histories were not always updated; and justification and clinical findings from x-rays were not always recorded.
- Arrangements for staff appraisals could be improved in many practices.

Inspections of dental practices have been well received and direct action has been taken to improve services provided to patients as a direct result of feedback provided in inspections.

HIW has continued to provide feedback to the dental profession on the trends and themes identified by inspections, to help to improve services more widely. We have engaged directly with the dental profession by way of presentations to Local Dental Committees and participation in training events organised by the Postgraduate Deanery. Feedback from these events has been positive with dentists appreciating the opportunity to hear how they can improve their services for patients.

We have also continued to hold regular meetings with our Dental Stakeholder Reference Group, which has representation from Welsh Government; health boards; Public Health Wales; the British Dental Association; General Dental Council, Postgraduate Dental Deanery and Community Health Councils. These meetings ensure HIW's inspection process remains relevant and ensures any trends and themes arising from inspections are fed back to relevant bodies on a regular basis. For example, as a result of HIW's feedback about practice compliance with Ionising Radiation (Medical Exposure) Regulations, the Postgraduate Deanery is considering amending the content of its training course,

which will help dentists to understand their obligations and provide a safer service for patients.

HIW will be publishing an annual overview report of dental inspections for 2015-16 in Summer 2016, which will provide a more in depth analysis of the key themes from our inspections and recommendations to help improve practice across the sector.

GP Inspections

Following a pilot programme of inspections in 2014-15, HIW conducted a programme of 27 inspections of General Practices (GPs) in 2015-16.

As with hospital inspections, each GP inspection considered how the practice met the Health and Care Standards under three domains: the quality of the patient experience, the delivery of safe and effective care and the quality of management and leadership.

HIW's inspection team consisted of an HIW inspector together with a GP peer reviewer and where possible a Practice Manager peer reviewer. Members of the local Community Health Council accompanied HIW inspectors to each GP inspection. The role of the CHC members was to speak to patients to gain their experiences and views of the practice.

During these visits a number of key trends arose:

- In general, we found good record keeping; good internal communication systems and effective management and leadership at the practices we visited. Patients told us they were satisfied with the care they received from doctors, nurses and practice staff.
- Access to appointments was highlighted as the most important issue for patients. We saw many different appointment systems in operation across the practices we visited, and patient satisfaction with them varied. We saw some practices where access to appointments was made more difficult because of a shortage of GPs, which raised questions about the resilience and sustainability of the practice to cope with patient demand.
- We found that in many practices, staff had not received training in safeguarding vulnerable adults (adults at risk of abuse or neglect).
- We found that some practices did not seek regular patient feedback as a means of identifying where improvements could be made to their service.
- We saw a lack of provision for patients with sensory impairment in some practices; and a lack of consideration of accessible information so that patients with additional needs can understand and be involved in their care where possible.

Again, the feedback provided as a result of these visits has prompted practices to take action to improve the service they provide to patients.

During 2015-16 HIW continued to hold meetings of our GP Stakeholder Reference Group, which included representation from Welsh Government, health boards, Public Health Wales, the Royal College of GPs, the British Medical Association and Community Health Councils. These meetings ensure HIW's inspection process remains as effective as possible, and ensures any trends and themes arising from inspections are fed back to relevant bodies on a regular basis.

For example, an ongoing concern of the GP Stakeholder Reference Group has been the issue of discharge information from hospitals to GP practices, which was a major finding of HIW's pilot GP inspection programme. HIW has also met with a Local Medical Committee who raised their concerns about the quality and timeliness of discharge information. HIW has raised this issue with NHS Wales, and is monitoring the strategic action being taken to improve the situation. HIW continues to monitor the issue of discharge for services and patients through our inspection programmes.

HIW will be publishing an annual overview report of GP inspections for 2015-16 in Summer 2016, which will provide a more in depth analysis of the key themes from our inspections and recommendations to help improve practice across the sector.

Death in Custody Reviews

HIW has completed 10 clinical reviews on behalf of the Prison and Probation Ombudsman (PPO) since April 2015. Of these, 6 deaths have been of natural causes, and 4 deaths were suicide.

The key themes arising across these reviews are chronic disease management and communication between the prisons and the local hospitals, in particular around cancelled appointments and discharge arrangements (from hospital).

During 2015-16 we recruited and trained a further five reviewers to ensure that HIW has the capacity to complete the clinical reviews in a timely manner. With the development of the new wing (approx. 400 extra prisoners) at HMP Parc and the building of a new prison in Wrexham (approx. 2000 prisoners), once these two prisons are fully operational, Wales will hold the two largest prisons in the UK.

HIW now have four mental health reviewers that can be appointed to self inflicted cases and five GP's that can be appointed to natural cause cases.

Betsi Cadwaladr University Health Board Governance Review

In June 2015 the Betsi Cadwaladr University Health Board was placed in Special Measures by the Minister for Health and Social Services following its failure to make sufficient improvement against long-standing concerns about governance, leadership and other issues. The Minister set out a number of areas in which tangible improvement needed to be demonstrated by the health board.

These were:

- 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.

During the Autumn of 2015 HIW and the Wales Audit Office (WAO) undertook work to assess progress made by the health board in respect of these areas. Our work found that while that had been some positive developments, fundamental work remained for the health board. In particular:

- The health board needed to secure a permanent Chief Executive
- The health board needs help with some basic aspects of governance, leadership, and service planning and turnaround
- A cohesive Board and executive management team remained a problem
- Revised committee structures still required work
- A long term plan was required for Mental Health services.

HIW and the WAO will be undertaking a further follow-up review during 2016-17.

Follow-up Review of Governance Arrangements at Cwm Taf University Health Board

During 2015-16 we published a follow-up review[1] which assessed the progress made by the health board in relation to a governance review that was published in 2012. The main findings of this review were that:

- It was clear that the health board has evolved over the past four years, with the follow-up review findings indicating that the health board has achieved a great deal since the original review had taken place
- There was evidence of improvements made in mental health services, which included a shift in focus from hospital to community based services, along with the redesign of older persons mental health services
- Clinicians within secondary care now feel that they are empowered to come up with their own ideas to improve the services they provide
- The health board is now in a clearer position in relation to risk management and, although the Board is aware that further improvements are required, the review team felt that the Board are now more assured that they are aware of the risks facing the health board

[1] http://hiw.org.uk/reports/special/specialreviews/cwmtaf/?lang=en

- There has been a strengthening in the role of the Board's Independent Members. Independent Members informed us they now feel better equipped and able to provide the level of scrutiny and challenge required.

Overall, we were pleased and encouraged with the progress that had been made by the health board since 2012. Most, if not all of the areas, have seen significant improvements.

Clinical governance review of the Welsh Health Specialised Services Committee (WHSSC)

During 2015-16 we published a review of the clinical governance arrangements WHSSC has in place[2], and how these related to patient outcomes. In undertaking this work we focused upon cardiac services. The key findings from our review were:

- WHSSC was in a period of transition working towards placing a much greater emphasis on quality when commissioning services. We found that this focus on quality had not always been present in the way that WHSSC discharged its functions
- WHSSC had published a report providing a review of the outcomes and impact of its work to reduce cardiac waiting times. This review highlighted deficiencies in its processes for the governance of this project - for instance we were not provided with assurance that the documentation of the process surrounding the selection of providers in England was robust
- We found weaknesses in the operation of WHSSC's Quality and Patient Safety Committee. For instance, information relating to initial concerns regarding cardiac waiting times had not been reported into the committee in a timely manner
- Our review raises the question of whether WHSSC's Joint Committee can be a truly independent decision making body when it is made up of both the providers and commissioners of specialised services in Wales
- There is an external perception that WHSSC's role and responsibility in managing specialised services is unclear.

Overall, our review has highlighted that WHSSC is at the beginning of a process to strengthen its clinical governance arrangements.

Ophthalmology Review

During 2015-16 HIW started our thematic review looking at Ophthalmology services in Wales. This review sets out to look across the boundaries of primary and secondary care to examine how providers are developing the service, care and support that patients need. The review consists of a two staged approach. The first stage commenced during early 2016, and involved engagement with health board staff and other stakeholder organisations to collate views on the current issues being experienced in relation to Ophthalmic Services to build up an all-Wales picture. Subsequently, stage two of the

[2] http://hiw.org.uk/reports/special/specialreviews/clinicalgovernance/?lang=en

review will consist of additional fieldwork visits to selected areas in order to test the stage one findings as well as collating the views of service users.

We will produce an overall report (later in 2016-17) of the review which will detail the relevant findings and make recommendations for improvements.

Local Health Boards Annual Reports

During 2015-16, HIW introduced a process of annual reporting to NHS Health Boards and Trusts highlighting the key themes and issues in their areas, arising from our work in 2014-15. These were presented at Board meetings and Board Development Days during summer 2015 and published[3] on our website in August 2015.

Further Information

Reports on all of our inspections are published on our website under Find an Inspection Report.

[3] http://hiw.org.uk/reports/localhealthboardstrusts/?lang=en

Delivering our responsibilities: 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.

HIW registers varied types of settings which includes, but not limited to mental health hospitals (incl. child and adolescents), laser and intense pulse light services, a telemedicine consultation and treatment agency (for dermatological and allergies). There were 28 new settings registered during 2015-16.

In addition, HIW also registered 15 new managers of currently registered settings and 8 variations to existing registrations. As part of our remit, HIW also register individual dentists, which enables them to provide private dental services in Wales, there were 115 new dentists registered in 2015-16.

Approved registration of a service is subject to the service demonstrating that they are able to comply with appropriate regulations and standards, and provide assurance that they can continue to do so. To facilitate this assurance we hold interviews with applicants and carry out a visit to the premises to scrutinise the services' policies and procedures. This ensures compliance so that the service is safe for the people that use it at the point of registration.

HIW continued to investigate intelligence received regarding unregistered settings providing services that could potentially need registration. This work resulted in 21 unannounced visits to these settings where we sought to establish whether registration was actually required. Where we identified registration was required we advised the service to either register or stop providing the service as to continue providing the service without registration is a prosecutable offence. We will be focusing attention in 2016-17 on how we deal with and respond to unregistered settings who do not co-operate with us.

Inspection of independent healthcare services

HIW inspections of independent healthcare services seek to ensure services comply with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and to establish how services meet the National Minimum Standards (NMS) for Independent Health Care Services in Wales. We aim to inspect these services at least every three years, but may visit more often if required as a result of intelligence or service changes. At the end of 2015-16, HIW remains on target to inspect all these services within three years by the end of 2016-17.

In April 2015, HIW revised our inspection methodology for independent healthcare services, including Class 3B/4 laser and intense pulsed light services. In order to be consistent with HIW's approach to the inspection of NHS services, inspections now focus on the following areas:

- Quality of patient experience
- Delivery of safe and effective care
- Quality of management and leadership

During 2015-16 HIW conducted the following independent healthcare inspections:

- 19 services using Class 3B/4 laser and intense pulsed light services for non-surgical purposes
- 2 Laser inspections (services using Class 3B/4 laser for surgical purposes i.e. laser eye surgery)
- 3 independent clinics
- 1 hospice for children
- 2 hospices for adults
- 2 dental hospitals
- 2 acute hospitals
- 1 termination of pregnancy service.
- 1 IVF clinic

The table below summarises the key themes that were identified in the independent service inspections (excluding non-surgical Class 3B/4 lasers).

What services do well	What services need to improve
Quality of patient experience	
Most patient questionnaires received by HIW during our inspections were positive. Specifically, patients spoke highly of the quality of care they received and that they were treated with dignity and respect by the staff looking after them.	We found that some services were not routinely seeking the views of the patients they had treated, nor making this information available to prospective patients. This is required by the regulations as it is a key way to help inform people who may use these services about the quality of the service they can expect to receive. It is also an important way for services to demonstrate that they act on views and feedback in making changes to improve services. We found that some services were not providing patients with important information about their service. The regulations require services to provide patients with a statement of purpose and service user guide and that each also contains the information required by the regulations. This is important as people who use services need to know that they will receive the right information, at the right time, provided by the right people, in a way and language they can understand in order to make the choice that is best for them.

What services do well	What services need to improve
Delivery of safe and effective care	
Services were found to be providing safe and effective care to patients. Most services also routinely audit and monitor the effectiveness of their service to ensure that the care provided is of a high standard and consistent with their own policies and procedures, as well as regulations, standards and other relevant professional guidance.	We found that some services need to ensure that the documentation used to underpin the delivery of safe and effective care is in place, appropriately used and routinely reviewed and updated. This is because patient needs and preferences are central to the assessment, planning and provision of their care. Also, good quality care planning and provision helps to ensure a positive patient experience. We found that some services had gaps in their policies and procedures and inadequate arrangements to monitor and review their polices and procedures. The regulations require services to implement polices and procedures and review them at appropriate intervals. This is important as services must ensure that patients are provided with safe, effective treatment and care that is based on agreed best practice guidelines and takes account of relevant regulations and standards.
Quality of management and leadership	
We found that services were well led and managed and that staff were being supported and enabled - via opportunities for learning and development for example - to provide a high standard of service to patients. Feedback from the staff we spoke with supported this.	We found that some services were not receiving strategic leadership and management oversight by Directors or others responsible for providing this. This is because services were not being visited at least every six months by such individuals in order to assure themselves of the quality of service being provided to patients within the business they were responsible for running.

What services do well	What services need to improve
Quality of management and leadership (continued)	
	The regulations require such visits to take place. This is to ensure that services operate within a clear and robust framework for decision making and accountability designed to achieve successful delivery of their purpose, aims, and objectives, in a manner that: • upholds organisational values and standards of behaviour • complies with regulations and standards • safeguards and protects patients and the people who work there.

Class 3B/4 laser and intense pulsed light services – key themes

Services providing treatments to patients using Class 3B/4 laser and intense pulsed light are registered with HIW as independent hospitals. However, the majority of these services are provided within beauty salons and clinics for aesthetic skin treatments, such as hair removal and wrinkle reduction. During these inspections we identified a number of areas for improvement and regulatory breaches across services which included:

- Insufficient arrangements for the safe use of laser and intense pulsed light equipment
- Up-to-date training in the safe use of equipment was needed
- Improvements to arrangements for managing risk and health and safety.

It was of particular concern to find that many services lacked sufficient awareness and understanding of the standards and regulations regarding the provision of Class 3B/4 laser and intense pulsed light services. The majority of services also did not have effective systems and processes in place to ensure they were meeting the relevant standards and complying with the regulations.

During the inspection of 6 of the 19 services, we identified areas of concern which we believed could potentially pose risks to patient safety. As a result, HIW sought the agreement of these services to voluntarily cease providing treatments to patients until these issues were addressed and sufficient assurance had been provided to HIW. Following our inspections, 5 services expressed their wish to cancel their registration with HIW as they no longer wanted to provide Class 3B/4 laser and intense pulsed light services.

As part of our work, HIW shared our inspection findings with other regulatory authorities, including the relevant fire authorities where we identified potential fire hazards. We have also made links with Laser Protection Advisors working in Wales to share our findings and raise awareness of the areas of concern.

HIW will be publishing our first annual inspection report of Class 3B/4 laser and intense pulsed light services for 2015-16 in Summer 2016, which will provide a more in depth analysis of the key themes from our inspection and recommendations to help improve practice across the sector.

Case Study

During 2015 HIW have been involved in a number of successful joint inspections. One example was our work with the Human Fertilisation and Embryology Authority. On 15 September 2015 we jointly inspected the London Women's Clinic (Cardiff). The purpose of the visit was to measure, not only their compliance with legislation, but to establish how well the clinic was organised and managed, the quality of the service patients receive at the clinic, how safe, suitable and secure the premises and equipment were, the clarity and relevance of information the clinic provides to patients and the competence of clinic staff to ensure safe clinical and laboratory practice. These were areas both organisations were required to explore and therefore it seemed a pragmatic approach to visit together and compare findings. The team consisted of six inspectors (five from HFEA and one from HIW) who had a broad range of clinical and regulation experience and one specialist clinician in the chosen area of inspection. We arranged pre inspection meetings to outline and confirm individuals' inspection areas. This ensured duplication was at a minimum, allowed for wider inspections and discussions with the regulated service. Whilst HIW only attended for one day on this occasion, relevant information which had been gathered on the second day was shared, which offered a rounded observation of the services being offered. The outcome was positive, with the service stating that it was a helpful, constructive inspection with both agencies dovetailing and clearly working together seamlessly. This has provided a platform for us to consider establishing a Memorandum of Understanding between both bodies, which could minimise regulatory overlap or duplication for the Welsh fertility sector.

Further Information

Reports on all of our inspections are published on our website under Find Our Reports and Reviews

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'[4].

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 2015-16 HIW undertook a total of four IR(ME)R proactive compliance inspections. Three of these inspections were conducted in diagnostic imaging departments within independent hospitals in Wales and one inspection was conducted in the radiotherapy department at Velindre NHS Trust, Cardiff.

During our inspections the following themes emerged:

- Patient feedback about their experiences of the services and staff was generally positive
- While the majority of written policies, procedures and protocols were in place, they needed to be updated to ensure they accurately reflect the requirements of IR(ME)R and what actually happens in practice, so that this is clear for staff to follow
- It was clear from the inspections that staff are committed to providing a high standard of service and while we identified areas for improvement across the four departments and two instances of regulatory breaches at Velindre, overall we found that safe care was provided to patients
- All departments inspected had audit programmes in place and there was evidence of audit activity being completed to help ensure that safe and effective care was provided.

HIW received a total of 45 notifications from health boards during 2015-16 involving 'exposures much greater than intended'. HIW did not receive any such notifications from the independent sector. Of these, two occurred in radiotherapy, the remainder occurred in diagnostic imaging services. HIW evaluated each of the 45 notifications to consider the severity of the incident and assessed whether the organisation had taken the appropriate actions to prevent similar occurrences in future and ensure patients were appropriately safeguarded. Where further information was required, HIW requested this from the health board to further inform our assessment. We found there were common causes that emerged from these notifications and variations in the number of incidents reported by health boards.

[4] Where incidents occur in which a person, whilst undergoing a medical exposure, has been exposed to ionising radiation much greater than intended, this should be investigated by the health care organisation and reported to HIW

In December 2015, HIW published our first annual report on regulatory activities in Wales in relation to IR(ME)R during 2014-15. The annual report included key themes from our inspection activity and an analysis of the notifications of incidents HIW received. We will be publishing our second annual report detailing our IR(MER)[5] work for 2015-16 during the Summer 2016. This will provide more in depth analysis as a basis for sharing good and noteworthy practice.

We have taken action to help us build in-house expertise to lead and support our IR(ME) R programme. We have worked closely with the Medical Exposures Group of Public Health England, who developed a training programme which was delivered to HIW staff in April 2016.

[5] http://hiw.org.uk/reports/natthem/2015/irmer1415/?lang=en

Delivering our responsibilities: Mental Health and Learning Disabilities

Mental Health and Learning Disability Inspections

Our mental health and learning disability inspections include both independent hospitals and mental health hospitals and community services provided by the NHS. Inspections and follow-up visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services throughout 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. In addition, Part 4 states that every in-patient must have access to an independent mental health advocate and this is another area that HIW monitors.

Since June 2015, our streamlined workbooks are an integral part of the inspection process ensuring our focus remains appropriate, updates in legislation are reflected and this approach has enabled all aspects of our work to be covered during monitoring and inspection visits. The full suite of workbooks[6] were published on our website and we will continue to review them periodically to remain focused on patient centered quality services.

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 requirements and/or 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 8 immediate assurance letters which have enabled us to have quicker assurance over some of the more urgent findings from our visits. In addition, in relation to the independent hospitals, a total of 2 non-compliance notices have been sent and this is the first stage of our enforcement process.

We identified a number of themes for the NHS and independent hospitals during our inspections last year relating to inadequate physical healthcare, a lack of adequate, staffing numbers, a lack of registered nurses and medical staff, a lack of robust care and treatment plans, inadequate/lack of essential policies and procedures and a lack of robust governance and clinical audit processes. Other specific themes identified within the NHS included: a lack of available beds, a lack of psychology and occupational therapy, a lack of training in a variety of areas, a lack of a clear admission criteria or its disregard and a lack of staff supervision. There was also a distinct lack of a clear maintenance programme for many hospitals visited. Specific themes identified for the independent hospitals included

6 http://hiw.org.uk/about/whatwedo/mentalhealth/?lang=en

a lack of documentation in relation to the responsible Individual visits and inadequate supervision records

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 and occupational therapy input across the independent sector is noteworthy
- the positive rapport between patients and staff, despite staff dealing with very challenging patients
- we observed an increase in NHS hospitals working towards and obtaining external accreditation, including Accreditation for Inpatient Mental Health Services (AIMS), Star Wards and Safewards, this is to be commended
- multi disciplinary team working including community based staff across NHS is generally effective and particularly in private providers staff felt that the opinions of all professional disciplines that attended the meetings were valued and listened too.
- the openness of staff and patients to engage with the inspection process across both NHS and independent hospitals is generally very good.

During the Summer we will be publishing an annual report for the Mental Health Inspection Programme which will provide a more in depth analysis of the key themes from our inspection and recommendations.

Monitoring the Use of the Mental Health Act

HIW has specific responsibilities to monitor the Mental Health Act. Throughout 2015-16 we conducted 59 Mental Health Act monitoring visits. A number of these visits were undertaken as part of our in-depth mental health reviews. Again this year we did not find any consistent failings regarding the administration of the Act throughout Wales. Generally there is a very high compliance with the Mental Health Act in both the NHS and independent sector. Where issues are identified within our inspections, these are reported to the NHS and private providers and actions are taken by the providers to promptly rectify any issues and inform patient where this is required.

For the first time during 2015-16 we commenced a programme of monitoring the implementation of the Act for patients in the community on Community Treatment Orders (CTOs). Throughout the health boards there are a significant number of patients detained in the community on CTOs and in some health boards there are nearly as many patients detained in the community, on CTOs, as in-patients accommodated on hospital wards.

We undertook a total of 3 visits to Cwm Taf, Cardiff and the Vale, and Aneurin Bevan health boards where we held interviews and discussions with patients, relatives, advocates and a cross section of staff involved in caring for patients. In all three reviews we found good examples of multi disciplinary team working and decision making. However, we identified issues with completion of documentation including the incorrect use of language when referring to the Act. We also noted that sometimes processes and systems affected the

consistency of continuity of the care being provided. In one health board we saw that this led to delays in booking transport for patients and in another health board a lack of a unified electronic system for patient information resulted in delays transferring information between the different organisations involved in caring for patients. During 2016-17 we will continue to extend our monitoring of CTOs with the other Health Boards within Wales.

We continue to find that individual Mental Health Act administration teams[7] are struggling to undertake their role in ensuring patient safeguards are upheld, i.e. appeals against detention, provision of rights monitoring, consent to treatment safeguards. This is due in the main due to a lack of resources. It is imperative that health boards and independent hospitals review the role of Mental Health Administrators to ensure that they have sufficient time to effectively undertake all aspects of the role.

Learning Disability Review

During 2015-16 we commenced a thematic review of learning disability services in Wales. This thematic review aims to assess the level of change and progress in learning disability services since our previous national review in 2007, which looked at how well the NHS in Wales commissioned and provided learning disability services. The review is a two phased approach.

HIW committed in our Operational Plan 2015-16 to conduct a joint piece of work with the Care and Social Services Inspectorate for Wales (CSSIW) in the area of learning disabilities, to consider issues across the health and care boundary. This joint work formed the first phase of the thematic review.

During the year HIW and CSSIW jointly undertook fieldwork in 6 local authorities (comprising of 5 different health boards). HIW assessed the experience of people who receive packages of care which are jointly funded by health and social care, by examining community based provision and by looking at commissioning by health boards of services for people with learning disabilities. At the same time, CSSIW undertook detailed fieldwork in the local authority to assess the efficiency, quality and safety of the care and support provided for people with learning disabilities. A national overview report of this work has been published[8].

The second phase of HIW's review of learning disability services will focus on NHS residential services. HIW will use all the information gathered during the joint review with CSSIW and inspections of residential services to assess progress against the findings of the 2007 review. HIW will publish a report of our findings in Autumn 2016.

7 These are established by the health boards and independent providers to ensure that patients' safeguards under the Act are upheld by the organisations.

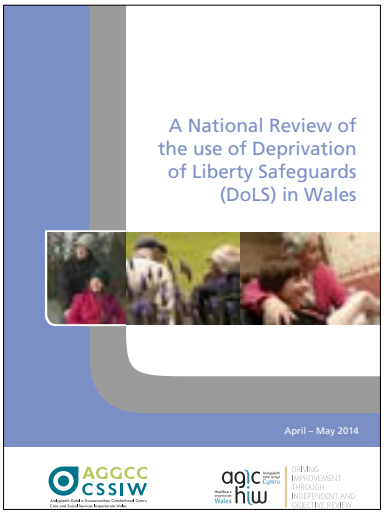
8 http://hiw.org.uk/reports/natthem/2016/nationallearningdisability/?lang=en

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 the 2014-15 annual monitoring report[9] was published in January 2016 .

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 2015-16, HIW published one review of a homicide committed by an individual known to mental health services. This review received significant attention when it was published.

The report[10] highlighted issues specific to the individual case and the main outcomes were:

- it was difficult to see how the incident could have been either predicted or prevented by health services;
- we did find areas for improvement relating to healthcare and support in the course of our review however we do not believe that the presence of these issues contributed to this tragic incident.

During 2015-16 we also published an evaluation of homicide reviews undertaken by HIW since 2007[11]. The purpose of the evaluation was to assess the impact the HIW reports, and the recommendations issued since 2007, have had on services that are being provided to mental health service users.

9 http://hiw.org.uk/reports/natthem/2016/DoLS1415/?lang=en
10 http://hiw.org.uk/reports/special/homicide/argoedhomicide/?lang=en
11 http://hiw.org.uk/reports/natthem/2016/homicideevaluation/?lang=en

The broad themes covered in HIW's evaluation report were:

- care planning, assessment and engagement with families/carers
- risk management
- diagnosis
- discharge and aftercare planning
- integrated and co-ordinated services
- communication and information sharing.

We found that the impact of our reports had been variable. Some organisations which were not the direct subject of a review, had established their own internal process to look at the recommendations from each report. However, some organisations had no formal process or mechanism in place to ensure wider learning from our reports. Some of the barriers to the implementation of the recommendations arise when action is required across multiple organisations or agencies, including non-health bodies. However, all of the stakeholders who had been subject to review said that our reviews were invaluable and should continue. There is an appreciation of the level of detail contained within our reports and it was felt that this was important in providing context and justification for the subsequent findings and recommendations.

Delivering Our Responsibilities: Supervision of Midwives

HIW fulfils the function of the Local Supervising Authority (LSA) and is therefore responsible for ensuring that statutory supervision of all midwives is exercised to a satisfactory standard across Wales.

During 2015-16 the Wales model of supervision has continued in line with the delivery plan key performance indicators (KPI's). There has been ongoing monitoring and evaluation of the model with quarterly reports produced, demonstrating a high standard of performance against the agreed KPI's and these reports are been shared within the LSA and with all key stakeholders.

The Supervisors of Midwives (SoM's) have developed several excellent initiatives in the past twelve months which have been agreed by the LSA and Heads of Midwifery and implemented on an All Wales basis:

- A Preceptorship Passport which is now used by all newly qualified midwives to support them within their first year of practice following qualification as a midwife
- The SoM's also provide support to student midwives in both the University and health board settings, informing them about the work of the LSA and offering them support and advice as required which supports their preparation for qualification as a midwife
- A revised annual supervisory review document which support the requirements of Revalidation and guides midwives through this process.

The 24 hour on call service provision has also proven to be successful and has provided women and the public with a point of contact, external to health boards, when requiring advice and support with concerns raised about care provision. The on call service has also provided midwives with a point of contact when they require advice.

As well as the positive aspects to the model, there have also been challenges in the past twelve months; the continued improvement to the timeliness of the supervisory investigation process and also the proposed changes to supervision as determined by the NMC. The implementation of the Wales model demonstrated an initial improvement in the time taken by SoM's to complete a supervisory investigation, but there remain occasions where timeliness is affected by matters which are not within the control of the SoM e.g. sickness absence of an individual. Therefore the anticipated improvement has been demonstrated with the implementation and progression of the new model, but timeliness remains an area that the LSA will be required to continuously audit.

In January 2015 the Kings Fund published the report commissioned by the NMC "Midwifery regulation in the United Kingdom". The report made the following recommendation:

"The NMC as the health care professional regulator should have direct responsibility and accountability solely for the core functions of regulation. The legislation pertaining to the NMC should be revised to reflect this. This means that the additional layer of regulation currently in place for midwives and the extended role for the NMC over statutory supervision should end".

The NMC accepted the findings of the Kings Fund report in full, in February 2015.

The role of the supervisors of midwives (SoMs) in the Wales model was originally agreed as an 18 month rotational role, with the allocation of step up and step off points to provide continuity and support to the supervisory team. Because of the proposed changes for midwifery supervision, interest from midwives applying to undertake the Preparation of Supervisor of Midwives (PoSoM) declined and the interviews held in October 2015 appointed only six midwives to the course. Also a number of SoMs left the role during 2015-16 for career progression and whilst this is a testament to the development of the midwives who undertake the SoM role, it has impacted on the number of midwives required to undertake this role until the removal of statutory supervision.

The LSA and Heads of Midwifery within all health boards in Wales have therefore requested a period of continuity within the SoM teams until March 2017. The SoMs who came into post in August 2014 have been asked to remain in post to provide stability and expertise, which also ensures support is available for any newly appointed supervisors of midwives.

A Taskforce has been set up in Wales to review the model of supervision in Wales and to advise the Chief Nursing Officer (CNO) of the best option to take forward to meet the changes required following the removal of statute in 2017. The LSA are an integral part of the Taskforce, which will develop the revised role of the SoM, a new model for supervision and the required training course which will meet the needs of the revised role. The LSA has liaised with the NMC with regards to the transition period and will continue to do so until the changes agreed by the Taskforce and the CNO have been implemented.

In June 2015 the LSA informed the Nursing and Midwifery Council (NMC) of its escalating concern with regards to the provision of midwifery care within maternity services in Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board (BCUHB). In response to the submission of information, the NMC took the decision to conduct an extraordinary review of midwifery supervision in the health board, which took place during 20–22 July 2015.

The report of the extraordinary review[12] has been published and it stated that two standards were unmet. The LSA prepared an action plan to restore full compliance with the NMC standards; an LSA audit of supervision performance in 2015 and the requirement for all midwives to have an annual supervisory review (97%) had been achieved. Both of these standards were met within 3 months.

12 https://www.nmc.org.uk/news/news-and-updates/reports-on-extraordinary-review-visit-to-north-wales

The LSA extended this work and carried out an audit programme of supervision across all seven health boards in Wales between October 2015 and January 2016. The focus of each audit was based on the framework of the BCUHB extraordinary review to ensure equity of application across the LSA region. The audit teams were made up of a LSA Midwifery Officer, a SoM from an external health board and a LSA lay reviewer.

The LSA lay reviewers remain 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 LSA lay reviewers in discussion with the LSA, chose the public's knowledge of supervision, and the midwives knowledge and preparation for Revalidation as the focus for their section of the audit reports. Revalidation is an NMC process that midwives are required to follow to confirm that they meet the requirements to remain on the Nursing and Midwifery Register. The lay reviewers concluded from their audit process that there was a marked improvement in women's knowledge of supervision from that gathered in 2014-2015 audits and that midwives in all health boards appeared to be well informed and prepared for the NMC Revalidation process.

Organisational Improvement

Dealing with Concerns

We have continued to improve and enhance our internal processes for dealing with issues of concern. The Risk and Escalation Committee continues to meet 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 committee considers issues that emanate from concerns or enquiries made to HIW and determines, dependent upon level of risk, what the appropriate action may be.

During 2015-16 we received over 300 concerns relating to either the NHS or the independent sector referring to different aspects of care and treatment provision. In general where this stems from a specific complaint we provide advice to the complainant on the appropriate route including re-directing to the health board and Community Health Council.

We are a member of the NHS Escalation and Intervention arrangements[13]. 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 2015-16, HIW held two Healthcare Summit days bringing together the key external reviewers working in Wales to share intelligence and form a consistent view about an organisation. HIW also carried out an evaluation of the effectiveness of the changes made to the Healthcare Summit process, and members' feedback showed that the changes had been positive. The change to a one day format ensures the intelligence shared is more focussed on the high level concerns and priorities of each organisation. The revised format also allows participants to form a view on the national themes emerging.

The Healthcare Summit welcomed new membership from the Wales Deanery and HIW started discussions to ensure that the 2016-17 healthcare summits have input from the UK professional regulators.

The Concordat Forum met four times during 2015-16 and a number of changes were implemented by HIW. To monitor its effectiveness, HIW conducted an evaluation and feedback from members showed that the changes had led to improvements in both the usefulness and effectiveness of the Forum. HIW chaired and facilitated the first three meetings, before chairmanship was handed over to the General Pharmaceutical Council.

13 http://gov.wales/docs/dhss/publications/140320escalationnhsen.pdf

HIW continued to build and maintain relationships with partner organisations and established and refreshed a number of its Memoranda of Understanding[14] in 2015-16.

HIW has attended and presented at the Welsh Independent Healthcare Association (WIHA) during 2015-16. The meeting in June 2015 was an information sharing session in which HIW and WIHA members engaged in discussions about HIW's approach to inspections of independent healthcare. Feedback from WIHA members was positive in terms of the overall changes we had to our report formats however members identified the need for greater consistency around the report and inspection format,

Peer and Lay Reviewers

During 2015-16, HIW continued to work with lay reviewers and clinical peer reviewers in our work programme.

HIW continued to expand their peer reviewer capacity to support the HIW work programme, with a number of recruitment exercises. We now have more than 200 peer reviewers with a range of professional expertise that we can call upon to support our work.

Lay reviewers spoke and listened to patients to ensure that their views were reflected in our work. We worked more closely with Community Health Councils, using their relevant expertise and undertook a campaign to attract volunteer lay reviewers which will bring HIW in line with other organisations.

In March 2016, HIW held a highly successful conference, bringing together HIW staff and reviewers for the first time. This conference was attended by over 120 delegates and gave the opportunity to reflect on our work programme over the last 12 months, provide information on the plans for 2016-17, gave opportunities for staff and reviewers to feedback and raise relevant queries and ensure everyone is working to the same goals and expectations.

Learning and Development

HIW continued to ensure learning and development for both staff and reviewers was an important focus for 2015-16. A new learning and development plan was produced and implemented, which continued the blended approach to learning and development by enabling staff to attend conferences, training days, information sessions and access e-learning packages.

HIW staff were given the opportunity to shadow and observe various types of inspections during 2015-16. This ensured staff had the chance to experience how an inspection is conducted, see how their work fits into the overall objectives of the organisation and identify if any improvements could be made.

14 http://hiw.org.uk/about/workingwithother/mou/?lang=en

We continued to provide peer and lay reviewers induction and training days which equipped them with the skills required to take part in inspections. HIW also ran a series of training sessions for staff, specific to the work that it does to enable them to develop their expertise.

Communications

We have considerably increased the number of followers for our twitter account, since set up in March 2015. The increase in followers helps our messages reach a wider audience.

Since September 2015 we have been working on developing a new user friendly website. We have listened to the feedback we have received from our users on the difficulties they faced when trying to access reports and information on our current site and have based the designs for our new website on our users needs.

One of the key features for our new website will be the Healthcare Services Directory. The new directory will allow users to easily access and read inspection reports for healthcare services in Wales that are inspected by HIW.

The new website has a simplified structure to make it easier for people to find the information they need.

In addition, one of our continued 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

During the year, it became apparent that the 3 week deadline for circulating the draft report to the setting was unrealistic in some cases, and could potentially impact on the quality of the final report, so a management decision was taken to revisit this target. This decision was based on the fact that if there are a number of issues arising at the time of inspection, then the setting is provided with verbal feedback at the time, and all potentially high risk issues are followed up with an immediate assurance letter within 2 days. The setting would be aware of any issues identified and these would not change vastly in the report. This decision has not impacted on our publication targets.

The following table shows that we published 75% of our reports within 3 months of the inspection taking place (compared to 67% reported last year).

	2014-15	2015-16
Immediate assurance letters issued within 2 days	68%	71%
Publish the final report within 3 months	67%	75%

Of the 25% of late published reports (24 in total), 10 reports were published within 2 weeks of target, 6 within 4 weeks and the remainder were later predominantly due to staff absence.

Finances

The following table shows how we used the financial resources available to us to deliver our 2015-16 Operational Plan.

		£000's
HIW Total Budget		**3,403**
Expenditure:		
Staff costs	2,739	
Non-staff costs	399	
Reviewer costs	530	
Total Expenditure:		**3,668**
Income:		
Independent healthcare	-257	
Dental registry	-96	
Total Income:	-353	
Total Net Expendutire:		**3,315**

What we said….	What we did….
Hospital Inspections	
Undertake a minimum of 10 inspections of a number of wards and departments in a range of NHS settings covering all health boards and trusts. This will include inspections in both acute and community hospitals, visiting up to 4 wards and/or departments per inspection.	We conducted 8 hospital inspections across 6 of the health boards. In some cases we visited two or three hospitals as part of the same inspection which meant we were able to broaden our coverage, visiting 15 hospitals and 43 wards in total.
Produce an annual summary of any trends and themes identified from this work.	We have produced an annual summary and this will be published shortly after this annual report.
Examine the actions being taken by each health board and trust to comply with National IPC Standards and their arrangements for monitoring compliance. Develop an inspection approach that takes account of how infection prevention and control is employed in practice by healthcare staff and also test organisational systems.	This is covered routinely as part of our hospital inspection process.
Ionising Radiation (Medical Exposure) Regulations (IRMER)	
Develop in-house expertise to lead and support our IR(ME)R programme.	During the year we have trained a number of our inspectors which will enable them to lead these inspections in future years.
Adapt the methodology to deliver IRMER inspections within the independent sector.	Three of the four IRMER inspections undertaken this year were at independent healthcare settings. Our learning from these has ensured we have a methodology fit for use in this sector.
Maintain the effective operation of the panel review incident notifications.	45 notifications received during the year all of which were evaluated for whether appropriate action had been taken to prevent similar occurrences in the future.
Undertake a minimum of 4 inspections of clinical departments within health boards.	5 inspections undertaken, 2 in NHS departments and 3 in independent healthcare establishments.
Publish the methodology used to conduct IRMER reviews.	We need to consult further with stakeholders before publishing this methodology so will do so in 2016-17 instead.

What we said….	What we did….
Thematic Reviews	
Ophthalmology	The review consists of a two staged approach. The first stage commenced during early 2016, and involved engagement with health board staff and other stakeholder organisations to collate views on the current issues being experienced in relation to Ophthalmic Services to build up an all-Wales picture. Stage two, to be undertaken in 2016-17 will consist of fieldwork visits which will test the stage one findings as well as collating the views of service users.
Learning Disabilities	Phase one of this work was completed jointly with CSSIW with the report published in June 2016. Phase two will focus on NHS residential services and be completed during 2016-17.
GP Inspections	
Conduct a program of 28 GP inspections.	We conducted 27 inspections GP inspections.
Work with NHS Wales Shared Services to understand how we can rely on the work of NHS Internal Audit for further assurance.	The work of NHS Wales Shared Services (NWSSP) is complimentary to the work of HIW and we have not identified any areas of overlap. Links have been established so that HIW and NWSSP Audit & Assurance can work together where appropriate in future. Relevant sections of NWSSP are also represented at the HIW summit process.
Dental	
Inspect approximately 150 NHS Dental Practices in Wales.	We conducted 133 dental inspections.

What we said….	What we did….
Pharmacists	
Embed the Memorandum of Understanding with General Pharmaceutical Council (GPhC) to share intelligence and escalate concerns. Consider how best to co-ordinate inspection work with the GPhC to ensure that both organisations receive the information they require.	MoU with GPhC is well established and regular sharing of intelligence has taken place. Two formal meetings held between HIW and GPhC in the year, and additional engagement in the handing over of the Concordat Forum chairmanship to GPhC.
Opticians	
Develop and pilot an approach to providing appropriate assurance of care provided by opticians. Consider a Memorandum of Understanding with the General Optical Council setting out how we will share intelligence and concerns.	Our work on the Ophthalmology Thematic review will continue to look at this into 2016-17. At the request of the General Optical Council we have delayed work on a MoU until next year.
Prison Inspections	
Expect to undertake up to 12 reviews of deaths in custody. The volume undertaken is dictated by the volume of cases commissioned from us by the Prison and Probation Ombudsman.	10 investigations undertaken.
Will improve the way in which the findings from our reviews of deaths in custody are shared with respective NHS Wales organisations, to ensure that the issues we find during these reviews relating to NHS care are addressed.	Links have been improved with NHS Wales and Welsh Government now receiving copies of HIW reports once completed. We have established more robust processes to ensure HIW is following actions relating to NHS settings directly at the end of each review. We also now attend the Prison Health Improvement Network which provides further opportunities to understand how reviews are being responded to, by NHS and prisons.
Contribute to 1 full joint inspection and 1 follow-up inspection of Youth Offending Teams with HMI probation.	One full joint inspection undertaken in December 2015 however the follow-up inspection has been scheduled by HMIP for July 2016.

What we said….	What we did….
Contribute to 1 full joint inspection with HMI Prisons.	We participated in one unannounced inspection in November 2015.
Regulation of Independent Healthcare	
Carry out 52 inspections across a range of independent healthcare settings (excluding mental health and learning disability establishments).	37 visits undertaken in total as follows: • 2 Acute Hospitals • 2 Dental Hospitals • 1 Private Dentist • 4 Hospices • 4 Independent Clinics • 2 IVF • 1 Termination of Pregnancy • 19 Laser • 2 Surgical Laser
Publish the methodology for our inspections within the independent healthcare sector.	We have developed our inspection tools methodologies significantly during the year but further field work testing is required before they can be published. This commitment will carry forward into 2016-17.
Continue to process applications to register or change their registration, as an independent healthcare setting, including individual private dentists, in a timely manner. Ensuring applicants demonstrate, or continue to demonstrate that they meet the relevant regulations and minimum standards.	During the year we processed: • 28 new registrations • 8 variations to existing registrations • 15 changes to registered manager • 115 dental registration applications
Begin a programme of work to enable online registration of services.	This commitment has been deferred and will be incorporate into a broader piece of work to review all of HIWs systems in 2016-17.
Continue our programme of visits to suspected unregistered providers.	21 visits undertaken.

What we said….	What we did….
Conduct a review of the fees charged for independent sector registration.	Work on this has commenced however the proposed changes to the Private Dentistry Regulations and potential legislative changes following the Green Paper "*Our Health, Our Service*" we consider it more appropriate to include a review of fees as part of progressing those changes.
Mental Health & Learning Disabilities	
Carry out a minimum of 11 inspections in independent settings. We aim to visit these hospitals at a minimum interval of no more than 24 months.	12 visits undertaken.
Continue a programme of 4 in-depth inspections of NHS wards across a number of health boards.	4 visits undertaken.
Undertake 10 targeted follow up visits where there are significant regulatory breaches and/or significant issues with patient care and treatment.	7 visits undertaken (5 independent and 2 NHS).
Publish the inspection tools used to review these services.	Published in June 2016.
Community Treatment Orders	
Review the use of Community Treatment Orders within 4 health boards and the outcome will be published.	3 reviews undertaken and reports published.
Mental Health Act Reviews	
Carry out a minimum of 50 reviews in settings where individuals are liable to be detained under the Act. Publish the management letters associated with our visits.	59 reviews undertaken and findings published.
Produce and publish the Mental Health Annual Report as soon as possible after the financial year which we are reporting on.	The 2014-15 report will be published later this summer.

What we said….	What we did….
Second Opinion Appointed Doctors	
Expect to respond to approximately 720 requests during the year.	In excess of 850 requests completed.
Deprivation of Liberty Safeguards (DoLS)	
Monitor the implementation of the safeguards by NHS and registered independent hospitals when caring for such patients who are unable to make decisions about their care.	This is undertaken as part of the inspection process for such services.
Publish a DoLs report jointly with CSSIW during the first quarter of 2016 relating to our findings from our routine data collection about the use of DoLs in Wales.	2014-15 annual monitoring report published in January 2016.[15]
National Preventative Mechanism (NPM)	
Continue to be a member of the NPM steering group and attend quarterly business meetings, contributing to the UK National Report as appropriate.	We have actively participated in the NPM quarterly business meetings and was asked to take the lead on a presentation highlighting trends in detention for the April 2016 meeting.
Homicide Investigations	
Expect to undertake one investigation 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 and financed by the Welsh Government.	One investigation undertaken and report published in March 2016[16].
Conduct a thematic review on lessons learned from previous homicide investigations.	Review undertaken and report published[17].

15 http://hiw.org.uk/reports/natthem/2016/DoLS1415/?lang=en
16 http://hiw.org.uk/reports/special/homicide/argoedhomicide/?lang=en
17 http://hiw.org.uk/reports/natthem/2016/homicideevaluation/?lang=en

What we said….	What we did….
Special Reviews	
Ensure capacity to undertake up to four special reviews.	During the year we conducted a Follow-up Review of Governance Arrangements at Cwm Taf University Health Board[18] and a Clinical governance review of the Welsh Health Specialised Services Committee (WHSSC)[19].
Undertake a joint follow-up review with the Wales Audit Office of Governance Arrangements at Betsi Cadwaladr University Health Board.	During the Autumn of 2015 HIW and the Wales Audit Office (WAO) undertook work to assess progress made by the health board in respect of these areas. Our work found that while that had been some positive developments, fundamental work remained for the health board.
Governance and Assurance of NHS Bodies	
Validate the self assessments against our wider intelligence and provide feedback to each NHS organisation	Self assessments were received during September 2015 and reviewed by relationship managers. Feedback will be provided through the health board annual reports that will be published at the end of August 2016.
Continue to review the self assessment process with others to maximise impact Continue and develop the process of annual reporting to NHS Boards highlighting the themes and issues arising from our various work streams	2014-15 annual reports were presented at board meetings for all health boards and trusts. These reports were then published in August 2015[20].
Formalise the collaborative approach to assessing governance with Wales Audit Office.	Work on this commenced towards the end of 2015-16 and will be completed in July 2016 with a joint paper setting out our approach published on our respective websites.

18 http://hiw.org.uk/reports/special/specialreviews/cwmtaf/?lang=en
19 http://hiw.org.uk/reports/special/specialreviews/clinicalgovernance/?lang=en
20 http://hiw.org.uk/reports/localhealthboardstrusts/?lang=en

What we said….	What we did….
Local Supervising authority for Midwives	
Ensure the new model of supervision continues to meet the standards and guidelines set by Nursing and Midwifery Council (NMC) and that all midwives who practice in Wales have access to, and receive, appropriate levels of supervision	There has been ongoing monitoring and evaluation of the model with quarterly reports produced, demonstrating a high standard of performance against the agreed KPI's and these reports are been shared within the LSA and with all key stakeholders.
Continue to work with all relevant stakeholders to monitor and evaluate the new model of supervision in Wales	We have continued to engage with a wide range of stakeholders including Heads of Midwifery, regulatory bodies and Welsh Government
Continue to work with the Chief Nursing Officer and relevant stakeholders to consider if there are supportive elements of supervision that could be retained and or rolled out to the nursing communities in support of NMC Revalidation.	This work is ongoing as we prepare for major changes to midwifery supervision from April 2017.
Publish an Annual Audit Report to reflect the progress made in supervision during 2014 -15 in line with NMC requirements.	Report published in August 2015[21].
Follow Up	
Undertake up to 30 follow up visits to seek further assurance on the progress made by health boards in response to recommendations made as a result of our inspections activity. Publish our findings from these visits.	We took a strategic approach to follow up during 2015-16 by asking health boards to provide an update on all action plans agreed during the 2014-15 inspection year. This allowed HIW to establish what progress had been made on individual actions and to assess the arrangements in place to ensure that any issues are not replicated elsewhere within the organisation such as on other wards, units or hospitals. In addition during all hospital inspections we reviewed whether previously identified issues were apparent.

21 http://hiw.org.uk/reports/lsareports/lsaannualreport1415/?lang=en

What we said….	What we did….
Escalation and Intervention Arrangements	
Contribute to the effective implementation of the NHS Wales Escalation and Intervention Arrangements.	We have attended and participated in all meetings convened under these arrangements.
Continue to implement our enforcement policy and guidance. Track unregistered services.	Policies, processes and documentation to support this work have been developed during the year. Training to use these policies, particularly in relation to criminal proceedings is arranged for the first quarter 2016-17.
Working With Other Regulatory and Advisory Bodies	
Evaluate the effectiveness of the Concordat Cymru forum.	We undertook an evaluation of effectiveness and presented it to the Concordat members in January 2016.
Host the Inspection Wales Project Manager and influence this programme to gain greater impact and transparency.	HIW has hosted this placement since February 2015. Further information can be found on the Inspection Wales Website[22].
Contribute to the Better Regulation Group.	This group disbanded during the year.
Actively influence the legislative agenda and policy development within Welsh Government specifically with respect to the NHS Green Paper.	We responded to a number of consultations, calls for evidence and attendance at National Assembly for Wales committees during the year. This included our response to the NHS Green paper[23].

22 https://inspectionwales.com/
23 http://hiw.org.uk/news/greenpaperresponse?lang=en

What we said….	What we did….
Across the UK and Beyond	
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 the European Partnership for Supervisory Organisations, the Five Nations Heads of Inspection Forum and Professional Standards Authority. Within Wales we have played active roles in chairing the healthcare summits, the Wales Concordat (until November) and 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.	Two healthcare summits held during the year attended by 15 external bodies.
Evaluate the revised healthcare summit process to maximise its effectiveness and impact.	2014-15 healthcare summits evaluated and learning used to develop a new format for 2015-16 which has been received positively by members.
Fully embed our operating protocol with Community Health Councils (CHCs) across Wales to enable better sharing of evidence between the two organisations to identify problem areas earlier, ensuring the experiences and views of patient help us to inform the risk assessment process	All relationship managers have established local information sharing arrangements with their respective CHC counterpart. We have invited CHC representation for all of our stakeholder groups and invited CHC members to participate in our GP inspection programme and undertake the patient experience element of the inspection.
Continue to build relationships and develop new Memoranda of Understanding and protocols with relevant professional bodies.	This activity is on-going and has resulted in a number of new MoUs being developed in 2015-16 and new relationships established. A full list can be found on our website[24].

24 http://hiw.org.uk/about/workingwithother/mou/?lang=en

What we said….	What we did….
Supporting Peer Review	
Support the Welsh Government as it sets up structures to oversee the co-ordination and extension of peer review within the Welsh NHS.	We have continued to support this programme of work during the year with responsibility for managing the review moving to Welsh Government from August 2015.
Continue to publish peer review reports and associated action plans on our website.	We have continued to publish all reports on our website[25].
Developing Ourselves as an Organisation	
Continue our recruitment activities to put in place the reviewer capacity essential to deliver our inspection and investigation programmes, specifically Lay Reviewers, GP Reviewers and investigate alternative approaches via collaboration with other regulatory bodies.	Peer reviewer numbers increased to over 200 during the year. We ran a campaign to recruit voluntary lay reviewers.
Develop new and existing Peer Reviewers by providing annual induction and training.	All peer and lay reviewers recruited during 2015-16 undertook an induction/training session prior to going out on inspection. A successful staff and reviewer conference was held in March 2015.
Produce Competency Assessment Framework forms for all new reviewers which informs any additional support/ training, to be completed by inspection managers following completed inspections.	Competency Assessment Framework forms have been produced and now used across HIW following all inspections.
Ensure accredited Continuing Professional Development is attached to the training we provide for our Peer Reviewers.	All training sessions hosted by HIW have certificates produced outlining the learning outcomes and are accompanied with copies of slides used during the session. This provides all the evidence our reviewers need to be able to claim CPD credits for attending our training sessions.

25 http://hiw.org.uk/about/whatwedo/inspect/peerreviewprogramme/?lang=en

What we said….	What we did….
Developing Our Staff	
Produce a new learning and development plan, which uses a variety of training methods and supports staff in accessing the learning and development they need to perform and progress.	Learning and development plan for 2015-16 produced and implemented providing a wide variety of learning opportunities for our staff during the year.
Provide every member of staff with an opportunity to observe at our inspections.	13 shadowing opportunities taken during the year.
Aim to have at least 75% of HIW staff survey respondents state that they have been able to access the right learning and development opportunities.	77% of staff agreed that they were able to access the right learning and development opportunities.
Hold at least 12 all staff learning and development sessions during 2015-16.	We arranged 18 all staff learning events during the year.
Provide joined up learning and development sessions with our colleagues in the Care and Social Services Inspectorate for Wales (CSSIW).	We have arranged four joint learning events during the year.
Advice and challenge	
Hold three Advisory Board meetings during the year to cover operational and strategic planning; and the impact of HIW.	Three meetings held in June, October and February.
Strengthening our communication	
Undertake and publish a survey to gauge awareness and perception of HIW and compare results to the 2014-15 survey.	Survey was issued in the January issue of the stakeholder newsletter.
Commence Phase 2 of the website development which will involve moving the existing website on to a new more user friendly platform.	New website launched 27 June 2016.
Develop a public information booklet that clearly and concisely sets out HIW's role in the inspection and regulation of healthcare services and providing clear advice on how to complain or raise concerns about healthcare services.	Booklet produced and used when attending conferences etc.

What we said….	What we did….
Publish biennial newsletters.	Since September we have moved to producing monthly stakeholder newsletters.
Review the format of our inspection reports and ensure that they continue to be published promptly following the inspection visit.	All inspection report formats have been reviewed during the year.
Undertake a formal consultation exercise to seek the views of stakeholders on our strategic priorities for the period 2015-2018.	We published our Strategic Plan 2015-18 on 22 May 2015 as a consultation document[26]. 33 responses were received and have been considered when deciding our plans for 2016-17 and onwards.

26 http://hiw.org.uk/about/plans/?lang=en