HEALTHCARE INSPECTORATE WALES

Annual Report 2018-19

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Important Note about Cwm Taf Morgannwg University Health Board and Swansea Bay University Health Board

This Annual Report covers the period from 1 April 2018 - 31 March 2019 and the boundaries and names of two of Wales' health boards changed on 1 April 2019.

Following the Bridgend boundary changes, Abertawe Bro Morgannwg University Health Board became Swansea Bay University Health Board; and Cwm Taf University Health Board became Cwm Taf Morgannwg University Health Board on 1 April 2019.

For the purposes of this report, we have used the correct names of the health boards during the 2018 – 2019 reporting period.

For further details on the new boundaries, please visit the relevant health board websites: www.cwmtaf.wales and www.sbuhb.nhs.wales

In Writing

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ
Phone: 0300 062 8163

Or Via

Email: hiw@gov.wales
Website: www.hiw.org.uk

978-1-78937-514-5 WG38420

Contents

5 **Foreword**
6 **HIW in numbers**
8 **What did patients tell us?**
10 **Our work**
12 **Our Resources**
14 **Working with others**
15 **Progress against our Stratgeic Plan**
20 **National and Local Reviews**
26 **Inspection Findings**
42 **Summaries of Local Health Boards and Trusts in Wales**
60 **Annex A - Commitment Matrix**

Abbreviations used:

Abertawe Bro Morgannwg University Health Board – **ABM**
Aneurin Bevan University Health Board – **Aneurin Bevan**
Betsi Cadwaladr University Health Board – B**etsi Cadwaladr**
Cardiff and Vale University Health Board – **Cardiff and Vale**
Cwm Taf University Health Board – **Cwm Taf**
Hywel Dda University Health Board – **Hywel Dda**
Powys teaching Health Board – **Powys**

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

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through the reporting and sharing of good practice.

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

Foreword

Last year marked the 70th anniversary of the NHS; founded by Tredegar-born Aneurin Bevan and still a source of pride to so many in Wales. Healthcare services have changed exponentially in this time with advances in medicine, ongoing financial pressures and increasing healthcare needs from an ageing population with complex conditions.

Balancing these pressures is a challenge for everyone working in modern health settings, and patients need to know that the healthcare they receive is safe and effective. The role of Healthcare Inspectorate Wales has never been more important.

In June 2018, we launched our three-year strategic plan Making a Difference which set out our vision and priorities to improve health and wellbeing for people in Wales and a clear mandate on how we will play our part in driving up standards in healthcare in Wales. As I reflect on this first year of our strategic plan, I am proud of the achievements so far as we strive to increase our impact, take action where standards are not met, be more visible and be the best organisation we can be.

This year we carried out 179 inspections, including follow up inspections, of hospitals, dentists, GP practices, mental health providers, independent healthcare and settings using ionising radiation.

Overall we saw a high standard of healthcare being delivered to patients, but there are some recurring themes that must be addressed.

It was clear from our hospital inspections that services continue to face significant challenges with regard to staffing levels. At a more local level, issues with appointment booking systems at GP practices were evident in many GP inspections last year with patients reporting long waits and difficulties securing on the day appointments to see a doctor.

Our dental inspections were good on the whole with some practices receiving outstanding reports with no suggested improvements at all. However in other dental practices, and indeed in most of our inspections across all settings, the safe storage and administration of medicines continues to be a problem. Care and treatment planning was poor in our mental health inspections with improvements needed to risk management in independent settings.

Following the allocation of some additional resource, we are in a position to increase our core activity within the NHS, enhance our follow up work, undertake more national and local reviews, and better respond to emerging in-year intelligence.

We have also embraced the latest digital technology into our work with the introduction of new electronic inspections and a simpler system of online payments for registration fees.

As we grow and develop as an organisation we continue to focus on delivering an effective service checking on the quality of care that people receive across Wales and taking action where standards are not met to support improvement.

If you have any comments on this report, our work or your experience of healthcare services in Wales, please get in touch.

Dr Kate Chamberlain, Chief Executive

HIW 2018 - 19 In Numbers

Hospitals

- **10** general hospital inspections
- **3** surgical inspections
- **120** patient questionnaires
- **3** follow up inspections

Dental

- **73** dental inspections
- **1803** patient questionnaires
- **5** immediate assurance letters issued

Offender Healthcare

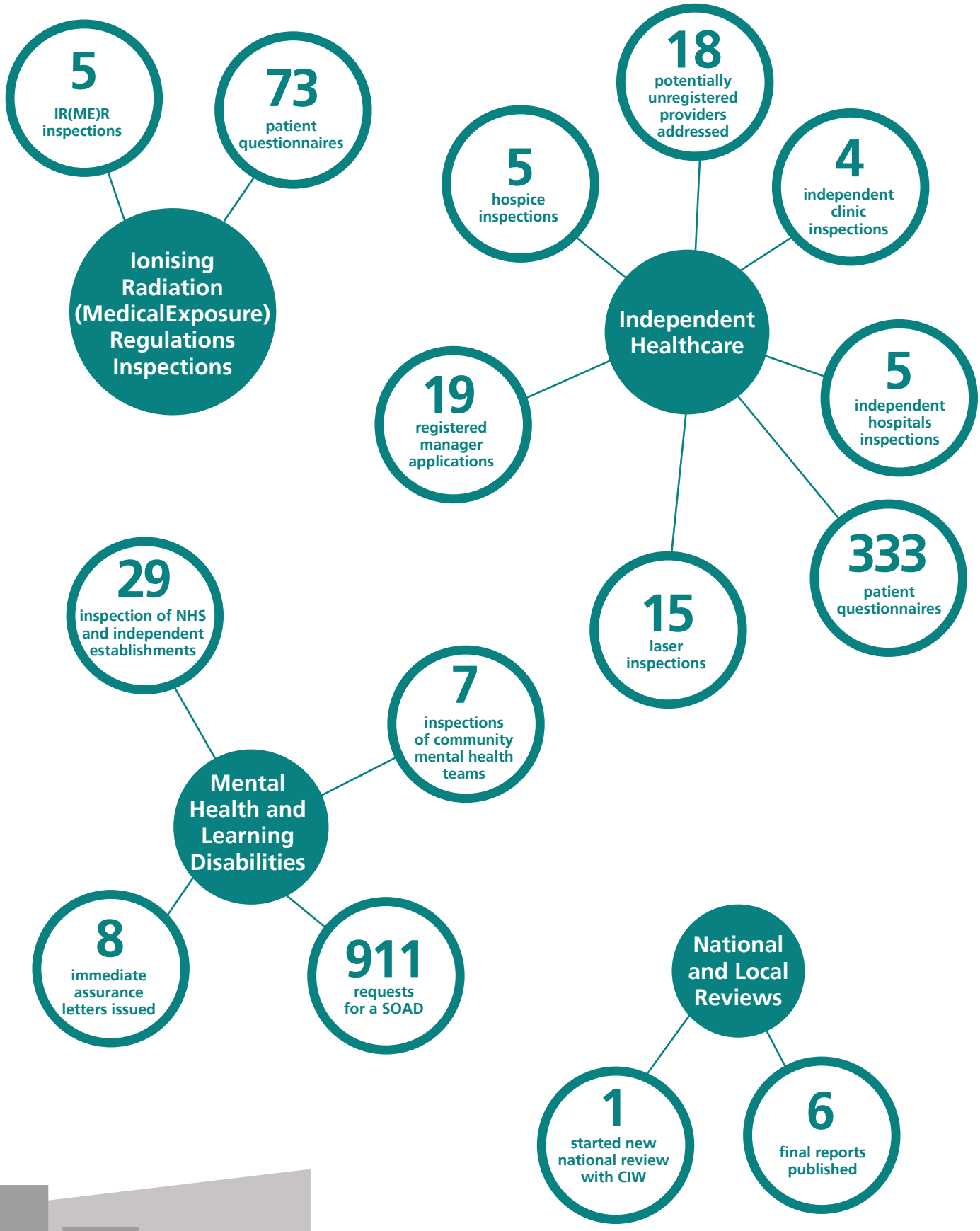
- **18** death in custody reviews
- **1** joint prison healthcare inspection
- **1** joint youth offending services inspection

Concerns

- **312** concerns from public and staff
- **37** 37 were rated as 'high' risk

GP

- **20** GP Inspections
- **5** immediate assurance letters issued
- **641** patient questionnaires


5
IR(ME)R inspections
73
patient questionnaires
Ionising Radiation (MedicalExposure) Regulations Inspections
18
potentially unregistered providers addressed
5
hospice inspections
4
independent clinic inspections
Independent Healthcare
19
registered manager applications
5
independent hospitals inspections
333
patient questionnaires
15
laser inspections
29
inspection of NHS and independent establishments
7
inspections of community mental health teams
Mental Health and Learning Disabilities
8
immediate assurance letters issued
911
requests for a SOAD
National and Local Reviews
1
started new national review with CIW
6
final reports published

What did patients tell us?

As part of the inspection process we ask patients if they would like to tell us about the care they receive by taking part in a questionnaire.

Last year we received 3106 completed patient questionnaires; a small increase on the total number of responses from the previous year (3060).

We also invited staff in hospitals and hospices to complete a questionnaire and we received 327 completed questionnaires from workers.

What did patients tell us?

We have separated the figures to show patient scores in 2018-19 by the type of setting (for example. hospital, GP, dentist etc.).

Overall rating

Patients generally rated their care as good.

- On average, hospital patients scored hospitals as 9 out of 10
- 99% of dental patients rated their dentist as good, very good or excellent
- 88% of GP patients rated their experience as good, very good or excellent
- 97% of patients receiving ionising radiation as part of a diagnostic procedure or treatment rated their experience as good, very good or excellent
- 98% of laser patients rated their experience as good, very good or excellent

Cleanliness

We also asked patients to rate the cleanliness and tidiness of facilities.

- 96% of hospital patients agreed the ward was clean and tidy
- 99.6% of dental patients agreed the surgery was fairly clean or very clean
- 99% of GP patients agreed the environment was fairly clean or very clean
- 99% of independent clinic patients agreed the environment was clean and tidy

Dignified Care

Dignified care includes staff being polite and sensitive to patients' needs.

- 97% of hospital patients agreed that staff were always polite and were kind and sensitive
- 91% of hospital patients agreed that staff provided them with help, in a sensitive way, so they could use the toilet
- 89% of hospital patients agreed that when they used the buzzer, staff came
- 94% of GP patients felt that staff treat them with dignity and respect

Communicating Effectively

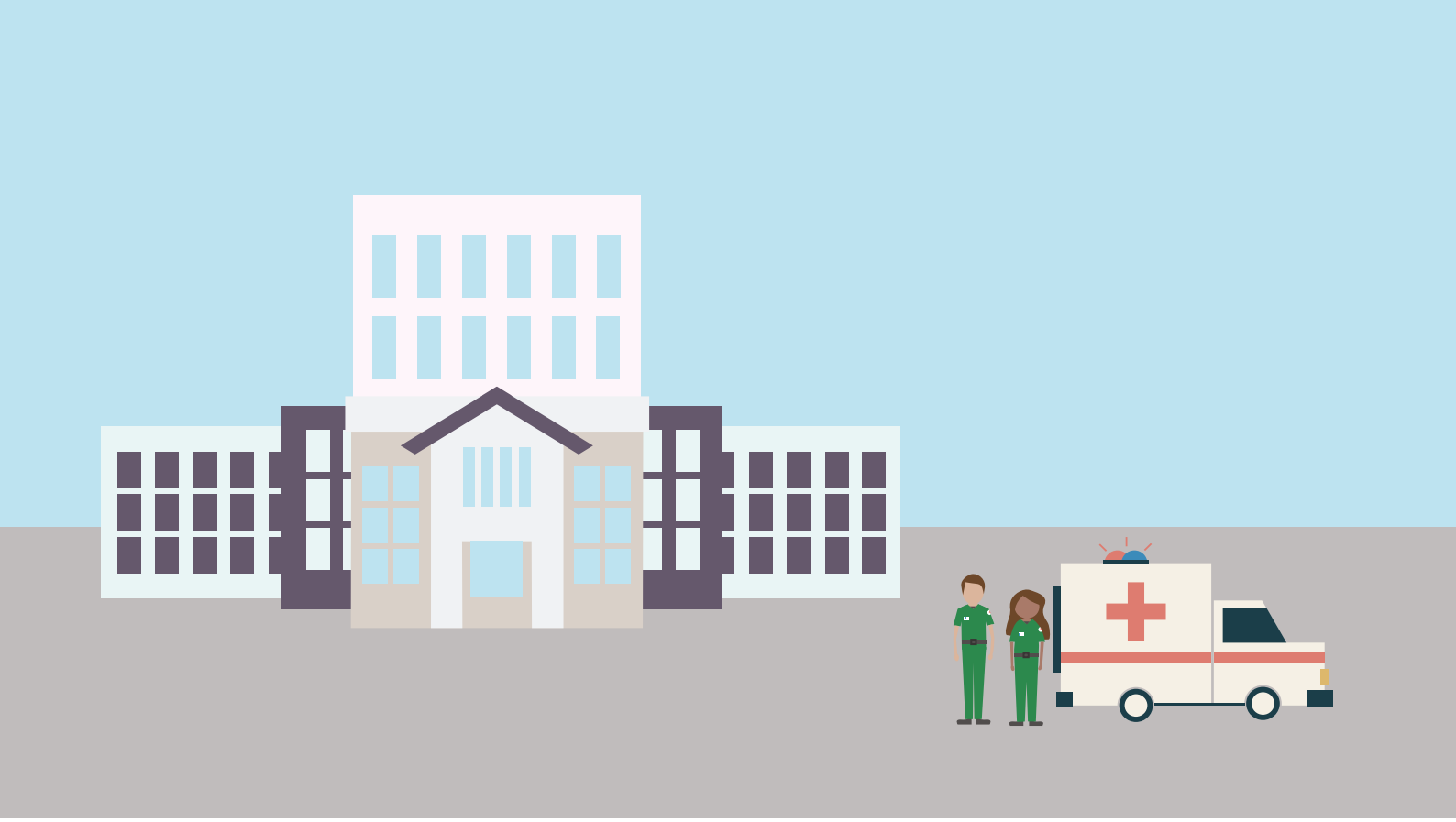
This includes how patients communicate with staff and how staff communicate with patients.

- 84% of hospital patients said they could communicate using their preferred language
- 92% of GP patients said they could communicate using their preferred language
- 96% of dental patients said they could communicate using their preferred language
- 89% of hospital patients said they felt that staff always listened to them
- 90% of CMHT patients said they felt that staff always listened to them
- 81% hospital patients agreed staff had talked with them about their medical conditions and helped them understand them
- 87% of CMHT patients believed staff had enough time to discuss their needs

Treatment options

This section covers how well treatments are explained to patients and their understanding and participation in the treatment process.

- 96% of GP patients said things were always explained in a way they understand and 91% said they felt involved in decisions about their care
- 95% of dental patients said treatment options were fully explained to them and 96% said they felt involved in decisions about their treatment
- 96% of IR(ME)R patients said they felt involved in decisions about their treatment and 96% said they were given enough information to understand the risks of the procedure
- 98% of patients receiving Laser treatment said they felt involved in decisions about their treatment and 90% said they were given enough information to understand the risks of the procedure



Cost of treatment

This section only covers treatment that is not provided free under the NHS.

- 96% of dental patients said the cost of treatment was made clear
- 98% of laser patients said the cost of treatment was made clear

Ease of access

This section looks at how easy it is to book an appointment.

- 98% of dental patients said booking an appointment was fairly easy or very easy
- 63% of GP patients said booking an appointment was fairly easy or very easy

Out of hours care

This section covers awareness of out of hours services.

- 76% of dental patients said they know how to access the out of hours service
- 79% of GP patients said they know how to access the out of hours service

Our Work

We check that people in Wales receive good quality healthcare. We put the patient at the heart of what we do, and we make sure our work promotes and protects equality and human rights for everyone. Our work is guided by the Well-being of Future Generations (Wales) Act 2015. In making decisions about the work we do, we balance the short term and long term needs of patients, working collaboratively with partners, patients and the community to support improvement.

Providing Assurance

We inspect the NHS in Wales. Our coverage in the NHS ranges from general practice to large hospitals. During 2018-19 we carried out 144 inspections in the NHS.

We also regulate and inspect independent healthcare. Independent healthcare includes a wide range of providers from full private hospitals to beauty salons who use lasers. During 2018-19 we carried out 29 inspections in the independent sector.

Dental practices rather than individual dentists undertaking private work need to register with HIW as a result of changes in the Private Dentistry (Wales) Regulations in 2017. We embarked upon a dental registration programme as a result registering practices rather than individual dentists, and by the end of 2018-19 we had completed the registration of all practices; 485 in total. We also maintained our dental practice inspection programme completing 73 inspections.

We have a specific responsibility to ensure that vulnerable people receive good care in mental health services, and we inspect mental health and learning disability settings in NHS and the independent sector. HIW considers how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. We also assess compliance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011, National Minimum Standards (NMS) for Independent Health Care Services in Wales.

We completed 29 mental health inspections during 2018-19.

Our work programme ensures that we meet our statutory requirements and we review areas of concern identified by intelligence and risk. Our Risk and Escalation Committee regularly assesses the evidence and intelligence available and reviews and refines our programme of work. We use what we know about services to determine our priorities.

In addition to our risk based inspections of the NHS and independent sector, HIW also undertakes national reviews. During 2018-19 we published reports in the areas of healthcare services for young people, substance misuse, patient discharge, community mental health and the prevention and promotion of independence for older adults living in the community.

Performance

Year	2 days met	2 days missed	3 months met	3 months missed
2018 - 19	94%	6%	92%	8%
2017 - 18	100%	0%	92%	8%
2016 - 17	91%	9%	82%	18%
2015 - 16	71%	29%	75%	25%

Performance Standards

We are explicit about the standards of service we provide.

- Where immediate assurance is required following an NHS inspection, letters will be issued to the Chief Executive of the organisation within two days
- Where urgent action is required following an inspection in the independent sector, the service will issued with a non-compliance notice within two days
- We publish all reports three months after an inspection as stated in our publication policy

During 2018-19 we published 92% of our reports within three months of the inspection.

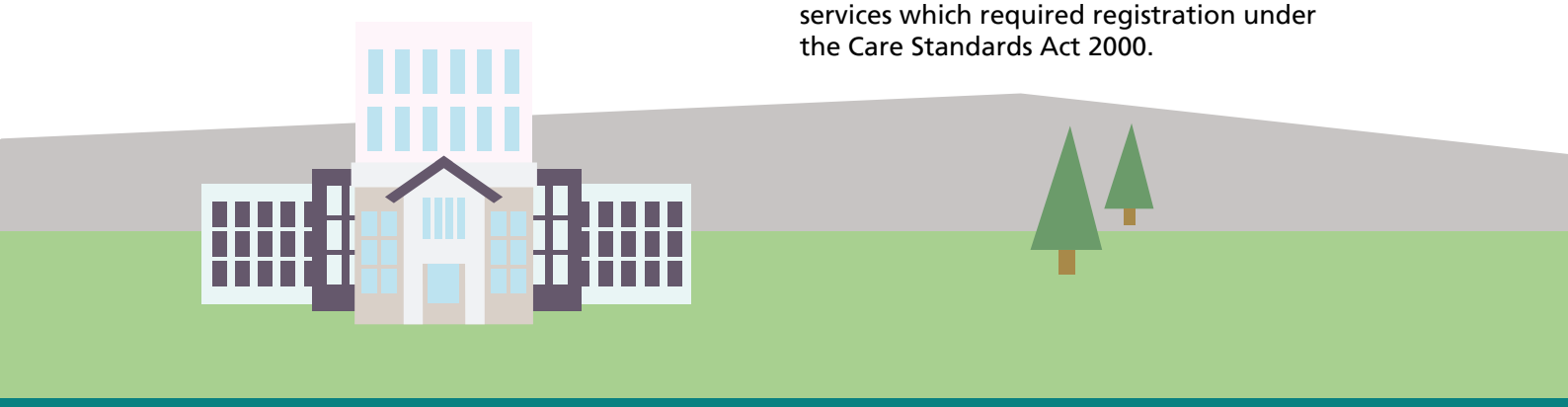
We reported 94% of issues of immediate concern within two days.

Promoting improvement

Many of our inspection and review reports contain recommendations intended to drive improvement in the quality of healthcare services. Our recommendations directly influence the actions of both service providers and health boards, and have led to improvement in the service delivered to patients. We have seen this in the majority of the ten follow up inspections that we carried out during 2018-19.

When we find that standards are not met, we make recommendations for improvement. The findings from our NHS inspections and reviews feed into the NHS Wales Escalation and Intervention Arrangements including those areas where we do not feel that sufficient progress is being made. If we do not receive sufficient assurance that action has been taken to address the issues we find in the independent sector, we take enforcement action.

In October 2018 we were successful in our first prosecution for illegally providing services which required registration under the Care Standards Act 2000.



Our Resources

Our People

The table below shows the number of posts in each team within HIW during 2018-19.

Team	Whole time posts
Senior Executive	3
Inspection, Regulation and Concerns	32
Intelligence, partnership and methodology	8
Strategy, Policy and Communication	5
Clinical advice (including SOAD service)	4
Business support (including recruitment, allocation and support of panel reviewers)	16
Total	**68**

Towards the end of 2018 we received further funding in order to build organisational capacity across our core functions. We subsequently ran a recruitment exercise to take the total number of posts in HIW to 78.

Due to timing of the recruitment process most of the extra posts were not filled until 2019. This contributed to an underspend in our budget for 2018 – 2019.

We rely on the input of peer and lay reviewers to assist in the delivery of our inspection and review programme. We currently have a panel of over 200 peer and voluntary lay reviewers and we will be expanding this pool during 2019 - 20 to meet the demand of our increased programme of inspections and national reviews.

Our peer reviewer panel consists of specialists including nurses, midwives, GPs, dentists, anaesthetists, surgeons and GP practice managers.

It also includes specialists in Mental Health Act Administration and a panel of psychiatrists who provide our second opinion appointed doctor (SOAD) service. Using peer reviewers provides a dual benefit; HIW receives specialist clinical input for inspections and reviews, and reviewers benefit from the learning provided by participation in our work and they are able to take this learning back to their own work environments.

We also have a pool of volunteers on our panel of lay reviewers who have the critical role of assessing patient experience through talking to patients and inviting them to complete questionnaires.

Finances

The following table shows how we used the financial resources available to us in the last financial year to deliver our 2018-19 Operational Plan.

	£000's
HIW Total Budget	3,934
Expenditure	
Staff costs	3,161
Travel and Subsistence	84
Learning & Development	17
Non staff costs	304
Translation	114
Reviewer costs	519
Capital ICT costs	55
Total expenditure (a)	**4068**
Income	
Independent healthcare	277
Private dental registrations	123
Total income (b)	**400**
Total Net Expenditure (a-b)	**3,668**

Working with others

In order to check that people in Wales receive good quality healthcare we work closely with a number of other organisations.

The effective sharing of information between organisations is critical in assessing the quality of healthcare being provided across Wales. During 2018-19 we hosted two healthcare summits bringing together external audit, inspection, regulation and improvement bodies to share intelligence about NHS organisations. Themes that emerge from these discussions were agreed and communicated to the Welsh Government.

We have strengthened our working arrangements with the Community Health Councils which has resulted in a more systematic sharing of work plans, emerging issues and early identification of joint working opportunities.

We continue to work closely with Care Inspectorate Wales, the Wales Audit Office and Estyn on areas of mutual interest throughout the year. Through a joint Inspection Wales presence at the Royal Welsh Show, we engage with the public and present our respective findings.

We have worked closely with the Welsh Government on new and emerging policy and legislation. Through our activities, we see how legislation, policies and standards work in practice. We feed back our findings and perspective at relevant opportunities, for example through formal consultations, evidence to National Assembly for Wales Committees and directly to the Welsh Government. We provided oral and written evidence for a general scrutiny evidence session on the work of HIW at the National Assembly for Wales' Health, Social Care and Sport Committee in February 2019.

We have also worked with other bodies to examine healthcare in other settings such as the clinical review of deaths in prison settings undertaken with the Prison and Probation Ombudsman (PPO), prisons in Wales undertaken by Her Majesty's Inspectorate of Prisons (HMIP) and reviews of Youth Offending Teams led by Her Majesty's Inspectorate of Probation.

Progress against our Strategic Plan 2018 – 2021

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

HIW aims to encourage improvement in healthcare by doing the right work at the right time in the right place. In order to make the greatest impact, HIW needs to work with others in the wider health and care system and communicate its findings effectively.

Over the last year, HIW has continued to work closely with partner organisations; holding regular summits and meetings with Community Health Council colleagues on a six monthly basis. These meetings have allowed us to exchange intelligence and calibrate our views on the risks and issues present across Wales. Close partnership working has also allowed us to avoid duplication of effort, delivering work jointly where appropriate.

We have continued to refine our planning processes, making use of available intelligence in order to ensure that we use our resources effectively. Our NHS Relationship Managers have acted as the first point of contact for health boards and trusts, assessing intelligence and risk in order to define our inspection and review work programmes.

Our Thematic Steering Board supports our aim of delivering the right work at the right time, by helping us to evaluate evidence from a range of sources in order to prioritise the development and delivery of the most appropriate reviews.

With a focus on the challenges set out in the Parliamentary Review of Health and Social Care in Wales (2018), HIW has continued to work with Care Inspectorate Wales (CIW) on reviews and inspections which cross the health and social care boundary. In 2018/19 we worked closely on the publication of a national report on Community Mental Health Teams and we continue to jointly deliver local inspections in this area. In early 2019, we are supporting CIW in undertaking a national review of the prevention and promotion of independence for older adults (over 65) living in the community. CIW are also acting as a key stakeholder in HIW's ongoing work on how care and treatment is provided to elderly people who have had a fall and how falls can be prevented.

To take action when standards are not met

HIW aims to take decisive action when standards are not met, and to this end, it is imperative that our work is of a high quality and underpinned by effective processes and legal frameworks

We implemented a Methodology Panel during 2018/19 to ensure that we review, update and develop our approaches in a controlled and prioritised way. This has helped us to continue to effectively assess healthcare provision against relevant standards and take action where there is a failure to meet those standards.

2018/19 saw us strengthen our approach to enforcement in the independent sector, including our Service of Concern process. We suspended an independent provider and delivered a number of urgent, focussed inspections. HIW successfully prosecuted an unregistered provider in October 2018 and this case allowed us to reflect on the type and pace of actions we take when we receive intelligence about such providers. We are working to improve the guidance published on our website so that those providing or considering providing independent healthcare services in Wales understand their legal responsibilities.

In 2018, we continued to develop the way we follow up on recommendations made during our inspections and reviews, publishing a policy setting out our approach. This will pave the way to greater activity in this area going forward.

HIW continues to work with Welsh Government on immediate policy and legislative developments such as the introduction of a duty of candour and a duty of quality, as well as revised board governance arrangements and the introduction of a new citizen's voice body.

To be more visible

To achieve our strategic goal, we need to build on our work to improve public and stakeholder understanding of HIW's role and the work we do.

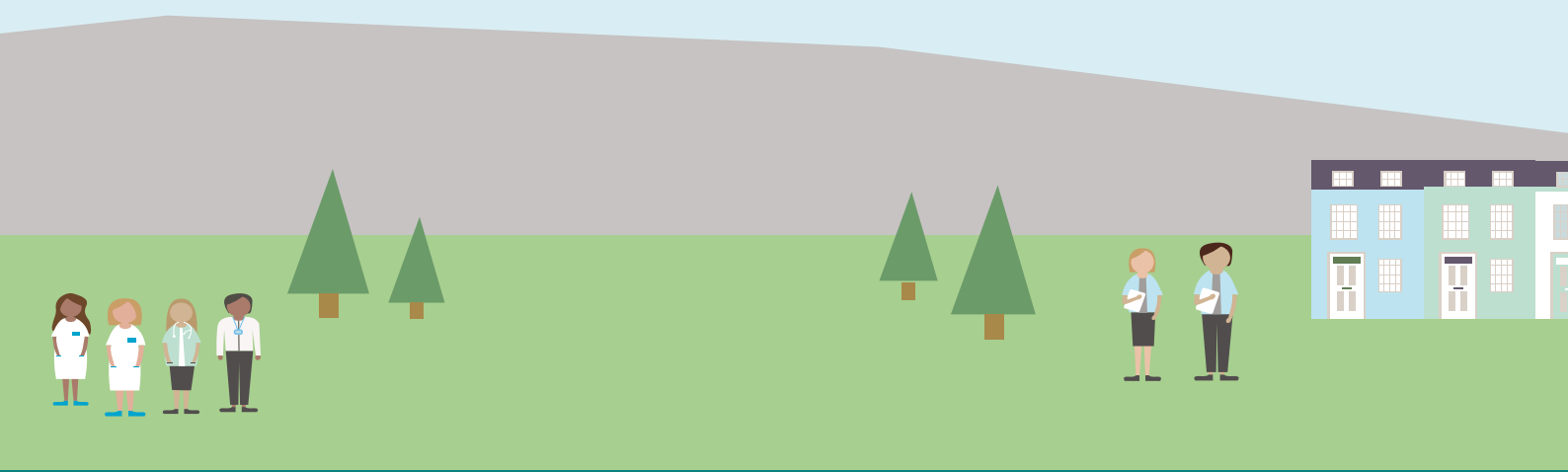
Over the course of the year we have worked to better use both digital and traditional media to communicate about our role, purpose and findings. We have worked proactively with the media and gained good coverage for our findings from a number of our reports and through a BBC Wales feature on the role of the inspectorate.

We have redesigned public facing documents to make them more relevant to the public, increased our following on social media and attended high profile events to communicate our purpose and the findings of our work. During the Royal Welsh Show in 2018 over 300 people took part in our survey on the work and findings of HIW, and we spoke to nearly 200 members of the public about their healthcare experiences.

We have also updated public facing documents, expanded our audience on social media and attended high profile events to communicate our purpose and the findings of our work.

We have started the development of new digital approaches to seeking views and perspectives from patients directly before and during inspections. This will help us to expand on the 3106 completed patient questionnaires received during the year.

We have worked closely with our stakeholder groups on new areas of work and, through our improved Healthcare Summits, we have been highly visible in providing a focal point for intelligence sharing and representing the collective views of those who scrutinise healthcare across Wales.



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

HIW's greatest asset is its people. During the course of the past year the organisation has made strides forward in developing as an organisation. Our latest staff survey shows improvement across all areas.

Through our ICT change programme we have introduced new ways of working that make us both more efficient as an organisation but also improves our information management and security. Our inspectors now work digitally in the field and share information with settings through new and improved hardware, systems and processes.

Those who need to pay for registration can do so quickly and easily online and where possible we have reused existing, tried and tested government systems to reduce the costs of implementation and future support. HIW became the first organisation in Wales to adopt the GOV.UK Pay system and in doing so made the system available in Welsh paving the way for other government organisations in Wales to use it.

We have launched a three year learning and development strategy and action plan for the organisation which has improved the learning opportunities available for all of our staff and reviewers. We have also encouraged consideration of individual learning opportunities in line with personal and professional development requirements.

We have introduced and embedded new governance around our review, methodology, workforce and finance functions improving our ability to plan, manage and martial our resources to organisational priorities.

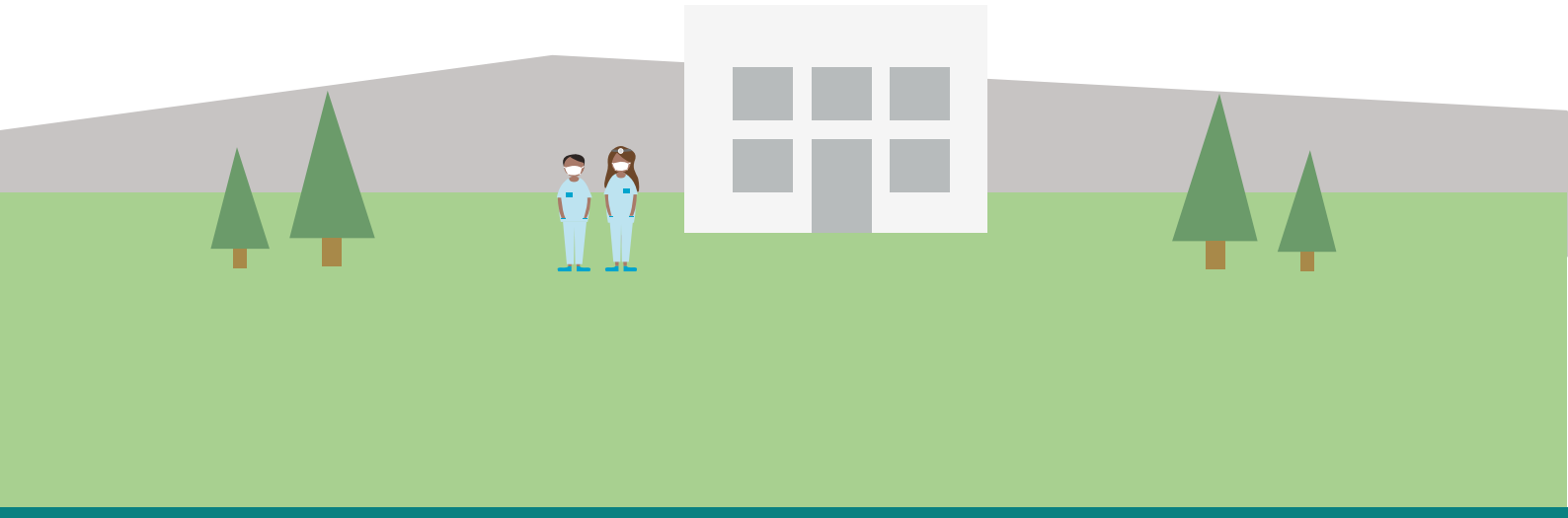
Following the in-year allocation of new resources to increase our activity across Wales, we have successfully delivered a recruitment campaign and induction programme to increase the people in our organisation by more than 10%.

National and Local Reviews

HIW delivers national reviews which enable us to examine how services are delivered across the whole of Wales. We are also commissioned to conduct independent reviews on matters of national significance.

We encourage people to tell us their views about what we should look at and we have a suggestion form on our website that can be completed by anyone who has a concern.

HIW has a close working relationship with the other inspectorates in Wales and we increasingly look for opportunities to work jointly; especially with Care Inspectorate Wales.



Substance Misuse

In July 2018, HIW and CIW published a joint review of substance misuse services in Wales. The purpose of our review was to assess the quality and effectiveness of care provided by substance misuse services across Wales.

Overall, we found people receive good care from passionate and caring staff, but access to services was limited in rural areas and generally inconsistent across Wales. Specifically, people found it difficult to get the treatment they needed from substitute prescribing (e.g. methadone), detoxification, rehabilitation and counselling services, because of long waits and a lack of capacity in services.

The review also identified weaknesses in oversight and regulation around the quality and safety of services. As such, Area Planning Boards may not be able to quickly identify, monitor and act on emerging themes and issues across all services in order to protect people's safety. Welsh Government and Area Planning Boards need to reconsider the way they seek assurance about performance of services.

Disappointingly, although some progress had been made, many of the issues identified in the report were similar to those HIW identified in its previous substance misuse report in 2012.

34 recommendations were made for Area Planning Boards and/or Welsh Government to consider.

Patient Discharge

In August 2018, HIW published a review of patient discharge from hospital to general practice. The way in which patients are discharged from hospital is critical to the effectiveness of their ongoing care in the community. The purpose of the review was to consider the quality and timeliness of discharge information provided by hospitals.

Overall, we found the quality and timeliness of discharge information was variable across Wales, with this area of the NHS requiring significant attention to ensure that safe and effective healthcare is provided.

It is clear that some parts of the NHS in Wales are making progress in the area of patient discharge but progress is far too variable across Wales. Where we saw increased usage of electronic discharge systems the quality and timeliness of information received by GPs was clearly improving.

We found that all health boards had appropriate policies in relation to discharge. However, there appears to be a lack of awareness and understanding of these processes from staff on some wards and this lack of clarity, combined with poor IT infrastructure and a failure amongst professionals to take responsibility for effective communication can put patients at risk.

13 recommendations were made for NHS Wales healthcare organisations and NHS Wales to consider as result of the findings.

Review of healthcare support for older people living in care homes in North Wales

In November 2019, we published a joint review with CIW into how we can work together to ensure the healthcare needs of older people living in care homes in North Wales are met.

We investigated how Betsi Cadwaladr UHB met the healthcare needs of older people living in residential and nursing care homes, and gathered the experiences of care home managers in accessing healthcare support for people from the NHS. We also examined how HIW and CIW can work in a more integrated way to improve outcomes for people living in care homes.

Feedback was variable across most of the service areas considered, but some common issues emerged which need to be addressed in order to provide seamless, good quality care, to individual residents and patients. Many of the issues highlighted in the report echo those found during the course of the Older People's Commissioner's review in 2014 and have a direct impact on the well-being of people living in care homes.

The report identified 16 areas for improvement which HIW and CIW are following-up.

Abertawe Bro Morgannwg University Health Board and the employment of Kris Wade

In January 2019, HIW published a review of Abertawe Bro Morgannwg University Health Board's handling of the employment and three allegations of sexual assault made against Kris Wade by patients within their learning disability service.

The review examined staff recruitment and employment, incident reporting, adult safeguarding, governance and culture, an assessment of ABM's desktop review, and learning disability commissioning arrangements between health boards.

The health board's internal desktop review identified areas of concern around safeguarding processes, incident reporting, recruitment practices and governance and culture. It also concluded that Mr Wade's actions could not have been 'predicted or prevented'.

On the limited evidence considered, the health board's own conclusions were not unreasonable, however, we believe that the conclusion that Mr Wade's actions could not have been predicted or prevented is not based on evidence to either support or refute it. What we can say, having considered a wider range of evidence, is that there was nothing in Mr Wade's training, supervision or occupational health records that would have indicated that he was unsuitable to work in a care setting.

The key themes to emerge from this review are:

- An unacceptable delay in the health board recognising and reporting the first allegation as a safeguarding issue
- The health board's investigation and subsequent disciplinary process took too long
- Whilst some improvements have been made to the health board's governance arrangements, progress in addressing these needs to be quicker.

Welsh Government should consider how the renewal of Disclosure and Barring Service (DBS) checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients. As a result of the findings from this review we made 24 recommendations to be addressed by Abertawe Bro Morgannwg University Health Board, Welsh Government and considered by all health boards in Wales.

Community Mental Health Teams

In February 2019, HIW and CIW published a joint review of Community Mental Health Teams (CMHTs) in Wales. This review is primarily a response to a report published by HIW in March 2016: Independent External Reviews of Homicides – An Evaluation of Reviews Undertaken by HIW since 2007.

The purpose of the review was to bring together the key themes to have emerged from HIW and CIW's joint-inspections of CMHTs across Wales in the last two years, as well as engagement with people who use services, carers, and the third sector.

Overall, we found that people receive an acceptable quality of care from hard working and compassionate staff. However, over the course of this review we frequently found disparity and variability in the standards, consistency and availability of treatment, care and support provided by Community Mental Health Teams across Wales. Welsh Government, Health Boards and Local Authorities need to carefully consider and examine the areas we have highlighted and act on our recommendations so that people living with mental illness will receive equitable care wherever they live in Wales.

The key themes to emerge from this review are:

- Access to Services
- Care Planning
- Delivery of Safe and Effective Care
- Governance

23 recommendations were made for improvement for Welsh Government, health boards and local authorities to consider.

Youth Review

In March 2019, HIW published a review of how healthcare services are meeting the needs of young people, including those who need to transition from child to adult services. The purpose of the review was to consider the quality and safety of care young people receive within child and adolescent mental health services (CAMHS), general healthcare services, palliative care services and when transitioning from child to adult services.

This work was part of wider thematic work being undertaken jointly by the four inspectorate organisations that make up Inspection Wales: Healthcare Inspectorate Wales, Care Inspectorate Wales, Estyn and Wales Audit Office.

The review found that overall, young people had predominately good experiences of care within services. We also found staff working hard to provide compassionate, dignified and person-centred care. However, we are concerned about the ability of CAMHS inpatient units in Wales to accommodate people who are high risk. This means that young people are not always able to receive timely care close to where they live and may be placed some distance from their home.

It was also disappointing to find that many of the challenges young people face when moving between child and adult services are well known, but still continue to be seen. More work is needed by health boards and Welsh Government to ensure young people across Wales have smooth and effective transition to support them into adulthood.

HIW has made 37 recommendations which we expect Welsh Government, all health boards and independent service providers to address.

National Review of Prevention and Promotion of Independence for Older Adults (over 65) Living in the Community

In March 2019, we published the first of 11 separate local authority area inspections as part of a national review of the independence of older people living in the community. The pilot inspection was conducted in January 2019 and led to the undertaking of a further ten inspections in local authorities in Wales, some of which were completed in 2018 – 2019 and will be published in 2019 – 2020.

CIW and HIW are working together to focus on the experience of older adults as they come into contact with and move through social care services up until the time they may need to enter a care home and we consider the times when people experience, or would benefit from, joint working between local authority services and health board services.

The inspection evaluates the quality of the service within the parameters of the four underpinning principles of the Social Services and Well-being (Wales) Act and considers their application in practice at three levels:

- Individual
- Organisational
- Strategic

We have and will continue to consider all expectations outlined in the Social Services and Wellbeing (Wales) Act codes of practice.

Falls Review

We carried out the planning, research and reporting for a review of care pathways surrounding older people and falls in 2018 – 2019. The work aims to provide information on complex, multidisciplinary, integrated models of care involving social care, housing, independent and voluntary sector providers, as well as health. Publication of the review in the reporting year 2019-20.

The review considered the issues currently faced in effective falls prevention, management and recovery, exploring the extent to which services are seamlessly integrated and focussed on person-centred and community-based care. It depicts a picture of a whole-system care pathway so that staff and patients can understand what they should experience and expect to see over the years to come in the context of falls services.

Wider learning about how we approach inspection of these types of models of care will emerge from this in 2019-20.

NHS Hospitals

We conducted 16 hospital inspections across Wales at ten different hospitals in total including three surgical wards. Each inspection considered how the service met the Health and Care Standards under three domains: the quality of the patient experience; the delivery of safe and effective care; and the quality of management and leadership.

Findings

Patients praised the care and treatment of staff in the hospital departments that we inspected. We observed excellent interaction and communication, and a kind compassionate approach being taken with all patients.

Care is excellent - cannot think of a way it can be improved. Very grateful for their kindness and help. Always try to find food the patient likes.

– Patient – Aneurin Bevan

We saw good management and leadership in some settings, and strong examples of multidisciplinary teams working effectively and efficiently.

Our inspectors observed clean and tidy wards and good infection control policies and procedures in some but not all settings. It is positive to note that on two orthopaedic wards at the Royal Glamorgan Hospital, there had been no incidences of hospital acquired MRSA or Clostridium Difficile for the past 600 and 1,000 days.

This suggests that the ward staff are vigilant in compliance with infection prevention and control.

We saw good management and leadership in some settings, and strong examples of multidisciplinary teams working effectively and efficiently.

During my stay on the ward, the staff were really friendly and helpful. The ward was always clean and tidy and the treatment was five star. Staff really attentive and made sure I was comfortable and looked after.

– Patient, Velindre University NHS Trust

The ward team are supportive of one another and work together. The ward manager thrives on providing excellent care to patients and also cares for the staff on the ward, encouraging and supporting all members of staff. I thoroughly enjoy working as part of this team

– Staff member, ABM

There were improvements following our recommendations in some of our follow-up inspections, however, it is disappointing that in some instances improvements had not been made.

Insufficient checks and poor maintenance of resuscitation equipment was an issue in several settings. In addition, in all of our surgical inspections, we identified poor compliance with the risk assessments for venous thromboembolism, in patients requiring trauma or other orthopaedic surgery. This, along with the issues around resuscitation checks, resulted in HIW issuing immediate assurance notifications to the relevant health boards.

The majority of our inspections highlighted issues around staffing, recruitment and retention, and in some health boards it was clear that these issues were leading to low morale and concerns around the potential for patient safety to be compromised.

There is low morale and mood on the ward amongst staff due to the constant threat of moving to other areas that you are not competent to work. Often leaving your own ward short staffed

– Staff, Cwm Taf

We could deliver higher standards of care if we had the right amount of staff to meet all patients individual needs

– Staff, Cwm Taf

It is difficult to provide a good standard of care due to staff: patient ratios, high demand… can compromise care. Everyone works as hard as they can however, patient needs are not always met

– Staff, Cardiff & Vale

Staff are under a lot of pressure but still carry out duties in a professional manner

– Patient, Hywel Dda

The secure storage and administration of medicines is still a problem in many settings in spite of HIW reporting this finding as a concern over a number of years. HIW will be raising this issue with Welsh Government and other relevant bodies to encourage improvement in this area.

In terms of staff training, we saw complete and well documented examples of the delivery of training and continual professional learning in some settings. However, we found scope for improvement in this area in during many of our inspections.

When inspectors considered quality improvement, research and innovation during inspection, the findings were variable across the wards and health boards, where some sites were actively engaged with this, and other were not. During one inspection, we positively identified that on one ward, the ward staff and multidisciplinary team at Withybush General Hospital, were members of a quality improvement group. From this, a training package for the prevention and management of patient falls had been developed and implemented. This resulted in a significant reduction in the incidence of falls, and this was later shared wider across the health board.

GP Practices

This year we undertook 20 inspections of general practices across the seven health boards in Wales. Each GP inspection considered how the practice met the Health and Care Standards.

Findings

Overall, staff were polite and courteous to visitors and patients, and patients were treated with dignity and respect. The majority of practices were clean and well maintained and we observed a welcoming environment at GP surgeries.

Patients told us they were happy with the care they received, but there were numerous complaints about the processes in place for booking appointments. This included poor availability of appointments, particularly at short notice, and long waiting times to see a doctor for routine appointments.

Good practice

One practice was taking part in a trial offering out-of-hours appointments to patients one day over the weekend. This was delivered as part of the cluster where GP practices took turns in offering appointments to patients within their cluster group. This meant that patients had local access to an out–of-hours service, and did not have to travel to one of the three primary care centres across Cardiff and the Vale of Glamorgan. We found this to be of noteworthy practice, and staff told us that patient feedback was positive about the service. The trial was shortly due to end, and it would be evaluated to determine whether to continue with this service in the future.

Great surgery. Difficult to make an appointment. Waited two weeks
– Patient, Cwm Taf

It is impossible to get an answer at 8:30am and then when the line is clear appointments are very scarce
– Patient, Hywel Dda

It can take 20 mins to answer a phone! [We need a] dedicated phone line. Time keeping on appointments needs looking at
– Patient, Aneurin Bevan

We saw evidence of good leadership in practices with cohesive and inclusive management teams in place. Some examples of good communication between practice teams was evident, and we identified good cluster working including a pilot for out of hours GP access in one health board.

Inadequate staff training records were noted in some practices with improvements required to ensure mandatory training is completed by all staff, and training renewal dates are not missed.

During some inspections, it was identified that not all practices recorded the Hepatitis B immunity status for all clinical staff. This meant that the practice could not produce evidence that all clinical staff had sufficient immunity to the virus.

We observed good examples of patient record keeping in many practices. Where it was necessary to make recommendations in this area, our recommendations generally related to consistency in the level of documentation within clinical records. On a number of occasions we also recommended that audit arrangements be reviewed in order to improve the quality of patient records.

We found that improvements were needed to processes for recording and considering concerns and complaints, including displaying information about the NHS Wales Putting Things Right process.

Dental Practices

In 2018-19 we continued our programme of inspections of general dental practices in Wales. This year we inspected 73 practices, including one follow up inspection. We issued immediate assurance or non-compliance notices following seven of these inspections where we identified immediate action was required to address serious patient safety concerns. Overall this is an improvement on the previous year when 13 immediate assurance letters were issued following inspections of 104 practices. We also found that practices responded appropriately when these issues were brought to their attention.

Some practices offer private only dental treatment, some offer a combination of NHS and private dental treatment and others provide NHS only services. During these visits we explored how dental practices met the standards of care set out in relevant legislation and guidance, including the Health and Care Standards and the Private Dentistry (Wales) Regulations.

This year also saw HIW complete the registration of all dental practices offering private dental treatment under the Private Dentistry (Wales) Regulations 2017; in total 485 practices were registered. This was a significant task undertaken with minimal additional resources and at times required the whole organisation to work together.

Overall practices engaged positively with the registration process but the quality of applications and supporting documentation submitted was variable.

There were also some additional benefits of the registration project; by contacting every practice in Wales over a time-limited period we were able to increase our awareness with dental teams.

We are seeing an increase in the number of patients contacting us with dental concerns which suggests that HIW's role is more visible in practices.

Another of HIW's key goals is to increase its follow up activity. During the registration process we were able to request updated improvement plans from all practices that had been inspected prior to their registration being granted, to seek assurance that actions had been taken to address all the recommendations we had made.

Excellent dentist, always compassionate, caring and professional. Practice staff are excellent, particularly the Practice Manager.

- Patient, Aneurin Bevan

Findings

We inspected dental practices in every local health board in Wales and the findings were generally very good. However, where we did identify areas for improvement they were similar to those found in previous years.

Patient experience was once again very good overall, with patients telling us that they are very happy with their care and treatment. Our inspectors often commented in reports that staff are friendly, professional and patient focussed.

We find that most practices are now actively engaging with patients to obtain feedback on the service provided. However, we regularly advise practices to display results of questionnaires or surveys and inform patients of actions taken to respond to their feedback and improve the service provided. Taking such an approach helps demonstrate to patients that their views are listened to.

I have always had complete faith in the dentists that have offered me dental care. I have had proceedings explained in depth & time to reflect on whether I wish to proceed. I have recommended the practice to others

– Patient, Betsi Cadwaladr

The care and service is the best I have ever received compared to other practices I have been with in the past

– Patient, Hywel Dda

In general, practices were well equipped and maintained to high standards of cleanliness. During many inspections, we also observed appropriate arrangements for the safe use of X-rays. However there were a small number of instances where significant improvements needed to be made regarding overall cleanliness, infection control and decontamination of dental instruments.

The quality of patient records was variable with excellent record-keeping in many practices and areas for improvement elsewhere. Issues arising most often were the need for:

- Correctly recording and updating medical histories and allergies
- Recording patient consent
- Recording of treatment options discussed with the patient and the justification for the treatment performed
- Cancer screening examinations where appropriate
- Secure storage of patient records

We found that many practices demonstrated good leadership and management and had a range of effective policies and procedures in place to support overall practice management. However, the application process for dental practices to register under the Private Dentistry (Wales) Regulations 2017 required the registered manager to sign a declaration that the policies and procedures required by the regulations were in place.

Despite this, at some inspections, we found examples of particular policies not actually being in place. This is very disappointing and does not reflect well on those practices. With the dental registration project now complete this provides a timely and relevant example to remind practices that they have a legal responsibility to comply with the regulations.

Arrangements for training and continued professional development is an area of strength for the vast majority of practices. However, we continue to identify that staff have not always received training in key areas such as, safeguarding, resuscitation training, fire safety and appropriate employment checks (Disclosure and Barring Service).

Overall, compliance with standards and regulations at dental practices is improving year on year. HIW is making fewer recommendations overall and the number of immediate patient safety issues is also reducing.

Mental Health and Learning Disabilities

HIW continues to undertake its responsibilities to monitor the Mental Health Act 1983 on behalf of the Welsh Ministers who have specific duties that they are required to do in law. These duties include formulating a report on how the Act is being implemented in Wales and ensure individual health boards and independent registered providers discharge their duties so that the Act is lawfully and properly administered throughout Wales.

During 2018 - 19 we undertook 17 independent healthcare inspections including one learning disability hospital.

Four of these visits were made to the same independent provider due to significant concerns from our inspections, and an additional two visits were made to another independent provider.

As part of these visits HIW monitored the use of the Mental Health Act, the Mental Capacity Act, including the Deprivation of Liberty Safeguards (DoLS) and the Mental Health (Wales) Measure 2010.

Findings

During the visits HIW identified many positive areas including; the respectful manner that staff communicated with patients, good team working and a motivated workforce. We also found that some services were working hard to reduce restrictive practices and that a good range of therapies and activities were available.

HIW made a significant number of recommendations to the individual health boards and requirements for the registered independent providers of care. We continued to identify many failings in the maintenance and refurbishment of wards and in some cases this was having a detrimental effect on patient care, privacy and dignity and patient safety. Some of the issues identified included; fire doors being wedged open, a lack of a nurse call system, lack of sanitary bins, lack of maintenance of garden areas, lack of sufficient alarms for staff and environmental issues impacting on patient privacy and dignity.

We also identified out of date policies and procedures and a lack of a comprehensive range of patient information available on the wards. There was also a lack of care and treatment and risk management plans, and a lack of staff training in some key areas, for example basic life support.

Issues with effective medicines management were again identified this year. This included; a lack of policies and procedures, inadequate completion of medicines administration charts, medicines cupboards not locked when not in use and medication on the wards, for patients, that had been discharged.

Other issues included a lack of bed capacity for acutely ill patients in the health boards. In contrast some of our independent health care providers had surplus capacity in some of their wards.

We continued to identify many good practices with the implementation and documentation of the Act and it was apparent that there was a good level of scrutiny and audit. Files were generally well organised and contained the necessary detention information.

We did however identify some issues with the administration of the Act including:

- Section 17 leave forms not being clearly marked where they were no longer valid (which could lead to confusion with the current section 17 leave entitlement of patients)
- Some recording issues in relation to the rights of patients under section 132
- A lack of detention papers in current patient records
- Delays in some reports being submitted for patients' appeals against their detention

Independent Healthcare

Our inspections of independent healthcare settings, other than mental health, seek to ensure that services comply with the Care Standards Act 2000, the requirements of the Independent Health Care (Wales) Regulations 2011 and to establish how services meet the National Minimum Standards (NMS) for Independent Health Care Services in Wales. We aim to inspect these services at least every three years, but may visit more often if required as a result of intelligence or service change.

Findings

Independent Hospitals

Overall our inspections of independent hospitals this year have been very positive; on one particular inspection we did not identify any improvements that were required. We have also seen a reduction in the number of immediate patient safety issues identified resulting in the issue of a non-compliance notice. Only one was issued in 2018-19 due to a service not being able to demonstrate Hepatitis B immunity for a single member of staff.

It was also positive that on all inspections:

- Patients told us that they were happy with the service they had received
- We observed staff demonstrating a caring and courteous approach to patients
- We found clear lines of responsibility and accountability on all inspections.

In the main, patient records were maintained to a high standard. However, we did identify some issues with legibility, staff not signing their designation, and care plans needing to be more individualised including ensuring they reflected action to be taken should an emergency arise.

Medicines management was an area where we made a range of recommendations; key issues identified were:

- inconsistent use of pain management tools
- not recording temperatures of medication fridges and rooms in which medication is stored
- regular checks of emergency drugs not being undertaken
- the need to maintain a medication stock list for the whole service.

Leadership and management was an area where very few recommendations were made. However, again this year we had to remind registered providers of their responsibility to undertake regular monitoring visits. Given that this has not improved since last year, we will be reminding providers more formally of their responsibilities.

My husband and I both feel this is a very warm and welcoming place. Staff are knowledgable and informative. You can tell they all enjoy their roles here.

- Patient, Independent Hospital, Cwm Taf

Hospices

On all five inspections we witnessed staff interactions with patients that were kind, caring and professional. We also observed that the services were well maintained, welcoming and offered a good range of facilities and activities appropriate for the patient group.

Overall, management of the services we inspected was good with positive multidisciplinary team working being evident on all inspections.

In the main, we found care plans to be patient centred, however, we did need to remind registered providers that care plans must be individualised and should be written from the perspective of the patient. In two services this was done particularly well and we could clearly see how the patient and carer had been involved in developing the plans for their care and treatment.

All of the hospices we inspected were conducting an appropriate range of audits. However, we often found that the results of audits were not displayed and actions arising from the audits were not documented.

The prevention and management ofpressure ulcers is a key risk that hospices need to address. We made some recommendations in this area around the use of repositioning charts and the need to ensure pressure ulcer risk assessments are undertaken when patients are admitted.

Medicines management was an area where we often made recommendations for improvement; key issues identified were:

- Staff not signing for medication immediately after administering it
- Staff not witnessing patients taking their medication
- Recording of medication fridge temperatures.

We did observe some good practice in this area, for example, where service nurses wore red tabards during medication rounds to discourage other members of staff interrupting them when carrying out this task. This helps the risk of making errors when administering medication by not being distracted.

Independent Clinics

As with other independent services we inspected this year we found that patient satisfaction was high for our registered clinics; this aligned with us observing caring, friendly and professional staff working at them. Overall, we saw that appropriate information was available for patients receiving treatment, however, the actual information provided to patients was not always recorded in their notes.

The use of chaperones was identified as an issue in all but one of our clinic inspections. Registered providers need to be clearer in recording the offer and use of chaperones.

The need to make better arrangements for people with hearing difficulties was also raised in 75% of our inspections.

Record keeping was the area under which most recommendations were made; key issues included:

- Records not clearly describing the treatment provided and by which practitioner
- Insufficient detail recorded in patient medical histories
- Verbal consent to examination or treatment not being recorded in patients' notes
- Care records not being signed and dated after each consultation.

In addition we identified that key documents such as the statement of purpose and patients' guide were significantly out of date. Registered providers must ensure that these documents are reviewed regularly and kept up to date at all times.

Class 3b/4 lasers and Intense Pulsed Light

Our findings in these types of inspections are very similar to previous years. On a positive note this means that we continue to see services that:

- Provide comprehensive information before treatment that enables patients to make an informed decision about treatment choices
- Are clean, tidy and well maintained
- Are committed to providing a positive experience for patients including appropriate arrangements for actively seeking feedback
- Store records appropriately
- Have arrangements to uphold the privacy and dignity of people receiving treatment.

However, rather disappointingly, we continue to find that key documents such as the Patients' Guide and Statement of Purpose are not kept up to date and do not include all information required by the regulations. We regularly find that:

- HIW's contact details are incorrect
- A summary of patient feedback is not included in the Patients' Guide
- The complaints process is not adequately described
- The Patients' guide is not available for people to take away
- Consent to treatment is not consistently recorded, especially when recording consent (verbal or written) at each treatment point within a course of treatment sessions
- Medical histories are not reviewed at each treatment point within a course of treatment
- Safeguarding policies need updating to include details of the local authority safeguarding teams. Also, staff need to undertake training in the protection of vulnerable adults and the protection of children
- Treatment registers do not always contain all of the information required by the National Minimum Standards.

Reassuringly, the number of non-compliance notices we issued this year was very low, but as with our overall findings, the reasons for doing so were similar to last year and related to services not having a contract with a Laser Protection Adviser (LPA). This meant that key policies and procedures such as the local rules and risk assessments had not been reviewed as required by the regulations and the service's conditions of registration.

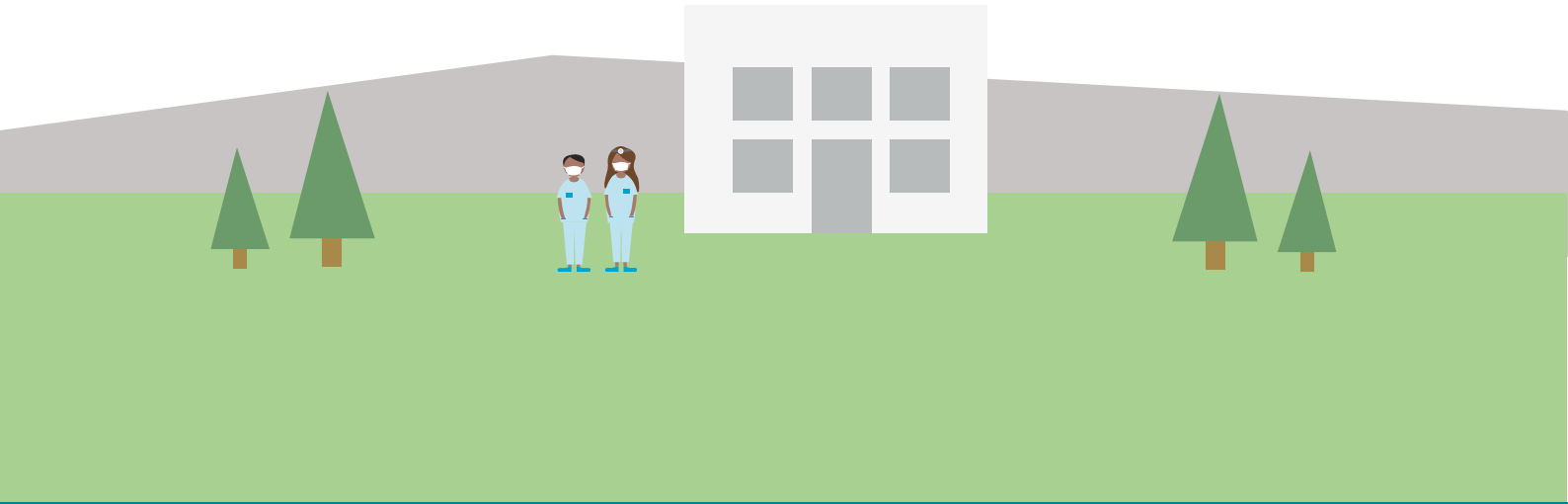
We also found one registered provider who could not demonstrate that the laser machine had been serviced and maintained as per the manufacturer's instructions. Both the appointment of an LPA, and regular maintenance of equipment, are vital to ensuring laser/IPL equipment is safe to use and registered providers are reminded that cost cutting in these areas is not acceptable and can lead to enforcement action being taken.

Ionising Radiation (Medical Exposure) Regulations (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.

During 2018-19 we completed five IR(ME)R inspections including an inspection at an independent hospital. These inspections checked that services were compliant with IR(ME)R and also looked at whether care and treatment was being provided in line with the Welsh Government's Health and Care Standards.

The inspections also covered all three modalities of medical exposures: Radiology, Diagnostic and Interventional Imaging, and Nuclear Medicine.



The service provided for me today was excellent. The nurse with me was really lovely. Very helpful"
– Patient, Hywel Dda University Health Board

Findings

On all of our inspections we asked patients to rate their experience; the vast majority said they would rate their experience as either excellent or very good. When asked what improvements could be made comments were varied. However, the availability of parking was an issue that was raised frequently.

It was also positive to see, on all inspections, staff being kind and respectful to patients. However, we found that improvements were required to the environment in two hospitals we visited to further promote the privacy and dignity of patients.

2018-19 was a year of change for employers with the new IR(ME)R 2017 regulations introduced in February 2018. Overall, employers had responded well to the changes, but we did identify the need to develop employer's procedures in more detail in all of our inspections. In two cases we identified that the employer did not have a procedure for a quality assurance programme for equipment; this after identifying in previous years that ageing and inefficient equipment was impacting on the timeliness of patient care. In addition, we identified that employers needed to do more to make information available for patients to ensure that the risks and benefits of exposure to ionising radiation were made clear.

2018-19 saw HIW issue its first Improvement Notice due to serious concerns identified at Prince Charles Hospital. We identified that National Diagnostic Reference levels were being exceeded and that the establishment of Local Diagnostic Reference Levels was inconsistent. Fundamentally these concerns arose because of a lack of governance and oversight of IR(ME)R by the health board and we would ask all IR(ME)R employers to reflect on whether the profile and focus of IR(ME)R compliance in their organisation is appropriate.

Offender Healthcare

Reviews of deaths in custody

The Prisons and Probation Ombudsman (PPO) is required to undertake an investigation of every death that occurs in a prison setting. HIW contributes 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 reviews critically examine the systems, processes and quality of healthcare services provided to prisoners during their time within a prison or Approved Premises. From 1 April 2018 to 31 March 2019 we were commissioned to complete 19 clinical reviews on behalf of the PPO.

Generally our death in custody reviews concluded that the care provided to prisoners in Wales was equitable with the expected level of care in the community.

We noted good relationships between prison healthcare staff and staff from health boards. We made recommendations for improvement in the standards of documentation of prisoners by health and medical staff including:

- Where care plan templates are used within the electronic clinical record, these should be accompanied by an individualised assessment of the person's needs and accompanied by specific and tailored interventions to meet these identified needs
- Training in relation to record keeping ensuring that there is consistency across all healthcare staff

Prison Inspections

HMI Prison Inspections of prisons in Wales are undertaken by Her Majesty's Inspectorate of Prisons (HMIP). There is a Memorandum of Understanding in place between HMIP and HIW, and we are invited to attend the HMIP inspections of Welsh prisons. These mechanisms enable us to share our learning from clinical reviews of deaths in custody and also to consider the governance of prison healthcare.

During 2018-19, we attended one HMIP inspection at HMP Berwyn near Wrexham. The inspection found good practice in regard to the health assessment of new prisoners, good mental health services, and the positive inclusion of a member of the pharmacy team. The inspection also identified some areas for improvement particularly in the areas of:

- A prison-wide strategy to support health promotion
- Health staff should always see prisoners returning from external hospital appointments to establish any treatment and support needs
- Suitable occupational therapy equipment and adaptations be provided and installed promptly
- There should be a formal and robust procedure to follow up patients who miss medicine doses
- Pharmacists should carry out medicines use reviews with patients
- Prisoners should have access to dental treatment within community-equivalent waiting times

Youth Offending Services

We continue to work in partnership with Her Majesty's Inspectorate of Probation in the review of healthcare provided within Youth Offending Services. These reviews also involve a range of other partner agencies including Estyn and CIW.

In March 2019 HIW participated in an inspection of Western Bay and considered the healthcare that young people received. Several issues were identified with young people not receiving an adequate level of healthcare and we contributed to the final report produced by Her Majesty's Inspectorate of Probation.

We noted that there were very limited health services to meet the physical, sexual, emotional and mental health needs of children and young people, and this was highlighted as an Area for Improvement in the report which can be viewed on HMI Probation's website.

Aneurin Bevan University Health Board

Overall, patient feedback was positive on all inspections. Patients felt they were treated with respect by staff, and the quality of the care they received was of a good standard.

We were pleased to find evidence of effective multidisciplinary working in some of our inspections, particularly in our GP and Mental Health inspections.

Engagement from the health board was good throughout 2018-19, with prompt responses provided to our requests for improvement plans. The health board also responded promptly to any concerns we received through our concerns process.

Unfortunately, we found that action is not always taken as a result of previous HIW inspections, and this has been particularly evident across the two mental health inspections conducted in 2018 - 2019.

Despite raising our concerns regarding the lack of shower facilities at St Cadoc's Hospital during our previous inspection in October 2016, there remained only two showers for up to 22 patients on the Adferiad ward when we inspected again in November 2018. Both showers had stained flooring and walls, as well as evidence of fungus around the window frames.

In addition, a number of issues identified at our inspection of County Hospital in 2017 were identified again at an inspection in 2018. We found that Care and Treatment Plans (CTP) were still not being fully completed and that the personal alarm system was not fit for purpose.

We issued three immediate assurance letters to the health board in 2018 – 2019 and we received sufficient assurance on the issues raised. This meant that the improvements had either been addressed or progress was being made to ensure patient safety is protected.

There are issues across the health board with regards to training being provided and kept up to date, as well as the overall standard of record keeping.

Hospitals

We inspected two hospitals: Ysbyty Aneurin Bevan (two wards) and Royal Gwent Hospital (surgical)

- Patients were highly complementary of the staff involved in their care and treatment
- Patients were appropriately supported and monitored at mealtimes
- Strong management and leadership within both hospitals
- Issues with staffing levels at both hospitals
- Improvements required relating to training for staff

Mental Health

Two mental health inspections in St Cadoc's Hospital and County Hospital

- Patients were treated with respect and care
- Good access to indoor and outdoor activities
- Effective communication between staff and teams
- Good use of meetings to plan and handover
- Issues with Mental Health Act application and documentation
- Recommendations from previous inspections not actioned
- The alarm systems at both hospitals were not fit for purpose and did not provide a safe setting for staff and patients

Dental

We inspected 14 dental practices

- Patients told us they were very happy with their care and treatment
- Patients being treated with dignity and respect
- Appropriate arrangements for the safe use of X-rays
- Patient records are not always maintained correctly and securely stored
- Staff are not consistently completing relevant training
- Patient information and the distribution of patient leaflets could be improved

GP

We inspected two GP practices

- Positive patient comments about the service
- Staff were polite and courteous to patients and visitors
- Good communication between practice teams
- Improvements to patient records and maintenance of staff training records to ensure renewal dates are not missed
- Increased promotion and usage of the chaperone service

IR(ME)R

We completed one IR(ME)R inspection at the Royal Gwent Hospital

- Patients reported a positive view of services provided by the department
- Patients felt involved in any decisions about their care
- Staff had a good awareness of the risks associated with ionising radiation and their responsibilities in this regard
- The health board must ensure it maintains the dignity, privacy and safety of patients who are transported to the holding bay of the department's in-patient area
- Aspects of the employer's (IR(ME)R) procedures need to be updated, developed and formally adopted
- Staff training and entitlement records need to be completed correctly, signed and dated by the trainee, and countersigned by the trainer for verification purposes

Community Mental Health

We undertook one Community Mental Health Team inspection – North Monmouthshire

- Service user feedback was generally positive about their care and treatment
- Staff were committed to providing a positive experience for service users in a difficult environment
- Service user assessments were completed in a timely manner
- We saw evidence of good team working between professional disciplines.
- The environment for service users
- Information for service users, including advocacy and complaint processes and procedures
- Some areas of health and safety, including a ligature point risk assessment
- Elements of recording in care records, to ensure a consistent high standard is met across the team
- Managerial processes and procedures to improve integrated working

Abertawe Bro Morgannwg UHB

Following the Bridgend boundary change, Abertawe Bro Morgannwg University Health Board became Swansea Bay University Health Board on 1 April 2019. For the purposes of this report which covers the 2018 – 2019 period we have used the former name of the health board.

In general, our inspections have shown that patients have been treated with dignity and respect and were happy with the healthcare provided. Many service areas have also demonstrated good leadership and management.

There were, however, some areas that required improvement including, record keeping and medicine management in some settings. The management and maintenance of resuscitation equipment must also be up to date, and staff must be appropriately trained in the equipment.

The way serious incidents are investigated is also inconsistent.

Historic governance was scrutinised in detail last year in relation to the health board's handling of the employment and allegations made against Kris Wade. Our review found that the issue of line of sight between the Board and operational services has been a recurrent theme since 2014. The current Board has accepted our recommendations and is maturing with a focus on improvement.

We also made a number of recommendations for all health boards in Wales as noted in our National Reviews section, and in more detail in the full report on our website.

Hospitals

We conducted an inspection at the Neath Port Talbot Minor Injuries Unit and a surgical services inspection at Morriston Hospital

- Patients were treated with dignity and respect in both hospital inspections
- Good infection control procedures
- Good systems in place to promote patient safety
- Good management of controlled drugs
- Timely management of trauma and orthopaedic patients
- Concerns about the management of theatre lists at the unit were expressed by staff
- Safety checks in theatre need strengthening
- Concerns over the number of never events
- Key equipment, resuscitation checks and audit arrangements need to be improved (NPT). These issues have been found in the minor injuries unit on previous visits
- Risk assessments for blood clots (Morriston)

Mental Health

We inspected the Tawe Clinic at Cefn Coed Hospital

- Patients were treated with kindness and compassion
- Information about advocacy was prominently displayed
- Efforts had been made to make the entrance and outside areas pleasant for patients to use
- Visible and supportive leadership
- Good compliance with health board mandatory training
- No call system for patients in bedrooms
- Lack of furniture in bedrooms
- Inadequate checking of emergency equipment
- Aspects of record keeping need improvement
- Information about how to raise a concern should be clearly visible
- Care and treatment plans need to be in line with the Mental Health (Wales) Measure

Dental

We inspected 13 practices

- Patients reported a friendly, professional and patient-focused service in 10 out of 13 practices
- Good leadership in 8 of the 13 practices visited
- Safe use of x-rays in 5 practices
- A good suite of policies and procedures in five practices

- Improvements need to be made in clinical record keeping in most practices – recording of medical histories, allergies, health promotion advice, treatment justification, consent and cancer screening.
- Gaps in staff training in safeguarding, resuscitation training, and fire safety.
- Improvements needed in the management of equipment including emergency equipment

GP

We inspected three GP surgeries

- Patients were treated with dignity and respect
- Surgeries were clean and accessible
- Evidence of engaged managers and good leadership

- Provision and checking of emergency equipment in two settings
- Policies and procedures needed updating in all practices
- Mandatory training gaps-resuscitation, safeguarding, infection control
- Website requires updating in two practices
- Provision of a working hearing loop at two practices

Community Mental Health

We inspected the Neath Port Talbot Community Mental Health Team

- Dedicated staff
- Patients treated with dignity and respect
- Evidence of supportive treatment plans for patients

- Environmental risks-such as ligature points (the service received an immediate assurance letter in relation to the environmental risks)
- Poor culture of incident reporting
- Discord between leaders leading to a poor culture at a senior level

Betsi Cadwaladr University Health Board

Our inspections of the health board over the past twelve months have been broadly satisfactory. Some of our visits have been a follow-up to previous inspections, and it is positive to report that most of the improvements had been implemented, and importantly, sustained.

One of the key challenges for the health board, noted during our inspection, is in maintaining patient flow through the emergency department at Glan Clwyd Hospital and tackling the prolonged waiting times for patients.

Whilst it was encouraging that none of our mental health inspections resulted in us issuing an immediate assurance letter, and it is clear that much effort is being made to improve services, we remain concerned about overall service capacity.

The health board must ensure that there is sufficient capacity in mental health inpatient services to meet the needs of its population. We are also concerned about the length of time some patients in the community may be waiting for access to psychological services, with some waiting up to two years. This is not acceptable and steps need to be taken to address this.

Whilst the GP inspections were positive overall, we were consistently told by patients of concerns regarding the ability to make appointments at their practice.

Overall, whilst it is positive to note some of the improvement across our inspections last year, it is clearly imperative that these are sustained and built upon by a health board that remains under special measures.

Hospitals

We inspected Bryn Beryl Hospital and Ysbyty Glan Clwyd Emergency Department

- ✓ Good evidence of person-centred care and staff engagement
- ✓ Effective risk assessment, auditing and reporting
- ✓ Clean ward environment and good infection control arrangements at Bryn Beryl Hospital
- ✓ Effective multidisciplinary working and a visible management team at Glan Clwyd Hospital
- ✓ Glan Clwyd was a follow-up to the visit in November 2016, and it was positive to note that the majority of listed improvements had been implemented and sustained
- ✗ Some issues found at the previous Glan Clwyd inspection were still present, in particular, patient identification arrangements and inconsistent usage of fluid charts
- ✗ At Bryn Beryl we noted issues in regards the provision of arranged activities for patients and the fact there was no television, radio, or a lounge for them
- ✗ A more dementia friendly environment is needed at Bryn Beryl
- ✗ At Glan Clwyd, patient concerns regarding waiting times and patient flow
- ✗ Whilst it was positive to see lots of new staff at Glan Clwyd, recruitment to vacancies is still a challenge

Mental Health

We inspected the North Wales Adolescent Unit

- ✓ Staff engage with patients respectfully
- ✓ The facilities and environment at the Child and Adolescent Mental Health Service (CAMHS) Unit in Abergele were found to be good
- ✓ Established governance arrangements were in place
- ✓ Good multidisciplinary working and coordination with community paediatric teams
- ✗ The external and internal environment required attention at the Hergest and Ablett Units
- ✗ Systems for maintaining the safety of patients and staff in the North Wales Adolescent Unit required improvements
- ✗ The health board faces challenges in ensuring that mental health services have enough capacity to meet the needs of its population

Dental

We inspected 21 dental practices

- Patients were able to make informed decisions about their treatment
- Services were well run and staff were committed to providing a high quality service
- Surgeries were well equipped and clean, with appropriate arrangements for safe use of x-ray equipment

- The need to strengthen the implementation of a range of clinical audits was found to be an issue
- Fire training required improvement at several inspections
- Wall mounted sharps bins not installed
- Steps to implement clinical peer review and self-evaluate using the maturity matrix dentistry tool

GP

We inspected six GP surgeries

- Good record keeping and internal communications in most inspections
- Professionalism of practice staff and good staff support services
- Cohesive and inclusive management teams in place

- Issues with appointment systems in all 6 inspections
- Inadequate training records were noted at several inspections
- Audits and data security were in need of improvement across many of the practices

IR(ME)R

We undertook one IR(ME)R at Wrexham Maelor

- Staff treated patients with dignity, respect and kindness
- Good compliance with theregulations
- The health board has been proactive in creating new procedures to meet the requirements of the new regulations

- Health board to consider how written patient information can be made more accessible and consistent
- Information on how patients can provide feedback or raise a concern about their care and treatment needs to be clearer
- Level of detail needs to be improved within the delegated authorisation guidelines for the justification of exposures

Community Mental Health

We conducted one cCommunity Mental Health Team inspection at Nant-y-Glyn

- Positive feedback from service users and a person-centred approach
- Auditing, reporting and escalation processes good at the CMHT
- Team managers to be both accessible and supportive

- The health board faces significant challenges in ensuring timely access to psychology and psychotherapy services, with delays of up to two years
- The physical environment of the CMHT required significant attention
- Problems with integrated ICT and lack of joint access to electronic records

Cardiff & Vale UHB

Inspection findings within the health board were generally positive. Where improvement was required, all services have responded constructively and engagement from health board leadership has also been positive.

Re-inspection of services by HIW has revealed improvement in many areas and it is clear that the health board sees external and internal scrutiny as a positive means of learning and improving.

Further work is required in general practices and some hospital settings to ensure that patients are aware of how that can raise a concern about the care they received.

HIW's inspection of the emergency and assessment unit at University Hospital revealed a number of issues which were impacting on the safety and dignity of patients. The health board must reflect on its own assessment of the arrangements that were in place prior to HIW's inspection and why more action was not taken in relation to issues of which it was aware.

Hospital

We carried out two inspections at St David's Hospital and the University Hospital Wales

- Broadly positive findings in relation to our follow up inspection of St David's hospital, with action having been taken in relation to previous findings
- A number of positive findings relating to our inspection of the emergency and medical assessment units at University Hospital of Wales.
- Training and induction provision appeared to be excellent
- We also observed excellent interaction between staff and patients in the emergency and assessment units with a kind compassionate approach being taken with all patients
- A number of immediate patient safety issues following our inspection of the emergency and medical assessment units at University Hospital of Wales
- Inadequate arrangements for treating and monitoring patients in the assessment unit and failure to regularly check resuscitation equipment and medicine to ensure that it could be used safely in the event of an emergency
- Further work is required in relation to the safe administration of medicine (St David's)
- Scope for greater involvement of social workers and speech and language and occupational therapy input (St David's)

Mental Health

We carried out one mental health unit inspection at Hafan y Coed in Llandough Hospital

- Peer review checks were being carried out with staff from other areas of the hospital to check the quality of care as a means of driving up standards and sharing good practice
- HIW's peer reviewers were impressed by the comprehensive needs assessments being carried out to develop patients' care and treatment plans
- Health and safety audits, including ligature audits, were thorough and up to date
- Whilst the health board has effective arrangements for managing the risk associated with 'patients sleeping out' of the unit this appears to be a common occurrence
- Garden areas in the Hafan y Coed mental health unit are dirty and unkempt. The unit relied on the staff to clean and maintain these areas, which they rarely had time to do. As the only outside space available to detained patients, the condition of these facilities has a significant impact on patient experience

GP

We carried out three GP inspections this year

- Patients were positive generally about their experience and in 2 of the 3 practices inspected they found it easy to make appointments
- There were some examples of good cluster working, including an out of hours pilot
- All practices were well maintained and clean
- All practices were considered to be safe and effective, although 2 required improvements to fully meet the health and care standards
- Practices were generally well led
- An immediate assurance letter was issued at 1 practice due to issues around checking drug fridge temperatures
- A range of improvements were required around administration of Putting Things Right, including better recording of complaints and provision of information to patients (all inspections)
- Scope for improvement in the quality of record keeping, including consistency of recording the reasons for prescribing or significant diagnoses (in 2 practices).

Dental

We inspected 11 dental practices

- Patients were happy with the care they received in all inspections
- The standard of record keeping was high or good in 7 of the 11 inspections completed
- We noted positive management and leadership in most inspections
- Most practices had appropriate arrangements for use of X-ray
- In general, practices were clean with few minor environmental issues requiring rectification
- Issues with frequency of checks, storage or location of emergency equipment in 6 inspections
- A number of practices should increase the levels of audit and quality improvement activities carried out

Community Mental Health

We inspected the West Vale Community Mental Health in Barry

- Safe and effective care was being provided with positive feedback from users, improved access and timeliness
- Consistently high standards of record keeping at the CMHT, including Mental Health (Wales) Act documentation
- Good, multi-disciplinary, approach in relation to service user assessments, care planning and reviews
- The CMHT service was in a period of substantial change which impacted upon processes, procedures, meetings and management structures
- Staff morale was affected as a result and there was a need for clarification with regards to these arrangements

Cwm Taf University Health Board

Following the Bridgend boundary change, Cwm Taf University Health Board became Cwm Taf Morgannwg University Health Board on 1 April 2019. For the purposes of this report which covers the 2018 – 2019 period we have used the former name of the health board.

We noted a somewhat mixed picture from our inspections in 2018-19. Across our inspections, patient feedback was generally positive and we found patients were treated with dignity and respect.

We were pleased to find evidence of effective multi-disciplinary working in some of our hospital and CMHT inspections. We saw truly integrated working between health and social care staff in our CMHT inspection in Merthyr and we believe other CMHTs across Wales could learn from this good practice.

However, we identified significant concerns in a number of our inspections. Of particular concern were the findings from our inspections in maternity services and surgical services in Royal Glamorgan Hospital, follow-up in elderly mental health wards in Royal Glamorgan Hospital, IR(ME)R in Prince Charles Hospital and dental inspection.

Our inspections across Royal Glamorgan Hospital have highlighted concerns around staffing levels, skill mix of staff and low staff morale.

Across our work, we have identified a lack of evidence of organisational learning from previous inspections. For example, during our surgical services inspection we highlighted issues regarding the checking of resuscitation equipment, it was therefore disappointing to find the same issue in our maternity services inspection within the same hospital a few weeks later.

We were particularly disappointed that our follow-up inspection of the elderly mental health wards in Royal Glamorgan Hospital identified that not only were the actions from the last inspection not completed, a number of new issues were identified, including concerns around medicines management.

During last year's mental health inspections we found issues with maintenance and the improvement of service environments. Again this year, we found environmental/estates maintenance issues in Royal Glamorgan Hospital and Tŷ Llidiard.

In our maternity services inspection, we were concerned about the sustainability, resilience and ability of service to provide care and treatment in a safe and effective way. We found significant staffing issues which impacted on delivery of safe and effective care in a number of ways including staff well-being, reviewing of incidents and concerns, mandatory training and clinical audits.

We also found a disconnect between a number of professional groups across the service which impacted on multidisciplinary team working. We continue to closely follow the progress of the health board in responding to these issues.

In our IR(ME)R inspection in Prince Charles Hospital, we found the service was non-compliant in respect of the assessment, monitoring and recording of patient radiation doses and the need to strengthen the employer's response to reports provided by the external radiation protection service. This meant that patients could have received exposures that were not as low as reasonably practicable or consistent with the intended diagnostic or therapeutic purpose.

We will be closely monitoring the findings from our programme of work in 2019-20 to gauge whether we are seeing better evidence of organisational learning and improvements being embedded and sustained across services. As part of this work, Healthcare Inspectorate Wales and the Wales Audit Office will be conducting a joint governance review within the health board.

Hospital

We conducted three hospital inspections: the acute stroke unit at Prince Charles Hospital and maternity and surgical services within the Royal Glamorgan Hospital

- Patient feedback generally positive and patients were treated with dignity and respect
- Effective care in relation to preventing pressure sores, falls and nutrition and hydration arrangements (with some areas for improvement)
- Evidence of effective management at ward level
- Evidence of effective multidisciplinary team working at 2 of the 3 inspections.
- We were not always assured that care was safe and effective and issued immediate assurance letters in two of three inspections
- To a greater or lesser extent each inspection identified issues with staffing
- Improvements needed to patient and carer information on how they may provide feedback, raise a concern (complaint) and how they may contact the local Community Health Council

- Of particular concern, we identified the following issues in two of three inspections:
- Issues with the checking of resuscitation equipment within different areas of the same hospital. HIW issued an immediate assurance letter on each occasion. This showed a lack of learning following inspections
- Issues with staffing levels and skill mix
- Staff told us that morale was low amongst the workforce
- Issues with availability of equipment for staff to carry out their duties
- Issues with security of medication and the recording of fridge temperatures
- Issues with pain assessment recording and patient pain monitoring

Mental Health

We conducted two mental health inspections: a CAMHS unit at Ty Llidiard and a follow-up inspection elderly mental health wards in Royal Glamorgan Hospital

- Patients felt safe and were treated with respect and kindness by the staff team
- At Ty Llidiard, we found innovative use of technology to engage and encourage patients to provide feedback about their experiences
- We saw good record keeping practice within the sample of Care and Treatment Plans and observation records we reviewed
- Some aspects of the environment had been addressed from the last inspection
- At Royal Glamorgan, we found good compliance in relation to mandatory training and annual appraisals
- Environmental changes must be completed in a timely way to support the needs of patients
- At Ty Llidiard, risk assessments had been completed to promote patient safety and wellbeing but no written plans had been developed setting out how these risks would be managed
- At Royal Glamorgan Hospital, we found the majority of identified improvements identified at HIW's previous inspection in 2017 had not been fully completed. The health board needs to be accountable for ensuring that any improvements identified are reviewed and monitored to ensure the service provides high quality, safe and reliable care
- At Royal Glamorgan Hospital, we also found significant medicines management concerns which resulted in HIW issuing an immediate assurance letter to the health board

GP

We inspected one GP surgery

- Patients were treated with dignity and respect and spoke positively about their relationship with staff
- The practice had its own ultrasound scanner and this had proven valuable in ensuring timely diagnosis of symptoms
- GPs triage patients for appointments to ensure highest priority need is dealt with on the day
- Improvements needed to clinical details within patient records, general record keeping and audit arrangements
- Staff needed recruitment and periodic employment checks, including Disclosure and Barring Service checks
- Improvements to the arrangements for oversight and accountability for any new medication added or changed to patient records

Dental

We inspected one dental surgery

- Commitment to providing a positive experience for patients
- Good range of policies and procedures in place
- The practice was non-compliant in a number of areas relating to decontamination and infection control, environment, resuscitation equipment and security of patient records and information. This resulted in HIW issuing a non-compliance notice to the practice
- We did not see evidence of good leadership or support of staff
- Improvements were needed to ensure all clinical staff receive up to date training relevant to their role and appropriate employment checks (Disclosure and Barring Service checks)

IR(ME)R

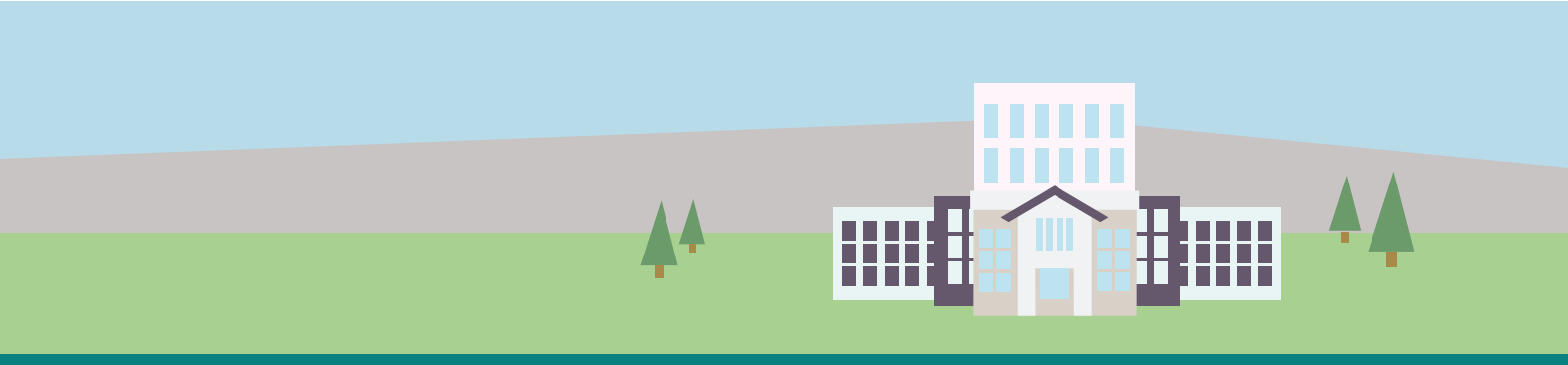
We conducted one IR(ME)R inspection at Prince Charles Hospital

- Staff who spoke with us were happy in their roles. Radiography students and new members of staff said that they felt supported by their colleagues
- Staff were respectful, professional and kind toward patients throughout our inspection
- Most patients said that they had received clear information which helped them to understand the risks and benefits of their X-ray procedure/treatment
- The service was non-compliant in respect of the assessment, monitoring and recording of patient radiation doses and the need to strengthen the employer's response to reports provided by the external radiation protection service
- A non-compliance notice was issued due to the seriousness of the issues identified
- Aspects of the content of a large number of employer's IR(ME)R policies and procedures need to be updated and provide more detail for staff to follow
- Improvements needed to ensure patients are fully aware of their right to raise concerns about their NHS care or treatment

Community Mental Health

We inspected Merthyr Community Mental Health

- Care was planned in a way that was person centred and response to the needs of service users
- Care and treatment plans and statutory documentation for service users detained under the Mental Health Act were detailed and completed to a high standard
- The service was a good example of truly integrated working between health and social care staff
- We saw effective management and leadership of the service and a positive culture in the team
- Improvements needed to compliance with mandatory training, including in safeguarding
- Staff reported the need for better engagement and understanding between GPs and the CMHT
- There needs to be progress and solutions to ensure the IT systems are fit for purpose and enable the right information to be available to the right staff at the right time



Hywel Dda UHB

We received positive responses from patients regarding their care and treatment in all inspections at Hywel Dda University Health Board in 2018 – 2019.

In three out of the four hospital inspection it was noted that staff undertook their duties in a professional, kind and sensitive manner when delivering care to patients.

However, standards and comprehensive completion of patient documentation was noted as an issue in all of the hospital inspections.

Unfortunately medicines management is still an issue in all of the hospital inspections despite us highlighting similar issues in the previous year. This is disappointing and the health board must address this problem.

The environment of care at the community mental health team inspection and mental health units required maintenance to promote patient, staff and visitor satisfaction.

It is pleasing to note that no immediate assurance letters were issued in regards to dental, CMHT and IR(ME)R inspections.

There were further positive findings in our dental inspections with two of the five dental practices we inspected receiving no recommendations for improvement.

Hospitals

We carried out four hospital inspections; in Glangwili, Withybush, Bronglais and Amman Valley Hospitals

- Staff were professional, kind and sensitive when delivering care to patients (3 out of 4 inspections)
- Ward based management was supportive and enabling (3 out of 4 inspections)
- Good staff engagement with inspection and focus on improving standards in all hospitals
- Palliative care and treatment was delivered to a high standard (Amman Valley)
- Good pain management (Withybush)

- Medicines management is still an issue in all settings
- Improvements needed to care planning, updating and safe storage of patient records
- Improvements to mandatory and specialist staff training
- Communication between healthcare professionals and patients or family members required improvement
- Patients unaware of what was going to happen next regarding treatment or discharge in one setting
- NHS Wales Putting Things Right information was not readily available for patients to read and take away (2 of the 4 inspections)

Mental Health

We inspected two mental health hospitals; Cwm Seren in St David's Hospital and Bryngofal at Prince Phillip Hospital

- Patients were treated with respect and kindness
- Patients' nursing records completed to a good standard
- Suitable arrangements in place for assessing, meeting and monitoring patients' nutritional needs
- Dementia friendly ward environment at Bryngofal

- Ward and external environment required some redecoration and maintenance
- Medical staffing levels need to be improved and more support for newly qualified nurses
- Complete and comprehensive statutory detention documentation
- Storage of chilled medication and administration of controlled drugs
- Information available for patients, carers and relatives should be consistent

GP

We inspected three GP practices

- Care and treatment provided in a dignified and courteous manner
- Information within patient records was of a good standard (2 out of 3 inspections)
- A useful system to monitor patient referrals and communication with the out of hours service had been introduced in one of the inspections
- Leadership and support for staff

- Immunisation status of all staff working at the practice must be collated
- All staff need to complete mandatory training, and job specific training for staff needs to be identified
- Some improvements needed to security of emergency equipment and drugs
- Some improvements needed to concerns and complaints arrangements

Dental

We completed five dental inspections

- Strong management and leadership
- Surgeries were maintained to a high standard
- Patients were happy with the service provided
- Good active engagement with patients to obtain feedback on the service provided

- Patient records must always be maintained in accordance with regulatory professional standards for record keeping
- Staff to complete mandatory training
- Equipment must be decontaminated in line with national guidance

IR(ME)R

We completed one IR(ME)R inspection at Bronglais Hospital

- Fully compliant with the regulations
- Patients received clear information to understand the risks and benefits of their treatment options

- Improvements to patient awareness of how to provide feedback about their experiences or raise a concern about their care and treatment
- Develop and implement a written procedure for quality assurance of medical exposures equipment

Powys Teaching Health Board

In 2018 - 2019 we inspected two general practices, an independent dental practice and a community mental health service as part of our national review of Community Mental Health Teams.

Overall we found that patients across primary care services received good quality care and treatment. Patient and staff interactions were good, demonstrating courtesy and dignity at all times. Staff told us they were well supported by colleagues within the practice and the appropriate supportive structures were in place.

Areas that could be improved included, information provision regarding the complaints process and, in a practice recently taken over by the health board, it was found that the sharing and learning from serious incidents or patient safety issues needed to be formalised.

Our only dental inspection here in 2018-2019 was Yvonne Wood Dental Hygiene, an independent practice in Welshpool. This was an outstanding inspection with no areas of improvements identified.

During our inspection at the CMHT building at The Hazels, Llandrindod Wells Service user feedback was very positive about the whole team. Staff were involved in the formulation of care and treatment plans and Service user assessments were conducted in a timely manner. We did, however, find that the building was in a very poor state of repair, and was in need of significant work to ensure it was fit for purpose. We also found that integrated working between the health board and local authority was fragmented which impacted upon the day-to-day working of the CMHT and was in need of improvement.

Community Mental Health

We inspected The Hazels Community Mental Health Team, Llandrindod Wells

- Service user feedback was very positive about the whole team
- Staff were involved in the formulation of care and treatment plans
- Service user assessments were conducted in a timely manner
- Staff were committed to providing a positive experience for service users in the difficult working environment
- Staff were able to provide some specialist services to service users therefore reducing the waiting time to receive treatment.
- The building is in need of refurbishment and repair
- Improvements needed for arrangements to transport service users to hospital
- Administration of the Mental Health Act documentation
- Elements of care documentation can be improved
- Integrated working between the health board and local authority could be improved
- Sharing of information regarding complaints, concerns and incidents between the health board, local authority and staff.

GP

We inspected the Presteigne Medical Practice and the Welshpool Medical Practice

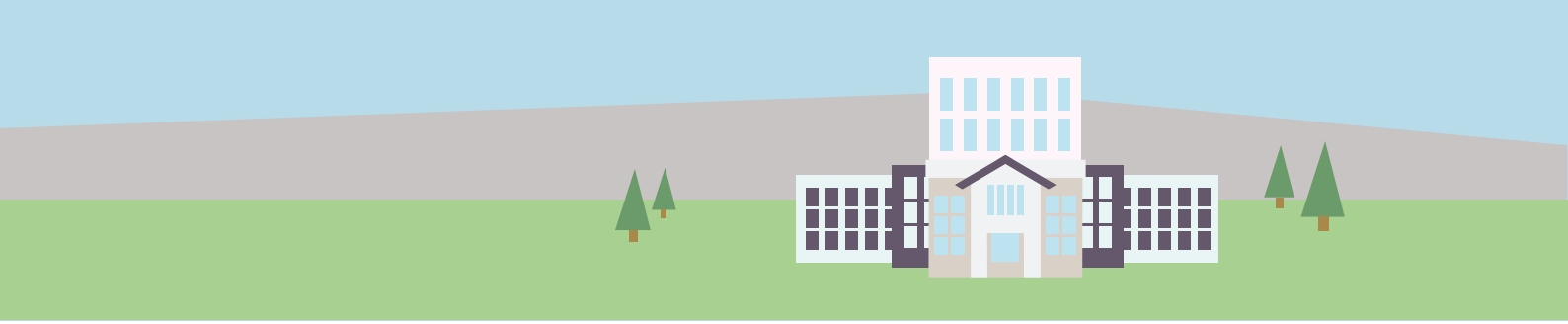
- No immediate assurance letters issued
- Positive and friendly interactions between staff and patients
- Supportive structure for staff
- Good standard of record keeping overall

- Better information provision needed regarding the complaints process
- Improvements to appointments process for patients with long term health conditions and regular clinics must be managed in a timely way
- Ensure that learning from significant events and safety incidents is appropriately shared and discussed by all staff within the practice

Dental

We inspected one independent dental practice

- Safe and effective care to their patients in a pleasant environment with friendly, professional and committed staff
- Patients very happy with the service they received according to our feedback
- Well run practice and that meets the relevant regulations to ensure the health, safety and welfare of staff and patients
- Evidence of various maintenance contracts to ensure the environment and facilities were safe and well maintained
- Infection control procedures were aligned to the relevant guidance and audit tools
- We found the practice to have good leadership and clear lines of accountability



Trusts – Public Health Wales, Velindre University NHS Trust, Welsh Ambulance Services NHS Trust

Public Health Wales (PHW)

HIW continues to review PHW activity and performance through attendance at their quarterly Quality and Safety committee.

There has been some change within the organisation with Independent Members joining, changes within the Executive Team and a focus on delivery on the first year of a long term plan. Whilst there are some clear challenges around screening services it is clear that there is a strong commitment to quality and improvement and a willingness to engage with HIW on its National Reviews programme.

In July 2018 HIW published its review of substance misuse services. There are a number of recommendations for PHW to consider, particularly around co-occurring mental health needs, complexity of needs and harm prevention.

We have also consulted with PHW and the 1000 lives programme as part of our stakeholder engagement to discuss our research and intelligence functions, and identify mutual areas of interest.

Velindre University NHS Trust

During the year HIW regularly engaged with the organisation through their Quality & Safety Committee, Board meetings and meetings with executive officers.

In 2018/19 HIW conducted one unannounced inspection of Velindre Cancer Centre, within Velindre University NHS Trust. Our inspection team inspected two wards (first floor and chemotherapy inpatient) and explored how the service met Health and Care Standards.

The inspection findings were largely positive, with evidence showing that service provided safe and effective care. We also identified some areas of improvement and have made recommendations to the trust regarding actions required to ensure full compliance with Health and Care Standards.

The Trust are also tackling ICT systems issues that can affect patient safety if not addressed.

Welsh Ambulance Services NHS Trust (WAST)

HIW has continued to develop the relationship with WAST, with regular meetings and communication with executives and staff.

WAST has been a key stakeholder in helping HIW develop the content of new tools for inspecting Emergency Departments. This means that the interface between the Emergency Departments and ambulance service is better considered and tested while undertaking inspections. This work will also allow us to better consider the perspective of paramedics, as well as the hospital staff that work with them.

During 2018/19, HIW staff undertook a visit to the WAST Command and Control Centre in Carmarthen. This helped us to improve our knowledge and understanding of this function and to more fully appreciate the challenges and processes used by call handlers.

HIW continues to review all WAST activity and performance to determine any risk to patient safety and there are clearly some ongoing challenges around response times to patients, and the handover of these patients to health settings.

Annex A - Commitment Matrix

The following table is a list of the objectives HIW set for itself for 2018-19 together with details of how HIW met the objective

What we said	Measured by	Outcome
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.	In addition to the project to register dental practices we processed 19 registered manager applications, 17 new provider registrations and 16 variations to existing registrations.
Deliverable 2 Conduct a programme of visits to suspected unregistered providers - as required. Deliver a programme of inspections in independent settings • Approximately 22 laser • Approximately 19 non-laser excluding mental health	Number of visits undertaken Number of inspections undertaken Number of reports published three months following inspection	We were made aware of 18 providers that potentially required registration. Following further investigation, including a visit to two providers, six applied to register, seven did not require registration and five confirmed that they would stop providing the service. We undertook and completed a criminal prosecution against an unregistered provider.
Deliverable 2b Deliver a programme of inspections in independent settings • Approximately 22 laser • Approximately 19 non-laser excluding mental health	Number of inspections undertaken Number of reports published three months following inspection	We carried out inspections of 29 independent settings, excluding mental health settings and private only dental practices. This was less than originally planned due to services de-registering upon notification of inspection and the need to undertake inspections in higher risk areas.

What we said	Measured by	Outcome
Deliverable 3 Ensure that concerns and Regulation 30/31 notifications are dealt with in a timely and professional manner	Number of concerns received Number of Reg 30/31 notifications received Analysis of source and action taken	During 2018-19, we received 340 concerns relating to either the NHS or the independent sector. We received 196 concerns regarding NHS settings or services. There was 126 concerns regarding independent healthcare provides registered with HIW We also received 18 concerns relation to unregistered providers or settings that do not require registration with HIW. 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. The Regulation 30/31 notifications continue to be managed in line with our process and dealt with effectively. In total we received 580 Regulation 30/31 notifications received. They are as follows: Death in Hospice – 389 Death excluding Hospice –5 Unauthorised absence – 57 Serious injuries – 95 Allegation of staff misconduct - 29 Outbreak of Infectious Disease – 3 Deprivation of Liberty Safeguards (DoLS)
Deliverable 4 Support legislative developments including: Continue Implementation of the Private Dentistry (Wales) Regulations 2017 Contribute to further policy development on regulation and inspection arising from the 'Services Fit for the Future' White Paper	Delivery of implementation plan following new dental regulations Future decisions on potential changes to the legislation	During the year we completed the project to register all dental practices offering private dental treatment. This resulted in the registration of 485 dental practices

Annex A - Commitment Matrix

What we said	Measured by	Outcome
Deliverable 5 Undertake a broad inspection programme in the NHS informed by intelligence and an assessment of risk including approximately: - 15 focussed inspections across the acute sector - 5 specific follow-up inspections - 28 GP inspections - 100 dental inspections - 5 IR(ME)R inspections - 5 surgical services inspections	Number of inspections undertaken	We carried out 132 inspections Hospitals - 13 NHS mental health units - 11 CMHT- 7 GP - 20 Dental - 73 IR(ME)R - 5 Surgical - 3 Follow-up – 6 (included in above figures)
Deliverable 6 Conclude our programme of ongoing thematic work including: - Patient Discharge - Community Mental Health - Youth Transition And commence a new thematic review towards the end of 2018	Publication of terms of reference of each project Publication of thematic review	During the year we published five thematic reviews relating to: - Patient Discharge - Substance Misuse Services - Community Mental Health Teams - Healthcare services for young people - Healthcare support for older people living in North Wales care homes We began work on our national review of care pathways surrounding older people and falls in 2018 – 2019. During 2019-20 we will commence national reviews into maternity services, and crisis care in mental health.
Deliverable 7 Continue our joint inspection work with UK agencies Approximately 16 death in c ustody reviews with the Prison and Probation Ombudsman Up to three joint reviews with HMI Prisons and HMI Probation	Number of inspections undertaken	We carried out 18 death in custody investigations. We undertook one joint inspection with HMI Prisons and HMI Probation.

What we said	Measured by	Outcome
Deliverable 8 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	2018-19 annual findings were presented at board meetings and board development days for Health Boards and NHS Trusts by Relationship Managers.
Deliverable 9 Publish annual reports summarising the themes and issues arising from our work. In particular: - Hospital Inspections - GP Practices Annual Report - Dental Practices Annual Report - Mental Health Act Annual - Monitoring Report - Deprivation of Liberty - Safeguards (DOLS) Annual Report - IR(ME)R - Laser Annual Report - HIW Annual Report	Publication of reports	NHS Hospital Inspections – an overall summary of our hospital inspection programme was not published due to the disparate functions and purposes of different hospital wards and settings inspected. General Medical Practice (GP) inspections - Annual Report 2017-18 – published 29 March 2019 General Dental Practice Inspections Annual Report 2017-18 – published 29 March 2019 Mental Health Act Annual Monitoring Report – published 16 July 2019 Deprivation of Liberty Safeguards (DOLS) Annual Report 2017-18 – published 2 May 2019. Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Annual Report 2017-18 – published 5 April 2019 HIW overarching Annual Report 2017-18 – published 19 July 2018

Annex A - Commitment Matrix

What we said	Measured by	Outcome
Deliverable 10 Undertake a programme of inspections in NHS and independent mental health settings including approximately: - 15 NHS mental health units - 19 independent mental health units Mental Health Unit inspections include: reviewing the application of the Mental Health Act 7 inspections of Community Mental Health Teams	Number of inspections undertaken	We carried out 29 inspections of mental health and learning disability units: - 11 NHS mental health units - 17 independent mental health units - 1 independent learning disability units Follow up – 6 (included in above figures) We carried out 7 Community Mental Health Team inspections.
Deliverable 11 Provide a Second Opinion Appointed Doctor service for about 750 SOAD requests	Publication of Key Performance Indicators	Key performance indicators have been formulated and shared with the health boards and independent healthcare providers. We are currently working on our systems to measure our performance more effectively.
Deliverable 12 Investigate homicides as commissioned by Welsh Government	Publication of Terms of Reference Publication of final report	We were not commissioned to undertake any new homicide investigations during 2018-19. We undertook a Special Review of ABMU Health Board's handling of its employment of Kris Wade during 2018-19. This review was published in January 2019
Deliverable 13 Hold two Healthcare Summits during 2018 -19	Clear audit trail of healthcare summits	We held two Healthcare Summits during 2018-19, chaired by HIW and attended by ten external bodies.

Annex A - Commitment Matrix – Continued

What we said	Measured by	Outcome
Deliverable 14 Publish reports from all our inspection and review activity in accordance with our performance standards.	Publication of reports Publication Schedule Publication of HIW performance against targets	Publication dates of all our reports are published on our website. The publication schedule can be found here: hiw.org.uk/publication-schedule
Deliverable 15 Continue our joint work with other UK and international agencies on joint inspections and influencing best practice	Participation in joint work Progression of joint thematic review of youth healthcare with Inspection Wales	HIW attended the European Partnership for Supervisory Organisations in Health Services and Social Care Conference. The purpose of the partnership is to help improve the quality of health and social care in Europe through connecting supervisory organisations in order to improve exchange of ideas, outcome of research, information and good practice. Two visits were undertaken by the Intelligence and Methodology teams to explore approaches and tools used by colleagues in Healthcare Improvement Scotland and the Regulation and Quality Improvement Authority in Northern Ireland. Senior staff attended the International Conference on Quality in Healthcare in Glasgow in order to learn from emerging and best practice elsewhere.
Deliverable 16 Evaluate the use of voluntary lay reviewers	Evaluation with recommendations for future action	Initial evaluation has begun with recommendations for future action being considered in 19/20

Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

www.hiw.org.uk

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales