Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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Checking people in Wales are receiving good care

Healthcare Inspectorate Wales

Annual Report 2016–2017

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

Our purpose

To check that people in Wales are receiving good care.

Our values

- Patient-centred: we place patients, service users and public experience at the heart of what we do
- Integrity: we are open and honest in the way we operate
- Independent: we act and make objective judgments based on what we see
- Collaborative: we build effective partnerships internally and externally.

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Foreword from HIW Chief Executive Dr Kate Chamberlain

The introduction of the Wellbeing of Future Generations (Wales) Act in April 2016, has served to reinforce the responsibilities of public bodies to think more about the long term, work better with people and communities and each other, look to prevent problems and to take a more joined-up approach. In our work we continued to uphold these values by focussing on the long term care for patients, working collaboratively with partners, patients and the community to drive improvement in healthcare. This will help create a Wales that we want to live in, now and in the future.

We design our work programme around intelligence and risk and we seek to use the resources at our disposal to best effect in order to

- Provide independent assurance on the safety, quality and availability of healthcare
- Promote improvement through the way in which we capture, analyse and reflect on the care that we observe being delivered
- Influence policy and standards by drawing attention to the factors that are supporting, or making more difficult, high quality services.

During 2016/17 we have again undertaken over 300 visits to various wards, establishments, health boards and bodies in the conduct of our work. Our reports naturally focus on highlighting those areas where we feel improvements can be made, but overall we have observed healthcare services with committed staff, that place patients at the heart of what they do, and who work hard to respond to demand in a way that maintains patient dignity whilst supporting the delivery of safe and effective care.

We have continued to observe a high standard of care being delivered in NHS services across Wales. The patients we have spoken to have generally been pleased with the care received and valued the work done by dedicated and committed staff. We found that staff were working hard to ensure that risks were being managed and appropriate care was provided in what, on occasion, could be pressured and challenging environments.

However, there are issues that we have raised again this year during ournspection programme such as infection prevention and control and record-keeping. It is also disappointing to note that aspects of medicines management continue to be an issue in spite of being highlighted as needing attention for a number of years.

There have been some positive messages regarding NHS governance during the year. The governance reviews that we undertook at Aneurin Bevan University Health Board and Welsh Ambulance Services Trust (WAST) were generally positive and we also found that Betsi Cadwaladr University Health Board had made progress since our original review, although challenges remained. In addition, the escalation status[1] for WAST was reduced from Enhanced Monitoring to Routine Arrangements during the year. However, it is also clear from our thematic reviews of Ophthalmology and Learning Disability Services that a lack of clear leadership and strategic planning for some service

[1] gov.wales/topics/health/nhswales/escalation/?lang=en

areas can directly affect people's experience and their ability to access care in a timely and appropriate way. It is also the case that the escalation status of three health boards (Abertawe Bro Morganwwg University Health Board, Cardiff and Vale University Health Board, Hywel Dda University Health Board) was raised from Enhanced Monitoring to Targeted Intervention during the year. Health Boards in Wales face a challenging agenda and it is important that whilst addressing their strategic and financial pressures they do not lose sight of the need to provide safe, effective and patient-centred care.

During our independent sector inspections we also observed generally high standards of care. The highest number of registered independent providers are services using class 3B/4 lasers and intense pulse light. The majority of these services are provided within beauty salons and clinics for aesthetic skin treatments and we continued to find a lack of awareness and understanding in these settings of the standards and regulations that should be applied.

HIW has specific responsibilities in relation to mental health which span both the NHS and independent sector. It is clear that services for people with mental health issues continue to face significant challenges with regard to staffing levels and the quality of the environment, which can create a challenging work environment for staff. For patients, there can be a lack of robust care and treatment plans and difficulties in getting joined up help in relation to both physical and mental healthcare needs as well as associated therapies and activities. It is important that we continue to focus attention on these services for individuals who may be particularly vulnerable and during 2017/18 we will be working jointly with Care and Social Services Inspectorate Wales (CSSIW) on the delivery of a joint thematic review of community mental health services.

We are keen that our work can be understood and used by policy-makers, managers, professionals and the public to support improvement. This Annual Report provides an overview of the work we have undertaken during the past year and what we have found. More detail is presented in the individual Annual Reports that we provide to each NHS health board and Trust. We will also provide more detailed analysis of the issues arising from our work in thematic analysis reports to be published later in 2017.

During 2016/17 we have been contacted over 300 times by patients, relatives or staff wanting to make us aware of issues that have caused them concern. Although it is not our role to investigate individual complaints we value the intelligence that this provides and it helps to inform our decisions on the services we should inspect. I welcome any feedback that you may have, good and bad, on the care that you have received.

Dr Kate Chamberlain
Chief Executive

Section one:
How we made our decisions

Our work for 2016-17 was structured to support the delivery of our activities in four key areas:

- Regulation of independent healthcare
- Inspecting the NHS
- Mental health and learning disabilities
- Supervision of midwives.

The collective combination of these activities supports the four priorities we aim to achieve:

- Provide assurance
- Promote improvement
- Strengthen the voice of patients
- Influence policy and standards.

Using Intelligence

Our decisions about where to focus our activities are risk based and intelligence led. Our approach is described on our website (hiw.org.uk/about/plans/operating/?lang=en).

We consider a number of environmental factors:

- Our population is changing, people are living longer and expect more from their health services
- Financial resources both for health services and HIW are scarce. We have to find ways to do more with less
- The ways in which care is provided is evolving in order to deal with these changes. This means that the complexity of service change is itself a factor we need to consider when assessing risk
- Legislative changes to the regulatory framework including changes to the dental regulations.

We use what we know about services and the information we have available to determine our priorities. This information includes:

- Vulnerability of the client group and the complexity of the service
- Evidence and intelligence about an organisation built up over time
- Specific data and information routinely available to HIW
- Issues and concerns shared with us by our partners
- Previous HIW reviews
- Public concern
- National priorities, new standards or quality requirements
- Recognised inequalities.

We analyse this information to ensure our decisions are consistent and based on evidence. To support this we have put in place:

- Relationship managers[2] for each NHS organisation to review intelligence and evidence to support the future planning process
- Memoranda of Understanding and information sharing protocols with other organisations to allow us to share information correctly
- An Intelligence Map to provide clarity on the information that is used on a regular basis
- Organisational records for each health board/trust and for independent providers
- A Risk & Escalation Committee that regularly and routinely assesses the evidence and intelligence available and reviews and refines our programme of work.

Our work programme ensures we meet our statutory requirements and review areas of concern identified by our relationship managers. It is also informed by the responses we received to the consultation we conducted into our Strategic Plan 2015-18. A number of the responses focussed positively on our intention to undertake National Thematic Reviews in several specific areas over the three year period, and included suggestions of additional areas that could be explored either as part of the current strategic plan or for consideration for the future.

Our in depth national review into Ophthalmology care was conducted and published in early 2017. This review received significant attention and provided the opportunity to establish relationships, and share our findings with key stakeholders. We also published our findings from the Learning Disability Thematic Review during autumn 2016.

[2] We have Relationship Managers for each health board and trust in Wales who review intelligence and areas of concern.

The functions and powers of HIW were considered by Ruth Marks in her 2014 review, "The Way Ahead: To Become an Inspection and Improvement Body". The report makes several recommendations for HIW and for Welsh Government, which we have responded to. In June 2015, the Welsh Government published a Green Paper called 'Our Health, Our Health Service' which included a section on the future of inspection of health and social care. In 2016-17 we worked with Welsh Government to evaluate the current legal framework and identify where improvements could be made. We also developed our approach to working more closely with the Care and Social Services Inspectorate Wales (CSSIW), which will continue through 2017-18. At the time of writing Welsh Government has begun consultation on the White Paper. We will consider the implications for HIW and ensure that our new three year strategy for 2018-2021 ensures that we are ready to play our part in driving improvement in healthcare in Wales.

Section two:
Delivering our responsibilities: Inspecting the NHS

Hospital Inspections

Our hospital inspections consist of broad, multi ward and multi-site hospital inspections which provide us with a greater opportunity to explore the wider patient safety, governance and management arrangements in place within health boards across Wales.

We conducted 16 of these hospital inspections within the seven health boards throughout Wales, visiting 20 hospitals and 27 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.

Almost without exception, we found that patients' and relatives' experience of healthcare during our inspections was positive; people told us that they were treated with kindness, courtesy and politeness. We also found that health boards placed a considerable emphasis on the delivery of safe and effective care, with some good examples seen of patient-centred care being provided by committed staff. The challenge for health boards is to provide strong leadership which supports and enables the effective delivery of services, and to ensure that their governance arrangements are sufficiently robust in support of sustainable provision of high quality, safe and reliable care.

The tables below summarises the key themes and service delivery issues that were identified in each domain from our 2016-17 inspections.

Quality of Patient Experience

What services do well
Dignified care: Across all our inspections we saw that patients were treated with kindness, courtesy and politeness with dignified care being provided. We also saw staff in all areas we visited, to be respectful and helpful toward one another, as well as those they were caring for. **Listening and learning from feedback:** We found that all health boards were striving to encourage patients and their families to offer views on their experiences of healthcare services and we saw evidence to demonstrate that attempts were made to improve aspects of services in relation to this feedback. However, health boards acknowledged that this was an area for improvement.

What services need to improve on
Dignified care: A number of the improvements identified regarding the provision of dignified care related to emergency departments. This was due to the need to ensure effective monitoring until patients could move efficiently through the department, either to discharge or to an environment most appropriate for their continuing care. Specifically, health boards were required to make improvements to such services, to prevent the need for patients to receive care on trolleys in corridors and other areas away from designated cubicles, or assessment and treatment areas. We found many instances whereby staff requests for ward repairs were not dealt with in a prompt way. In addition, we found some examples of poor lighting, delays in refurbishment and decoration of some clinical areas and a need for dementia friendly environments. Health boards must ensure that there is compliance with legislation and guidance to provide safe clinical environments. **Patient information:** We also found that the provision of bi-lingual information and the ability of patients to discuss their health needs in Welsh was inconsistent across all health boards. In general, signs in NHS facilities across Wales need to be readily available in Welsh as well as English in accordance with the Welsh Language Measure (Wales) 2011. **Listening and learning from feedback:** Health boards need to improve how they obtain patients, relatives and carer's views about theservices provided. There is also a need for clarity about what improvements are made in direct response to patients' views and as a consequence of informal and formal concerns/complaints.

Delivery of safe and effective care

What services do well

Infection prevention and control:

Most wards and departments were clean and tidy – patients and relatives who completed a HIW questionnaire expressed their satisfaction with the cleanliness of ward areas.

All health boards had a comprehensive infection control policy in place and we found that regular audits were being undertaken in clinical areas to ensure that staff were adhering to their respective local policy and good practice principles.

Managing risk and promoting health and safety:

All NHS hospital services inspected were able to demonstrate how they worked to ensure that risk management and health and safety was an essential component of patient care and in the protection and support of staff.

Preventing pressure and tissue damage:

During all our inspections, we saw that staff had assessed patients in relation to the risk of them developing pressure damage to their skin. We were also able to confirm that staff took appropriate action to prevent patients developing pressure and tissue damage.

Medicines management:

We found that staff received useful and regular support from pharmacy colleagues. During each of our inspections, we saw that nurses were undisturbed when administering medication to minimise the risk of error and to enable them to support and advise patients at those crucial times.

What services need to improve on

Infection prevention and control:

Health boards need to ensure that staff adhere to infection prevention and control local policy and best practice and guidelines at all times. This is as a means of ensuring optimum hand hygiene and equipment that is always clean and ready for use.

Record keeping:

As with previous years, we found that record keeping could have been better. It is imperative that clinical teams have access to clear, concise and complete records of patients' clinical presentation, in order to support decision making and discharge planning.

Medicines management:

Focus needs to be maintained on compliance with all aspects of medicines management. In particular health boards need to improve audit activity, and ensure that medication is always appropriately and safely stored.

We also found issues in relation to the use of patient identity bands, and the recording of prescribed oxygen on patient medication charts and legible prescribing.

Quality of management and leadership

What services do well

Governance, leadership and accountability:

All health boards had a range of clinical governance arrangements in place; standards of care in wards and departments were assessed and monitored by ward sisters and senior managers on a regular basis. The support of clinical practice 'educators' was also found to be of benefit in supporting ward staff to sustain and improve care standards and improved services to patients.

Staff who spoke with us, or those who completed a HIW questionnaire, offered positive comments overall about the support they received in their day to day work.

Workforce issues:

Each health board in Wales adopted a proactive approach to the recruitment and retention of staff. It was evident that health boards were exploring a number of ways of ensuring that they would have access to a skilled and stable workforce.

What services need to improve on

Governance, leadership and accountability:

The application of internal governance arrangements was found to be variable. This together with movement of key personnel during health board re-structure exercises led to some instability in service provision and reduced levels of clear communication between senior managers and staff involved in direct service provision.

Workforce issues:

Health boards need to ensure that staff receive a timely annual appraisal that results in a clear, achievable personal development plan. This is in order that staff are supported to be competent in the delivery of safe and effective care to patients.

Health boards were not always compliant with their stated local mandatory training programmes. This was reported to be due to difficulty in releasing staff from their caring duties.

A recurrent theme related to the variable knowledge NHS staff had of the Mental Capacity Act (MCA) 2005 and use of the Deprivation of Liberty Safeguards (DoLS). In a number of cases, staff lacked sufficient knowledge about how, or when, they should be applying the requirements of the MCA as a whole, or the DoLS in particular. We found variable understanding of this legislation during a number of our NHS hospital inspections.

Where, during an inspection, we identify immediate risks to the safety and welfare of patients, these are immediately brought to the attention of senior representatives within services. Common issues for immediate improvement during 16-17 were:

- The absence of patient identification wristbands which could have led to medication administration/treatment/investigation error
- Compliance with the Mental Capacity Act (2005) Legislation. Failure to do this has the potential to undermine patients' human rights
- Effective and prompt application of the Deprivation of Liberty Safeguards
- Improvements to aspects of medicines management, such as the need for oxygen therapy to be prescribed on patients' medication charts, monitoring of drug fridge temperatures and improved security of medicine storage areas
- Monitoring and treatment of patients in non-clinical areas of emergency departments such as corridors. This practice may have an impact on patient safety and dignity.

The key themes and service delivery issues that we have identified is not an exhaustive list of our findings, but highlights the main themes we identified in 2016-17. 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.

Our work with health boards is not limited to the inspection visits we make. The evidence that we gather through inspections is considered alongside our analysis of concerns that are raised with us, information shared by other agencies and our observations of health board governance.

During 2017 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 inspection and recommendations.

CASE STUDY

In February 2016, HIW undertook an inspection at University Hospital Llandough, part of Cardiff and Vale University Health Board. The inspection focussed on two medical wards and three wards delivering mental health services for older people. As a result of the inspection it was necessary for HIW to seek immediate assurance around a number of patient safety matters including staff levels, aspects of record keeping and the management of medicines. As a result of these issues and other serious matters identified during the inspection, HIW concluded that it was not assured that the systems in place in the areas we visited were ensuring that patients consistently received high quality, safe and reliable care.

The health board engaged positively with HIW during 2016, providing regular updates on progress against agreed actions. HIW was able to observe the health board making use of its quality and safety governance structures as a means of learning from the issues raised and tracking improvement action. In February 2017, as means of gaining further assurance on action taken, HIW conducted a follow up inspection to University Hospital Llandough. Whilst our inspectors made a number of new, minor recommendations as a result of inspection, they also concluded that the health board had taken appropriate action to address the previous, serious concerns. This included improvements to the way in which the physical health needs of mental health patients were being met, pro-active and effective management of staffing levels and ensuring that staff could complete mandatory training.

Dental Inspections

In 2016-17 we continued our routine programme of inspections of all general dental practices in Wales. Some practices visited offer private only dental treatment, some offer a combination of NHS and private dental treatment and others provide NHS only services. In our Operational Plan for 2016-17 we set an objective to inspect 150 dentists. During the year we inspected 75 dental practices and undertook 5 follow up dental inspections (to practices previously inspected by us) during 2016-17. This reduction reflects the fact that our plan is reviewed continuously throughout the year and where appropriate we adjust our work programme on the basis of intelligence and risk.

During these visits we 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.

At each inspection we asked patients about their experience of care received from the dental teams treating them and once again this year, patients reported positively about this. Dental practices were good at keeping to time during the day and in general patients did not experience delay in getting an appointment when more urgent treatment was needed. 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.
- In four practices we identified that urgent improvements were required as we discovered out of date medication, dental materials and some of the contents of emergency kits (for patient collapse).
- A need to improve some aspects of the decontamination process, for example, the daily checks which should be carried out on sterilisation and cleaning equipment.
- 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. On two occasions our assessment of records indicated such poor standards of record keeping that we recommended urgent improvements be made.
- We found that practices often did not have good systems for keeping information about staff up to date and easily accessible. On four occasions we were unable to see documentation (related to staff) required at inspection. In all four examples we urgently sought and received the missing information immediately post inspection.

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

We have 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 through attendance at Welsh Dental Committee meetings and presentations at training events organised by the Postgraduate Deanery. Feedback from these events has been positive with dentists and other members of the dental team 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 the Health and Safety Executive. 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 past feedback about practices needing to improve their systems and approach to seeking regular patient feedback, the Postgraduate Deanery has prepared a questionnaire which practices can use to seek the views of their own patients. This has helped practices with their obligations to ensure that the patient perspective is considered in service provision.

An annual overview report of dental inspections for 2016-17 will be published in 2017, which will provide a more in depth analysis of the key themes from our inspections and recommendations to help improve practice across the sector.

HIW will continue with its programme of routine, planned inspections to dental practices across Wales in 2017-18 and will continue to prioritise visits to those which are higher risk. Follow up inspections to practices where inspection judgements have been negative will also continue.

GP Inspections

This year we undertook 27 inspections in 2016-17 of General Practices.

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.

At each inspection visit, the inspection team consisted of an HIW inspector together with a GP peer reviewer and a Practice Manager Peer reviewer. Members of the local Community Health Council accompanied inspectors to each GP inspection and where Community Health Councils were not used (in North Wales); HIW lay reviewers undertook the same role. The role of CHC members and HIW lay reviewers was to speak to patients to understand their experiences and views of the practice.

During these inspections a number of common themes emerged:

- Overall patients reported high levels of satisfaction with the care they were receiving from the GP practice teams. We found some examples of excellent leadership and very cohesive teams with structures and processes that worked well, even in those practices that included numbers of relatively new members of staff.
- We frequently heard patients tell us that booking appointments could prove difficult, with busy telephone lines and a narrow window of time within which to book on the day appointments. Some practices also offered an online appointment booking facility, but did not always promote this as well as they could.
- We found that in many practices, the overall process for safeguarding vulnerable people needed to be improved. This included the need to ensure that all staff had received training and to the required level. On occasion, the safeguarding policies themselves needed to be updated to include details of local contacts.
- There were many instances where physical access into GP practices was extremely difficult for wheelchair users, those with limited mobility, or those with pushchairs. We made recommendations advising practices to reconsider and improve access to buildings on a number of occasions. This is to ensure improved equality of access.
- We found that practices this year were still not consistently compliant with the NHS complaints procedure – Putting Things Right. In addition, some practices needed to improve their arrangements for seeking regular feedback from patients. Improving both of these would help to ensure that the patient perspective is considered and better understood.

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 2016-17 we 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 help to ensure that our inspection process remains as effective as possible, and provides a mechanism whereby any trends or themes arising from inspections are being fed back to relevant bodies on a regular basis.

We will publish an annual overview report of GP inspections for 2016-17 in 2017, 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

The Prisons and Probation Ombudsman (PPO) is required to undertake an investigation of every death that occurs in a prison setting. We contribute to these investigations by undertaking a clinical review of all deaths within a Welsh Prison or Approved Premises[3]. This arrangement is defined within a Memorandum of Understanding between the PPO and Healthcare Inspectorate Wales (HIW).

These reviews critically examine the systems, processes and quality of healthcare services provided to prisoners during their time within prison or Approved Premises.

Since 1 April 2016, we have been commissioned to complete 16 clinical reviews on behalf of the PPO. Ten of the 16 deaths have been of natural causes, with six deaths being self-inflicted. This is an increase from the previous year, where we only completed ten reviews.

Specific issues are highlighted in the individual clinical reviews carried out by HIW. However, the key themes are in regards to chronic disease management and the lack of communication between the prisons and secondary care services. We ensure that relevant issues are fed back to the relevant local health board by requesting a formal response to the issues identified. HIW also share the learning with colleagues in Welsh Government, this is an established process for HIW to escalate concerns that relate to prison healthcare in Wales which fall out of the remit of the PPO.

Inspections of prison establishments in Wales are undertaken by Her Majesty's Inspectorate of Prisons (HMIP). There is an MOU in place between HMIP and HIW, and we are also invited to attend the HMIP inspections of Welsh prisons; these mechanisms enable us to share our learning from clinical reviews.

[3] Approved Premises, formerly known as probation or bail hostels, are residential units which house offenders in the community. They provide enhanced levels of protection to the public and reduce the likelihood of further offending. They are recognised under the Offender Management Act 2007.

Ophthalmology Review

During 2016-17 we published a thematic report following our review of Ophthalmology Services in Wales. The review focussed on 'wet' Age Related Macular Degeneration (AMD), due to risks associated with any delay in treatment for patients. The review set out to look across the boundaries of primary and secondary care to examine how providers were delivering and developing services. The review fieldwork involved discussions with clinical leads from each health board as well as discussions with staff responsible for coordination and delivering the care and treatment required by patients. The key findings from the review included:

- Eye care services across Wales have insufficient capacity in secondary care to meet current demands.
- The absence of key personnel can cause parts of the care pathway to stop working effectively increasing the risk of potential avoidable harm to patients.
- The unsuitability of environments in secondary care from which services are being delivered was consistently reported as an issue. The lack of space and facilities are limiting capacity to meet demands on the service.
- Health board staff concerned about a lack of investment in the development of services in recent years.
- Health boards need better information about the demand capacity gap to enable informed workforce planning decisions.
- Poor working relationships between primary and secondary care in some health board areas have hindered efforts to improve joint working.
- We saw some new initiatives across Wales relating to delivery of 'wet' AMD services, including the introduction of non-medical injectors; however progress in development and delivery of these initiatives has not been consistent across health boards.
- Public awareness was identified as an issue which requires more attention. Greater clarity is required around conditions and the services available for individuals with eye care problems.

Overall our review highlighted a lack of leadership and focussed strategic planning within health boards to develop ophthalmic services. Further focus is required to develop services to fully utilise available resources to strengthen infrastructure and sustainability of eye care services.

Learning Disability Review

During 2016-17 we completed our thematic review of learning disability services in Wales. We undertook detailed fieldwork alongside the Care and Social Services Inspectorate Wales (CSSIW) in six community learning disability health teams from five different health boards.

We 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 local authorities 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 was published in June 2016[4].

During 2016-17, we conducted the second phase of the review of learning disability services which focussed on NHS residential services. We conducted inspections of NHS provided residential services in Wales, including:

- Settings which were established after the closure of large institutions to accommodate people who had significant health needs, but who did not require traditional hospital accommodation.
- Assessment and Treatment Units, which provide accommodation for people experiencing crisis or who need to undergo a period of assessment in order to identify what type of placement will best meet their needs.

Individual inspection reports were published for each of these settings on our website (www.hiw.org.uk/) and an overview report was published in December 2016[5].

Overall, we found that people with learning disabilities were treated with dignity and respect by staff working with them.

When we inspected community learning disability health teams, our findings were mostly positive. We found:

- Staff made an effort to ensure people were involved in decisions about their care, where this was possible, even where verbal communication was limited. However, we noted that there was a lack of Speech and Language Therapy (SALT) in some areas to help people with their communication needs.
- Individuals received help that was well co-ordinated and met their needs.
- Staff faced significant challenges associated with the Continuing Healthcare (CHC) funding process which could lead to delays for people and their carers. However, staff worked hard to try to overcome these issues to provide people with consistent care.
- Timely and appropriate referrals by health staff working together to achieve shared outcomes for people.

[4] National inspection of care and support for people with learning disabilities – Overview – June 2016 (hiw.org.uk/reports/natthem/2016/nationallearningdisability/?lang=en)

[5] Learning Disability Service Thematic Report – December 2016 (hiw.org.uk/reports/natthem/2016/learningdiasbilityreview/?lang=en)

- Patient records were of a good quality, but relevant information about a person was sometimes not all held in the same place and joint health and social care records were rare.
- Staff told us they received regular managerial and clinical supervision.

By contrast, we found that NHS residential services for people with learning disabilities required significant improvement in many areas. We found that whilst people usually received good individual care from staff who tried their best to care for patients, this was often not underpinned by good management and staffing arrangements. Our findings included:

- Environmental issues – maintenance jobs which had not been attended to and uncleanliness and malodour in some settings.
- Patients and staff in a number of settings told us that meals were sometimes poor, there was sometimes little choice or variety and that food portions were small.
- A lack of communication aids which could help people to express themselves and enhance their understanding.
- Incomplete and inconsistent record keeping, with some information not dated, not contemporaneous and record entry of poor professional quality.
- Staffing issues – high staff turnover and high staff sickness; limited input from registered nurses; and managers did not always have the time required to devote to managing services. In some areas this led to a lack of effective leadership and governance.
- Staff were not always up-to-date with health boards' mandatory training, including the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, cardiopulmonary resuscitation and safeguarding vulnerable adults.
- Senior health board managers did not always have oversight of these settings.

We recommended that all people living in NHS learning disability residential settings should have a thorough, multidisciplinary reassessment of their current needs for care and support, and that health boards consider the purpose and suitability of these settings.

We found that strategic planning and governance of learning disability services as a whole could be improved. We saw that there was not enough joint planning with local authorities to ensure that the right service provision was available for people in the area. Work was also needed around succession planning and the sustainability of learning disability services.

Following our review we have completed further inspections to those settings which caused significant concern to follow up the serious issues we found. We have also continued our dialogue with health boards and with Welsh Government about the findings of our review. We will continue to monitor how health boards implement our recommendations to improve the service they provide to people with learning disabilities.

Patient Discharge Review

During 2016-17, we began our thematic review to evaluate effectiveness of patient discharge arrangements from secondary to primary healthcare, specifically:

- Quantity and quality of information provided by secondary to primary healthcare and whether this can be improved.
- Timeliness and accuracy of discharge information and what are the barriers to achieving best standards.
- The impact of poor discharge information has on the care provided to individuals.
- Compliance with guidance, Welsh Government Health and Care Standards; and
- Understanding mechanisms used for information sharing and whether improvement is possible.

Review fieldwork will encompass all health boards in Wales. The fieldwork approach that has been adopted includes review of records; review of documents (including policies and procedures); discussions with staff and patients; and public consultation.

The review will conclude later in 2017 with an all Wales report outlining any local or national recommendations for improvement.

Community Mental Health Services Review

During 2016-17, we started our thematic review focussing on adult community mental health services in Wales. The review will be undertaken alongside CSSIW and look at Community Mental Health Teams (CMHTs) and consist of inspection visits in 2017-18 to CMHTs based in each health board area. The review will also involve discussions with representatives from relevant stakeholder organisations, strategic leads from each health board, and we will also seek to collate the views of patients and carers, in relation to their views and experiences of community mental health services.

Following each CMHT visit undertaken there will be an inspection report published. Subsequently, there will also be an all-Wales overview thematic report published in March 2018 that will detail the main themes of the review.

Governance Reviews

During 2016-17 we undertook governance reviews of Aneurin Bevan University Health Board (ABUHB) and the Welsh Ambulance Services NHS Trust (WAST). These reviews focused on the effectiveness of the health board and trust's arrangements for managing and learning in relation to:

- Complaint/Concerns from receipt to resolution.
- The reporting and management of incidents.
- The role of the Quality and Patient Safety Committee in providing assurance regarding safeguarding and improving patient safety.
- An understanding of components of effective learning in regards to:
  i. Commissioned Reviews
  ii. Recommendations from External Bodies; and
  iii. Compliance with guidance and Welsh Government Health and Care Standards.

Aneurin Bevan Governance Review

Overall, we have found that ABUHB was been able to demonstrate effective governance and leadership in relation to the areas that we examined. Our review found:

- Effective leadership was being provided by senior and departmental staff with a commitment to learn from concerns and incidents and to make improvements as appropriate.
- The health board's governance structure in relation to patient safety appeared to be working well and is fit for purpose.

Whilst overall we are pleased and encouraged with what we found, we also identified the following areas which require further focus:

- Timeliness of responding to concerns in line with Putting Things Right is proving challenging.

- An inconsistent approach relating to the completion of Datix forms (web based incident reporting) following incidents, with the timeliness of completing entries being an issue.
- Delays in the vetting and validation of Datix forms following an incident resulting in delays in the investigation commencing.
- The health board also needs to continue the development of its Corporate Learning Committee to ensure that effective learning is spread throughout the health board.

Welsh Ambulance Services NHS Trust (WAST) Governance Review

Overall we found that WAST able to demonstrate effective governance and leadership in relation to the areas that we examined. Our review identified that:

- The Trust's Quality, Patient Experience and Safety Committee appears to be working well
- Non-Executive Directors demonstrated expertise combined with an appropriate level of challenge and support
- Improved management of concerns and an increase in compliance with timeframes outlined within Putting Things Right guidance.

However, we found that there are also some improvements required to:

- Ensure effective learning when staff report an incident – staff were not always informed of the outcome of an incident that they reported
- Furthermore, it was highlighted to us that the Datix system can hinder staff in recording incidents in a timely way.

WAST is an organisation that has re-engaged with its staff and is heading in the right direction, but still has challenges ahead in ensuring that it continues this positive trajectory.

Betsi Cadwaladr University Health Board Joint Governance Review

During early 2017, HIW and the WAO undertook a joint review of governance arrangements in response to previous work undertaken during 2013, 2014 and 2015. The review considered the original themes from the 2013 review and also issues that have emerged since.

The review work was designed to:

- Provide clarity on whether the Health Board can demonstrate it is making the necessary improvements
- Provide an agreed assessment to assist the Health Board and Welsh Government in ensuring that the interests of citizens and patients are protected
- Fulfil our responsibilities as external review bodies to examine progress and outstanding issues and to report on them clearly and openly; and
- To support improvement and inform any further required 'turnaround' activities.

We found that the Health Board has clearly made improvements since our original review. Nevertheless, a number of challenges and operational improvements that we identified in 2013 remain, and are taking considerable time to address. We would expect the Health Board to be giving particular attention to the following:

- Recovering financial performance and developing financial plans which are economically sustainable
- The rapid development and agreement of an overall strategy, approvable Integrated Medium Term Plan (IMTP)[6] and underpinning clinical strategy
- Fully embedding new quality assurance arrangements into the revised organisational structure
- Developing new performance measures that align to delivery of objectives and improving population health and well-being
- Effectively responding to two high-profile reviews into mental health services which are due to be published later this year
- Building stronger relationships with partners, which is crucial in ensuring that current and future needs of the population can be met; and
- The need to improve each of the specific service areas identified by Welsh Government as part of the special measures improvement framework.

Local Health Board Annual Reports

During 2016-17, we continued to highlight key themes and issues arising from our work in 2015-16, to NHS Health Boards and Trusts through annual reporting. These were presented at Board meetings and Board development days during summer 2016 and were published on our website in August 2016.

Further Information

Reports on all of our inspections are published on our website under Find Our Reports and Reviews (hiw.org.uk/find-service/?lang=en)

[6] Health Boards and Trusts are required to submit their Integrated Medium Term Plans (IMTP) to Welsh Government for approval. The IMTP sets out how each Health Board or Trusts respond to day to day pressures without losing sight of how they plan to align key services, staff, finance and the public to delivering the outcomes intended for the populations they serve over a medium term (three year) time frame. As well as demonstrating corporate priorities and actions, Integrated Medium Term Planning must also be the vehicle for strengthening partnership working across the public and third sectors, acknowledging that securing many health outcomes will depend upon more than one organisation playing their part.

Section three:
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.

We register varied types of settings which include, but are not limited to mental health hospitals (incl. child and adolescents), laser and intense pulse light services, telemedicine consultation and treatment agency (for dermatological and allergies). There were 16 new settings and 10 new managers registered during 2016-17.

In addition, we also completed the change of 13 managers of currently registered services and 16 variations to existing registrations. As part of our remit, we currently register dentists individually, which enables them to provide private dental services in Wales, there were 139 new dentists registered in 2016-17.

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 at the point of registration, so that the service is safe for the people that use it.

We also continued to investigate the intelligence we received regarding unregistered settings providing services that could potentially need registration. This generated a number of enquiry letters to be sent to these settings in order to establish whether registration was required. We advised these settings to cease providing the service until a registration had been completed and confirmed that they could be at risk of prosecution by continuing to provide an unregistered service.

Enforcement

During 2016-17 we focussed our attention on how we deal with and respond to unregistered settings who do not co-operate with us. We have taken strides over the past twelve months to strengthen our ability to take enforcement action. This has included undertaking specialist criminal investigation training provided by South Wales Police, revising our Enforcement Policy and guidance and developing a new approach to dealing with unregistered providers which sees us working with providers who wish to register, but taking stronger action against those that chose to ignore the requirement to register.

Inspection of independent healthcare services

Our inspections of independent healthcare services seek to ensure services comply with the Care Standards Act 2000, the 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.

During 2016-17 HIW conducted the following independent healthcare inspections:

- 23 services using Class 3B/4 laser and intense pulsed light services for non-surgical purposes
- 5 independent clinics
- 1 dental hospital
- 2 acute hospitals

Inspections of independent clinics and acute hospitals

As with our inspections of NHS services, our inspections of independent clinics and acute hospitals focus on:

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

Overall, the quality of patient experience in these settings was good, with feedback from patients in independent acute hospitals being particularly positive. Across all independent clinics and acute hospitals HIW only issued one non compliance notice – in respect of records management. There were, however, two common themes for improvement across all settings.

- Safeguarding. Services need to do more to ensure that their policies and procedures provide clarity for staff about how to respond to a potential safeguarding concern. This needs to be supported by training for staff that is regularly updated.
- Communicating effectively. Some services need to improve the way in which they provide key information to people, both verbally and in writing, in the language of need; particularly with those people who wish to communicate in Welsh.

Class 3B/4 laser and intense pulsed light service inspections

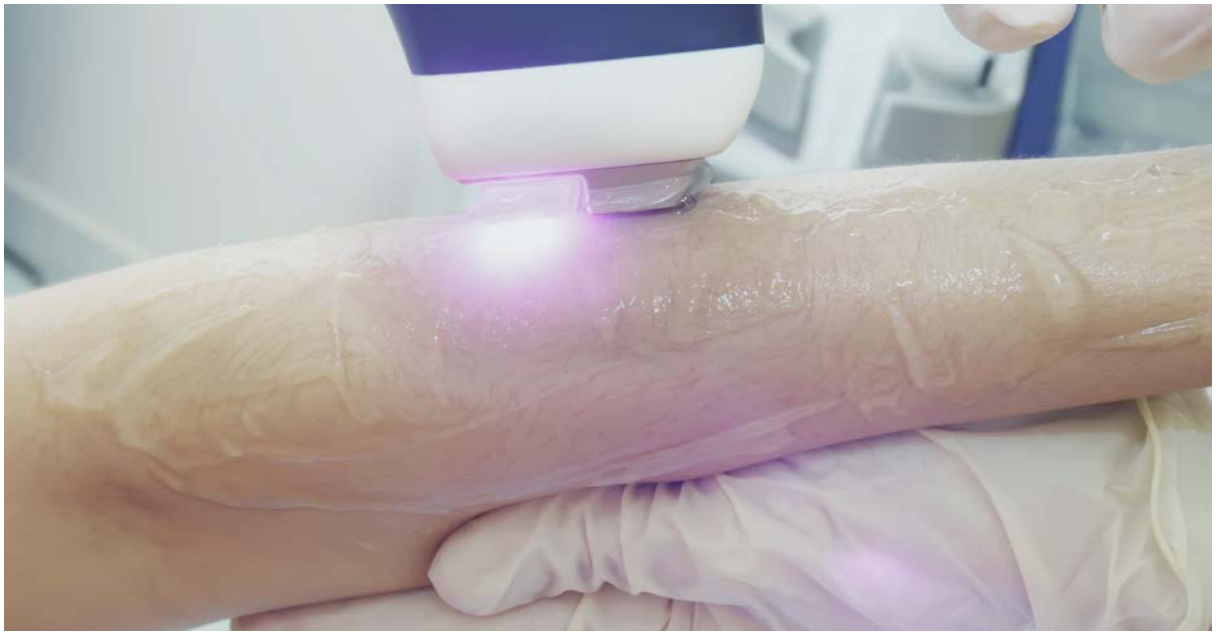
Services providing treatments to patients using Class 3B/4 laser and intense pulsed light are registered with HIW as independent hospitals. However, the majority of these services are provided within beauty salons and clinics for aesthetic skin treatments, such as hair removal and wrinkle reduction. It was disappointing to find that while some individual providers had improved, overall the areas for improvement were similar to those found in the previous year. 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.
- Effective governance and quality assurance systems.

As found in 2015-2016, it was of particular concern to find again 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.

As a result of our inspections, we identified where four services were required to address immediate areas of concern and received assurance that improvements had been made. One of these services concluded that they no longer wished to provide Class 3B/4 laser and intense pulsed light services and requested to cancel their registration with HIW.

During the year, we successfully supported the placement of a trainee Laser Protection Adviser. As a result of this placement improvements were made to the inspection methodology and supporting guidance for ongoing inspections.



Section four: Monitoring compliance against Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)

Healthcare Inspectorate Wales is responsible for monitoring compliance against the Ionising Radiation (Medical Exposures) Regulations IR(ME)R 2000 and its subsequent amendments in 2006 and 2011. The regulations are intended to protect patients from hazards associated with ionising radiation.

During 2016-17 we completed a range of activity to monitor compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). This included five inspections as we planned of NHS provided services and reviewing incidents notified to HIW 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. We also conducted a total of 80 inspections of NHS and private dental practices that used radiography equipment. In relation to IR(ME)R, we adopted an approach proportionate to the size and complexity of these services and considered the arrangements in place for the protection of patients. For inspections of dental practices, inspection teams included peer reviewers who were dentists.

Whilst we identified areas for improvement during our inspections, overall services had arrangements in place to provide safe and effective care to patients in relation to IR(ME)R.

During 2016-17, we received 65 notifications of incidents where patients had been exposed to ionising radiation 'much greater than intended'. We required healthcare services to provide us with details of their investigation findings and the action taken as a result. We evaluated this information to determine whether the service had taken sufficient action to reduce the likelihood of a similar incident happening again. Incidents were only closed when we were content with the action taken by the service.

In September 2016, we published our second annual report on regulatory activities in Wales in relation to IR(ME)R[7]. The annual report included key themes from our inspection activity and an analysis of the notifications of incidents HIW received during 2015-16. We will be publishing our next annual report detailing our IR(MER) work for 2016-17 in 2017.

[7] HIW Activities and Enforcement under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) – Annual Report 2015-16 (hiw.org.uk/docs/hiw/reports/160922irmerannualen.pdf)

Section five:
Delivering our responsibilities: Mental Health

Mental Health Inspections

Our mental health 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 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 receive a comprehensive mental health and physical health assessment. In addition, part 4 of the Measure states that every in-patient must have access to an independent mental health advocate and this is another area that HIW monitors.

During 2016-17 we undertook a review of the tools and methodology that we use as part of our inspection process to ensure that our focus remains appropriate and takes account of legislative changes. The full suite of workbooks will be published on our website during the summer of 2017.

Our reports provide more context about our visits and enable readers to have in depth information regarding the setting, our findings and recommendations and the 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.

Areas of Noteworthy Practice

During our mental health inspection visits we have identified a number of areas of noteworthy practice, including:

- The positive rapport between patients and staff, despite staff dealing with very challenging situations.
- An increase in NHS hospitals working towards and obtaining external accreditation, including Accreditation for Inpatient Mental Health Services (AIMS), Star Wards and Safe wards, this is to be commended.
- Multi disciplinary team working, including the work of community based staff across NHS and independent providers, was generally effective and evidence of good patient outcomes was apparent.
- There was generally very good readiness of staff and patients to engage with the inspection process across both NHS and independent hospitals.
- Access to advocacy services and information about these services.

However, in this inspection year we issued 19 immediate assurance letters, requiring prompt information about the action to be taken about some of the more urgent findings from our visits.

A number of themes arising from our inspections this year were also evident in 2015/16. These themes related to the need to ensure adequate physical healthcare alongside mental healthcare; instances of inadequate staffing numbers including a shortfall in registered nurses and medical staff; a lack of robust care and treatment plans; and some challenges in leadership and governance and clinical audit processes.

Other themes which were noted during 2016/17 included: occasions of a lack of privacy and dignity for patients; a range of issues with medication; ligature risk assessments that required updating; and poor cleaning of environments of care. Within the NHS there continued to be signs of a shortage of available beds and difficulties accessing therapies such as psychology and occupational therapy. We also found instances of unclear admission criteria or inappropriate admissions; and a lack of staff supervision or inadequate records of supervision. There also continues to be a lack of a clear maintenance program for many hospitals visited.

During the autumn 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, 1983. Throughout 2016-17 we conducted 53 Mental Health Act monitoring visits. A number of these visits were undertaken as part of our in-depth mental health reviews.

During 2016-17 we also undertook a review of the tools that we use as part of our inspection process for monitoring the use of the Mental Health Act. The tools were rewritten to take account of the Mental Health Act 1983 Code of Practice for Wales that came into effect in October 2016. This suite of workbooks will also be published on our website during the summer of 2017.

Again this year we did not find any major consistent failings regarding the administration of the Act throughout Wales. Generally there is good compliance with the Mental Health Act in both the NHS and independent sector. Where issues are identified in 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 patients where this is required.

Some of the issues, identified included that the reading of patients rights under section 132[8] was not consistently repeated and the recording of section 17[9] leave documentation did not always detail an adequate amount of information. Within some

[8] Section 132 – informs patients of their rights under the Mental Health Act.
[9] Section 17 – this allows the Responsible Clinician (RC) to grant a detained patient leave of absence form hospital.

Health Boards there were insufficient numbers of section 12[10] doctors and delays in providing information to Mental Health Act tribunals was apparent because of frequent responsible clinician changes.

We continue to find that individual Mental Health Act administration teams[11] were 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.

Areas of Noteworthy Practice

Throughout our Mental Health Act Monitoring visits we have noted a number of areas of noteworthy practice, including:

- Well maintained records with good evidence of administrative and medical audit
- Comprehensive Approved Mental Health Professional (AMHP) reports and positive feedback about their role
- Assessment of capacity generally well recorded.

A more detailed report on our findings will be published in the autumn.

Deprivation of Liberty Safeguards (DOLS)

The review process of the NHS and private providers includes a consideration of the circumstances and needs of patients who may be subject to DOLS. 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 Wales (CSSIW) on this area of work and the 2015-16 annual monitoring report[12] was published on 4 May 2017.

We attend the Welsh Government Mental Capacity Act and Deprivation of Liberty Safeguards leadership group to discuss legislative changes and good practice.

[10] Section 12 – a doctor who has been approved by the Welsh Ministers under the Act as having special experience in the diagnosis or treatment of mental disorder. In practice Local Health Boards take these decisions on behalf of the Welsh Ministers.

[11] Doctors who are approved clinicians are automatically treated as though they have been approved under Section 12. These are established by the health boards and independent providers to ensure that patients' safeguards under the Act are upheld by the organisations.

[12] Deprivation of Liberty Safeguards: Annual Monitoring Report for Health and Social Care 2015-16 (hiw.org.uk/reports/natthem/2017/?lang=en)

Section six:
Supervision of Midwives

Following the passing of a Section 60 Order by the Privy Council, the decision was confirmed to dissolve Local Supervising Authorities (LSAs) across the UK on 31 March 2017. Until 1 April 2017, HIW, on behalf of Welsh Ministers, fulfilled the function of the Local Supervising Authority (LSA) for Wales. Accordingly, it was responsible for ensuring that statutory supervision of all midwives, as required in the Nursing and Midwifery Order (2001) and the NMC Midwives Rules and Standards (2012), was exercised to a satisfactory standard across Wales. From 1 April 2017, the model of supervision in Wales changed and Clinical Supervisors for Midwives were to be employed in all health boards.

Aware of the likelihood that LSAs would be dissolved, 2016-17 represented a challenging but nevertheless successful period for the LSA in Wales.

Despite significant staff turnover, as Supervisors of Midwifes (SoMs) returned to their substantive health board employers, the LSA in Wales was able to maintain SoM to Midwife ratios across Wales, ensuring that supervision could be sustained during this period.

The LSA worked closely with the Chief Nursing Officer's (CNO) taskforce as it focused on a smooth and effective transition to the new supervision arrangements. The taskforce developed and implemented the new health board model of supervision delivery, ensuring that all of the best aspects of statutory supervision were incorporated, as a means of ensuring midwives continue to be supported in their practice.

Organisationally, HIW's work on the transition of supervision included the transfer of responsibility for historical investigation records to the CNOs office and the movement of SoMs from the LSA back to their substantive posts in health boards.

HIW, on behalf of the LSA, would like to thank all stakeholders who worked with and supported the LSA and the SoMs in discharge of this important statutory function.

Section seven: 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.
- Allocate responsive visits as a result of gathered intelligence.

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

During 2016-17 we received approximately 327 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 key 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 2016-17, we hosted two Healthcare Summit days bringing together external audit, inspection, regulation and improvement bodies working in Wales to share intelligence and form a consistent view about individual Health Boards and Trusts in Wales. The format ensures the intelligence shared isfocussed on the high level concerns and priorities of each organisation and also allows participants to form a view on the national themes emerging.

In addition, we engaged with the UK professional regulators to ensure that the relevant intelligence that they hold is considered during the healthcare summits – this was done via a single representative attending to bring the views of the other professional regulators. We continued to build and maintain relationships with partner organisations and established and refreshed a number of its Memoranda of Understanding[14] in 2016-17.

[13] NHS Escalation and Intervention arrangements (gov.wales/docs/dhss/publications/140320escalationnhsen.pdf)
[14] Memoranda of Understanding (hiw.org.uk/about/workingwithother/mou/?lang=en)

Peer and Lay Reviewers

During 2016-17, we continued to work with lay reviewers and clinical peer reviewers in our work programme and expanded our peer reviewer capacity to support our work programme, by completing 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 a number of 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.

Learning and Development

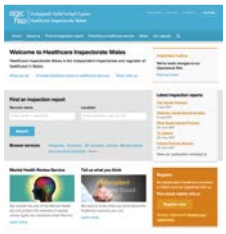
We continued to ensure learning and development for both staff and reviewers was an important focus for 2016-17 and beyond. A new learning and development plan was produced and implemented, which continued the blended approach to learning and development by enabling staff to attend conferences, specific and targeted training days, information sessions and access e-learning packages.

Staff were given the opportunity to shadow and observe various types of inspections during 2016-17. This ensured that we 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.

We continued to provide peer and voluntary lay reviewers' induction and training days which equipped them with the skills required to take part in inspections.

We concluded the year by developing and publishing a learning and development strategy, spanning 2017-19, to ensure staff and reviewer development continues to be an important focus.

Communications



New website launched
29 June 2016

34,338 visitors
to the website up
to 31 March 2017

YouTube channel launched
September 2016

Increase in positive media coverage
Increase in public engagement
Published **6** thematic reviews

Director of Inspection.
Investigation and Regulation
appeared on BBC news to talk
about our Ophthalmology Review

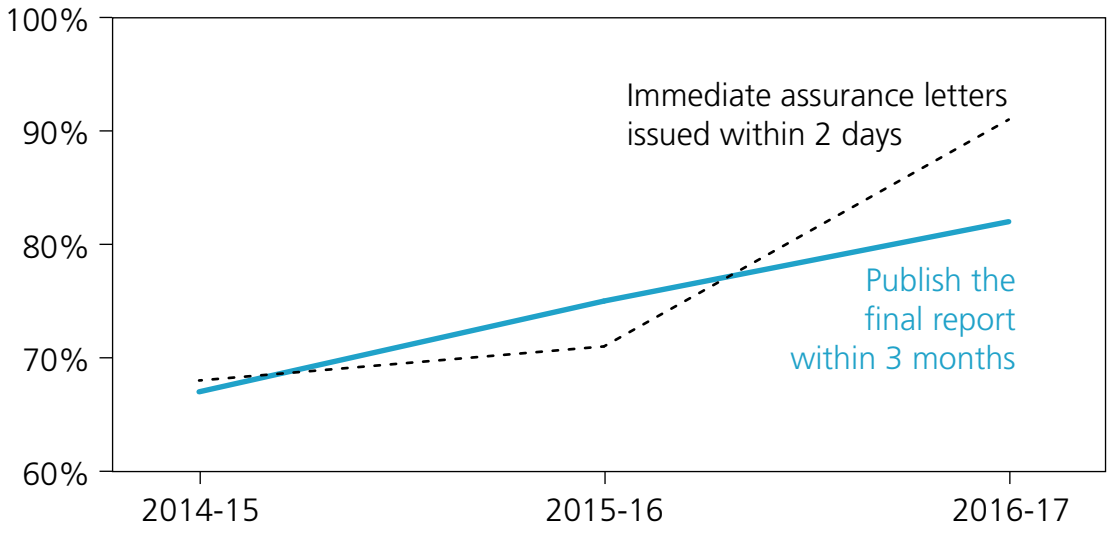
Spoke to **400** people at
the Royal Welsh Show to
raise awareness of our
inspection work

Our Twitter channels in English and Welsh received a combined total of
92,562 impressions... compared to 81,316 during the previous period

In addition, one of our continued targets for the year was to improve the timeliness of reporting and we set ourselves some very challenging targets. These were:

- To report issues of immediate concern within 2 days
- To publish the final report within 3 months

The following graph shows that we published 82% of our reports within 3 months of the inspection taking place (compared to 75% reported last year).



Of the 18% of published reports which missed the target (38 in total), twelve reports were published within 2 days of the target due to the publication date being a weekend. Four were published within 1 week of target, two within 2 weeks. The remainder were late predominantly due to unanticipated staff absence and other contributory factors.

Finances

The following table shows how we used the financial resources available to us to deliver our 2016-17 Operational Plan.

	£000's
HIW Total Budget	**3,586**
Expenditure:	
Staff costs	2,997
Non-staff costs	295
Reviewer costs	481
Total Expenditure (a):	**3,773**
Income:	
Independent healthcare	-274
Private dental registration	-64
Total Income (b):	**-338**
Total Net Expenditure (a-b):	**3,435**

Commitment matrix

Delivering our responsibilities: Regulation of independent healthcare

What we said:	How we will do it:	What we achieved:
Providing assurance Process applications to register or changes to registration in a timely manner. Ensure all applications can demonstrate they meet relevant regulation and minimum standards.	Registration applications determined within 12 weeks of full and complete submission.	During 2016-17 we received 82 new independent health care applications, with 57 applications going on to completion with registration granted. There were 16 applications received that were not completed in 201617 and 9 that were cancelled, returned or withdrawn. A significant factor in the time taken to process applications is the need to be in receipt of all the relevant information that needs to be forwarded by the provider. While the average time of completion from the initial application was above the 12 week target, our performance once all information has been submitted, while not reported, will have been significantly better. We have improved our application and monitoring processes and believe that performance against the target will be both improved and more accurately monitored in 2017-18. We received 146 new applications from private dentists of which 139 were granted registration. There was 1 application that was received during the 2016-17 year but is still being processed and 6 applications were returned or withdrawn.

What we said:	How we will do it:	What we achieved:
Providing assurance Conduct a programme of visits to suspected unregistered providers • As required. Deliver a programme of inspections in independent settings • Approximately 25 laser • Approximately 11 non-laser.	Number of visits undertaken. Number of inspections undertaken.	We have written to four suspected unregistered providers. As a result we have been informed that two providers are in the process of applying to register, one is not providing a service that requires registration. The other setting we contacted has not provided a response and this will be followed up in line with our enforcement process. 23 Laser inspections undertaken 6 Non Laser inspections undertaken.

Delivering our responsibilities: Regulation of independent healthcare

What we said:	How we will do it:	What we achieved:
Providing assurance Publish all reports associated with our inspections • 3 months following inspection.	Number of reports published 3 months following inspection.	153 (80 %) inspection reports published within 3 months. 39 (20%) inspection reports completed after 3 months.
Support improvement • Ensure that concerns and Regulation 30/31[15] notifications are dealt with in a timely and professional manner.	Number of concerns received. Number of Reg 30/31 notifications received.	Independent Healthcare Providers are required to inform us of significant events and developments in their service. These R30/31 notifications continue to be managed in line with HIW's process and dealt with effectively. Reg 30/31 Notifications received: • Death in Hospice – 611 • Death (excluding Hospice) – 6 • Unauthorised absence – 47 • Serious Injuries – 145 • Allegation of staff misconduct – 39 • DoLS – 8 • Infectious disease – 2 Anyone can raise a concern with us about Independent Healthcare. We received a total of 95 concerns during the year.

[15] Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 require the registered person to notify HIW about prescribed events.

What we said:	How we will do it:	What we achieved:
Providing assurance	Analysis of source and action taken.	Information provided enables HIW to assess a healthcare provider's ability to comply with the 2011 Regulations and that patients are being appropriately safeguarded. The information is fed into our intelligence frameworks on a case by case basis and helps direct our risk assessment of healthcare organisations, directing our work activities.

Delivering our responsibilities: Regulation of independent healthcare

What we said:	How we will do it:	What we achieved:
Influencing policy and standards Support legislative developments including: • Implementation of new dental regulations • Relevant legislative development following 'Your Health, Your Health Service'.	Delivery of implementation plan following new dental regulations. Responses to consultations regarding legislative developments.	The Private Dentistry (Wales) Regulations 2017 (www.legislation.gov.uk/wsi/2017/202/contents/made) were introduced on 1 April 2017 with all guidance and supporting documentation for the application process published on our website. We responded to a consultation on the Public Health (Wales) Bill, in particular highlighting potential issues with the registration of lasers used for non-surgical purposes. We also responded to consultations concerned with the introduction of medical examiners in Wales and with the modernisation of midwifery regulation.

Delivering our responsibilities: Inspecting the NHS

What we said:	How we will do it:	What we achieved:
Providing assurance Ensure that concerns and notifications are dealt with in a timely and professional manner.	Number of concerns received Analysis of source and action taken.	• Anyone can raise a concern with us about the NHS in Wales. We received a total of 231 concerns during the year. All concerns are reviewed weekly and inform decisions about our activities and priorities.
Providing assurance Undertake a broad inspection programme informed by intelligence and an assessment of risk including approximately: • 15 focussed inspections across the acute sector • 15 specific follow-up inspections • 28 GP inspections • 150 dental inspections • 5 IR(ME)R inspections • 5 reviews of care across a broad range of health settings.	Number of inspections undertaken.	• 16 focussed inspections across the acute sector • 20 specific follow-up inspections • 27 GP inspections • 75 dental inspections • 5 IR(ME)R inspections • 5 reviews of care across a broad range of health settings.
Providing assurance Continue our programme of thematic reviews by undertaking a review of Learning Disability Services.	Publication of Learning Disability report during 2016-17.	We completed our thematic review of **learning disability services** in Wales. We undertook detailed fieldwork alongside the Care and Social Services Inspectorate Wales (CSSIW) in six community learning disability health teams from five different health boards. A national thematic report was published in June 2016.

Delivering our responsibilities: Inspecting the NHS

What we said:	How we will do it:	What we achieved:
Providing assurance Continue our programme of thematic reviews by undertaking a review of Ophthalmology.	Publication of Ophthalmology report during 2016-2017.	Our in depth national review into **Ophthalmology** care was conducted and published during in early 2017. This review received significant attention and provided the opportunity to establish relationships with key stakeholders. We published our national review in January 2017.
Providing assurance Continue our programme of thematic reviews by undertaking a review of Discharge.	Commencement of thematic review on Discharge.	We began our **discharge** thematic review in 2016-17 to evaluate effectiveness of discharge arrangements from secondary to primary healthcare. The fieldwork will encompass all health boards in Wales and will include reviews of records; review of documents (including policies and procedures); discussions with staff and patients; and public consultation. The review will conclude later in 2017 with an all Wales report outlining any local or national recommendations for improvement.

Delivering our responsibilities: Inspecting the NHS

What we said:	How we will do it:	What we achieved:
Providing assurance Continue our programme of thematic reviews by undertaking a review of Community Mental Health Services.	**Providing assurance** Continue ow on Community Mental Health.	During 2016-17, we started our thematic review on **community mental health** focussing on adult community mental health services in Wales. The review will be undertaken alongside CSSIW and look at Community Mental Health Teams (CMHTs) and consist of inspection visits in 2017-18 to CMHTs based in each health board area. The review will also involve discussions with representatives from relevant stakeholder organisations, strategic leads from each health board, and we will also seek to collate the views of patients and carers, in relation to their views and experiences of community mental health services. Following each CMHT visit undertaken there will be an inspection report published. Subsequently, there will also be an all-Wales overview thematic report published in March 2018 that will detail the main themes of the review.
Support improvement Publish all reports associated with our inspections 3 months following inspection.	Number of reports published 3 months following inspection.	119 (100%) reports were published within 3 months of inspection.

Delivering our responsibilities: Inspecting the NHS

What we said:	How we will do it:	What we achieved:
Providing assurance Continue our joint inspection work with UK agencies • Approximately 12 death in custody reviews with the Prison and Probation Ombudsman • Up to 3 joint reviews with HMI Prisons and HMI Probation.	Number if inspections undertaken.	In 2016-17, we have been commissioned to complete 16 clinical reviews on behalf of the PPO. Ten of the 16 deaths have been of natural causes, with six deaths being self-inflicted. This is an increase from the previous year, where we only completed ten reviews. We have provided support on a HMI Prison inspection during 2016-17.
Influencing policy and standards Take a high level view on the effectiveness of governance arrangements in each NHS body through: • Further development of the Relationship Management function • Producing an Annual Report for each Health Board and NHS Trust.	Publication of NHS body Annual Reports.	2015-16 annual reports were presented at board meetings and board development days for health boards and trusts by Relationship Managers. These contained a high level view on governance and were published in August 2016. 2016-17 annual reports will be published in July/ August 2017.

Delivering our responsibilities: Inspecting the NHS

What we said:	How we will do it:	What we achieved:
Supporting improvement Publish annual reports summarising the themes and issues arising from our work. In particular: • Hospital Inspections • Primary Care • Mental Health Services • IR(ME)R • Mental Health Act Annual Monitoring Report • Deprivation of Liberty Safeguards (DOLS) Annual Report • Local Supervising Authority Annual Report.	Publication of reports.	• Hospital Inspections published 5 October 2016 • Primary Care Reports – – GP report published 2 September 2016 – Dental published 28 September 2016 • Mental Health Services published • IR(ME)R published 22 September 2016 • Mental Health Act Annual Monitoring Report – published 26 October 2016 • Deprivation of Liberty Safeguards (DOLS) Annual Report – published 4 May 2017 • Local Supervising Authority Annual Report published 2 June 2017.

Delivering our responsibilities: Mental Health and Learning Disabilities

What we said:	How we will do it:	What we achieved:
Providing assurance Undertake a programme of inspections in NHS and independent mental health settings including approximately: • 10 NHS mental health units • 12 independent mental health units • 60 Mental Health Act visits • 5 specific follow-up inspections.	Number of inspections undertaken.	• 9 NHS mental health units • 13 independent mental health units • 53 Mental Health Act visits • 7 specific follow-up inspections.
Supporting improvement Publish all reports associated with our inspections • 3 months following inspection.	Number of reports published 3 months following inspection.	41 (100%) reports were published within 3 months of inspection.
Patient experience Provide a Second Opinion Appointed Doctor service as required • Develop and publish effective targets for the effective management of this service.	Number of requests received. Publication of targets.	In excess of 900 requests completed. Targets are being developed to manage the service and are due to be published in 2017/18.
Influencing policy and standards Investigate homicides as commissioned by Welsh Government.	Publication of Terms of Reference. Publication of final report.	HIW were not commissioned to undertake any new homicide reviews during 2016-17.

Delivering our responsibilities: Local Supervisory Authority – Supervision of Midwives

What we said:	How we will do it:	What we achieved:
Supporting improvement Publish an annual report reflecting the progress made in supervision during the year.	Publication of the report. Lay reviewer contribution to the report.	Local Supervising Authority Annual Report was published on 2 June 2017. For 2016-17 we produced a shorter report for the Local Supervising Authority due to its closure there was no involvement of lay reviewers.
Providing assurance Ensure the new model of supervision continues to meet the standards set by the NMC and that all midwives in Wales have access to supervision.	Quarterly reports collated and shared with key stakeholders to demonstrate achievement against the Key Performance Indicators (KPI's) of the new model of supervision.	Quarterly reports collated and shared with key stakeholders.
Patient experience Conduct an audit of maternity services in each health board to ensure the patient perspective is being considered.	Publication of the audit reports. Engagement of lay reviewers to support LSA audit process.	All Local Supervising Authority for Midwives Annual Health Board Audit Reports have been published on our website hiw.org.uk/reports/lsareports/?lang=en Lay reviewers supported the audit process.

What we said:	How we will do it:	What we achieved:
Influencing policy and standards Consider the options for Wales in light of the Kings Fund recommendations.	LSA MO attendance and contribution to CNO Taskforce with key stakeholders to propose a new (non-statutory) model of supervision in Wales based on the principles outlined in the Department of Health paper 'proposals for changing the systems of midwifery supervision in the UK'. Action plan toward transition to non statutory model for midwifery supervision.	The LSA worked closely with the CNO Taskforce and ensured a smooth transition to new supervising arrangements.

Enablers

What we said:	How we will do it:	What we achieved:
Supporting improvement Launch a new website in June 2016.	Launch new website during June 2016.	New and improved website launched on 29 June 2016 www.hiw.org.uk Over 34,000 visitors to the site since launch. New features include a user friendly inspection report directory, online contact forms, registration section for providers and informative information on the role and responsibilities of HIW.
Providing assurance Hold 2 Healthcare Summits during 2016-17.	Clear audit trail of healthcare summits.	Two healthcare summits were chaired by HIW during the year and attended by over ten external bodies.

What we said:	How we will do it:	What we achieved:
Patient experience Hold 3 Advisory Board meetings during 2016-17.	Host 3 Advisory Board meetings during 2016-17.	HIW Advisory Board meetings held on 8 June; 3, 5 Oct 16; and 8 Feb 17.
Providing assurance Meet our performance standards for publication of reports.	Publication of performance standards. Inclusion of Publication Schedule on new website.	Publication dates of all HIW reports are now published on the new website publication schedule: hiw.org.uk/reports/schedule/?lang=en