Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Annual Report

2020 - 2021

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

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

Independent

Objective

Caring

Collaborative

Authoritative

Goal

To encourage improvement in healthcare by doing the right work, at the right time, in the right place; ensuring what we do is communicated well and makes a difference.

Through our work we aim to:

Provide Assurance

Provide an independent view on the quality of care.

Promote Improvement

Encourage improvement through reporting and sharing of good practice.

Influence Policy and Standards

Use what we find to influence policy, standards and practice.

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01.

Foreword

Foreword

Alun Jones
Interim Chief Executive

I am pleased to introduce this Annual Report covering our work and findings for 2020-2021 and summarising progress against our three year strategy "Making a Difference", which expired in March of this year.

With the onset of the COVID-19 pandemic the year has been like no other for healthcare services and for Healthcare Inspectorate Wales (HIW). Despite this, we have remained true to our commitment to check that people in Wales are receiving good quality care and to encourage improvement by providing rapid feedback from our work. I am proud of the way in which we have adapted our approach to assurance and inspection to continue our work, whilst being mindful of the burden it can have on NHS services during an extremely pressured time. We have also had to consider the safety of our own people during this period and it is testament to their commitment and resilience that we have been able to deliver the change needed to our organisation, at pace.

In a year where infection prevention control, the environment of care and workforce management have been more important than ever, we have focussed our attention on these areas. We have also focussed on the delivery of healthcare in new settings, such as field hospitals and mass vaccination centres, where potential risks to the quality of patient care may be high due to the speed in which they were mobilised, the volume of people being treated and the temporary nature of these settings.

Healthcare services must continue to consider and respond effectively to the risks resulting from this change, ensuring appropriate consultation on those changes and effective communication with patients.

Our overall view is that the quality of care provided across Wales over the past year has been of a good standard. We identified numerous examples of innovation and outstanding efforts from staff to ensure that care provision could continue during a hugely challenging period. I commend the commitment, resilience and flexibility of staff across NHS Wales and independent healthcare services who have worked tirelessly to provide care to patients.

At the time of writing, the pandemic is not over and a key area to have emerged from our work over the year is the continued need for infection prevention and control arrangements to be strengthened, particularly in hospital settings to reduce the risk of transmission. It is also clear the pandemic has, and will continue to have, an impact on the well-being of staff who have worked tirelessly in highly pressured environments to maintain services for patients. As we continue along the path of recovery, the pressures and challenges facing healthcare services in addressing the backlog of patients awaiting treatment mean that arrangements will need to be in place to support staff to deliver safe and effective care.

Our organisational strategy "Making a Difference" came to an end this year and we have engaged with our staff, stakeholders and the public to help us assess progress against our priorities. This work will also provide us with a foundation on which to build our future strategy. I am pleased with the progress we have made over the past three years and this work has resulted in the organisation being in a good position to respond to the challenges ahead. There will, no doubt, be accelerated change within healthcare over the coming years both to take on the best of the innovation and change during the pandemic, but also to tackle the unprecedented demand on services. Change can introduce risks to the quality of care that can be delivered and as the health and care environment continues to evolve then so will HIW. Our future strategy and plans will ensure our work remains relevant to the way care is delivered, we operate flexibly within an uncertain external environment, and we respond to issues quickly and in a proportionate way.

If you have any questions, comments, ideas or feedback on our work, please do get in touch with us – we would love to hear from you.

02.

2020-2021 in Numbers

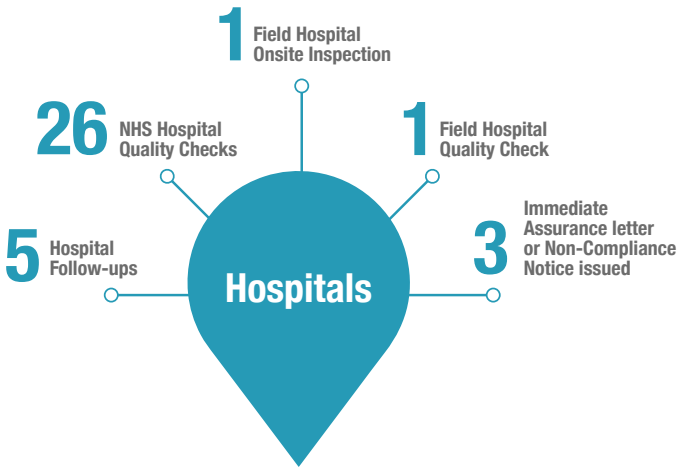
2020-2021 in Numbers

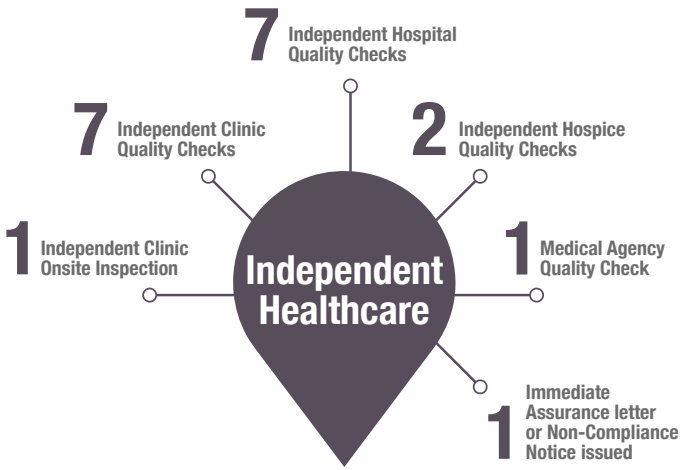
HIW has continued to deliver its commitment to check that people in Wales are receiving good quality care throughout the pandemic. In response to the COVID-19 pandemic, we adapted our ways of working and developed a new approach which enabled us to conduct assurance work entirely offsite. We did this to ensure that we were not placing additional burden on the NHS at a very difficult time or putting our own staff at risk. We carried out 118 pieces of work, including onsite inspections, Quality Checks and focussed inspections. This, together with our broader assurance work through concerns received from the public, calls to our first point of contact telephone line, whistleblowing, safeguarding information and broader intelligence work, ensured we could continue to discharge our function. We conducted a small number of more traditional, onsite inspections during the year where our intelligence monitoring identified serious concerns and indicated that there may be an imminent risk to patient safety.

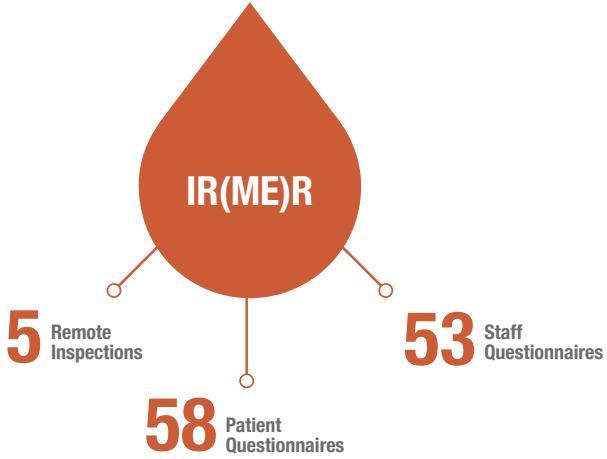
Quality Checks enabled us to deliver our statutory function offsite starting with an evidence review to consider infection prevention and control arrangements, governance arrangements and what environmental changes had been implemented to maintain the safety of staff and patients. These three areas aligned to the key areas set out in the NHS Wales Planning Framework and are areas we already know, through our work and through advice received from our Clinical Advisors, are crucial to the delivery of safe, effective patient care. Each of our sector-specific methodologies considers these three areas plus other pertinent areas to that sector. The work specifically explores arrangements put in place to protect staff and patients from COVID-19, enabling us to provide fast and supportive improvement advice on the safe operation of services during the pandemic.

Our approach during the pandemic has been underpinned by four principles:

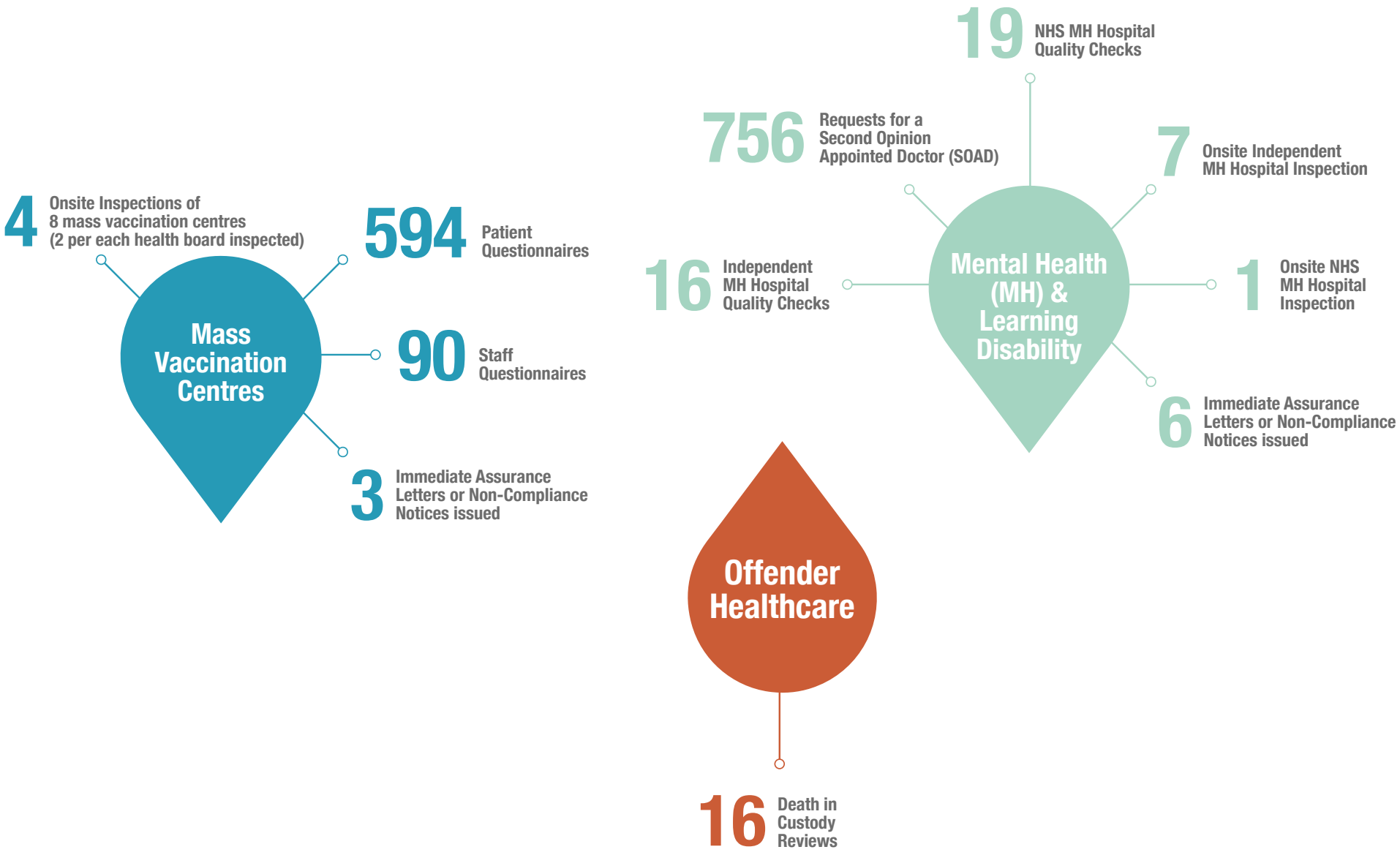
- Reduce the burden and regulatory pressure of our work on healthcare settings at such a pressured time, whilst still delivering our statutory functions
- Maintaining an oversight of healthcare services and providing assurance to the public and Minister through a focus on intelligence and working closely with partner organisations
- Supporting the NHS, Welsh Government and other organisations directly in responding to the pandemic
- Preparing HIW to enable it to continue to deliver its purpose in the face of the current and ongoing challenges, whilst meeting our duty of care to HIW colleagues.







[16]At the start of the pandemic, dental practices were required to make significant changes to the way they operated, seeing only emergency patients until new arrangements for working were put in place. Our focus was on supporting them to understand the guidance and adapt to the changes, resuming our programme of work through inspections and Quality Checks once practices were open on a more routine basis.


Mass Vaccination Centres
4 Onsite Inspections of 8 mass vaccination centres (2 per each health board inspected)
594 Patient Questionnaires
90 Staff Questionnaires
3 Immediate Assurance Letters or Non-Compliance Notices issued
Mental Health (MH) & Learning Disability
19 NHS MH Hospital Quality Checks
756 Requests for a Second Opinion Appointed Doctor (SOAD)
7 Onsite Independent MH Hospital Inspection
16 Independent MH Hospital Quality Checks
1 Onsite NHS MH Hospital Inspection
6 Immediate Assurance Letters or Non-Compliance Notices issued
Offender Healthcare
16 Death in Custody Reviews

Registration Activity

Enforcement - Independent Healthcare

- 14 Services of Concern Identified
- 6 Civil Action Taken
- 9 Potential Unregistered

Independent Healthcare Services

- 19 Variations of HIW Registration Conditions
- 22 New Registrations
- 9 Cancellations of HIW Registrations (Provider)
- 26 Changes of Manager
- 13 Cancellations of HIW Registrations (Manager)
- 21 Changes of Responsible Individual

Private Dental Practices

- 28 New Registrations
- 18 Cancellations of HIW Registrations (Provider)
- 33 Cancellations of HIW Registrations (Manager)
- 44 Registered Managers
- 1 Variation of HIW Registration Conditions
- 3 Changes of responsible individual

62k Facebook Reach

236.6k Twitter Impressions

Communication and Engagement

113,188 Website Sessions

Newsletter Subscribers Increased From: **4339** to **6204**

Concerns

343 Concerns From Public and Staff

03.

Engagement with Patients, the Public and Staff

Engagement with Patients, the Public and Staff

The views of patients and staff are an extremely important means through which we can understand the workplace culture within a ward, or other healthcare setting, and also help us to gain insight into the care which is being delivered. As part of our assurance and inspection processes, we consider what the experience is for patients by seeking their views of the service we are considering. We ask patients to tell us about the care they receive by completing a questionnaire, and when we are able to speak to patients in person during onsite visits, we gather views directly. We also commission surveys for our National and Local reviews to provide members of the public with a means of providing their views on national services across Wales (such as Mental Health Crisis Care), or to provide their views on services delivered in a particular locality or by a particular organisation (such as Welsh Ambulance Service NHS Trust).

In 2020-2021, social distancing restrictions, the need to reduce footfall in healthcare settings, and the need to reduce the risks to our own staff, lessened the opportunities for us to engage face-to-face with people using our traditional methods.

As we initially worked through the challenges posed by COVID-19 we made use of online surveys as our main means of engaging with patients and staff. We used online surveys during the following pieces of work:

- IR(ME)R focussed inspections;
- Mass Vaccination Centre focussed inspections.

Staff views are also very important to the overall understanding we build of a service. Healthcare services, across both the NHS and independent sector were keen for their staff to share their views with us, and helped by promoting the staff surveys we ran in 2020-2021. This meant we continued to get a good response from staff working in the areas we were considering.

We received a total of 1283 patient responses from this work and we heard views from 219 staff. We also engaged with the public, and with stakeholders as we completed the analysis of progress against our three year strategy 'Making a Difference'. We gathered 150 survey responses.

Location of Concerns

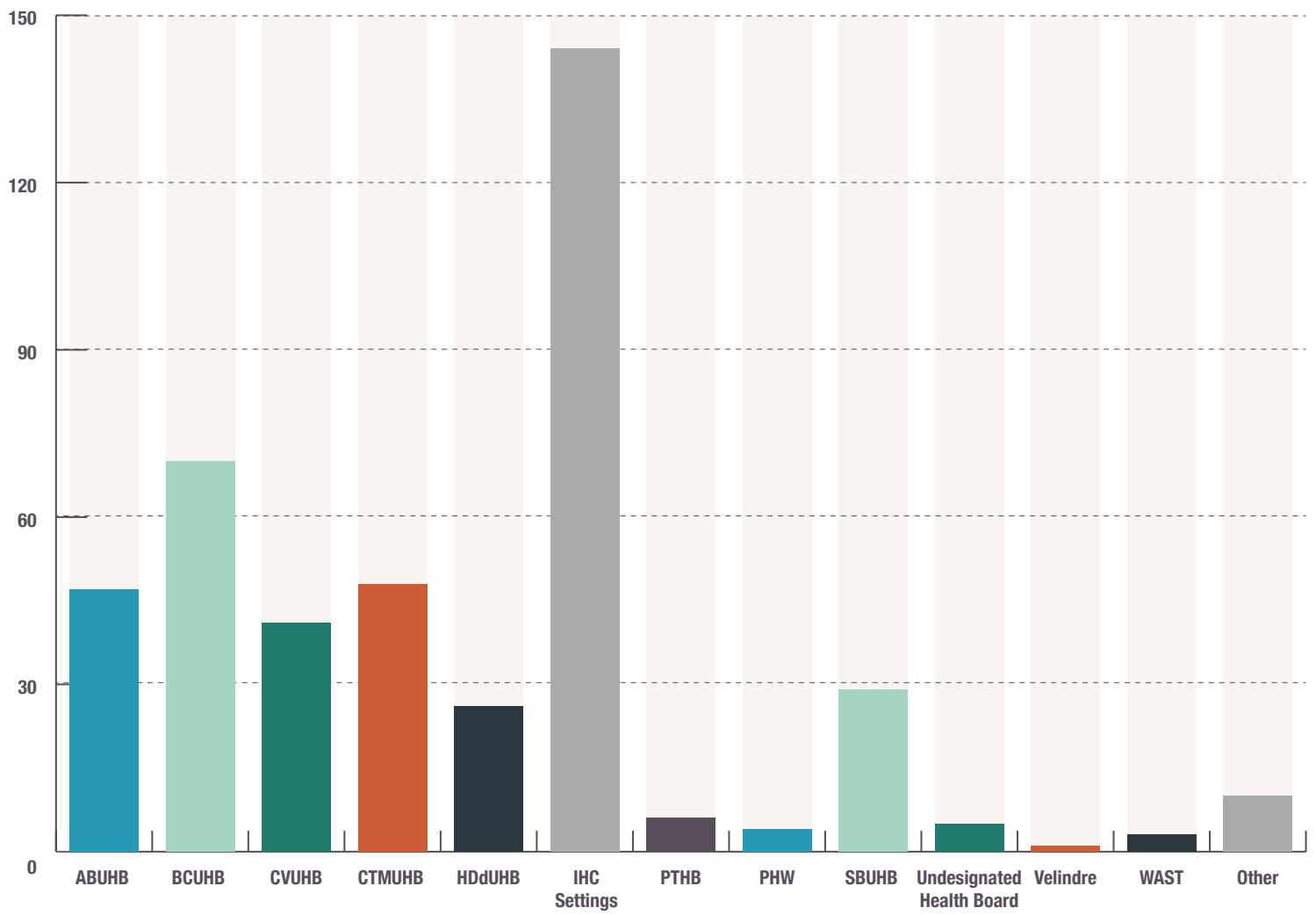
We received a total of 434 concerns from April 2020-March 2021, which is an increase of sixty seven compared to the previous year.

434
April 2020 - March 2021

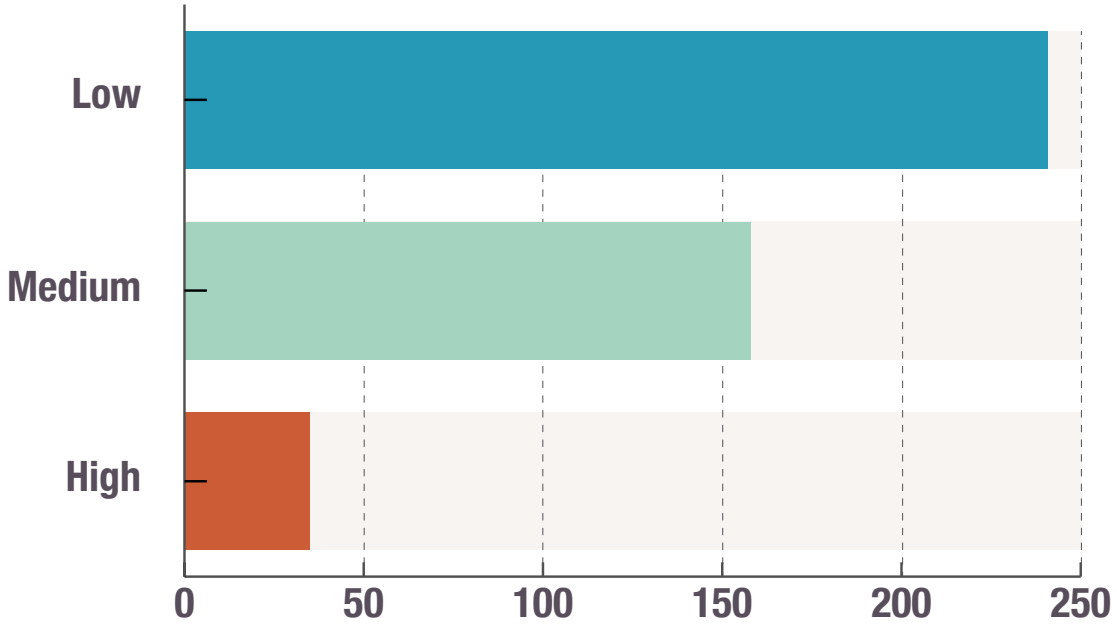
367
April 2019 - March 2020

NHS Health Board Abbreviations

ABUHB	Aneurin Bevan University Health Board (UHB)
BCUHB	Betsi Cadwaladr UHB
CVUHB	Cardiff and Vale UHB
CTMUHB	Cwm Taf Morgannwg UHB
HDdUHB	Hywel Dda UHB
IHC Settings	Independent Healthcare Settings
PTHB	Powys Teaching Health Board
SBUHB	Swansea Bay UHB
PHW	Public Health Wales
Velindre	Velindre University NHS Trust
WAST	Welsh Ambulance Services NHS Trust



Risk levels of concerns received



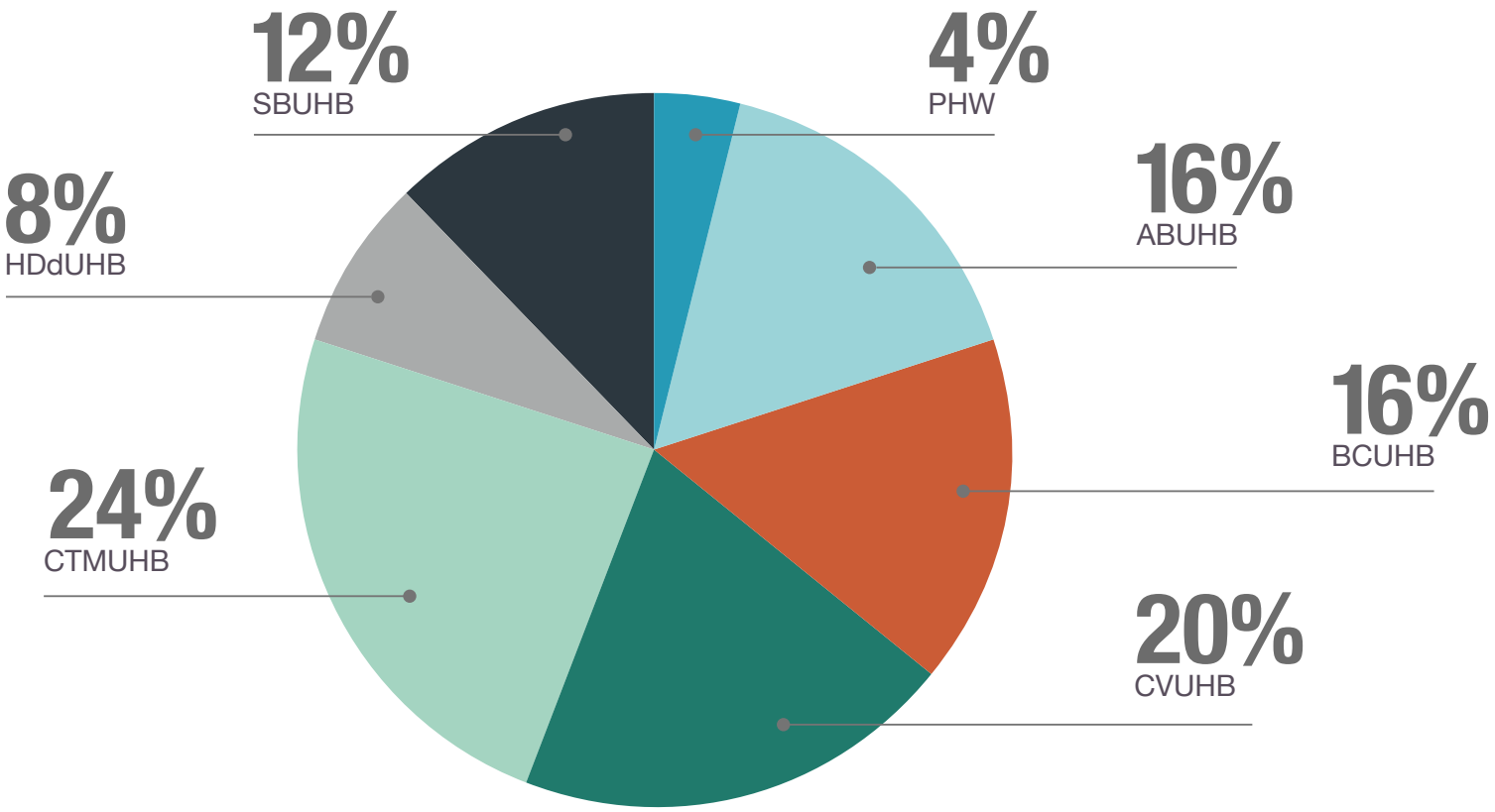
During the COVID-19 pandemic, concerns have been an invaluable source of intelligence to us and their importance cannot be underestimated. Some of the onsite inspection work we undertook during 2020-2021 was as a direct result of high risk or concerns of a repeated nature that we received. We have sought assurance from healthcare providers in written form, and through requests for evidence, in order to maintain the safety of patients and healthcare workers.

Whistleblowing Concerns (NHS)

Around a quarter of the concerns that we received, 100 in total, came from whistle-blowers. Fifty one of these concerns were in relation to NHS health boards or trusts and forty seven whistleblowing concerns were in relation to independent healthcare settings. Two whistle blowing concerns were in regards to non-registrable / identifiable healthcare settings.

Of these 100 whistleblowing concerns, nineteen were graded as high risk, forty seven medium risk and thirty two low risk.

Common themes identified from concerns received were mainly in relation to two key areas. The first group of concerns were in relation to care, treatment, and procedures. The second group of concerns related to infrastructure, staffing and facilities. These concerns were received from a range of individuals including, patients, their families, friends, staff and allied health professionals.



04.

Our Work

Our Work

Providing assurance

We provide an independent view on the quality of care delivered by NHS and independent healthcare services across Wales.

We do this by conducting onsite and offsite activities across a range of NHS settings including hospitals, GP surgeries, dental practices, mental health units and Community Mental Health Teams. In the independent sector we regulate and inspect healthcare settings by registering a range of providers including independent hospitals and clinics, dental practices, mental health units, hospices and laser treatments at beauty salons. We monitor compliance against conditions of registration and consider the quality of care being delivered.

Alongside inspection and registration activities, HIW uses information about healthcare services to gain assurance in relation to the quality and safety of services provided to citizens in Wales. This includes:

- Listening to concerns
- Monitoring incidents and notifications
- Examining safeguarding concerns and outcomes
- Monitoring compliance with legislation
- Actively engaging and sharing information with healthcare providers and partner agencies.

By triangulating evidence from a number of sources HIW obtains a fuller picture about the quality of care and support provided by healthcare services in the NHS and independent sector. Where there is evidence that quality standards are not being met HIW is able to take action and drive improvements, including through inspection and regulation activities.

We have a specific responsibility in relation to protecting the rights of vulnerable patients detained under the Mental Health Act 1983; Mental Capacity Act 2005 and checking the implementation of Deprivation of Liberty Safeguards which were introduced in 2009.

We also have a specific responsibility to monitor the use of Ionising radiation in healthcare. Ionising radiation is used in a range of different ways and falls under three broad categories of diagnostic imaging, radiotherapy and nuclear medicine.

Our work programme ensures that we meet our statutory requirements and that we review areas of concern identified through a range of intelligence sources. Our Risk and Escalation Committee assesses the evidence and intelligence available on a monthly basis, and determines our programme of routine and responsive inspections. A similar process takes place at our Review Steering Board which prioritises and plans national and local reviews, scrutinising the progress of reviews throughout the year.

Performance standards

We are explicit about the standards of service we provide.

- Where urgent action is required following an NHS inspection, Immediate Assurance letters will be issued to the Chief Executive of the organisation within two working days
- Where urgent action is required following an inspection in the independent sector, the service will be issued with a Non-Compliance Notice within two working days
- We aim to publish all onsite inspection reports three months after an inspection as stated in our publication policy. Performance against this target was affected this year due to the decision to halt our publication process between 14th April and 28th May in light of pressures on healthcare services. Despite this during 2020-21 we published 93% of our reports within three months of the inspections
- We introduced a new performance standard for our Quality Checks. The aim of these was to provide rapid feedback about the quality of services and to publish all our findings a near to one month after the date of the work taking place as possible. During 2020-2021 we provided rapid feedback on all of our work with almost two thirds of Quality Checks published within a month of work being carried out
- Across all our assurance and inspection work in 2020-2021, we reported fourteen issues of immediate concern. Ten of these we reported within our two day target.

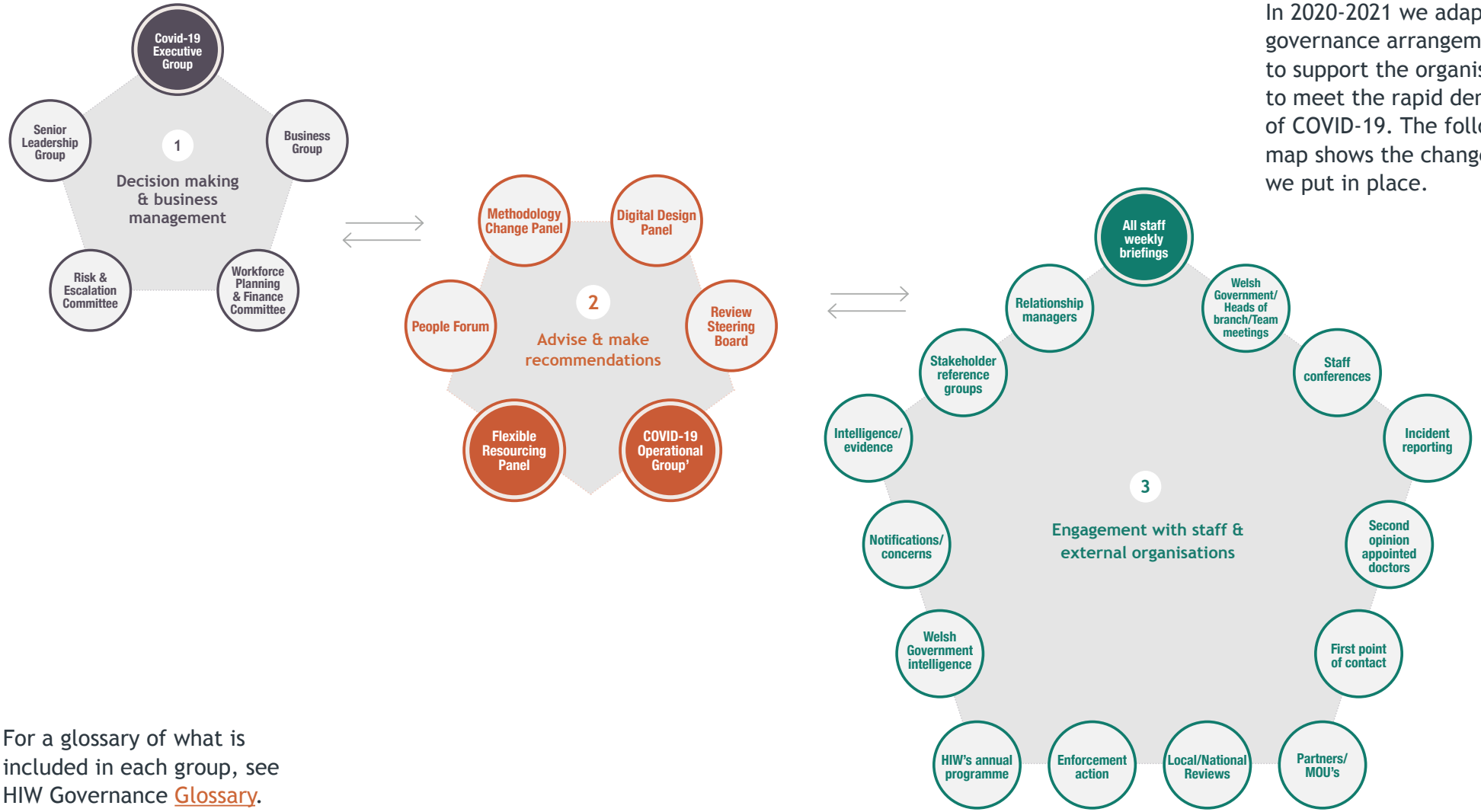
Promoting improvement

We use our governance arrangements to help us determine which sectors, settings and themes to prioritise in our assurance, inspection and review activity. Our governance map and glossary provides more detail about the mechanisms we use to challenge our own work programme to ensure we continue focussing our resources in the right places at the right times. Many of our reports contain recommendations intended to drive improvement in the quality of healthcare services. Last year we introduced a more systematic approach to follow-up of our recommendations. This approach includes structured follow up of our review work (both national and local); a process to support decision making and taking follow up action where inspections identify areas of concern and a standard 3 month follow up after each Quality Check. Each of these additional 'check points' provides us with another opportunity to identify concerns, challenge poor practice and to make recommendations to drive improvement in services.

Influencing Policy and Standards

Through our activities we see the direct application of legislation, policies and standards within healthcare services. Using this unique perspective, we use these findings to contribute to consultations, provide evidence to Welsh Parliament Committees, and feedback directly to Welsh Government policy officials. We also share our findings with policy makers at other government bodies, regulators, inspectorates and professional bodies. Following Royal Assent in June 2020 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, we continued to assess the impact of implementation of this Act on our work and our role in improving the quality of healthcare delivered in Wales. As the implementation of the Act gathers pace, we will continue to work on this, to ensure that our approach to seeking assurance takes account of the requirements introduced by the Act – the duties of quality, candour and establishment of the Citizen Voice Body. We contributed to seven consultations undertaken by external organisations last year on a range of issues that impact upon, or relate to, our work.

HIW Governance Map 2020-2021



In 2020-2021 we adapted our governance arrangements to support the organisation to meet the rapid demands of COVID-19. The following map shows the changes we put in place.

For a glossary of what is included in each group, see HIW Governance Glossary.

05.

Collaboration with Others

Collaboration with Others

We have long recognised the importance of the effective sharing of information between organisations in assessing the quality of healthcare being provided across Wales. The challenges of COVID-19 brought this into even sharper focus and we placed more importance than ever on working with our partners, seeking opportunities for joint working wherever we could.

Each year, we host healthcare summit events during which we bring together external audit, inspection, regulation and improvement bodies to share intelligence about NHS organisations. We were able to host these events virtually during 2020-2021 and this forum continued to be a rich and valuable source of information and route for information sharing. Themes that emerged from these discussions were agreed and communicated to the Welsh Government and fed into NHS Wales' escalation and intervention discussions.

We were able to enhance the work we undertook to explore the quality of care delivered at the newly established Mass Vaccination Centres through the strong joint working arrangements we have developed with the Community Health Councils (CHCs) across Wales. CHCs sought feedback from people about their experience of receiving vaccinations. We worked closely with the CHCs to understand the results of their survey, and this additional source of patient feedback was invaluable in helping us to draw conclusions about the standard of care being provided at these centres.

We have continued to work closely with Care Inspectorate Wales (CIW), Audit Wales and Estyn on areas of mutual interest throughout the year, including joint reviews.

We undertook a joint piece of follow up work with Audit Wales to consider improvements to governance arrangements implemented at Cwm Taf Morgannwg University Health Board following our last joint review there.

We published a number of joint statements with CIW during the year, in our capacity as the inspectorates of health and social care in Wales.

Collaborating with others across the year

April

In April 2020 we published a joint statement emphasising the importance of personalised, individual advance and future care planning in ensuring people receive high-quality and dignified care. The COVID-19 pandemic highlighted the need for this process to ensure people's wishes and best interests are taken into account in a personalised way through bespoke advance care planning discussions. Our message aimed to make clear that guidance unequivocally recommends that decisions are made on an individual basis and never for groups of people.

May

In May 2020 we published a joint statement on 'Speaking up'. Speaking up is an essential element of a safe culture and should be 'business as usual' for everyone working in care, regardless of their role. It is a means by which those working in care can raise concerns about safety, maintaining this as a priority for the whole system. Everyone who has a role in providing care needs to be more vigilant so that we can reduce the risk of avoidable harm to people. We re-issued this statement jointly again in May 2021, taking another opportunity to emphasise the importance of keeping safety in care at the forefront of people's thinking.

August

In August 2020 we published our joint annual monitoring report into the operations of the Deprivation of Liberty Safeguards (DoLS) in Wales.

September

In September 202012 we reported on joint work we did with Care Inspectorate Wales (CIW), Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS), Her Majesty's Inspectorate of Probation (HMIP), and Estyn. The work focused on sexual and criminal exploitation of children in the Newport area.

October

In October 2020 we wrote jointly, ahead of the winter period, to all health boards, NHS trusts and Local Authorities in Wales, sharing the key issues that we had identified collectively through our work in the preceding six months. The aim of this was to provide another opportunity to reinforce key areas for improvement.

[1] JICPA review outcome letter
[2] Looking at how we keep children and young people safe in Newport

2020

2021

We supported CIW with their Disabled Children Review, by conducting interviews with strategic and operational healthcare leads. The report will be published in autumn 2021.

With the onset of the pandemic early in the year, our Independent Healthcare lead worked in conjunction with the National Clinical Commissioning Unit (NCCU) to implement enhanced arrangements for monitoring patient and staff safety in independent mental health hospitals. This included seeking assurance on business continuity arrangements and regular updates on staffing levels at all hospitals. NCCU established a command centre approach so that hospitals had direct access to support and advice; any issues arising were shared with HIW in order to identify who was best placed to support and advise the hospital on the challenges they faced. These arrangements were in addition to the reporting requirements set out in the legislation which governs the regulation of these establishments. This work was done jointly in recognition that it would reduce burden and save providers from needing to send the same information and have the same conversations with two parts of the quality assurance system at a time when they were facing unprecedented challenges. Wherever possible assurance check-ins with the hospitals were also conducted jointly again reducing burden for all concerned.

This was a valuable piece of work which enabled us to maintain our oversight of these settings and their arrangements, and to better understand any potential risks emerging within mental healthcare settings in the early days of COVID-19.

Our Clinical Advisor team were also part of Welsh Governments Field Hospital development group, Nosocomial Transmission Group and Pandemic Modelling Forum. Our engagement in these ensured we were sighted on emerging models of care and pandemic specific guidance, using this information in the planning and delivery of our own work.

We continued to support independent healthcare providers to deliver safe and effective care. As part of the pandemic response, independent hospitals were utilised to support NHS Wales, for example, by performing surgical procedures. We focussed on getting up to date guidance out to independent providers explaining the practical implications of implementing this arrangement, and how to maintain regulatory compliance. Engagement with private dentistry providers was important during the pandemic. This was to ensure that dental practices offering 'private only' dental treatment were aware of relevant public health advice and guidance. We ensured that guidance issued by Welsh Government was available to these providers and that the concerns of private dentists in relation to restrictions were represented in our discussions with the Chief Dental Officer.

HIW is a founder organisation and one of twenty one bodies designated to the UK's National Preventative Mechanism (NPM). The HIW representative attends the business meetings, is a member of the steering committee and the mental health sub group.

The Optional Protocol to the Convention against Torture and Other Cruel, Inhumane or Degrading treatment or Punishment (OPCAT) is an international human rights treaty designed to protect individuals deprived of their liberty. The treaty came into force in June 2006 and the twenty one bodies that make up the NPM fulfil a key requirement of the treaty to ensure all places of detention are independently monitored. HIW considers implementation of the treaty and examines conditions of detention, the treatment of detainees and makes recommendations and requirements.

06.

National Reviews

National Reviews

HIW has an ongoing programme of National and Local reviews which helps us to evaluate how healthcare services in Wales are delivered. Local reviews are pieces of work we undertake which explore an aspect of one organisation or region, whilst National reviews explore healthcare services across Wales. We also undertake joint reviews with other organisations, both locally and nationally.

Review Proposals

We consider a range of factors to help us decide when and where to undertake a review. This includes intelligence from other organisations, such as other inspectorates, regulators or Welsh Government, and information we receive from concerns or complaints. We encourage members of the public and other stakeholders to suggest areas for us to consider in our Local and National review work and this can be done by completing a review suggestions form which is on our website.

All review proposals are considered by our Review Steering Board (RSB). This group researches, discusses and prioritises suggested topics and makes recommendations for any further work that we may undertake. The final decision on whether a proposal becomes the topic of a review is taken by our Risk and Escalation Committee (REC), which, taking account of the resources available in HIW, considers our planned programme of work against emerging risks within the healthcare system.

National Review of Maternity Services

The aim of this review was to explore the experiences of women, their partners and families, and the extent to which health boards provide safe and effective maternity services. The catalyst for this piece of work was the issues identified during our 2018 inspection of maternity services at the Royal Glamorgan Hospital in the former Cwm Taf University Health Board. In summer 2020, we completed phase one of this National review reporting on our key findings in a report published in November 2020[3]. Across Wales, we found many examples of good practice, however, we also identified some variability in the quality of care and treatment. We found that women were able to make informed decisions about their care and received good support and advice.

[3] https://hiw.org.uk/sites/default/files/2020-11/20201118HIWNationalReviewofMaternityServicesEN_0.pdf

We found staff to be committed and dedicated, doing their utmost to provide high quality care. However, it was clear from our inspections and survey results that staff were working under pressure and felt that there were not enough staff to enable them to do their job properly.

We identified that improvements were needed to ensure women could adequately express their birth choices and we identified that the number of different professionals women saw on their pregnancy journey resulted in a lack of continuity of care.

On a number of inspections we identified that urgent improvements were needed to ensure neonatal resuscitation and emergency equipment was being regularly checked to ensure it was always ready for use. The security of new-born babies on in-patient wards, and management of medicines, also required some urgent improvements. Issues which carry such a high level of risk are dealt with us immediately on inspection through our Immediate Assurance process, with the relevant health board providing us with details of the actions they have taken to address these concerns.

We found that health boards had good arrangements in place to maintain a clear oversight of their maternity services, with clear staff structures and clear lines of accountability. Whilst there were good processes in place for investigating clinical incidents and concerns, there was room for improvement to ensure learning from incidents and work needed to ensure that a positive reporting culture is promoted so that quality of care is maintained and improved.

Work started on phase two of the review, but due to the COVID-19 pandemic, in January 2021 we decided to delay the work for a period of six months. We recently reviewed our position for phase two plans alongside our risk based inspection and reviews programme for 2021-2022 and our resources. Following careful consideration, we took a decision not to progress with phase two as set out in our terms of reference. Instead, for issues identified in relation to aspects of maternity care that were outside the original scope of the national review, we will seek assurances through follow up and our routine work programme.

National Review of Mental Health Crisis Prevention in the Community

The decision to undertake this review was based on a number of concerns relating to people's ability to access timely care, to prevent them reaching a crisis with their mental health. In 2019, we undertook a joint piece of work with CIW where we considered the care provided by Community Mental Health Teams and identified that initial access to mental health services is an area in need of improvement. In addition, we highlighted a lack of knowledge in some primary healthcare professionals, about the range of referral services available for people suffering with mental health issues.

Earlier than this, in 2018, during our review of Substance Misuse Services[4], we also identified significant challenges around holistic working within mental health services. This included issues with long waiting lists after referral to mental health services, with staff at substance misuse services highlighting concerns that referral processes were sometimes overly complicated and inconsistent.

The review commenced in early 2020, but due to the pandemic has continued longer than initially anticipated. The work continues to progress and will conclude in autumn 2021. As part of this work we are reviewing our previous findings in this area alongside any other intelligence available to us, including work on crisis care undertaken by other organisations in Wales. The review focuses on support provided by GPs and other NHS services across Wales to prevent mental health crisis, and what third sector organisations do to support this. We have conducted a survey to gather views from people who use mental health services, their partners and families to gain their opinion of the services they receive to help manage their mental health condition and prevent crisis. We are analysing the findings of the survey to identify any themes and are also exploring how well services work together to provide holistic care. We aim to publish the national report detailing all these findings later this year.

[4] https://hiw.org.uk/sites/default/files/2019-06/180725smen.pdf

COVID-19 National Review

The immense impact of COVID-19 on people and on healthcare systems, led to our decision to undertake a COVID-19 themed national review to explore the quality and safety of care delivered by healthcare services in Wales during 2020-2021.

The review brought together the findings from all of our assurance activity across both the NHS and independent healthcare services from the onset of the pandemic until 31 March 2021, identifying key themes, good practice and areas to support improvement.

We published our report on 30 June 2021[5].

Our work over this period comprised of our new Quality Checks, focussed inspections and some onsite inspection work. The work focussed predominantly on three areas; infection prevention and control (IPC) arrangements, governance arrangements and the healthcare environment. Our findings from this work enabled us to reach an overall view that the quality of care provided across Wales during the pandemic was generally of a good standard. We identified numerous examples of outstanding efforts made by staff working in healthcare services throughout Wales, during a hugely challenging period. We commended the commitment, resilience and flexibility of staff across both NHS Wales and independent healthcare services, who have worked tirelessly to provide care to patients and to each other.

During this time, our work enabled us to identify themes and learning which we wanted to share rapidly with healthcare services across Wales in order to maximise the impact of our work to support improvement in healthcare. We shared these messages through our Quality Insight Bulletins. We published the first of these in December 2020 and the second edition in February 2021. In our December edition we noted the increased incidence of skin and eye problems in staff working in high risk areas who were using higher levels of PPE. We found that arrangements for fast tracking staff access to dermatology and ophthalmology services was patchy across Wales and we recommended health boards ensure their arrangements for staff were sufficient. In our February edition, we shared the important message that there were improvements needed to ensure that shortfalls in IPC arrangements (identified via audits) were addressed and problems resolved. We also identified the need for staff to maintain social distancing, and reminded services of the importance of this. In addition we reported our findings from a focussed inspection of two newly formed Field Hospitals within Hywel Dda University Health Board. The evidence we found at this inspection had demonstrated the speed and extensive preparation that had been undertaken in difficult circumstances in order to make this service operational and available as part of the arrangements to tackle the pandemic.

[5] https://hiw.org.uk/covid-19-national-review-2021

07.

Assurance and Inspection Findings

Assurance and Inspection Findings

Hospitals

During this period we conducted twenty seven Quality Checks of NHS hospitals, including ten community hospitals. Our Quality Checks covered numerous different types of hospital wards including stroke wards, paediatric units, step down facilities and minor injuries units. We also conducted focussed inspections of two new field hospital sites, which included an element of onsite inspection work, converted from their original use to help provide additional bed capacity during the first wave of the pandemic.

Our overall view of the three key lines of enquiry is that these were generally managed to a good standard. We found highly dedicated staff teams, detailed knowledge of IPC procedures, and environments of care that had been adapted to operate safely to help keep staff and patients safe.

We spoke to senior ward staff at each Quality Check, and were given numerous examples of outstanding efforts made by staff during a significantly challenging period. We recognise the commitment, resilience and flexibility of staff who have worked tirelessly to provide care to patients.

Environment

We considered how services designed and managed the environment of care to maintain safety for patients, staff and visitors.

Significant changes have been made to physical environments to ensure social distancing can be adhered to in hospital settings. This includes reduced bed numbers, signed one way systems and separate entrances and exits. Footfall had been carefully managed to reduce the number of people onsite at any one time, including staff and visitors. We were also told of staff introducing digital methods for patients to keep in contact with friends and families. Multidisciplinary teams also kept in touch digitally and continued to involve family members and carers which can be more efficient and reduces travel time. Health boards should consider to what extent digital meetings can be maintained after the pandemic, taking into account the most efficient use of time and the most effective way of involving patients and their families given their circumstances.

As part of our Quality Checks, we considered whether all settings had completed environmental risk assessments. We noted a number of settings where these had been done but were out of date, or where follow up actions had not been completed, particularly when larger scale capital works were required. We recommended risk assessments are updated and that any areas of risk identified through these are addressed.

Infection Prevention and Control (IPC)

We considered how services have responded to the challenges presented by the pandemic, which included how well they manage and control the risk of infection, to help keep patients, visitors and staff safe.

Appropriate and effective IPC arrangements are an essential part of the strategy for minimising the transmission of the COVID-19 virus. We found a number of positive arrangements in place to strengthen IPC across all settings which included a strong focus on hand hygiene, cleanliness and the correct provision and use of Personal Protective Equipment (PPE).

Hospital settings implemented different zones, red for COVID-19 positive patients and green for patients who had tested negative, as highlighted in the NHS Wales COVID-19 Operating Framework. Whilst all settings completed investigations following a COVID-19 outbreak, we identified some examples where the process, and sharing of lessons learned, could be strengthened. We found arrangements were in place for testing patients and staff to identify positive cases of COVID-19.

We checked all settings had appropriate IPC guidance and policies in place, and had recently completed IPC risk assessments. Whilst we noted these were almost always in place and easily accessible for staff, we did note some settings where follow up actions were not fully completed. Risk assessments form the basis of ensuring IPC rules are applied fully and specifically to a setting, and any gaps can have a significant impact on the system as a whole.

A key area to have emerged from our work is the need for healthcare services to continue to strengthen their infection prevention and control arrangements in order to mitigate the risk of any future outbreaks of COVID-19. We know the virus will continue to evolve, and whilst on the whole we believe that infection control has been managed appropriately, hospital settings will need to continue to learn from outbreaks and work to minimise transmission as much as possible in the future.

Governance

We explored whether management arrangements ensured sufficient numbers of appropriately trained staff were available to provide safe and effective care.

It is clear that the pandemic has, and will continue to have, an impact on the well-being of staff. In all our Quality Checks, senior staff spoke highly of their teams who have worked tirelessly in highly pressured environments. All senior staff told us of additional support structures in place for teams, both formal and informal, to help maintain and improve mental well-being.

Prior to the COVID-19 pandemic, our inspections of hospital settings regularly reported that setting aside time for mandatory training and performance appraisals was difficult for staff. The lack of face-to-face training and the added pressures from the pandemic has only exacerbated this issue. Mandatory training is not always seen as a priority area, however, it is a key way of ensuring staff are able to provide safe and effective care to patients in important areas.

As we continue along the path of uncertainty and recovery, the pressures and challenges facing healthcare services in addressing the backlog of patients awaiting treatment will increase. The potential negative impact on the well-being of staff should not be underestimated. Services will need to ensure arrangements are in place to support staff to maintain safe and effective care, for example sufficient time for supervision meetings, adequate rest times, accessible support services and good engagement from managers and leaders.

Field hospitals

We conducted a focussed inspection of two Hywel Dda field hospitals in October 2020 at sites that had recently been converted from their original uses in preparation for the second wave of the pandemic in 2020. At the time of our visit, both sites were empty and were in the final stages of preparation to receive patients.

We found evidence of extensive planning by the service in preparation for the provision of safe and effective care to patients in the unique environments. The health board had established a new governance model to manage the size and complexity of the project, including a number of workstreams with many partner agencies involved.

The health board had tested the viability of establishing and operating a field hospital by opening Ysbyty Enfys Caerfyrddin, as a pilot for eight weeks during the summer of 2020. This meant they were able to test the environments, workforce, equipment operations manual, patient criteria, panel process and technology.

General Practices

We adapted our Quality Check approach in order to check on the quality of care being provided by GP practices during the pandemic. Again, this was based on the three areas identified as crucial to the delivery of safe patient care during the pandemic, although we adapted our lines of questioning to take account of how GP services are provided and the type of care they give.

We conducted eight Quality Checks, spread across all health boards in Wales. Our overall view is that the services we checked using this method were managed to a good standard. The introduction of virtual appointments at the start of the pandemic has been a substantial change to the operation of GP practices. The ongoing requirement to maintain social distancing and increased IPC requirements throughout healthcare are likely to mean this appointment method was not a temporary fix purely for pandemic times, the sector must fully consider the challenges associated with this model and ensure risks such as digital exclusion, online security and overall suitability of this appointment method are mitigated as far as possible. We found significant changes made to layouts of practices to support social distancing and infection control, committed senior staff keen to provide a quality service and detailed knowledge of infection prevention and control procedures.

We spoke to practice managers and lead GPs at each of our Quality Checks, who always spoke highly of the dedication shown by the staff teams. GP practices are small settings with small staff teams, and it can be more complex to maintain resilience and an ongoing quality service. However all the practices we checked had managed vacancies and short absences well and continued to provide their services.

General Practices

Environment

Significant changes were made to practice environments due to the continued need for patients to attend face-to-face appointments. The practices in which we conducted our checks described operating one way systems, reducing seating in waiting areas and replacing carpets or soft fabrics with wipe clean surfaces.

We considered the arrangements in place to ensure that if GPs had to carry out home visits they could do so safely and in line with COVID-19 procedures. We found that in some practices arrangements were in place to provide clinicians with grab bags to ensure suitable equipment and PPE were readily available. However, we found some examples where COVID-19 risk assessments were not completed prior to staff completing a home visit. Therefore, we recommend that GPs conduct an appropriate COVID-19 risk assessment prior to any home visits, to help mitigate the risk of COVID-19 transmission.

Infection Prevention and Control (IPC)

It was positive to find that most practices had made a range of improvements to IPC arrangements. These are clearly essential during the pandemic to help minimise the virus transmission. We found a number of positive arrangements in place to strengthen IPC which included a strong focus on hand hygiene and cleanliness. We also noted settings had strived to ensure the correct provision of Personal Protective Equipment (PPE), and had provided staff with training in how to use it correctly.

We generally found IPC risk assessments in place, and updated policies and procedures to support staff in maintaining safe and effective care.

Governance

We found that risk assessments were in place to ensure staff were safe to work in the practices. Many staff who were shielding or higher risk were also supported in working from home where possible. In general, greater flexibility has been implemented, which allowed staff to have a better work/life balance.

We saw some evidence to suggest that GP cluster arrangements during the pandemic had worked well.

In some clusters a joint assessment service for COVID-19 had been developed, which was provided on a rota basis between GP partners of each practice to maintain staff and patient care.

General Practices

We found a positive example where one cluster had been proactive in developing a new initiative that looked at referral patterns, compared with the same period last year, to ensure that the levels of activity were maintained, particularly in relation to cancer referrals. We consider this to be an example of good practice, and is something other practices should consider to help ensure vulnerable patient groups receive timely care, and to minimise the potential wider harm from COVID-19.

Mass Vaccination Centres

While GP settings regularly run clinics for flu vaccinations, the number of people and planned speed of the vaccination programme for COVID-19 meant separate venues were required in order to deliver the Vaccination Strategy for Wales. We inspected eight Mass Vaccination Centres in April 2021.

We issued questionnaires to patients and staff at Mass Vaccination Centres (MVC), using both our electronic survey tool and issuing paper questionnaires. We received 594 responses from patients and 90 responses from staff.

We found that appropriate arrangements had been put in place by health boards to oversee the safe implementation of their vaccination programmes, despite the unique environments and the speed at which they have been mobilised and staffed. We saw positive examples of the safe management of COVID-19 vaccines, good infection prevention and control measures and safe care being provided to patients by dedicated and hard-working staff.

100%

of staff respondents felt that infection prevention and control procedures were followed.

However, we did require some improvements to be made during our visits in order to maintain patient safety, including increased audit activity, better compliance with fire safety and evacuation procedures and more regular checking of resuscitation equipment. Where we found these issues, without exception, the health boards were prompt and effective at resolving the risks we identified.

95%

of staff who worked at a health board vaccination centre said they had had relevant training to allow them to undertake the role at the vaccination centre with confidence.

Mental Health

The provision of mental healthcare during the pandemic has been challenging and complex for both the NHS and independent healthcare service providers.

We adopted our new approach of undertaking remote Quality Checks for most of our work in mental healthcare settings. This approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was particularly high because of the spread of COVID-19. The figures below also demonstrate that we applied our full onsite inspection approach on seven occasions where we considered the level of risk to patient safety to be of sufficient concern. Throughout the pandemic we also continued to operate our Review Service for Mental health (RSMH), and our concerns and notifications processes. We also continued to respond to patients in mental health settings who contacted us during this period.

We undertook:

- Thirty three Quality Checks: eighteen NHS and fifteen independent healthcare providers
- Seven on-site inspection visits: one NHS and six independent healthcare providers .

We reviewed and where necessary sought further assurance about:

- 151 patient concerns
- 553 Regulation 30 and 31 Notifications[6].

We saw that the pandemic required rapid and unprecedented change in the way that healthcare services were delivered across Wales, and whilst many of the mental healthcare services we considered had coped well, we also heard that in some areas the pandemic had significantly impacted on patients and staff.

[6] Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 require the registered person of an independent hospital, independent clinic, or independent medical agency to notify us about particular events that occur relating to patient safety. This is a legal requirement.

Preventing and controlling the spread of COVID-19

It was positive to find that arrangements had been put in place in many settings to provide patients with information about the pandemic and national and local restrictions. Individualised risk assessments and care management plans relating to COVID-19 arrangements had been put in place to support patients, and to promote understanding about the importance of social distancing, good hand hygiene, and the use of face masks to protect themselves and others.

We found that mental healthcare services had introduced new infection prevention and control measures to minimise the transmission risk of COVID-19, and also introduced practical and procedural changes to enable continuity of care, and to support patients and staff well-being throughout the pandemic. New arrangements were introduced to adapt the care environment, and we learnt of the changes made to ensure settings were compliant with national guidance for social distancing and infection prevention and control.

A significant amount of in-patient mental healthcare in Wales is provided in settings offering single bedroom en-suite facilities, an environment conducive to social distancing and isolation of patients with suspected or confirmed COVID-19. However some services are provided in older settings, and we heard that significant efforts had been made to redesign some clinical areas to reduce the risk of virus transmission; we saw that this was harder to achieve in some facilities than others.

Dignified and least restrictive care

National and local restrictions have meant that patients were at times unable to have leave of absence, or receive visits from family and friends. The requirement for social distancing and the need for Personal Protective Equipment (PPE) also radically changed the way in which in-patient mental healthcare has been provided throughout the pandemic.

It was reassuring to hear patients speaking positively about their relationship and interactions with staff during our inspection visits. We also observed staff interacting and engaging with patients in a dignified and respectful way during our inspection visits. We have in previous years stressed the importance of meaningful social and recreational activities for patients. We were pleased to find that significant efforts had been made to develop

additional activities to support patients during this time, including therapies, educational and recreational activities. We strongly encourage service providers to maintain this additional provision after the pandemic.

We were told that video calling could be used to enable patients to maintain contact with family and friends during periods when visiting and leave arrangements were not permitted. However, we noted poor Wi-Fi access in some facilities, poor access to ward mobile phones, and as patient access to personal phones and other electronic devices might be dependent on risk assessment or level of independence, we were concerned that for some patients contact with family and friends might have been inhibited.

We therefore encourage mental healthcare settings to ensure they are maximising all opportunities, and provide assistance when necessary, to enable patients to maintain contact with family members and friends.

It was positive to find that during periods when restrictions were eased significant efforts had been made to enable visiting to resume in a safe and supportive way. Some settings had bought additional garden furniture or had identified dedicated space for visiting. Enhanced cleaning regimes and 'track and trace' arrangements had been introduced. We found that visiting arrangements were generally well managed, and the necessary risk assessments were in place to ensure the safety of patients, visitors and staff was maintained.

Safe and effective care

We were told about arrangements that had been introduced to enable patients to participate in consultations with members of the multi-disciplinary care team, or with advocates and to participate in mental health review tribunals using telephone and video conferencing facilities. We were concerned, however, that some patients may have experienced digital exclusion and therefore found it prohibitive to use digital means of engagement. We encourage mental healthcare settings to seek feedback from patients about their experience in order to find out whether they felt engaged and enabled to participate in discussions about their care and treatment during the pandemic.

In previous years we have commented on variability in the quality and robustness of risk assessments, and care and treatment planning documentation, so it was pleasing to see examples of good practice in this area during our inspection visits. In some cases we saw evidence that care documentation and risk assessments had improved following earlier inspections, however, we continued to see examples of inadequate care planning and risk assessment, and overall improvement is still needed to ensure all aspects of care documentation are completed to the required standard.

Through our Quality Checks and inspection visits we considered whether environmental risk assessments had been undertaken and acted upon, and as in previous years we identified the need for routine maintenance, redecoration and replacement of fixtures, fittings and furniture in some settings.

Mental Health

We were concerned to find inconsistent practice in relation to the timely and appropriate completion of ligature risk assessments and mitigating actions in a significant number of NHS mental healthcare settings. We found examples where action had not been taken to reduce or remove identified ligature point risks, as well as risk assessments that were over twelve months old. As a result we wrote to the Chief Executive of NHS Wales to raise our concerns and to ask that action be taken in this area.

The Second Opinion Appointed Doctor (SOAD) Service

HIW operates the SOAD service for Wales and we appoint registered medical practitioners to approve some forms of treatment. We currently have Service Framework Agreements with 19 SOADs to provide this service in Wales. The role of the SOADs is to safeguard the rights of patients who are detained under the Act and either do not consent or are considered incapable of consenting to treatment (Section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether or not the patient has capacity to consent.

They must be satisfied that the patient's views and rights have been taken into consideration. If they are satisfied, the SOAD will issue a statutory certificate which then provides the legal authority for treatment to be given. After careful consideration of the patient and approved clinician's views a SOAD has the right to change the proposed treatment. For example a SOAD may decide to authorise only part of the proposed treatment or limit the number of electroconvulsive therapies (ECTs) given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

- liable to be detained patients on CTOs (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients
- serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57)
- detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (Section 58)
- patients under eighteen years of age, whether detained or informal, for whom ECT is proposed, when the patient is consenting having the competency to do so (Section 58A), and
- detained patients of any age who lack the capacity to consent to electroconvulsive therapies (ECT) (Section 58A).

Due to the ongoing COVID-19 pandemic and health and safety concerns regarding on site visits for the SOADs, we continue to operate a temporary COVID-19 safe methodology for the SOAD service. On-site hospital visits have been, and remain, temporarily suspended and replaced at this time with teleconference or telephone call appointments.

We continue to work with the Mental Health Act administrators in health boards and independent providers to ensure that patients get timely access to a SOAD and that the process is as smooth as possible to ensure that the rights of patients are protected.

In Wales during 2020-2021, there were 956 requests for a visit by a SOAD and this remains consistent with figures from 2019-2020.

These were:

- 869 requests related to the certification of medication
- Sixty requests related to the certification of ECT
- Twenty seven requests related to medication and ECT.

The following table provides a breakdown of requests per year:

Requests for visits by a SOAD, in 2020-2021

Year	Medication	ECT	Both	Total
2020-2021	869	60	27	956

A regular programme of training is provided to all SOADs to encourage best practice. In the year 2020-2021 two training events were held, focussing on the topics of ECT and Antipsychotic medications.

Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the fifth consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed by our lead SOAD for Wales on a monthly basis.

We have carried forward last year's improvements to the review process and are identifying fewer discrepancies. Further improvements from our previous report continue in relation to the following areas:

- There continue to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3 form
- Copies of CO2 and CO3 forms (if applicable) are always attached to the review of treatment form which enables a timely and efficient review process
- Clarified instances where a S61 review of treatment form is required for numerous health board and independent settings throughout the year, which has ensured detained patients are receiving their S61 reviews as appropriate.

We have continued to find that information regarding patient consent and capacity status is not accurately captured in records submitted to us. We plan to redesign these forms in the near future to make the information required more explicit.

The audits of the review of treatment forms will be ongoing and further findings will be reported upon during our 2021-2022 report.

The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.

The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017. The regulations are intended to protect people from hazards associated with ionising radiation. Our inspection approach checks that services are compliant with these regulations (IR(ME)R) and also looks at whether care and treatment is being provided in line with the Welsh Government's Health and Care Standards.

During 2020-2021 HIW completed five IR(ME)R inspections, covering the three modalities of medical exposures. These inspections also covered both NHS and independent hospitals.

Due to the COVID-19 pandemic these inspections were undertaken remotely. From an IR(ME)R compliance perspective this made little difference as we were still able to ask providers to undertake the full self-assessment and hold the same discussions that we would in our on-site inspection approach, albeit virtually rather than in person. However, it did mean that we were not able to observe the environment in which services were delivered nor speak to patients directly about their experience. To address the issue we developed an online patient survey; the QR code to access the survey was displayed on posters in the services we inspected and we promoted the surveys through our social media channels.
HIW received fifty eight completed IR(ME)R patient questionnaires and fifty three staff questionnaires covering these five inspections.

Findings

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. We also saw evidence to show that there were clear arrangements in place for patients to provide feedback on their experience. This is a positive finding as we have in the past recommended that more needed to be done in this area.

During our IR(ME)R assurance activity we met experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R and we were assured that examinations at all sites inspected were undertaken safely.

97%

of IR(ME)R patients surveyed felt that they were treated with dignity and respect during their appointment.

94%

of IR(ME)R patients we surveyed, who had an appointment within the last year agreed that 'COVID-19-compliant' procedures (e.g. use of face masks, sanitising hand gel) were evident during their time at the setting.

97%

of staff who responded to the question said their organisation has implemented the necessary environmental changes to become COVID-19 compliant.

However some common themes have emerged this year with similar recommendations for improvement being made across all five pieces of activity. They are summarised as follows:

- Employer's Procedures (EP) – on several occasions we identified that these did not provide enough detail and did not reflect the actual agreed practises staff described to us. We also saw that procedures were not up to date and had not been reviewed. Therefore, whilst staff could describe safe practises to us, we could not be assured that the written procedures would provide new, locum or agency staff with the required level of information to guide them in performing their relevant roles.

Examples of common areas where detail was lacking in Employer's Procedures included:

- Accidental or unintended incident reporting - we highlighted that the incident reporting EPs did not always include sufficient detail around the process. For example who was responsible for the action of each stage
- Diagnostic Reference Levels (DRLs) – EPs did not sufficiently detail the frequency of reviews, the ratification process and required action from staff showed doses consistently exceed agreed doses
- We found references to IR(ME)R 2000, which are outdated regulations, within procedures and other documents we reviewed
- Pregnancy EPs and relevant documents did not always reflect the terminology used in IR(ME)R 2017. Also, pregnancy enquiry EPs were a common area where agreed practise described by staff was not reflected accurately in the EP itself.

Entitlement is the process of defining the roles and tasks that individuals, referred to as duty holders, are allowed to undertake. We identified that duty holders had not always been formally notified of their entitlement and scope of practice under IR(ME)R.

Clinical audit is a key component of ensuring care and treatment is provided safely and ensures there is a focus on continuous improvement. Audit documentation we reviewed did not always include sufficient details around the frequency of the relevant audits or clearly detailing actions required as a result of the audit.

In most cases staff told us that they felt supported by senior management and the wider organisation. However, they did tell us that they struggled in terms of capacity to undertake all relevant tasks required as part of their duty holder roles, in particular clinical audit.

Dental Practices

Due to restrictions introduced during the pandemic and in keeping with our commitment to reduce the burden on healthcare providers so that they could focus on keeping people safe, our inspection activity in relation to dental practices has been significantly reduced this year.

In the early part of the pandemic (March-July 2020) practices were working under a Red Alert issued by the Chief Dental Officer for Wales which prevented them from undertaking any treatment that involved an aerosol generating procedure (AGP) and were encouraged to triage patients by telephone. Patients were only seen face-to-face if they were not displaying symptoms of COVID-19 and required urgent treatment; even then patients had to be referred to an urgent dental centres if an AGP was required to relieve any pain. Since July 2020, practices have been able to provide a greater range of treatments depending on practice readiness and COVID-19 prevalence in their local community.

With limited dental treatment available during the early part of the year our focus turned to supporting practices and providing them with relevant and up to date information required to manage their establishments safely during the pandemic. During the course of the year we issued eighteen newsletters to practices and answered hundreds of telephone calls and emails from practices seeking advice on interpreting the guidance being issued from the Chief Dental Officer and other relevant expert bodies.

We have continued to undertake inspections where necessary. During 2020-2021 we received concerns regarding thirteen dental practices. The main themes from these concerns related to providers operating outside of COVID-19 restrictions, and non-compliance with guidelines issued by the Chief Dental Officer. This included concerns around the inappropriate use of AGP's during the pandemic. Whilst most of these concerns were resolved by seeking written assurances from the practice, there were four occasions where we did not obtain sufficient assurance through correspondence and needed to make further enquiries via an onsite inspection. The decision to inspect was not taken lightly and in all cases was done so on the basis of the level of evidence we received to suggest patient and/or staff safety was being put at risk.

Dental Practices

During these inspections we did identify occasions where dentists had undertaken an AGP during the Red Alert period. These included treatments for temporary crown restoration, permanent fillings and root canal treatment. Whilst the dental practitioners were able to verbally justify their non-compliance with the Red Alert guidance, this was not appropriately documented in the patient dental records. We could not therefore be assured that the safety of patients and the practice staff had been appropriately considered.

We also identified the following issues where Standard Operating Procedures for Dental Management of Non COVID-19 patients had been incorrectly applied:

- A dental surgery had not been de-cluttered and contained items that could not be cleaned effectively
- PPE not being changed following AGPs and before cleaning commences
- Insufficient evidence of fallow time compliance between procedures, with no record of the time at which the AGP element of the treatment had finished
- No expert verification of air changes per hour (where air changes were unknown)
- The strength of the detergent being used was not in accordance with recommendations.

Given the airborne nature of transmission of COVID-19, these findings were particularly concerning, and posed a significant risk to the safety of patients and the wider dental team. Therefore, our inspections resulted in us issuing a number of Non-Compliance Notices which required the practices in question to undertake immediate improvements to maintain patient safety. We also prevented AGP treatments being provided in one of the practices for a short period while remedial actions were carried out.

Finally, we identified issues at one practice with the provision of conscious sedation. This treatment is not usually available for NHS patients so is predominantly available as a privately funded option. Over the last year we have developed a new piece of methodology that enables us to consider the arrangements for conscious sedation and in particular whether these are compliant with Service Standards for Conscious Sedation in a dental care setting. These Standards were introduced by Welsh Government via a Welsh Health Circular in June 2018 and we would encourage all practices offering conscious sedation to self assess their compliance with these standards, at least annually, and ensure that all documentation required by the standards is available for inspection by HIW.

Independent Healthcare

Independent Hospitals, Clinics and Medical Agencies, except those providing treatment with a laser for cosmetic purpose, continued to operate during the pandemic. Therefore it was important that we continued to check that patients were still receiving good care through our newly developed remote Quality Checks.

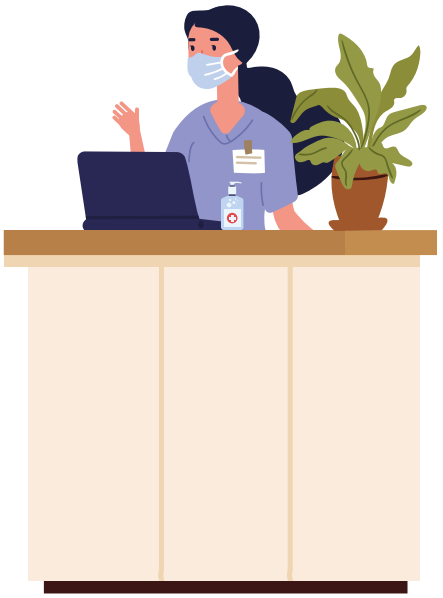
These services would normally be inspected every three years but the changes to our ways of working and the development of the remote Quality Check approach provided an opportunity to conduct assurance activity in all acute hospitals and maintain activity levels for all other types of registered services.

Overall, the assurance activity conducted on independent services this year had very positive findings. During our COVID-19 national review we identified and referenced some innovative solutions being provided and several of these were identified in independent hospitals and clinics through our Quality Checks. Our overall findings are summarised as follows:

Independent Hospitals

Throughout the pandemic, independent hospitals have been utilised as COVID-19 free environments as a means of providing urgent scheduled care, such as surgery on behalf of the NHS. This support has been essential and we found clear and focused efforts had been made to enable independent hospitals to remain open and prevent nosocomial transmission of COVID-19. These arrangements included robust environmental risk assessments, pre-admission COVID-19 testing and the requirement for patients to self-isolate at home prior to admission. On arrival to the hospitals, new front of house triage and testing processes are now in place, which aim to detect any patients with potential COVID-19 symptoms.

We are aware of new initiatives that have been introduced to help keep patients safe during the COVID-19 pandemic. This includes one provider implementing new colour coded 'patient pathways' to help guide patients through the hospital. Under this model, the pathway the patient takes is dependent on any requirements for COVID-19 testing and self-isolation before the appointment, and the reason for the visit. We consider this a positive initiative, as it defines an appropriate healthcare journey for patients and in particular those who are clinically vulnerable to help reduce the risk of potential infection.



Infection Prevention and Control (IPC)

Appropriate and effective IPC arrangements have been a priority to combat transmission of the COVID-19 virus. We found that in all independent hospitals, enhanced IPC arrangements had been introduced that were in line with Public Health Wales guidance aimed at reducing nosocomial transmission. It is very positive to note that there have been no reports of patients contracting COVID-19 during their stay at an independent hospital.

We found that arrangements were in place to ensure staff could access appropriate Personal Protective Equipment (PPE) and training had been provided on its correct use. We were also told about new initiatives which had been introduced in independent hospitals to help reduce the risk of nosocomial transmission. One such initiative was making additional scrubs available for staff, enabling uniforms to be washed on site instead of staff taking them home to clean.

Whilst there were no cases of patients testing positive for COVID-19 at independent hospitals, we are aware of one small outbreak amongst a staff group. The transmission was attributed to staff removing masks when taking a break. This incident highlights how an apparent small lapse in PPE use can have significant consequences. It is vital that providers continue to remind staff about their responsibilities, especially as we see changes to COVID-19 alert levels, and at the time of writing, reductions in restrictions on activities.

Governance

It is clear that staff have been working in hugely challenging environments since the start of the pandemic. During our Quality Checks providers told us about a range of positive supportive interventions that had been implemented to help maintain the well-being and mental health of staff. One notable intervention was the use of reflective practice and Schwartz Rounds[7], where staff from all disciplines meet to reflect on the emotional aspects of their work. It was felt that this approach was helping staff feel supported during the pandemic; we therefore encourage all hospital managers to explore this, or similar approaches, as a tool to help support staff. We would suggest that hospital managers need to monitor the take up of these interventions to ensure staff are fully supported through these challenging times.

It was positive to find that specific training on COVID-19 has been provided to staff in all settings. Within independent healthcare settings, completion of mandatory training has also remained high throughout the pandemic, with e-learning replacing the traditional face-to-face and classroom based training. In addition, we found that mandatory training compliance was being closely monitored, along with training for COVID-19 arrangements.

Independent hospitals in Wales do not provide emergency care and the pathway is based on outpatient services and scheduled care. As a result, healthcare providers are more able to plan staffing levels in advance of hospital appointments or admissions. Consequently we found that overall staffing levels have remained stable throughout the pandemic. Hospital managers told us how they held early conversations with staff to support them to feel confident in the workplace; these included discussions with staff who may need to shield or self-isolate.

[7] Schwartz rounds provide a structured forum for clinical and non-clinical staff to come together to talk about the emotional and social challenges and rewards of working in healthcare. Schwartz rounds are not intended to be problem solving forums or to focus discussions on the clinical aspects of patient care, they are intended to provide time and space for reflection with colleagues so that staff feel more supported in their work.

Keeping staff up to date with changing guidance and operating procedures has been a key challenge for all healthcare providers during the pandemic. Hospital managers have recognised this and described the arrangements they had put in place to keep staff updated on the rapidly changing guidance and advice for COVID-19. They highlighted to us that more frequent communication was essential, and this had been addressed through virtual team meetings and video calls to maintain regular engagement with staff. It was positive to find that such communication has also been extended to all staff working on the site, including those from the NHS.

Independent Clinics and Medical Agencies

Our Quality Checks of independent clinics and medical agencies showed that these types of services have been proactive in their response to the pandemic, adapting quickly to provide safe and effective care to patients. In some instances, this included the introduction of remote appointments to enable patients to have virtual consultations, and discussions regarding potential treatments. It was positive to find that these arrangements included secure processes to verify patient identification prior to consultations and before prescribing medication.

A range of environmental changes have been made to allow for safe social distancing, to help mitigate cross-infection when staff and patients attend the clinic. This includes reducing the number of patients who are allowed into the clinic at a time, and creating more space between appointments. We found a good example of innovation where adaptations had been made to allow clinicians to ensure weight measurements can be taken safely, via the purchase of Bluetooth weighing scales. This allowed the registered manager to record the weight via an app while maintaining social distance from the patients.

Infection Prevention and Control (IPC)

In line with Public Health guidelines, enhanced arrangements have been introduced in independent clinics, aimed at reducing COVID-19 transmission. This has included arrangements to ensure staff can access appropriate Personal Protective Equipment (PPE) and training has been provided on its correct use. IPC policies were updated to reflect COVID-19, and additional training has been provided for staff on IPC.

Staff training and knowledge on IPC policies and procedures and correct use of PPE are both vital to ensure staff are able to follow the relevant IPC processes to ensure patients and staff are kept safe.

It was positive to find that in one setting a new COVID-19 patient survey had been developed, with results showing that all patients who completed the survey were positive about feeling safe and confident following their visit to the setting. Other settings should consider seeking feedback from patients about their care during these challenging times.

Governance

The consideration of staff well-being during the pandemic is essential. In some independent clinics there are very small staff teams, and ongoing informal arrangements were in place to discuss the risks of working during the COVID-19 pandemic, and to maintain staff well-being. However, staff will naturally be feeling increased levels of anxiety and possibly stress, therefore we encourage employers to ensure supportive interventions are in place to help maintain the well-being and mental health of staff.

Compliance with mandatory training is generally good. However, as might be expected, access to face-to-face training during the pandemic has been challenging. We therefore encourage employers to explore online options for training and e-learning. Failure to ensure staff training is up to date may potentially result in unsafe practice and increased risk to patient safety, therefore, all employers should strive to ensure their workforce receives timely training appropriate to their roles.

Positive steps had been taken to identify staff who are classed as high risk for COVID-19, and systems put in place to accommodate this. This includes examples where laptops and secure software packages have been purchased for staff who are high risk, or are shielding to allow them to securely work from home. This is vital to safeguard the health and well-being of staff during the COVID-19 pandemic.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

We have not conducted any inspections or Quality Checks of registered laser or IPL services this year. This is principally due to them needing to be closed for significant periods of the year and very little certainty over how long they might remain open when permitted to provide treatment. We also recognised that this was an uncertain and stressful time for these services and their lack of activity reduced the need for inspection activity and the added burden of our assurance work at this time.

Instead, throughout the year, we have continued to ensure that up to date advice and guidance was available on how to operate safely once they were permitted to open. We worked with Welsh Government to ensure that the guidance and risk assessments being issued were suitable and applicable to these types of establishments.

We would take this opportunity to remind registered laser/IPL providers to set time aside to focus on regulatory compliance. Below are some suggestions for immediate attention:

- Ensure that your devices have been serviced and calibrated
- Check that your Laser Protection Adviser arrangements are in place
- Undertake a review of policies, procedures, risk assessments, statement of purpose and patients' guide
- Check your COVID-19 precautions are in line with latest guidance.

Offender Healthcare

During the year, considerable pressures were experienced within the prisons systems due to COVID-19. Overall, we concluded that the healthcare and treatment received within the prisons environment has been equitable to that which could have been provided in the community. Compared to last year, we were commissioned to undertake one less death in custody review.

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

Our clinical reviews of all deaths in custody in Wales critically scrutinise and evaluate the systems, processes and quality of healthcare services provided to prisoners during their time in prison or Approved Premises.

Death in custody reviews

HIW were commissioned to undertake sixteen death in custody reviews (DIC) last year. These reviews were conducted at five out of the six prisons located in Wales. No reviews were undertaken in relation to HMP Prescoed.

The following table identifies the number of reviews conducted in each prison:

HMP	Quantity
HMP Parc	5
HMP Cardiff	4
HMP Berwyn	4
HMP Swansea	2
HMP Usk	1

Overall, across our DIC clinical reviews, areas of good practice were identified. Generally, our reviews demonstrated evidence of well-organised and motivated healthcare teams working with prisoners across Wales that showed a caring attitude and desire to do the best for their patients. We found clear processes were in place to ensure each prisoner received an effective screening and assessment at the start of their time in prison. This process also enabled early identification of risk and need for specialist input to be identified and sought.

In relation to emergency situations, there was evidence that systems and protocols were in place to provide first aid to critically ill patients and promote patient well-being.

Again this year we identified, across our reviews, that overall, referrals to appropriate agencies within the prison service were undertaken in an appropriate manner. This included referrals to optician, dentists, physiotherapists and health professionals.

Areas requiring improvements were also noted in our reviews. Documentation was one such area.

Offender Healthcare

Ensuring complete, comprehensive and detailed documentation is an essential component of ensuring patients care needs are identified and addressed accordingly.

We identified a need for staff to receive training in relation to record keeping in order to enable a consistent and detailed account of a prisoner's health needs and treatment.

Performing comprehensive clinical observations was also identified as an area requiring improvement. The undertaking and documenting of a prisoners, pulse, blood pressure, respiratory rate and temperature are key fundamental observations that need to be carried out when a prisoner becomes unwell. These observations provide a benchmark which can assist practitioners to identify whether a prisoners health is deteriorating.

Finally, we identified that improved support for staff following extremely stressful situations such as a patient cardiac arrest were required. Providing support services and opportunities for staff debrief sessions following these types of experiences are important for the general well-being and mental health of staff.

Prison inspection 2020-2021

Inspections of Her Majesty's Prisons (HMP) in Wales are undertaken by Her Majesty's Inspectorate of Prisons (HMIP). Links to their inspections can be found here.

We are invited to attend the HMIP inspections of Welsh prisons under the auspices of a Memorandum of Understanding in place between HMIP and HIW. These processes allow us to share our evaluations from clinical reviews of deaths in custody and also to consider the quality of prison healthcare provisions.

During 2020-2021, we attended one HMIP inspection at HMP Swansea. In addition we assisted HMI Probation remotely on their substance misuse thematic review. Six locations were chosen across the United Kingdom, with Swansea being the service in Wales reviewed. The report is presently being compiled and will be published on their website in due course.

Offender Healthcare

The inspection of HMP Swansea found the following good practice:-

- At the time of inspection most routine health services had ceased temporarily in response to the pandemic. It was identified that essential services were maintained by effective triage followed by face-to-face appointments with the nurse or GP on the wings or in the healthcare unit
- There were effective partnership working practices in place with the local healthcare provider, Public Health Wales, and the Welsh Government to ensure that every COVID-19 symptomatic prisoner was tested
- It was identified that the crisis team, made up of mental health practitioners, had provided valuable additional resource to identify risk and need of prisoners on arrival, and provided some immediate support during a period when existing conditions could be exacerbated by the extended time locked in cells
- Quarantine arrangements (referred to as cohorting) were in place for:
  - Symptomatic prisoners,
  - Those vulnerable to the virus, and
  - Prisoners in their first fourteen days.
- It was noted that arrangements for those vulnerable to the virus were appropriate.

However, the inspection also identified some areas for improvement in the following areas:

- Governance of mental health services required improvement. It was identified that the primary and crisis mental health services lacked structured monitoring and oversight of their effectiveness and outcomes for prisoners. This led to HIW escalating concerns regarding prison healthcare governance to Swansea Bay University Health Board
- Segregation of new prisoners required improvement. The effectiveness of quarantine for new prisoners was undermined by the practice of allowing prisoners arriving on different days to mix with each other
- It was identified in the inspection that overall medicines administration practices were poor and posed unnecessary risks.

08.

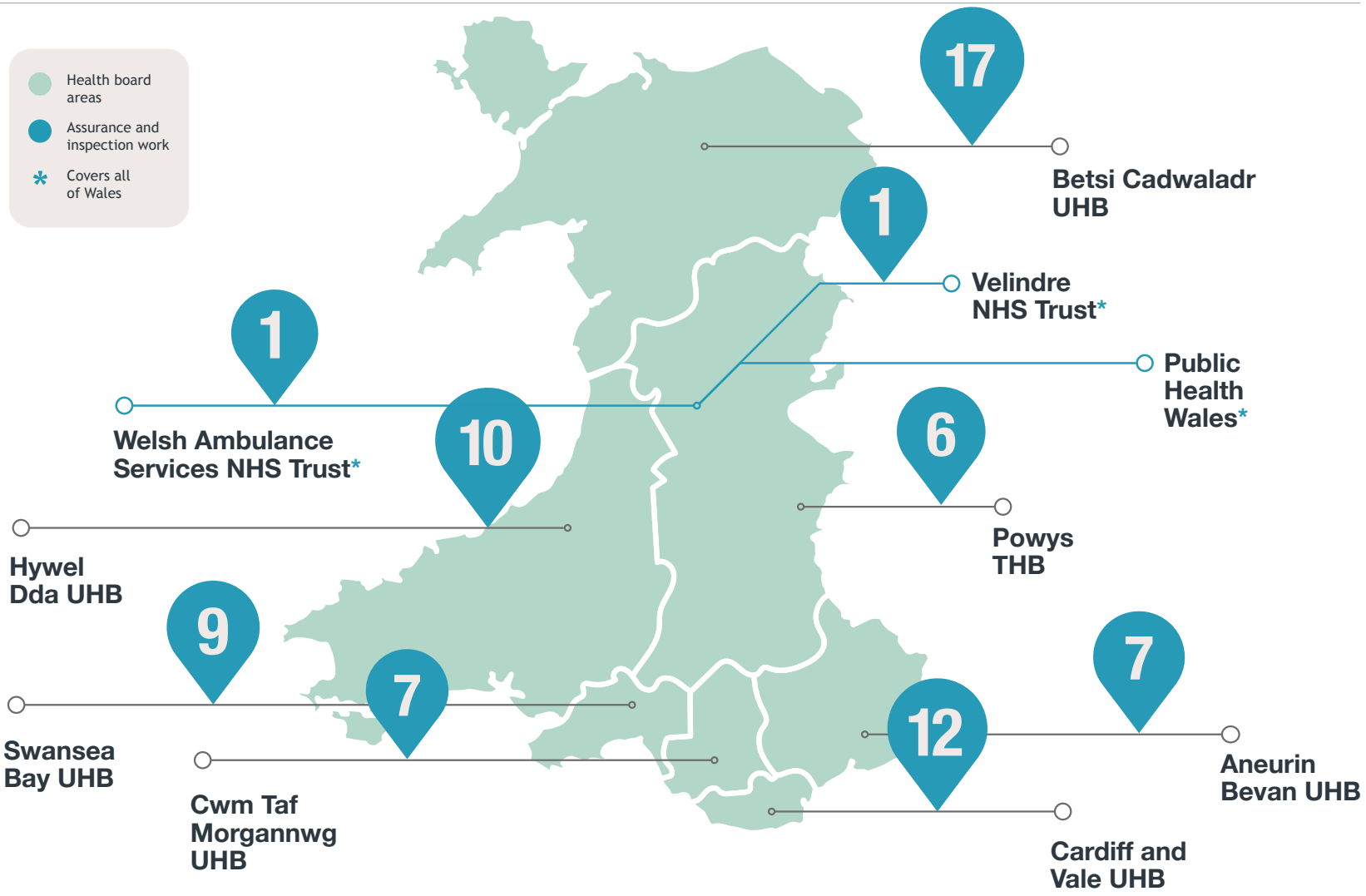
NHS Health Boards and NHS Trusts

The next section provides an overview summary of the work we did within health boards and trusts across Wales during the period from the beginning of April 2020 to end of March 2021. The summaries should be read in the context of the impact COVID-19 had on our work programme and our approach to work during this time. Our adapted approach to inspection is covered in detail in our Assurance and Inspection Section of this report. The summaries relate to our view of the NHS healthcare services provided by a health board or trust and do not cover any private independent healthcare services within the locality.

NHS Health Board and Trusts

The following key findings arose from our work and should be noted by all Health Boards across Wales.

It is clear that the pandemic has impacted the ability for face-to-face training, but staff training even if this is delivered remotely, remains a key mechanism for ensuring that staff are equipped to deliver safe and effective care. We would like to see improvements on compliance rates during our work in future, particularly as this has been an issue in previous years.



Aneurin Bevan UHB

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board

In 2020 – 2021 we undertook seven pieces of assurance and inspection work in Aneurin Bevan UHB. During the year we did not receive any intelligence in relation to the health board which resulted in us needing to increase the volume or alter the type of assurance work we had planned to carry out. All seven pieces of work undertaken by us were Quality Checks, three of these were of general hospital wards, two of these were of mental health wards, one Quality Check was of a learning disability ward and one of a GP practice.

Aneurin Bevan UHB

Engagement with the senior team at the health board has been very good, and they have welcomed the changes we have made to our assurance approaches during this challenging year. It has also been pleasing to see the majority of the health board's governance and assurance mechanisms have continued during the pandemic.

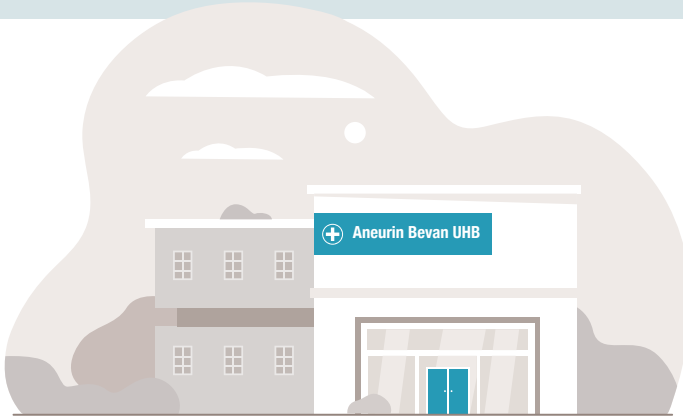
Each piece of work gave rise to specific findings and each was reported on via an individual summary. Overall, there were a number of positive findings but there were also areas for improvement. The following table describes the recurring themes which we identified from this work. The list is not exhaustive of our findings but indicates those areas that we repeatedly found as part of our work:

Positive

- COVID-19 specific guidance and policies had been introduced to support staff in how to safely carry out their work
- There were good supplies of Personal Protective Equipment (PPE) and staff had been trained in how to safely put this on and take it off again (donning and doffing)
- Enhanced infection prevention and control (IPC) arrangements, including increased cleaning had been put in place.

Improvements identified

- Compliance with mandatory training was inconsistent and often low
- We noted some issues with the standard of record keeping
- Need to strengthen aspects of ligature risk assessments, both in terms of identification and management, but also in terms of timely actions.



Betsi Cadwaladr UHB

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

In 2020 – 2021 we undertook seventeen pieces of assurance and inspection work in Betsi Cadwaladr UHB. The work involved a variety of offsite checks and onsite work. During the year we received a number of concerns related to services within the health board which resulted in us needing to increase both the volume of work and alter the type of assurance work we had planned to carry out.

Five of these pieces of work were Quality Checks of various hospital wards across various sites within the health board. Three were follow up checks on previous inspection visits we had carried out. Two were Quality Checks of GP practices. One was a Quality Check of a dental practice. Four were Quality Checks of a variety of mental health wards across the health board.

We undertook two focused inspections, one of Mass Vaccination Centres within the health board and one of ionising radiation services (an IR(ME)R inspection).

Two of the pieces of work within Betsi Cadwaladr were onsite inspections. During 2020-2021, we only conducted onsite work when the risks were high and issues could not be explored remotely.

Betsi Cadwaladr UHB

Through this year our engagement with the health board on any areas of concern has been positive and their responses have been prompt and comprehensive. The health board responded promptly to adapt services and environments during the time of the pandemic.

In November 2020 the health board was de-escalated from special measures to targeted intervention and their improvement work continues to focus on Mental Health, Leadership, Engagement and Strategy, Planning and Performance.

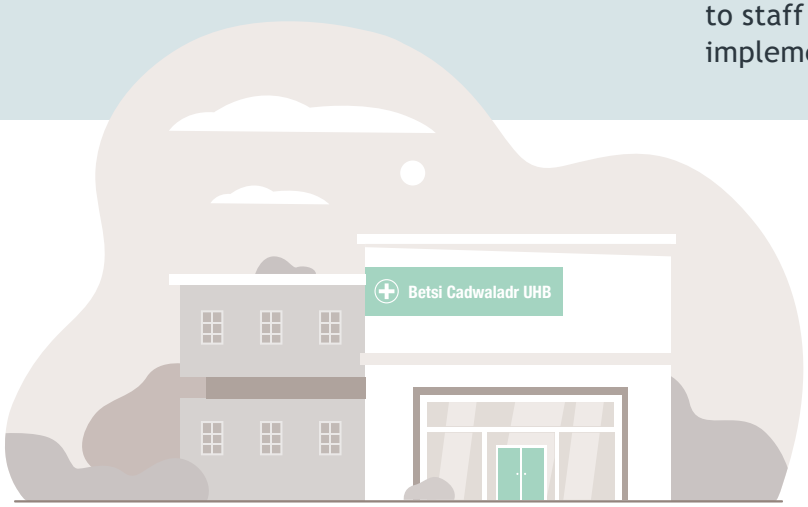
Each piece of work we undertook gave rise to specific findings and each was reported on via an individual summary. Our programme of assurance activity during 2020-2021 has highlighted a number of areas of good practice but also areas of concern which required improvement. The following table describes the recurring themes which we identified from this work. The list is not exhaustive of our findings but indicates those areas that we repeatedly found as part of our work:

Positive

- Enhanced infection prevention and control (IPC) arrangements had been put in place
- Staff worked with dedication and flexibility throughout this challenging period
- Follow up work demonstrated sustained and continued improvement in areas that we had previously identified as an issue.

Improvements identified

- Actions identified from audits and risk assessments had not been documented or followed through
- As a result of reconfiguring services to meet some of the demands arising from the pandemic, it was challenging to ensure patient placements in Mental Health services were appropriate
- Policies needed to be regularly reviewed, updated and communicated to staff to ensure they were implemented effectively.

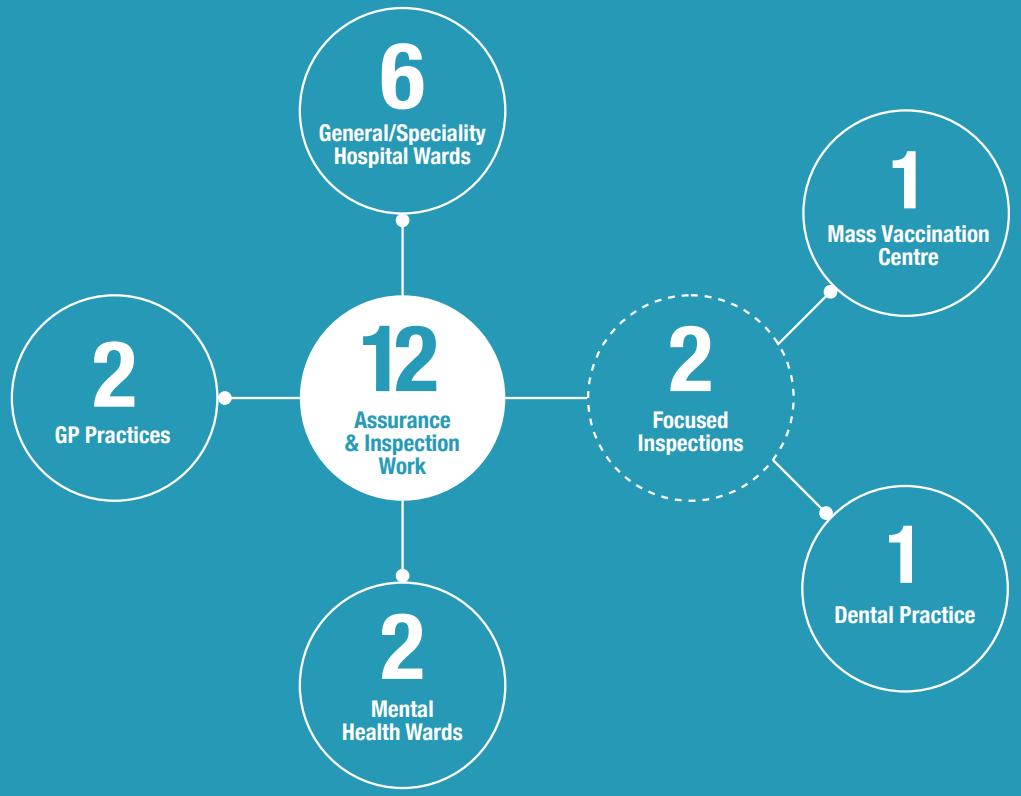


Cardiff and Vale UHB

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cardiff and Vale University Health Board

In 2020-2021 we carried out twelve pieces of assurance and inspection work in Cardiff and Vale UHB. The work involved a variety of offsite checks and onsite work. During the year we received concerns about a dental service within the health board which resulted in us needing to increase both the volume of work and alter the type of assurance work we had planned to carry out.

Six of the pieces of work were Quality Checks of various wards and specialties across the health board. Two were Quality Checks of GP practices and two were Quality Checks of mental health wards within the health board. We conducted one focused inspection which involved visiting two Mass Vaccination Centres and one onsite inspection to a dental practice.



Cardiff and Vale UHB

We maintained frequent communication with the health board throughout the pandemic, and our engagement regarding any issues of concern has been positive, with timely and substantive responses being provided to us when requested. It has also been evident through our engagement that the health board continues to regard external scrutiny as a positive means for learning and for continuous improvement.

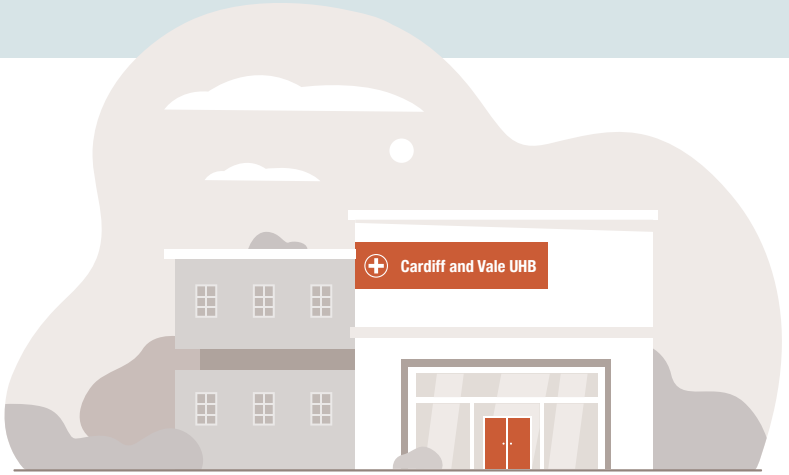
Each piece of work gave rise to specific findings and each has been reported on via an individual summary. Overall, there were a number of positive findings but there were also areas for improvement. The following table describes the recurring themes which we identified from this work. The list is not exhaustive of our findings but indicates those areas that we repeatedly found as part of our work:

Positive

- Up-to-date policies, guidance and communication with staff regarding COVID-19
- Enhanced infection prevention and control (IPC) arrangements including increased cleaning schedules
- Supporting and assisting patients to maintain contact with family and friends through the use of electronic communication.

Improvements identified

- Environmental and IPC risk assessments which would identify areas for improvement were not always carried out in a timely way
- Staff were not all up to date with mandatory training requirements
- Need to strengthen aspects of ligature risk assessments, both in terms of identification and management, but also in terms of timely actions.



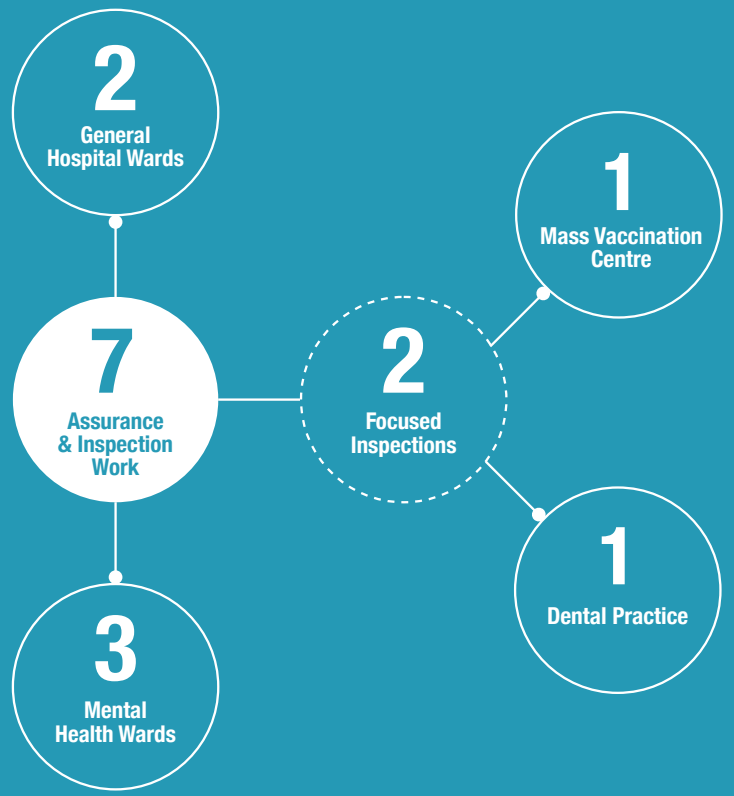
Cwm Taf Morgannwg UHB

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

In 2020-2021 we undertook seven pieces of assurance and inspection work within Cwm Taf Morgannwg UHB. The work involved a variety of offsite checks and onsite work. During the year we received concerns about a dental practice within the health board which resulted in us needing to increase both the volume and type of assurance work we had planned to carry out so that we could appropriately consider the risks raised with us.

Two of the pieces of work we conducted were Quality Checks of general hospital wards, three were Quality Checks of mental health settings across the health board. We undertook one focused inspection of Mass Vaccination Centres delivered by the health board and also conducted one onsite dental inspection.

During the year, alongside Audit Wales, we also undertook a joint follow-up review of our 2019 governance review. This follow-up review recognised that the health board is making good progress to address the recommendations that we made in 2019, particularly when taking account of the challenges it has faced in responding to the pandemic. Whilst the pandemic response has impeded progress on improvements in some areas, meaning some actions haven't progressed as quickly as the health board originally intended, it has been encouraging to note that progress has been made in ensuring a greater focus on quality, patient safety and risk.



Cwm Taf Morgannwg UHB

Our own engagement with the health board on any issues of concern requiring escalation has been positive, with timely and substantive responses being provided to us when requested. Accountability and responsibility for quality and safety is now clearer. Leadership of quality and patient safety has been strengthened, including the introduction of new roles to support quality and patient safety. Arrangements for the identification and management of risk have been strengthened, and positive steps have been taken by the health board to improve organisational culture and learning.

Each piece of work gave rise to specific findings and each has been reported on via an individual summary. Overall, there were a number of positive findings but there were also areas for improvement. The following table describes the recurring themes which we identified from this work. The list is not exhaustive of our findings but indicates those areas that we repeatedly found as part of our work:

Positive

- Processes had been put in place to ensure staff had up to date guidance regarding COVID-19 arrangements
- Increased cleaning schedules with evidence of infection prevention and control (IPC) audits and good support from the IPC team
- Positive efforts to help maintain communication between patients and family / friends using video calls and electronic means.

Improvements identified

- Compliance with mandatory training was low and there was a need to explore alternative options to face-to-face training
- Actions identified from audits needed to be strengthened
- Need to strengthen aspects of ligature risk assessments, both in terms of identification and management, but also in terms of timely actions.

Cwm Taf Morgannwg UHB

Joint Follow-up Review of Quality Governance Arrangements in Cwm Taf Morgannwg University Health Board

In November 2019, HIW and Audit Wales undertook a joint review of quality governance and risk management arrangements within Cwm Taf Morgannwg University Health Board[8]. The joint review found a number of fundamental weaknesses in the health board's governance arrangements in respect of patient safety and the quality of care. Fourteen recommendations were made, relating to risk management, the handling of incidents, claims and concerns, patient safety and organisational culture.

In September 2020, we commenced a joint follow-up review with Audit Wales, of the health board's progress against the fourteen recommendations made during our 2019 review. We were mindful of the impact that the pandemic had on the ability of the health board to respond to the recommendations, however, given the significant issues identified in 2019, we felt it was important to establish what progress had been made.

Our follow-up review found the health board is making good progress to address the recommendations that we made in 2019, particularly when taking account of the challenges it has faced in its response to the pandemic. The pandemic has clearly impeded progress on improvements in some areas, meaning some actions haven't progressed as quickly as the health board originally intended.

Notwithstanding the good progress recognised through our follow-up work, there is still work to do in each of the areas identified in 2019. As such, all fourteen recommendations should remain open, and we will continue to monitor the health board's actions against the issues identified in our follow-up review. The review's findings can be found in our joint report, which was published on 18 May 2021.

[8] https://hiw.org.uk/sites/default/files/2019-11/Cwm-Taf-Morgannwg-UHB-Joint-review-Eng.pdf

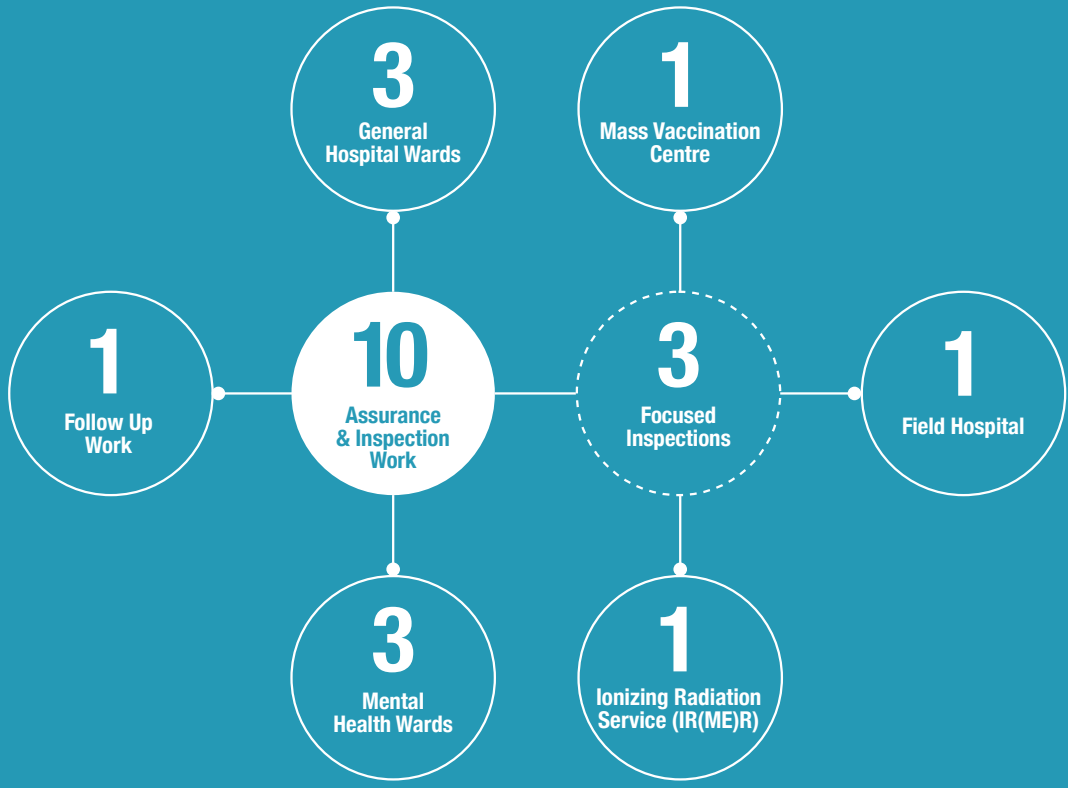
Hywel Dda UHB

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

In 2020-2021 we undertook ten pieces of assurance and inspection work in Hywel Dda UHB. The work involved a variety of offsite checks and onsite work. During the year we did not receive any intelligence in relation to the health board which resulted in us needing to increase the volume or alter the type of assurance work we had planned to carry out.

Three were Quality Checks of general hospital wards across the health board, three were Quality Checks of mental health wards. We undertook one piece of follow up work to check on improvement work following a previous inspection.

We conducted one focused inspection of Mass Vaccination Centres provided by the health board, one focused ionising radiation inspection (IR(ME)R inspection) and one focused inspection of Field Hospitals at the point when they were newly developed.



Hywel Dda UHB

We engaged regularly with the health board throughout the year, and found them to be proactive and positive on all occasions. They were also extremely responsive to all our requests for evidence and positive about continuing with our offsite form of assurance work.

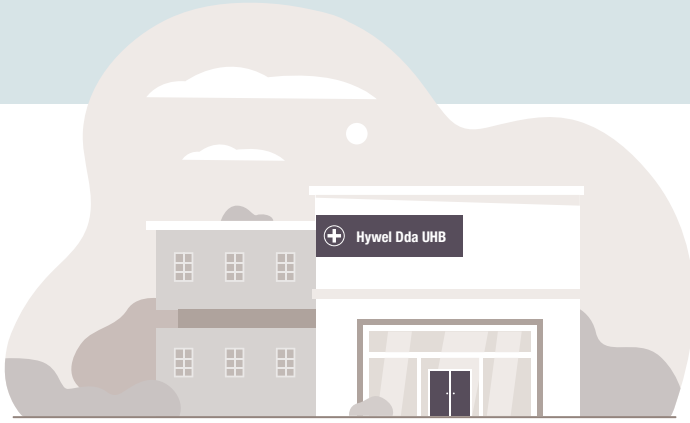
Each piece of work gave rise to specific findings and each has been reported on via an individual summary. Overall, there were a number of positive findings but there were also areas for improvement. The following table describes the recurring themes which we identified from this work. The list is not exhaustive of our findings but indicates those areas that we repeatedly found as part of our work:

Positive

- Enhanced infection prevention and control (IPC) arrangements in place including enhanced cleaning and zoning used to separate confirmed and potential COVID-19 positive patients from others
- Patients were supported to maintain contact through electronic means with families and friends and a new Patient Liaison team was introduced across the health board to specifically support in-patients with this
- Strong commitment from the health board to support well-being of staff during and after the initial waves of the pandemic.

Improvements identified

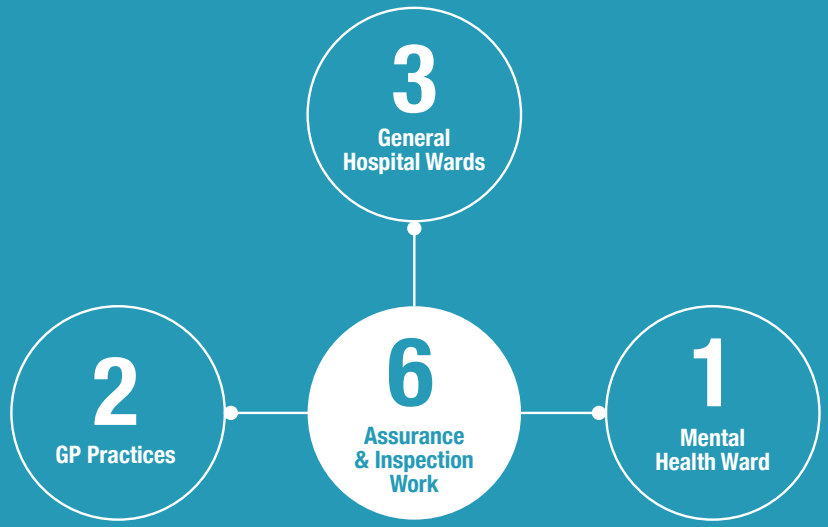
- Rates of compliance with mandatory training were variable and this needed attention to increase training rates
- Need to strengthen aspects of ligature risk assessments, both in terms of identification and management, but also in terms of timely actions
- When risk assessment tools are required, and used, the actions identified should always be undertaken and followed up in a timely manner.



Powys Teaching HB

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

In 2020-2021 we undertook six pieces of assurance and inspection activity across the health board. All of this work involved the use of our offsite assurance tool – a Quality Check. During the year we did not receive any intelligence in relation to the health board which resulted in us needing to increase the volume or alter the type of assurance work we had planned to carry out. Three of the Quality Checks were of different general hospital wards at different community hospitals throughout the health board. We also conducted one Quality Check of a mental health ward and two Quality Checks of GP practices.



Powys Teaching HB

During the most difficult of years, it was pleasing to find an engaging and supportive management team who welcomed HIWs plan to carry out a revised activity of assurance work. Engagement with the senior executive team, ward managers and GP management staff during quality checks was positive and productive.

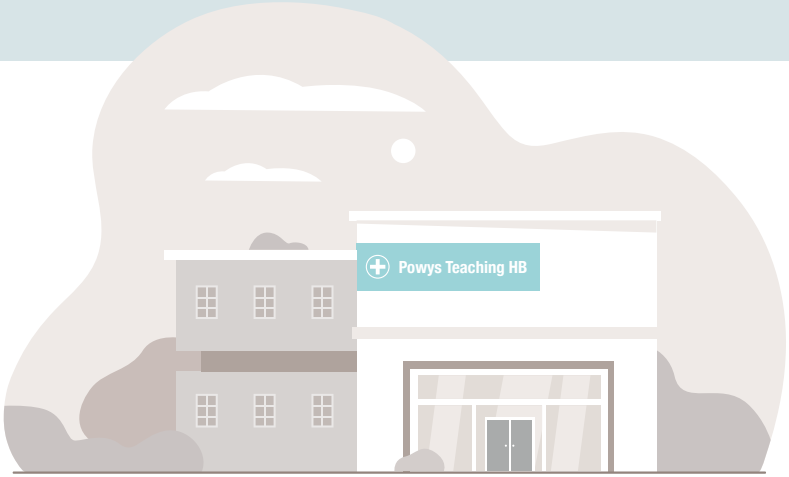
Each piece of work gave rise to specific findings and each has been reported on via an individual summary. Overall, there were a number of positive findings but there were also areas for improvement. The following table describes the recurring themes which we identified from this work. The list is not exhaustive of our findings but indicates those areas that we repeatedly found as part of our work:

Positive

- Various Infection Prevention and Control (IPC) measures in place to uphold standards, including access to guidance and support and physical changes to the environment
- Family involvement in Multi Disciplinary Team meetings through the use of remote technology
- Sufficient personal protective equipment (PPE) and training to use it safely.

Improvements identified

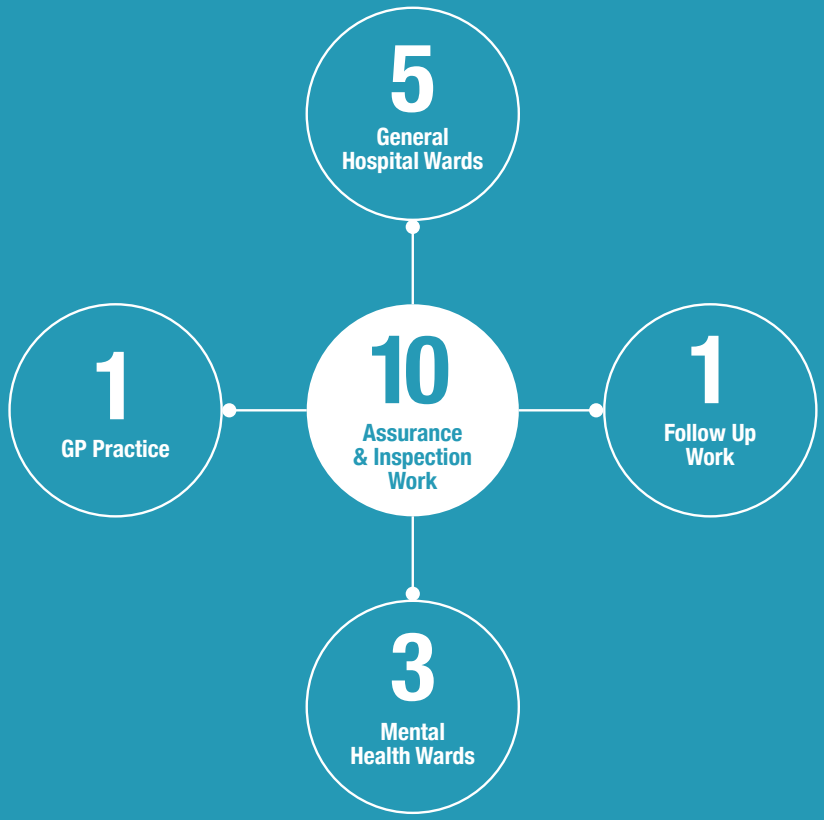
- Ensuring risk assessments were kept up to date and undertaken in a timely manner
- Considering how to meet different cognitive needs in one setting.



Swansea Bay UHB

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

In 2020-2021 we undertook ten pieces of assurance and inspection activity in Swansea Bay UHB. All of this work involved the use of our offsite assurance tool – a Quality Check. During the year we did not receive any intelligence in relation to the health board which resulted in us needing to increase the volume or alter the type of assurance work we had planned to carry out. One of the Quality Checks was of a GP practice, five were of a variety of general hospital wards of various specialties and three were of mental health wards in the health board. We also conducted one piece of follow up work to check on improvement work following a previous inspection.



Swansea Bay UHB

The relationship between HIW and the health board has remained strong throughout the pandemic. There has been strong engagement at all levels and positive engagement with our new approaches to inspection.

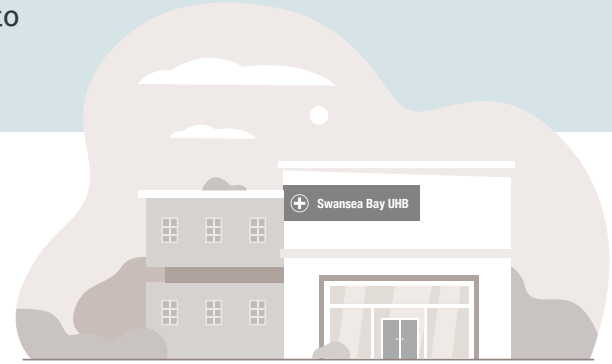
Each piece of work gave rise to specific findings and each has been reported on via an individual summary. Overall, there were a number of positive findings but there were also areas for improvement. The following table describes the recurring themes which we identified from this work. The list is not exhaustive of our findings but indicates those areas that we repeatedly found as part of our work:

Positive

- Enhanced infection prevention and control (IPC) arrangements had been put in place to minimize the risk of COVID-19 transmission. This included a weekly visit to some areas by a specialist IPC nurse who checked to ensure that policies and procedures were being followed appropriately
- There was evidence of daily checks on emergency and resuscitation equipment which helped to ensure this kit was ready for use at all times
- Staff had been flexible in where they worked and in taking on additional tasks (with training) to enable patients with different needs to be cared for appropriately.

Improvements identified

- Ensure that actions identified through audits of nursing care tools are followed up and acted on in a timely manner
- Need to strengthen aspects of ligature risk assessments, both in terms of identification and management, but also in terms of timely actions
- Ensure appropriate medicine storage arrangements are in place so that medicines which need specific temperature control are kept in accordance with manufacturing requirements.



Velindre University NHS Trust

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre offers specialist cancer treatment and hosts the Welsh Blood Service.

Velindre was found to have sufficient arrangements in place to promote the safety and well-being of patients when HIW undertook a Quality Check of the Cancer Centre (Floor 1 Ward) in March 2021 where no areas for improvement were identified. The trust also reported only a small number of serious incidences and no public concerns about the services provided were reported to HIW.

The trust's governance arrangements provided assurance that operation during the COVID-19 pandemic met the needs of the population within the constraints on the service and remained accountable to decisions taken by the trust.

There was also a reduction in referrals in to the service during the pandemic; the trust expects a surge in demand during 2021 which may include the later identification and more cancer cases at a later stage of progression. This could potentially put additional pressure on the service.

The environment of the cancer centre remains a risk to Velindre. Planning and approval of a new cancer centre in Cardiff is underway, however there is some strong opposition to location of the trust's proposed development.

Welsh Ambulance Service NHS Trust

As was the case for the rest of the NHS, this has been a challenging year for WAST. The COVID-19 pandemic has led to a very different year to previous years. Initially, demand for ambulance services dropped considerably, with very few people requiring emergency ambulances. However, during the summer of 2020 and into the winter, the demand increased.

The winter was a substantial challenge for WAST. Demand was very high across Wales, and the reduced capacity in Emergency Departments (due to social distancing) led to delays in handing patients over to hospitals. When patients cannot be handed over to hospitals, the vehicle cannot respond to community calls, leading to delays in responding to 999 calls.

In December 2020, WAST declared a critical incident due to the high demand on the service, especially in the south east. The public was asked to only call for an ambulance in the most serious circumstances. WAST worked hard to resolve this issue, and this led to the deployment of additional resources from the Military and Fire Services.

Pressures on WAST services have continued during the year, the issues of handover delays and community waits have been ongoing for several years and still persist. Further action from WAST and health boards will be needed to improve the situation.

Local Review Welsh Ambulance Service NHS Trust

During 2019-2020, we completed a local review of the Welsh Ambulance Service Trust and focussed on how calls were handled and prioritised at their Clinical Contact Centre (CCC). Our findings from this review were published in a report called Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centre, on 30 September 2020[10].

The review highlighted that processes were in place which aim to provide safe and effective care to patients. Handover delay was a regular occurrence for the trust and was having a significant effect on the service. This was affecting the ability of the trust to adequately respond to service demands, due to limited availability of ambulance resource. We found that the negative impact of the delays experienced with ambulance to hospital patient handovers, was consistently raised by staff throughout our fieldwork.

In response to the issues outlined above. We are undertaking a local review of WAST to consider the impact of ambulance waits outside of Emergency Departments on patient safety, privacy, dignity and overall experience.

[10] https://hiw.org.uk/sites/default/files/2020-09/20200923%20-%20WAST%20Review%20-%20FINAL%20ENGLISH.pdf

The COVID-19 pandemic has introduced unique and unprecedented pressures on the healthcare system; in view of this, the review will consider patient experiences over the past twelve months, to enable us to understand what impact COVID-19 has had. We plan to publish the review report in autumn 2021.

Public Health Wales

Although we did not undertake any direct review or inspection work in Public Health Wales (PHW) during 2020-2021, it is important to highlight the vital role that PHW had in the response to COVID-19 in Wales. This included providing expert public health advice on COVID-19, publishing daily surveillance data and supporting key elements of the Welsh Government's Test Trace Protect strategy such as coordinating contact tracing and laboratory analysis of test results.

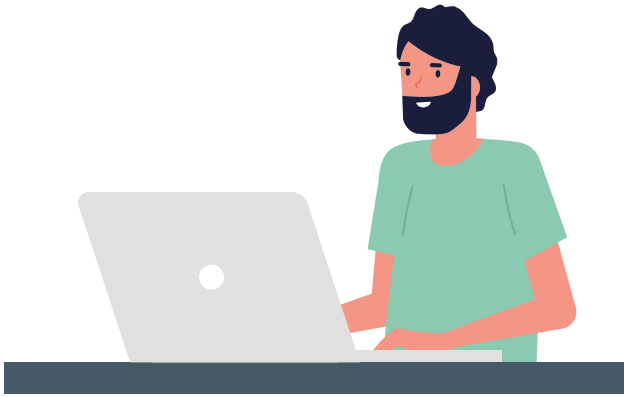
PHW also had a key role in relation to the national COVID-19 vaccination programme, which included supporting vaccine research, strategic oversight of vaccine trials in Wales and leading the planning for the delivery of the vaccination programme.

The response to COVID-19 resulted in a significant change to normal business in PHW, which included pausing some public health services and functions, such as temporarily pausing some national screening programmes.

It was positive to find that arrangements were in place to re-introduce the screening programmes by prioritising those participants classed as high risk, and that adaptions for COVID-19 had been made across the screening pathways to ensure services were safe. However, PHW recognise there is a significant challenge ahead to account for all participants who will have had their screening delayed during the pandemic.

To enhance the testing capacity in Wales, PHW was successful in securing funding from Welsh Government to significantly grow its microbiology function during 2020-2021. This included a significant number of new roles, a new laboratory and the development of hot labs across hospitals to deliver rapid COVID-19 testing on site.

The contribution of staff in PHW to the national effort in tackling COVID-19 must be commended. This includes microbiology staff who provided a 24/7 service to deliver test results, and staff from across all parts of the organisation who were released from their normal duties, and mobilised into new roles and functions to support the COVID-19 response.



09.

Our Resources

Our Resources

Our people

The table shows the number of full or part time posts in each team within HIW during 2020-2021.

Team	Whole time posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence, and Methodology	14
Strategy, Policy and Communication	5
Clinical advice (including SOAD service)	4
Corporate Services (including business support)	18
Total	**83**

For 2020-2021 we had a budget of approximately £4.3m. As part of our commitment to support the broader response to the pandemic in Wales we made members of staff available to the NHS, Welsh Government and broader public services. We also contributed financial resources where possible. Although the pandemic impacted our ability to deliver core activity within the NHS, we continued to respond to emerging in-year intelligence which gave us immediate cause for concern. We directed a significant portion of our resources to the development of new methods for gaining assurance offsite, aligned to the key areas set out in the NHS Wales Planning Framework, to give us flexibility and agility in delivering our role during an unprecedented time. We will continue to strengthen that approach in 2021-2022. In addition to this, we strengthened other key areas of our organisation with additional resource, namely our Concerns function.

We have posts equivalent to approximately eighty three full-time equivalent staff.

We currently have a panel of over 150 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have over thirty Patient Experience Reviewers and Experts by Experience. We have developed a new Framework for Clinical Advice, which has been used to determine what clinical support we need to strengthen our inspection and assurance methods in 2021-2022.

Finances

The table shows how we used the financial resources available to us in the last financial year to deliver our 2020-2021 Operational Plan.

	£000's
HIW Total Budget	4,376

Expenditure	
Staff costs	3,831
Travel and Subsistence	6
Learning & Development	2
Non staff costs	42
Translation	65
Reviewer costs	295
ICT Change Program costs	217
COVID-19 contributions	335
Total expenditure (a)	4,793
Income	
Independent healthcare	278
Private dental registrations	160
Legal fees	-
Total income (b)	438
Total Net Expenditure (a-b)	4,355

10.

Commitment Matrix

Commitment Matrix

The following table is a list of the objectives HIW set for itself for 2020-2021, together with details of how HIW met the objective.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 1		
Process applications to register, or changes to registration, in a timely manner Ensure all applicants can demonstrate they meet relevant regulation and minimum standards.	Registration applications determined within 12 weeks of full and complete submission	The following registration work was completed during 2020-2021 according to our target timescale: <u>Independent Healthcare Services</u> • 22 New Registrations • 26 Changes of Registered Managers • 21 Changes of Responsible Individuals • 9 Variations of HIW Registration Conditions <u>Private Dental Practices</u> • 28 New Registrations • 44 Changes of Registered Managers • 3 Changes of Responsible Individuals • 1 Variations of HIW Registration Conditions

Deliverable 2

Conduct a programme of visits to suspected unregistered providers • As required Deliver a programme of Quality Checks on independent settings in line with our frequency rules. • Approximately 20 Quality Checks of services, including acute hospitals, hospices and clinics • Approximately 39 laser Quality Checks Deliver full inspections in the highest risk areas, where we believe there is serious risk to patient safety.	• Number of visits undertaken • Number of Quality Checks undertaken • Provide rapid feedback from quality checks, publishing as near to a month after the work as possible • Number of full inspections undertaken • Number of reports published 3 months following quality check	We continued to respond to reports of unregistered providers during the pandemic. We carried out 17 Quality Checks of independent services. We carried out 1 onsite inspection of an independent service. We did not carry out any laser Quality Checks due to the closure of these establishments during the COVID-19 pandemic. 60 reports within four weeks of the quality check taking place. We published 27 reports 3 months following a focused inspection.

Deliverable 3

Ensure that concerns and Regulation 30/31 notifications are dealt with in a timely and professional manner	• Number of concerns received	During 2020-2021 we received 434 concerns from the public or staff. We also received 9 concerns in relation to unregistered providers or settings that do not require registration with HIW.

	• Number of Reg 30/31 notifications received • Analysis of source and action taken	All concerns are reviewed weekly and inform decisions about our inspection activities and priorities. Independent healthcare providers are required to inform us of significant events and developments in their service. These Regulation 30/31 notifications continue to be managed in line with our process and dealt with effectively. In total we received 1,094 Regulation 30/31 notifications received. They are as follows: • Death in Hospice – 498 • Death excluding Hospice -11 • Unauthorised absence – 99 • Serious injuries – 280 • Allegation of staff misconduct - 89 • Outbreak of Infectious Disease – 97 • Deprivation of Liberty Safeguards (DoLS) – 20 In total we received 44 Regulation 25 (The Private Dentistry (Wales) Regulations 2017) notifications during 2020-2021 They are as follows: • Serious injuries – 1 • Outbreak of an Infectious Disease - 43 • Allegation of staff misconduct – 0 • Death of a patient – 0 We took necessary action on all relevant notifications by communicating effectively with Independent Healthcare Providers.

Inspecting the NHS

Deliverable 4

Deliver a programme of approximately 130 quality assurance checks in the NHS across all settings (excluding mental health) informed by analysis of risk and how our resources are best deployed. Deliver full inspections in the highest risk areas, where we believe there is serious risk to patient safety.	• Number of Quality Checks undertaken • Provide rapid feedback from quality checks, publishing as near to a month after the work as possible • Number of full inspections undertaken • Number of reports published 3 months a following quality check	We carried out the following Quality Checks and inspections: • 1 field hospital focussed inspection • 1 field hospital Quality Check • 5 hospital follow ups • 26 NHS Hospital Quality Checks • 8 GP Quality Checks • 5 IR(ME)R focussed inspections • 4 focussed inspections of Mass Vaccination Centers We published 94 Quality Checks during 2020-2021. 60 of these were published within four weeks. We published 29 onsite inspection reports during 2020-2021. 27 of these were published within 3 months following the inspection.

Deliverable 5

Continue our programme of national reviews including:

- Maternity services

Commence work on:

- COVID-19: Themes and learning from our work
- Mental health crisis prevention care

Undertake follow-up work on previously published local or national reviews, including:

- Requesting updated improvement plans, and assessing these to understand progress made against the recommendations
- Analysis, production and publication of the review
- Publication of terms of reference for these reviews
- Commence programme of follow up work

During the year we published:

- National Review of Maternity Services
- Local Review of Breast Screening Services within Public Health Wales
- Local Review of the Patient Management Arrangements within the Welsh Ambulance Service Trust

We started work on our National Review of Mental Health Crisis Prevention, which will be published winter 2021.

We completed stage one of our follow up process for the review reports we published earlier in the year. We have approved the responses received from the organisations involved in our National Review of Maternity Services, and for the two local reviews undertaken in WAST and PHW. We will undertake stage two of the reviews follow-up process of each in 2022.

Deliverable 6		
Conduct a high level review of each NHS body through • Further development of the Relationship Management function • Producing an annual statement for each health board and NHS Trust	Publication of health board and NHS trust annual statements.	2020-2021 annual findings were presented at board meetings and board development days for health board sand NHS Trusts by Relationship Managers. In arriving at the annual report health board summaries Relationship Managers considered: • findings from our 2020-2021 quality check, inspection and review programme • intelligence gathered through attendance at a number of key virtual health board meetings such Quality & Safety meetings and one to one meetings with key health board personnel • concerns received through our concerns process • virtual meetings with external partner organisations such as the Audit Wales and Community Heath Councils We have strengthened our relationship management function through the introduction of deputy relationship mangers and executive leads to provide further support and resilience.

Our work in mental health

Deliverable 7

Undertake a programme of Quality Checks for NHS and independent mental health and learning disability settings including approximately: • 20 wards within NHS mental health and learning disability services • All 20 registered independent mental health and learning disability hospitals • Continue to undertake full inspections where concerns or intelligence suggest there is a serious risk to patient safety	Number of inspections undertaken	We carried out 8 onsite inspections and 35 Quality Checks mental health hospitals: • 1 onsite NHS Mental Health hospital inspection • 19 NHS Mental Health hospital Quality Checks • 7 onsite independent Mental Health hospital inspection • 16 independent Mental Health hospital Quality Checks

Deliverable 8

Provide a Second Opinion Appointed Doctor service for approximately • 1000 SOAD requests	Publication of Key Performance Indicators.	We received 956 requests for a SOAD.

Sharing what we find

Deliverable 9

Publish reports from all our assurance activity in accordance with our performance standards	Publication of reports according to our Publication Schedule Publication of HIW performance against targets	We created a new COVID-19 section of the website where all healthcare providers and members of the public could easily and quickly find our statements, guidance and FAQs. COVID-19 | Healthcare Inspectorate Wales (hiw.org.uk) We created new subscriber lists for all registered independent healthcare settings, where we regularly issued covid related newsletters We issued 3 quality insight bulletin to NHS and independent healthcare settings - Quality Insight bulletin - COVID-19 | Healthcare Inspectorate Wales (hiw.org.uk) We continue to share our inspection reports, statements, and news with our 6,204 subscribers every month via newsletter. We published 94 Quality Checks during 2020-2021. 60 of these were published within four weeks. We published 29 onsite inspection reports during 2020-2021. 27 of these were published within 3 months following the inspection.

Deliverable 10

To actively share our findings and recommendations with stakeholders, service providers and the public to influence and drive improvements in healthcare. In particular in relation to: • Hospital Inspections • GP Practices • Dental Practices • Mental Health Act Annual Monitoring Report • Deprivation of Liberty Safeguards (DoLS) • IR(ME)R • Lasers • HIW Annual Report	Publication and dissemination of our findings in a number of ways including: • Learning bulletins distributed • Case studies of good practice distributed • Improved website content	We held regular workshops with Community Health Councils and quarterly summits with NHS and independent healthcare sector. We created a new newsletter for all registered independent healthcare settings. Via this newsletter we kept them up to date on all Covid related issues, including guidance and approach. We issued 3 quality insight newsletters to NHS and independent healthcare settings We have supported improvements to our website in 2020-2021 including: New COVID-19 section of the website where all providers and members of the public could easily and quickly find our statements, guidance and FAQs.

Working with others

Deliverable 11

Continue our joint inspection work with UK agencies • Approximately 16 death in custody reviews with the Prison and Probation Ombudsman • Up to 3 joint reviews with HMI Prisons and HMI Probation	Publication of reports according to our Publication Schedule Publication of HIW performance against targets	• We carried out 16 death in custody investigations • We undertook 1 prison inspection with HMI Prisons and HMI Probation • We supported HMI Probation with their Substance Misuse Review in prisons across the UK, the focus in Wales was on HMP Swansea

Deliverable 12

Our three planned reviews with other Inspection Wales members are: • Disabled Children's Review with Complex Needs (With CIW) • Review of health board and Trust Quality Governance arrangements (Governance reviews with Audit Wales) • CIW providing support to our Mental Health Crisis review	Consolidation of key findings and emerging themes with CIW and Audit Wales.	• We supported CIW with the Disabled Children's Review, report to be published late autumn 2021 • We undertook a joint follow up review with Audit Wales looking at the Governance arrangements in Cwm Taf Morgannwg. The report was published in May 2021 • CIW had involvement in design of work through our stakeholder group for our Mental Health Crisis review

11.

'Making a Difference' 2018-2021 Strategy

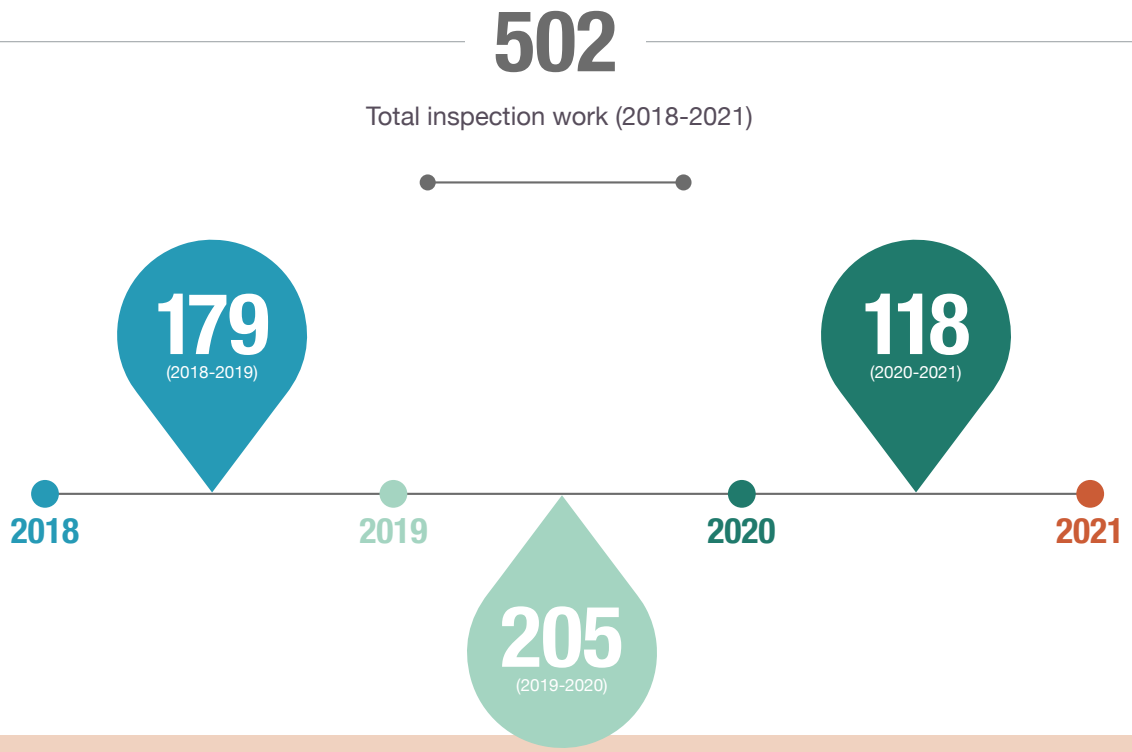
A reflection of our progress

A reflection of our progress

March 2021 marked the end of Healthcare Inspectorates Wales' (HIW) three year strategy, 'Making a Difference'. This strategy was designed to continue the organisations journey as an inspectorate which makes a positive difference to the people of Wales by encouraging improvements in healthcare. HIW is a small but ambitious organisation, with an equally ambitious goal. In order to achieve this, our priorities over this last three year period have been:

1. To maximise the impact of our work to support improvement in healthcare
2. To take action when standards are not met
3. To be more visible
4. To develop our people and organisation to do the best possible job.

We have undertaken a significant amount of work within healthcare services over this period which is illustrated by the following:



We have made much progress as an organisation in delivering against our four priorities, and the following chapters summarise our organisational view as to the extent of the advancements we have made. We ran two internal surveys asking our own staff for their view of our development and progress as an organisation. However, to properly evaluate our progress it was important to us that we gather views from the public, and from those that we work for and with. We ran a series of online surveys in June 2021, reaching out directly to over 700 stakeholders, asking them to provide their views of us, and we ran an online survey for the general public. In total, we received 150 fully completed responses from this work. We were grateful that stakeholders, our staff and members of the public took the time to provide their views as these have helped to further the understanding we have of our strengths and areas where we could improve.

Survey Evaluation

We evaluated the survey responses and below is a summary of what respondents told us. The analysis is separated into each of our priority areas.

Priority 1:

To maximise the impact of our work to support improvement in healthcare

81% of stakeholders who responded to our survey told us that we had made good progress in maximising the impact of our work. One comment described our work in Wales during the pandemic as "leading the way" and also we were told that our announced work can have more benefit to healthcare services than unannounced work. We do a mixture of announced and unannounced work, and it will be important to us going forwards, that we compare the pros and cons of the two approaches and ensure that we select the approach which has potential for the most improvement in the circumstances.

In our general public survey, 74% of respondents told us that they knew they could use HIW to find out about the quality of a local care service. This is a positive result and is a baseline we are likely to want to improve on in future. The public told us that information on a service is 'useful and reassuring'.

100% of the peer reviewers who responded to our survey told us that they felt we had chosen to do the right work in the right places. These are registered healthcare professionals who are close to services and the way they operate, and it is very encouraging that those who understand services as well as they do consider we are targeting our work appropriately.

Priority 2:

To take action when standards are not met

69% of stakeholder respondents thought we had made good progress against this objective, however 31% thought this was an area in which we have not as much progress towards our goal as in other areas. We were provided with some constructive comments which will help us to consider this area going forwards. Some comments suggested the need for us to do more follow up work. This is an area we have already acknowledged and are in the process of introducing a new system which will help us monitor and address services which are repeatedly failing, or who we identify have significant (but not necessarily repeated) failings.

Our peer reviewers who work closely with us were highly positive in feeding back on this priority, 100% of respondents said that the work they had done with HIW in inspection and assurance had helped to identify areas for improvement in healthcare. It was also positive to note much interest from members of the public who would told us that they would like to hear from us about their local services, and whether or not they are providing good quality care.

Priority 3:

To be more visible

68% of our stakeholder respondents told us that as an organisation we have been visible to the public, healthcare professionals and professional bodies. For the 32% who said we needed to improve on our visibility, this was accompanied by comments about areas we could improve and increase our visibility such as in primary care and by campaigns which share a more general view of what HIW is and the role we have. It is so valuable to the organisation that we are now able to consider our future strategy with this insight to guide us and to challenge us on the way we have done our work up to now.

We were keen to hear whether the general public knew they could raise concerns about healthcare services with us in HIW and we specifically asked this question in our survey. 65% of respondents knew they could raise concerns with us and of these, 56% also knew how to contact us and share views. We showed people, through this survey, how to navigate to our concerns page and what they would need to fill in, and once we had done this we had a very positive response, with 87% of people saying that it would be easy to use this method should they need to. However, clearly this is an area that we need to do more work on. We want to increase the awareness amongst the general public of contacting us to raise concerns and then make it easy for them to understand how they can do this. Our understanding of the public's views and experiences of healthcare services are an important means through which we build an overall picture of how well healthcare services are being delivered.

Priority 4:

To develop our people and organisation to do the best possible job

It has been our intention over the last three years, to develop our organisation so that we become more effective in delivering our role. We have asked this question of ourselves internally but also wanted to understand whether our progress has been visible externally too. We are pleased to be able to report that 68% of our stakeholder respondents said that we had developed and improved, citing a 'strengthening' relationship with us in our work and stating that the self-assessment process we introduced as part of our adapted approach to assurance and inspection has been 'welcomed and effective'. We were also provided with some constructive suggestions on where to go next with this, and how to develop yet further, notably the need to continue ensuring our processes are streamlined and simplified as far as they can be. Where this is not possible we will strive to ensure we have communicated our rationale clearly to healthcare services so that they understand the need for some of our processes and how they contribute to our work.

We asked our staff what they thought about the development of the organisation over the last three years. Staff were very positive about the ICT solutions that have been implemented over this time to help make the job we do more streamlined. Much focus has also been given to learning and development of our staff over this period and this was reflected in the positive responses staff gave to this question.

Staff provided comments on areas in which they thought our learning and development should focus in future, suggesting that development for peer reviewers and internally, for staff who hold Relationship Manager roles would be good areas to expand our training offer. Staff were particularly complimentary about the series of hot shot training sessions on a wide variety of clinical areas which had been provided during the last year.

Organisational Reflection on our three year progress

01

To maximise the impact of our work to support improvement in healthcare

HIW's first priority in its three year strategy, which ended in March 2021, was to maximise the impact of its work in order to support improvement in healthcare. This priority placed an emphasis on doing the right work, at the right time, in the right place whilst ensuring that our work was well communicated. It was our strong belief that greater impact would be achieved by working with others in the heath and care system. As a result, our key aims were to:

- Improve our approach to the analysis, use and sharing of intelligence
- Work closely with other inspectorates, especially Care Inspectorate Wales (CIW)
- Make sure our work is easy to understand.

HIW has transformed the way it analyses, uses and shares intelligence, forging closer relationships with key partners and increasing the frequency and opportunities for sharing and receiving information with organisations such the Community Health Councils, Audit Wales and Care Inspectorate Wales. We have continued to refine the way in which we host the twice yearly healthcare summits. These meetings are now spread over two days to ensure that there is adequate time to discuss each NHS organisation so that key partners can calibrate their views on issues and risks and draw out national themes which are then shared with the Chief Executive of NHS Wales.

We have significantly strengthened the governance arrangements for our review work since 2018. Our Review Steering Board (RSB) now considers a range of evidence, including submissions from external parties, and uses a staged process for the development of national reviews, enabling HIW to undertake research and evaluation before committing resources. This ensures that HIW can maximise the impact of its work through effective prioritisation. The RSB also oversees the delivery of all reviews, including local and joint reviews undertaken in health boards or trusts. We have developed innovative ways to inform people of our review findings, including the use of stakeholder learning workshops and the use of bulletins to share emerging findings from our work.

At the onset of the COVID-19 pandemic it was necessary for HIW to re-invent the way it undertook assurance work. We halted routine, onsite, inspection work in March 2020 and developed an offsite Quality Check approach. We fast tracked the development of a shorter reporting style which enabled us to publish reports in around a month as opposed to the three month timescale associated with a full inspection. This change allowed us to maximise the impact of our work by providing rapid feedback to the healthcare system as it dealt with an emergency situation.

"Such reports provide excellent opportunities to use as a benchmark"

– comment received in HIW's general public survey, reviewing our progress 2021

In line with our strategic commitments, the period between 2018 and 2021 saw HIW involved in a number of joint reviews and inspections. This included working with Audit Wales on a high profile joint review of governance arrangements at Cwm Taf Morgannwg University Health Board which we published in early 2021.

We work closely with Care Inspectorate Wales as issues and risks emerge in the health and social care sectors and we have undertaken joint inspections with them in a number of service areas including community mental health. We have also worked closely with the Community Health Councils and in particular we worked together to undertake a national review of maternity services.

In December 2019, we took part in a Joint Inspection of Child Protection Arrangements (JICPA) in Newport. The joint inspection was the first pilot inspection in Wales involving five inspectorates reviewing child protection arrangements. Whilst logistically challenging, this pilot clearly demonstrates the benefits of working jointly with other inspectorates on areas of mutual interest to improve services in Wales. We expect to continue working in this way in the coming years.

To take action when standards are not met

HIW's second strategic priority for the 2018-2021 period was to take action when standards were not met. A number of factors contribute to this goal, including the nature of legal frameworks defining our powers, the quality and timeliness of our work, the way in which we engage with those whom we inspect and regulate, and the way in which we escalate issues when we become aware of them.

In support of this priority, since 2018, we have aimed to:

- Monitor our approach to inspections and reviews to ensure they remain relevant and effective
- Improve our communication with current and prospective independent healthcare providers
- Work with Welsh Government to review the scope and application of the legal powers available to HIW.

The way in which we plan and deliver our inspection and review programme is one of the biggest areas of change for HIW over the past three years. We are committed to ensuring that every piece of assurance work counts, and as a result, we invest heavily in the processes that generate our programme of work. Our monthly Risk and Escalation Committee (REC) ensures that we can adjust our work plans in a dynamic way in order to respond to risk within the healthcare system. In addition, we have now moved to quarterly planning processes to ensure that our programme of work remains relevant. We have developed our Relationship Manager network for NHS health boards and trusts to include Deputy Relationship Managers and Executive Leads. This has increased our capacity to monitor key developments in, and challenges faced by, these organisations. This allows us to adjust our work programme as required.

We have increased the size of our methodology team over the past three years so that we can keep our approaches up to date, exploring the most appropriate areas of healthcare delivery when undertaking assurance work. Following the onset of the COVID-19 pandemic in 2020, and the need to halt our routine onsite inspection work, we deployed a number of our inspectors on methodology projects. The result of this was the creation of an off-site assurance approach which we call Quality Checks. This approach represents a paradigm shift for HIW, leading us to more fully explore a range of possible actions before taking the decision to undertake an onsite inspection.

The Quality Check process enables us to take action where standards are not met, but at great pace. This was particularly useful during the early stages of the COVID-19 pandemic, where it was imperative that services understood any risks in the way they were operating as soon as possible.

The 2018-21 period has seen us overhaul our approach to follow up, both for our inspection work and for national and local reviews. Our new approaches in these areas strengthen the way in which we hold services to account for the actions they must take following an inspection or review. We have also developed a Service of Concern process for the NHS which formalises the approach we take when we find serious or repeated failures in service quality. The process involves publicly placing a Service of Concern designation on a setting so that we discharge our duty to provide information to the public on the quality of services. We believe the Service of Concern process will ensure that rapid and focused action is taken by a range of stakeholders when concerns arise about the quality of care.

We have undertaken a significant amount of work over the past three years to strengthen our communication with independent sector providers. Initially this took the form of clearer guidance on our website to support prospective services requiring support in understanding what is legally required of them.

"I felt HIW really improved its profile and presence as a supportive agency for dental practices throughout this pandemic which I greatly appreciated. Historically I felt HIW was very disconnected from healthcare establishments & viewed predominantly as an arm's length policing watchdog. I've always felt HIW needed to build more positive supportive links with healthcare establishments. I felt its efforts during the pandemic were pleasantly surprising, perfectly pitched and well received. Thank you & well done HIW."

Our enforcement activities over the past year are detailed earlier in this report (link). During the three year period associated with our 2018-2021 strategy, we have continued to strengthen our Service of Concern process for the independent sector, where necessary making use of restrictions on activity in order to keep patients safe. During this period we undertook an increasing number of enforcement activities, including our first prosecution of an unregistered independent service.

Over the past three years we have continued to engage with Welsh Government on the scope of our powers, including highlighting any limitations associated with the current legislation within which we operate. It is clear that capacity for legislative change during this period has been limited by developments around the exit of the United Kingdom from the European Union and the onset of the COVID-19 pandemic in 2020. HIW continues to exploit the full range of its current powers and has contributed to the development of the Health and Social Care (Quality and Engagement) (Wales) Bill which became law on 1 June 2020. HIW is currently working with Welsh Government on the implementation of key features of the Act including the launch of a new Citizen's Voice Body and the introduction of the Duty of Candour and Duty of Quality.

03

To be more visible

In 2018 we set ourselves the challenge of becoming more visible as an organisation and to improve public and professional understanding of, and engagement in, our work. Increasing our visibility across Wales allows us to gather a broader range of intelligence giving us the ability to make better decisions on where there are areas of risk, to take further action and to support improvement. Over the past year, during the COVID-19 pandemic, it has been even more important for HIW to be visible in continuing to check that patients are receiving good quality care, providing rapid feedback on our findings and ensuring independent healthcare settings are advised of the latest regulations.

More specifically, since 2018, we have aimed to:

- Develop and enhance the way we listen to the public
- Improve the way we inform people about what we do
- Develop the way we involve people in our work.

There is still more work to do in this area, however, we feel we have made good progress toward this priority.[13] In 2018, just over a quarter of people in Wales were aware of the inspectorate.[14] In 2020, that had increased to just under 40%. In a recent [15] public survey over 73% of respondents knew that they could find out information on the quality of their local health service through HIW.

We have worked to achieve our aims through delivering a number of improvements.

We have improved our use of digital media to communicate about our role, purpose and findings. We have implemented a social media strategy, improved our usage of online surveys and redesigned public facing documents to introduce a new, creative approach to presenting our findings to make them more accessible and engaging. Over the past year we have introduced Quality Check Summaries and an HIW Quality Insight which has enabled rapid feedback of our findings to healthcare services. In a recent survey over 75% of respondents had seen one of our reports and over 90% of respondents were interested in receiving our newly designed reports.

These developments have enabled us to increase public and professional involvement in our work. Since 2018, across our inspection and review work, we have had over 11,500 responses from patients and over 1000 from staff. This included 630 women and seventy six staff members who took part in our work on the Breast Test Wales service and this year almost 600 members of the public and ninety healthcare staff took part in our focussed inspections of Mass Vaccination Centres.

[13] Wales Omnibus, Beaufort Research Ltd - September 2018
[14] Wales Omnibus, Beaufort Research Ltd - September 2020
[15] HIW Strategic Engagement Survey June 2021

Feedback has suggested that we can make further improvements in this area through further engagement with patient and carer representative groups, more targeted usage of social media on HIW's role and more work to increase visibility in primary care and contractor professions.

Our work around Mass Vaccination Centres, Field Hospitals and our COVID-19 National Review have helped us to remain visible in delivering our role during the pandemic. Engagement with stakeholders and with the media on our findings has been positive.

"The ability to share intelligence is useful and vital. The information and knowledge of how the other organisations review the NHS helps inform our work."

We have worked to build stronger relationships with healthcare providers and other professional bodies to improve understanding of our role and purpose and how we can work together to support improvement. Over the past year, to develop a wide knowledge and awareness of HIW's role at the earliest possible stage in health professionals careers, we have increased direct engagement with education and training providers including universities. We have presented to universities across Wales at faculty meetings, to highlight our role. These sessions have been well received and by the start of the next academic year our ambition is that this will be accompanied by sessions delivered by HIW to undergraduate and postgraduate students in the fields of health sciences and allied health specialities.

We have used key conference and seminars to build our visibility and communicate the findings and learning from our work. Whilst this has been more difficult this year, given the restrictions associated with the pandemic, we have attended and hosted digital learning events. In particular we chaired an improvement event with over 150 NHS Wales staff to consider progress on the findings of our National Review of Maternity Services. We also hosted the National Healthcare Summit digitally and they continue to be a focal point for intelligence sharing and representing the collective views of those who scrutinise healthcare across Wales.

"Year on year the contributions from partners improve."

Evaluation of the summits has provided excellent feedback. The [16]majority of attendees who responded feel that they are well run and provide the forum to share intelligence, information and knowledge as well as sharing views on the performance of healthcare services across Wales.

[16] HIW Healthcare Summit Feedback May 2021

04

To develop our people and organisation to do the best possible job

HIW's greatest asset is its people.

Our aim since 2018 has been to improve the way we work so that we are consistently effective and efficient. We have also sought to improve our approach to developing and supporting all who work for HIW, so that they can do the best possible job in the interests of patients and the public.

To deliver these aims we set ourselves the following high level actions:

- Implement a change programme to enhance HIW's ways of working
- Invest in developing the skills and knowledge of our people
- Develop a workforce strategy that includes consideration of succession planning and career pathways.

We have made a number of significant achievements against this priority. Our change programme has seen us embrace the latest digital technology with the introduction of new electronic inspections, a simpler system of online payments for registration fees and a new data and information management system, a project due for completion in 2021.

We have grown the organisation effectively and introduced new governance around our review, methodology, workforce and finance functions improving our ability to plan, manage and develop our resources.

We implemented a three year learning and development strategy and action plan for the organisation which increased our investment in training, offered development opportunities to staff to build their skills base, enable career progression and make the organisation more resilient. In a recent [17]staff survey most people reported that they felt that they are able to access the right learning and development opportunities to help improve their performance and develop their career.

[17] Civil Service People Survey 2020

"[18]Very friendly and responsive. I have communicated with various teams in person and in writing and the service was excellent. Members of HIW were very understanding and helpful to aid practices to achieve the best that they could. The last inspection I experienced staff were professional, realistic and supportive.

"Increase opportunities for people in other organisations to work with HIW on a part time basis or secondments."

We have evaluated how we use voluntary lay reviewers and implemented a new network of Experts by Experience and Patient Experience Reviewers to enhance the capture of the patient voice during inspections.

Over the past year, with the onset of the COVID-19 pandemic, we have seen the demand for flexibility within our workforce increase dramatically. Working from home, working differently and responding quickly to changing priorities were all challenges throughout the year. We have been committed to taking a flexible approach to how our staff work, supporting them to deliver their roles in a safe and efficient way to support their well-being.

We introduced a well-being policy to support staff during the pandemic as well as a flexible resourcing model in order to quickly adapt to changing priorities. We developed a regular programme of training sessions for our staff and reviewers, and those in other government departments, on COVID-19 related matters including infection control level 1, resilience, debrief and PPE and received positive feedback.

[18] HIW Stakeholder Survey June 2021

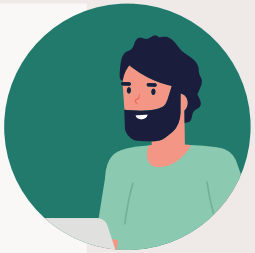
"[19]I just wanted to write and thank you personally for the training you gave us. I've been so nervous about going out and catching COVID-19 and now I can go about my job with confidence. Not working in health or social care I've never had to think about infections so the training was invaluable. It was easy to understand and at the right level. Thanks for your support and kindness."

In a [20]recent staff survey 88% of respondents felt that they had been given the necessary equipment to work from home and all staff felt they could work remotely effectively but felt it had been challenging at times. 90% of staff felt that they had been able to stay connected with colleagues whilst working from home and over 95% of respondents felt that decisions had been taken and communicated in a timely way during the pandemic.

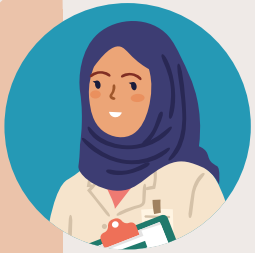
We have quickly evolved as an organisation to introduce an adapted approach to assurance and inspection to ensure we continued to deliver our role during the pandemic in a proportionate and appropriate way given revised operating models, restrictions and the importance of the safety of our staff. Feedback from healthcare settings on our approach has been positive, however, there are clear suggestions as to how we can improve which we will consider in future plans.

[19] WG department feedback
[20] HIW Staff Survey, October 2020

"It was a reassuring temperature check that focussed on our processes during the pandemic. The self-assessment tool was easy to follow and the actual review was well handled and well informed."



"Seek feedback after inspections."



"The communication with the team was very well organised and informative. It is appreciated that the Quality Checks are in place to ensure that practices are following the guidelines of the key areas."

"Critical to retain the new ways of working especially during the pandemic maximising technology options for engagement. Ensure appropriate induction and training programme for new recruits and ensure practice based staff are able to support inspections."

HIW Governance Map Glossary

Decision making and business management

Senior Leadership Group (SLG)

SLG oversees the corporate governance of HIW and it is the executive decision making body for us.

Business Group

Business Group monitors activity across all areas of HIW, which is then cascaded to staff straight after the meeting.

Workforce Planning and Finance Committee

This Committee considers bids from all staff, for resource / training / conferences. The Committee considers these requests, check available budget and relevance to the role of the individual/team.

Risk & Escalation Committee (REC)

The REC is the group that takes action to maximise the delivery of HIW's programme of activities, and escalates any recommendations / decisions that require a change in process to SLG.

Advise and make recommendations

Methodology Change Panel (MCP)

The main role of MCP is to create new methodology, change existing tools/workbooks and develop guidance / supporting information.

Digital Design Panel (DDP)

Discuss and approve/reject/defer any new business requirement documents, configuration documents / functional specifications and CAB docs that have been submitted. It also checks progress of current change requests and prioritises accordingly.

People Forum

The main tasks of the Forum are to discuss staff issues, develop and manage actions, and to provide a link between staff and SLG.

Review Steering Board (RSB)

Its main role is to monitor the delivery of current reviews, explore proposals and make recommendations for further HIW investigation including national and local reviews.

Information and Intelligence

Stakeholder Reference Groups

These groups bring together representatives from the sector to provide us with constructive challenge and advice about our work in GP, dental and mental health.

Relationship managers (RMs)

RMs are the first point of contact for HIW staff and health boards / trusts. They also take the lead in determining the inspection and assurance activity within each particular health board.

Concerns / notifications meetings

The aim is to monitor / escalate any concerns or notifications that require action.

Heads of Branch (HoBs) Meetings

The aim is to enhance working practices and information sharing across all areas of HIW.

Team Meetings

Each team holds regular meetings which usually follow the monthly SLG meeting to enable the Head of Branch to update staff on any actions arising from SLG.

People Forum

The main tasks of the Forum are to discuss staff issues, develop and manage actions, and to provide a link between staff and SLG. Any changes that affect all staff will be discussed at the Forum first, to ensure the approach is sound (e.g. the annual L&D plan, any ICT changes, updates to process documents).

Staff Conferences

Staff conferences are held as and when required, usually twice a year. All staff are required to attend these to address HIW wide issues.

Education and Public Services (EPS) group meetings

The primary aim is to provide updates on activities across all areas of the EPS Group and to pass on key messages. Our Chief Executive represents HIW.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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