Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales Annual Report 2019-2020

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

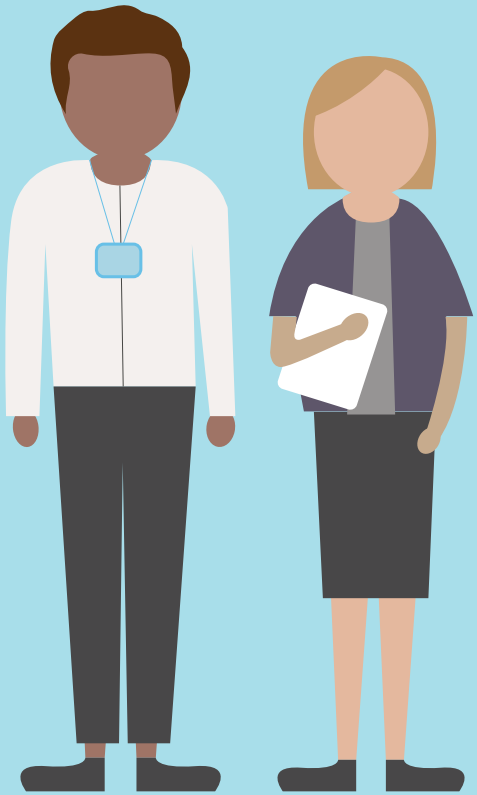
Our priorities
Through our work we aim to:

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

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

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

Contents



Foreword

I am pleased to introduce our Annual Report for 2019 – 2020. At time of writing, health and care services across Wales have had to rise to meet the challenges of a global pandemic, Covid-19. This has introduced unique and unprecedented pressures on the system that will continue through the winter months. Services have adapted, changed and expanded to cope with these pressures and the response across Wales has to be commended.

This report covers the period 1 April 2019 to 31 March 2020 meaning that restrictions on our work due to the pandemic only affected a small proportion of our routine inspection programme and the majority of our work was completed as planned.

On completion of the second year of our three-year strategy 'Making a Difference' we have built on a solid foundation to deliver our goal to encourage improvement in healthcare by doing the right work at the right time in the right place; ensuring what we do is communicated well and makes a difference.

Following the allocation of new resources we successfully built the capacity of our organisation, increasing our core activity within the NHS and our ability to undertake a range of activities in response to emerging in-year intelligence. We also increased the number of national and local reviews undertaken and built on the joint work we deliver with Care Inspectorate Wales.

Of particular note was our response to sources of intelligence that indicated failings in quality governance and maternity services at Cwm Taf Morgannwg University Health Board. We conducted an urgent joint review of governance arrangements with Audit Wales highlighting a number of fundamental issues and weaknesses and making a number of recommendations for improvement. We also commenced a national review of maternity services across Wales which is due to report in late 2020.

In 2018 the Parliamentary Review of Health and Social Care challenged inspectorates to consider their approach to inspecting complex, integrated systems of care. Our Review of Integrated Care - Focus on Falls marked a new approach for HIW, working with a range of partners to consider the effectiveness of a system of care involving services from both health and social care, as well as the private, independent and voluntary sectors.

We generally saw a high standard of healthcare being delivered to patients during our inspections. However, I want to flag up some recurring themes from our work, which must be addressed.

We found that medicines management and safe storage of medicines is still an issue on some wards and in GP practices. In addition, infection prevention and control standards are not always met and resuscitation equipment is at times not maintained. In GP practices we found that DBS checks are not always carried out and that record keeping in relation to staff immunisation could be improved in some cases. Patients also reported problems booking appointments to see a doctor.

The findings from our dental inspections were very positive on the whole. However, we identified a range of improvements in the area of infection prevention and control and in ensuring that suitable arrangements are in place to protect patients and staff in a medical emergency. We received assurances in a timely manner, but it is frustrating that many of the issues requiring immediate attention were the same as those identified in 2018-19.

Maintenance and refurbishment of wards was an issue in many of our mental health inspections and the quality of care plans varied considerably.

We have made steady progress in developing as an organisation to maximise our impact, take action where standards are not met, be more visible, and do the best possible job. This is a firm foundation on which to build, adapt and deliver our important work during the unique, challenging situation brought about by a global pandemic.

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

Alun Jones
Interim Chief Executive, Healthcare Inspectorate Wales

HIW 2019-2020 in Numbers

This year we carried out 205 inspections, including follow-up inspections, of hospitals, dentists, GP practices, mental health providers, independent healthcare and settings using ionising radiation.

Hospitals

- 6 follow-up inspections
- 3869 patient questionnaires
- 31 general hospital inspections
- 915 staff questionnaires
- 1 surgical inspection
- 23 Immediate Assurance letters issued for NHS hospitals

GP

- 25 GP inspections
- 816 patient questionnaires
- 15 Immediate Assurance letters issued

Ionising Radiation (Medical Exposure) Regulations Inspections

- 3 IR(ME)R inspections
- 93 patient questionnaires

Dental

- 68 dental inspections including 5 follow-up
- 2019 patient questionnaires
- 14 Non-Compliance Notices
- 1 Immediate Assurance letters issued

Independent Healthcare

- 7 independent clinic inspections
- 4 Non-Compliance Notices
- 508 patient questionnaires
- 27 laser inspections
- 7 independent hospital inspections

HIW 2019-2020 in Numbers

Mental Health and Learning Disability

- 66 patient questionnaires from community mental health teams (CMHT)
- 958 Second Opinion Appointed Doctor (SOAD) visits undertaken
- 8 Immediate Assurance letters or Non-Compliance Notices issued
- 3 inspections of community mental health teams
- 28 inspections of NHS and independent establishments
- 1017 requests for a SOAD

Registration Activity

Independent Healthcare Services

- 26 New Registrations
- 16 Variation of HIW Registration Conditions
- 17 Change of Manager
- 17 Cancellation of HIW Registration (Manager)
- 7 Cancellation of HIW Registration (Provider)
- 10 Change of Responsible Individual

Private Dental Practices

- 2 Variation of HIW Registration Conditions
- 25 Change of Manager
- 6 Change of Responsible Individual
- 20 Cancellation of HIW Registration (Manager)
- 22 New Registrations
- 6 Cancellation of HIW Registration (Provider)

HIW 2019-2020 in Numbers

Enforcement – Independent Healthcare

- Potential Unregistered Services reported – 14
- Of these registration required – 9
- Services of Concern[1] – 4
- Civil Action[2] – 4

Communication & Engagement

- Attended 6 conferences or major events
- 484,700 Twitter impressions (increase of over 300%)
- HIW Facebook pages launched
- 319, 631 sessions on our website (increase of 14%)
- Newsletter subscribers increased from 946 to 4339

National and Local reviews

- Started 2 new national reviews
- Started 2 local reviews
- 2 published reviews

Offender Healthcare

- 17 death in custody reviews

Concerns

- 367 concerns from public and staff
- 15 were classified as 'high risk'

[1] A Service of Concern is when a service continues to be non-compliant and is kept under review

[2] Civil action can only be taken against services that are registered with HIW and can include varying or imposing conditions of registration, suspending registration, or seeking urgent cancellation of registration

The Views of Patients

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

Last year we received 3869 completed patient questionnaires; an increase of 763 on the total number of responses from the previous year.

We also invited staff in hospitals and hospices to complete a questionnaire, and we received 915 completed questionnaires from employees; an increase of 588 on the total number of responses from the previous year. This large increase is mainly due to the national review of maternity services, in which the staff questionnaire was heavily promoted.

What did patients tell us?

Overall, patients told us they were pleased with the care they received. We have separated the figures to show patient survey results in 2019-2020 by the type of setting.

Overall rating

The percentage of patients who rated their care as good, very good or excellent ranged from around 90% to 100% across all settings:

- 88% of patients scored hospitals as 8 out of 10 or better
- 99% of dental patients rated their dentist as good, very good or excellent. This is the same score as last year
- 94% of GP patients rated their experience as good, very good or excellent. This is a 6% increase on last year
- 97% of patients receiving ionising radiation as part of a diagnostic procedure or treatment rated their experience as good, very good or excellent. This is the same score as last year
- 100% of laser patients rated their experience as good, very good or excellent. This is a 2% increase on last year.

Cleanliness

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

- 97% of hospital patients said the ward was clean and 96% said it was tidy
- 96% of dental patients said the surgery was very clean and a further 4% said it was fairly clean
- 86% of GP patients said the environment was very clean and a further 13% said it was fairly clean
- 97% of independent clinic patients agreed the environment was clean and 98% said it was tidy.

The Views of Patients

Dignified care

This includes the fundamental human rights of dignity, privacy and informed choice for patients.

- 97% of hospital patients said that staff were always polite, kind and sensitive
- 82% of hospital patients said that staff provided them with help in a sensitive way so they could use the toilet
- 94% of hospital patients said that staff came when they used the buzzer
- 99% of GP patients said that staff treat them with dignity and respect.

Communicating effectively

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

- 81% of hospital patients said they could communicate using their preferred language
- 86% of hospital patients agreed staff had talked with them about their medical conditions and helped them understand them
- 92% of hospital patients said they felt that staff always listened to them
- 94% of GP patients said they could communicate using their preferred language
- 96% of dental patients said they could communicate using their preferred language
- 85% of CMHT patients said they felt that staff listened to them carefully
- 80% of CMHT patients believed staff had enough time to discuss their needs.

Treatment options

We asked patients about how well treatments were explained to them and their understanding and participation in the treatment process.

- 97% of GP patients said things were always explained in a way they understand and 95% 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
- 99% of patients receiving laser/ Intense Pulsed Light (IPL) treatment said they felt involved in decisions and 99% said they were given enough information to understand the risks of the procedure.

Cost of treatment

For treatment not provided free under the NHS.

- 97% of dental patients said the cost of treatment was made clear
- 99% of laser patients said the cost of treatment was made clear.

Ease of access

We asked about ease of booking an appointment.

- 97% of dental patients said booking an appointment was fairly easy or very easy
- 76% of GP patients said booking an appointment was fairly easy or very easy.

Out of Hours care

In terms of awareness of Out of Hours services.

- 77% of dental patients said they know how to access the Out of Hours service
- 82% of GP patients said they know how to access the Out of Hours service.

Our Work

Providing assurance

We provide an independent view on the quality of care by inspecting a range of NHS settings in Wales including hospitals, GP surgeries, dentists, mental health units and community mental health teams.

In the independent sector we regulate and inspect healthcare settings by registering a range of providers and monitoring their compliance; these settings include independent hospitals and clinics, dentists, mental health units, hospices and laser treatments at beauty salons.

We have a specific responsibility in relation to protecting the rights of vulnerable patients who are detained under the Mental Capacity Act and Deprivation of Liberty Safeguards.

Towards the end of this financial year, we began work to introduce a more systematic approach to following up on findings from our inspections and reviews, and this will be reflected in next year's annual report.

Our work programme ensures that we meet our statutory requirements and that we review areas of concern identified through a range of intelligence sources. Our Risk and Escalation Committee assesses the evidence and intelligence available on a monthly basis, and determines our programme of routine and responsive inspections.

A similar process takes place at our Review Steering Board which prioritises and plans national and local reviews, scrutinising the progress of reviews throughout the year.

Performance standards

We are explicit about the standards of service we provide.

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

During 2019-2020 we published 96% of our reports within three months of the inspection. We reported 98% of issues of immediate concern within two days.

Performance				
Year	2 days met	2 days missed	3 months met	3 months missed
2019-2020	98%	2%	96%	4%
2018-2019	94%	6%	92%	8%
2017-2018	100%	0%	92%	8%
2016-2017	91%	9%	82%	18%
2015-2016	71%	29%	75%	25%

Our Work

Promoting improvement

Our governance arrangements enable us to determine which sectors, settings and themes to prioritise in our inspection and review activity. Our governance map and glossary routines our internal scrutiny process in more detail.

Many of our reports contain recommendations intended to drive improvement in the quality of healthcare services and we've introduced a more systematic approach to follow-up this year.

Influencing Policy and Standards

Through our activities we see how legislation, policies and standards work in practice. We take the opportunity to feed back our findings and from this unique perspective at through consultations, evidence to Welsh Parliament Committee, and directly with Welsh Government policy officials and policy makers at other government bodies, regulators, inspectorates or professional bodies.

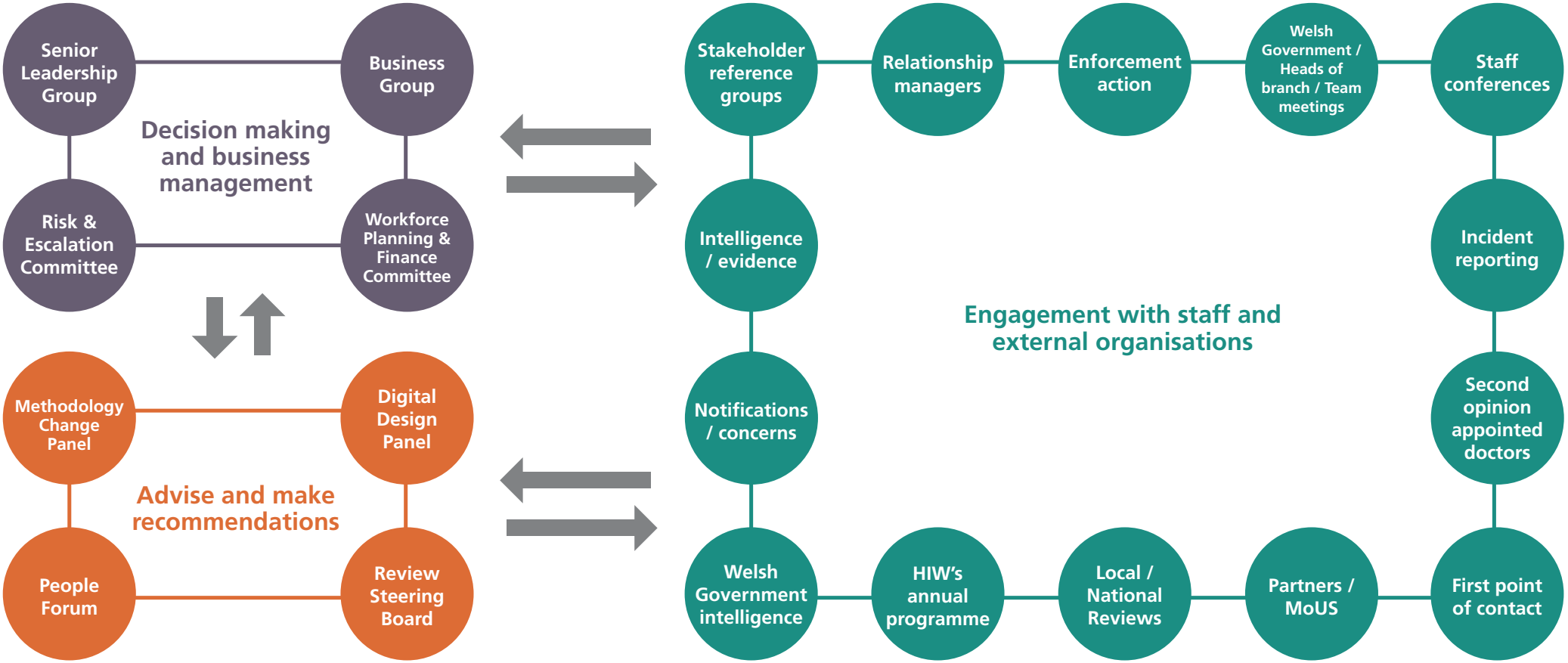
We contributed to 10 consultations undertaken by external organisations last year on a range of issues that impact upon or relate to our work. These included the Welsh Parliament (formerly National Assembly for Wales), NHS Wales, British Medical Association (BMA), General Dental Council (GDC), Welsh Government and the General Medical Council (GMC).

In 2019 – 2020 we attended the Health, Social Care and Sport Committee on four occasions including:

- Written and oral evidence on Mental Health in Policing and Police Custody in April 2019
- Written and oral evidence at a joint evidence session with CIW on the Health and Social Care (Quality and Engagement) (Wales) Bill in September 2019
- Written and oral evidence at a joint evidence session with CIW and HMI Prisons on the Provision of Health and Social Care in the Adult Prison Estate in October 2019
- Presentation of our independent report with Audit Wales at a factual briefing of our Joint Review of Quality Governance at Cwm Taf Morgannwg UHB in January 2020.

HIW Governance Map

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



Working with Others

The effective sharing of information between organisations is critical in assessing the quality of healthcare being provided across Wales. During 2019-2020 we hosted two healthcare summits bringing together external audit, inspection, regulation and improvement bodies to share intelligence about NHS organisations. Themes that emerged from these discussions were agreed and communicated to the Welsh Government and fed into NHS Wales' escalation and intervention discussions.

Through the joint working arrangements developed with the Community Health Councils, our National Review of Maternity Services was able to develop an inclusive and effective survey, which was completed by over 3,000 mothers in Wales. This was only made possible by the collaboration in both design and dissemination of the survey to the public.

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

In 2019-2020 we began supporting CIW with their Disabled Children Review, by conducting interviews with strategic and operational healthcare leads; we will continue supporting this review throughout 2020. Through a collaborative Inspection Wales presence at the Royal Welsh Show, we engaged with the public and provided information on findings from our reviews.

We provided our views in the consultation and scrutiny processes of new and emerging policy and legislation including the Health and Social Care (Quality and Engagement) (Wales) Bill which was introduced in June 2019. HIW gave evidence with CIW to the Health, Social Care and Sport Committee in September 2019.

During 2019 we worked with CIW, Estyn, Her Majesty's Inspectorate of Probation (HMIP) and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) to develop an inspection framework which looked at child protection arrangements. The topics covered by the Joint Inspection of Child Protection Arrangements (JICPA) were child exploitation (sexual and criminal) and trafficking.

In December 2019 a pilot inspection was carried out in the Newport area to test this framework with all five inspectorates on site; a first for Wales. A summary of the findings, Looking at how we keep children and young people safe in Newport, was published on our website in September 2020.

A further pilot was delayed due to the Covid-19 pandemic, however, the JICPA operational group has continued to meet with a view to carrying out a future programme of work.

In March 2020 we contributed to provisions in the emergency Coronavirus Act 2020, including temporary changes in mental health settings and the Second Opinion Appointed Doctor (SOAD) service for Wales.

Progress against our Strategic Plan 2018 – 2021

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

HIW places a strong emphasis on the use of intelligence in developing its work programme. By carrying out the right work, at the right time, in the right place, HIW can deliver a key element of its role which is to encourage improvement in healthcare.

Over the past year we have continued to focus on the use of intelligence and strengthened governance arrangements in order to ensure that we maximise our impact by making informed decisions about the work we do. Our newly established Reviews Steering Group has enabled us to take account of a range of information when considering which healthcare theme or service to review at a national level. It has allowed us to maintain oversight of the development and delivery of a programme of local and national reviews which expanded in 2019 as a result of increases to our inspector workforce in late 2018. Of particular note within this programme was the completion of 26 inspections in support of the first stage of our national review of maternity services. A report setting out the findings from this stage will be published in November 2020.

We have continued to collaborate with key partner organisations ensuring that we have access to, and can share, information critical to the discharge of our own functions and the functions of those partners. Where there is a mutual benefit in doing so we have also worked with our partners to deliver specific inspections or reviews. We worked with Care Inspectorate Wales on our programme of Community Mental Health Team inspections and also involved them in our national review of integrated falls services. We worked with Audit Wales to undertake a joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board. As part of our national review of maternity services, we also collaborated with the Community Health Councils to design and disseminate a survey which was completed by over 3,000 mothers.

As part of our three year strategy, launched in June 2018, HIW committed to delivering a piece of work to consider the most effective and efficient way in which to share its findings so that they are easy to understand. This work has started, and has continued at pace into the 2020-2021 inspection year as HIW considered alternative ways in which to deliver its role during the Covid-19 pandemic.

Progress against our Strategic Plan 2018 – 2021

To take action when standards are not met

HIW's ability to take timely action when standards are not met is dependent upon a number of factors. These factors include the nature of the legal frameworks which define our powers, the quality and timeliness of our work, how we engage with healthcare organisations and the way in which we escalate issues.

We have developed a planning process which allows us to take account of a range of intelligence when constructing our annual programme of inspections and reviews. This makes use of our network of health board and NHS Trust relationship managers., known risks to patient safety, and the need to investigate any particular challenges facing the health system nationally. For some types of services, particularly in the independent sector where there is generally less or no oversight via NHS safety and assurance processes, HIW has established rules around frequency of inspection visits.

As a way of operating, the development of annual plans requires us to continually monitor our approaches, adapting them or creating new ones according to need. We have arrangements to prioritise and project manage this work and have developed our capacity and capability in this area over recent years.

There are a range of circumstances that may lead us to take enforcement action when acting as the regulator of independent healthcare services in Wales. In spite of what may be appear to be unique circumstances in each enforcement case, it is important that we take regulatory action in a proportionate, consistent and effective way. We have been working hard over the last year to simplify our processes in this area and have also introduced more detailed performance information to allow us to ensure that we take timely action where we become aware of unregistered services. We have also continued to take enforcement action as necessary as a consequence of issues we identified at inspection. The enforcement action we have taken during this period is summarised on page 34.

Following up on inspection findings is another key activity in our commitment to taking action where standards are not met. Over the last year we have developed new arrangements which ensure that a range of follow-up activities are considered at the end of every inspection carried out. These arrangements will be implemented during the 2020/21 inspection year.

We continue to strengthen the way we communicate with current and prospective independent healthcare providers. In 2019-2020 we improved the guidance available to prospective registrants, including clarifying expectations of them. This is a major piece of work and will continue into 2020-2021.

In the independent sector our legal powers support us in ensuring that relevant services register with us and comply with regulations. We continue to engage with Welsh Government on the scope of our powers and any limitations associated with current legislation. In the NHS, we have contributed to the development of the draft Health and Social Care (Quality and Engagement) (Wales) Bill including provision of written evidence and attendance at a committee evidence session.

Progress against our Strategic Plan 2018 – 2021

To be more visible

To achieve our strategic goal, we need to improve public and professional understanding and engagement in our work.

Over the course of the year we have made progress in becoming more visible as an organisation. In 2018, just over a quarter of people in Wales were aware of the inspectorate[3]. In 2019, that has increased to just under 40 per cent[4]. We have achieved this through delivering a number of pieces of work.

We have trialled a new creative approach to presenting our findings to make them more accessible and engaging. Our National Review of Integrated Care: Focus on Falls, saw us introduce animation and illustrations of aspirational and dysfunctional care pathways, based on our findings. The approach sought to better explain the individuals' experience of the prevention and treatment of falls and to help both healthcare professionals and the public understand what good care should look like. Feedback on the approach was positive and forms a firm basis for communicating the findings of future reviews of complex systems of care.

We have developed a social media strategy that, together with the usage of other digital tools, has seen us successfully increase public and professional involvement in our work. In particular, as part of our National Review of Maternity Services, we worked closely with the Community Health Councils and other stakeholders across Wales to create an online patient and staff survey. We advertised the survey predominantly using our newly launched Facebook presence and through our work to engage with local organisations to help raise the profile of our work within communities. This resulted in over 3,300 patients and 600 staff providing their views of maternity services in Wales. Online surveys are now used as standard across the inspection process, alongside more traditional methods, enabling people to provide their comments and feedback in as many ways as possible.

As a result of our strategy our online presence has seen rapid growth over the past year with significant increases in social media followings, website traffic and subscribers registered for our newsletter.

We have continued to build our visibility and reputation through attendance at key conferences and seminars to communicate the findings and learning from our work. During the Royal Welsh Show in 2019 368 people took part in our survey on the work and findings of HIW, and we spoke to over 480 members of the public about their healthcare experiences. We also used the NHS Wales Confederation and Improvement Cymru conferences to present our findings to Healthcare professionals to encourage improvement.

We have also developed a stronger relationships with Healthcare Education Improvement Wales (HEIW) and other professional bodies to improve understanding of our role and purpose and how we can all work together to support improvement.

Our Healthcare Summits continue to be a focal point for intelligence sharing and representing the collective views of those who scrutinise healthcare across Wales.

[3] Wales Omnibus, Beaufort Research Ltd - September 2018

[4] Wales Omnibus, Beaufort Research Ltd - September 2019

Progress against our Strategic Plan 2018 – 2021

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 we have made further progress on developing as an organisation. Our latest staff survey shows improvement across all areas, with the organisation achieving its highest ever results for staff engagement, managing change and having the tools we need to do our jobs.

Over the past year the organisation has been through significant change both in terms of building capacity to increase our core activity within the NHS and through the introduction of new ICT systems that have made us more efficient and information secure. Despite this, in the most recent staff survey, we have maintained positive feedback on managing the change process and giving our people the tools they need to do their jobs effectively.

In recruiting a new cohort of inspectors to the organisation we refreshed and improved our induction process to ensure new staff were effective in their roles as quickly as possible. As a result we were able to deliver more inspection activity during the year and worked on new reviews, both national and local.

Our digital improvements, including paperless inspections and online payments, are now fully integrated with our business processes and we have moved to the build phase of the organisation's new data and information management system, a project that has remained a priority throughout the year.

Having increased our focus and investment in learning and development, we have taken significant steps toward becoming a learning organisation. In a recent staff survey most people reported that they felt that they are able to access the right learning and development opportunities when they need to and that activities they have completed over the past year have helped improve their performance.

We have also conducted a review of how we use voluntary lay reviewers, forming a firm basis for the roll out of a new network of Experts by Experience and Patient Experience Reviewers that will enhance the capture of the patient voice during inspections.

National and Local Reviews

HIW delivers national reviews which enable it to examine how services are delivered across the whole of Wales. We also undertake local reviews of issues that may be specific to a single organisation or a particular region.

Review Proposals

There are many factors which help us decide when and where to undertake a national or local review including intelligence from other regulators or inspectorates, and information from concerns or complaints. Through a review proposal form on our website, we encourage people to provide their views on what we should look at.

All the proposals that are received are reviewed by our Review Steering Board (RSB). This group researches, discusses and prioritises suggested topics and makes recommendations for any further work that we may undertake. The final decision on whether a proposal becomes a review is taken by our Risk and Escalation Committee which considers priorities and resources available in HIW.

National Maternity Services Review

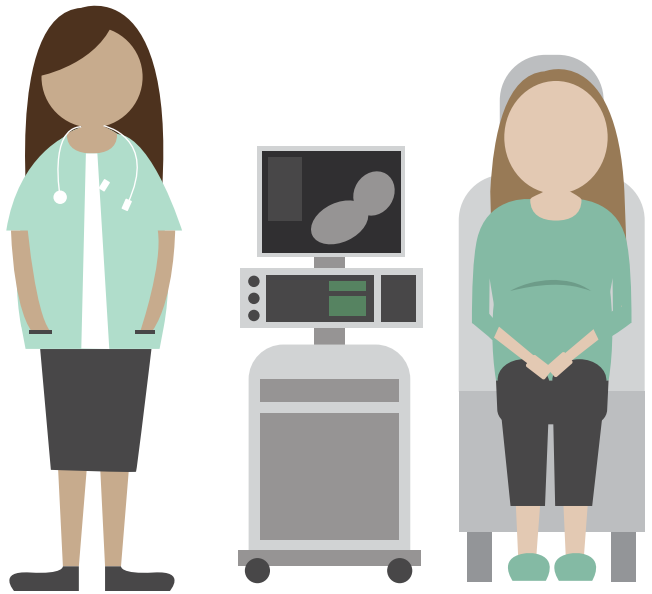
Our decision to undertake this review was based on concerns relating to pressures within maternity services across Wales, and the issues identified during our inspection of maternity services at the Royal Glamorgan Hospital in the former Cwm Taf University Health Board in October 2018.

The review has been split into two phases and explores the experiences of women, their partners and families, and the extent to which health boards provide safe and effective maternity services. It also aims to enable health boards to recognise the strengths within their maternity services, and areas which require improvement.

Phase one included 15 unannounced inspections of hospital maternity units, 11 home from home maternity birthing units, executive team interviews, governance document reviews, and extensive surveys with the public and maternity staff. The findings from these inspections have been published on our website and the review's phase one report will be published in November 2020.

Across all health boards we found many examples of good and noteworthy practice. However, there was some variability in the quality of care and treatment and it was necessary to highlight a number of issues including checks on equipment, audit, learning and arrangements for infection prevention and control.

Phase two commences in October 2020 and includes visits to community services, such as antenatal and postnatal care.



National Review of Mental Health Crisis Prevention

During 2019-2020 we commenced our scoping process to determine how we would undertake a national review of mental health crisis services across Wales. Our previous work, including our Community Mental Health Team Review and our Substance Misuse Services Review, identified managing people in crisis and the timely access to services, as an area requiring improvement.

The review commenced in early 2020 and will progress throughout the year, concluding in spring 2021. We will review our previous findings alongside any other intelligence available to us, and work undertaken related to crisis by other organisations in Wales. Our aim is to identify and establish any themes, trends or concerns that have emerged nationally, and to identify good practice in supporting people, to help prevent an episode of mental health crisis.

Review of Integrated Care: Focus on Falls

In September 2019, we published our national review of the integrated pathway of care for falls amongst people over 65 in Wales: Review of Integrated Care - Focus on Falls. Falls are a common problem for older people, with one in three people over 65 likely to suffer a fall each year.

This was an innovative review where we set out examples of aspirational and dysfunctional pathways. We produced a set of animated videos to better explain the individuals' experiences of the falls pathway.

We made eight key recommendations and highlighted learning for staff working with older people who are at risk of suffering a fall, and health and social care managers. We recommended that there should be a National Falls Framework for Wales, to standardise the approach to preventing, treating and reabling older people who are at risk of falling or have already fallen. We also recommended that each health board should work closely with local authorities in their area to produce a local pathway for falls that can be flexible to the needs of the individual whilst also being consistent with a national framework.

Local Reviews

Joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board

In April 2019, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives published a highly critical review of maternity services at the former Cwm Taf University Health Board. This review identified a number of serious concerns and service failures.

Partly in response to this report, as well as our own concerns over governance and risk management, an urgent joint review of governance arrangements was initiated with Audit Wales.

The Joint Review of Quality Governance Arrangements at Cwm Taf Morgannwg University Health Board took place during summer 2019 and was published in November 2019. It highlighted a number of fundamental issues and weaknesses in the health board's quality governance arrangements and 14 recommendations for improvement, which are expanded upon in pages 46 – 47.

The findings from the joint review were accepted in full by the health board. Whilst we have been encouraged by the health board's response to the review's 14 recommendations, the scale of the challenges to improve quality and patient safety governance should not to be underestimated and will require continued focus and sustained commitment by the health board.

It is also important for Welsh Government to reflect upon the issues raised in this report and give consideration to any wider lessons about how they gain assurance on the robustness of quality governance arrangements across other NHS bodies.

Public Health Wales

In November 2019, HIW started a review of Breast Test Wales, the NHS breast screening programme provided by Public Health Wales (PHW).

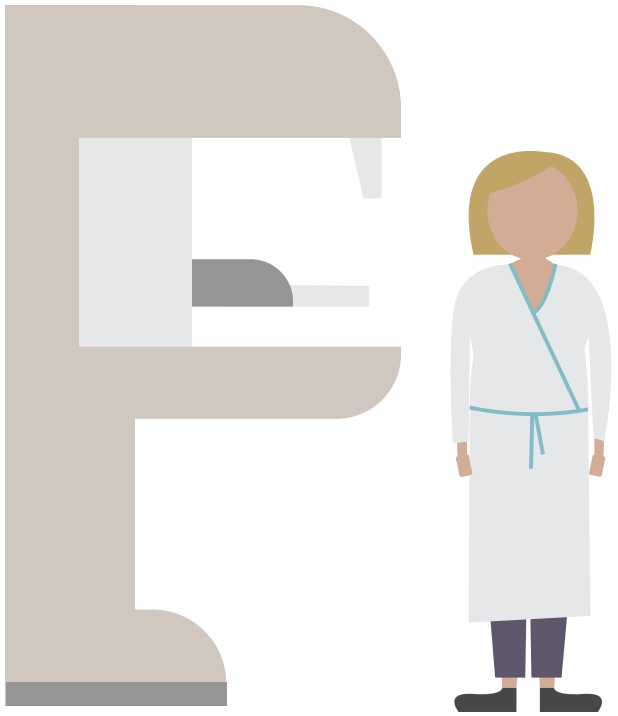
The purpose of the review was to explore whether the breast screening process is managed in a timely manner for women who have an abnormal screening mammogram.

We spoke with staff based in the PHW headquarters, and staff in the regional breast screening centres in Cardiff, Llandudno and Swansea.

We used a survey to capture views from women who had been recalled to attend an assessment clinic, and who went on to receive a benign outcome (a cancer was not identified).

It was very encouraging to find that overall, women reported an excellent experience. However, our review identified some regional workforce challenges across Wales which affect the timeliness of care women received. We also found that the Breast Test Wales staff were caring, dedicated and passionate about providing the best possible service for women.

We published our report in October 2020.



Local Reviews

Welsh Ambulance Service NHS Trust (WAST)

As part of the HIW local review programme and the ongoing concerns across Wales in regards to ambulance waiting times, we started a local review of the Welsh Ambulance Service NHS Trust in November 2019. The review explored how risks to patient health, safety and well-being are managed whilst waiting for an ambulance.

The review set out to specifically assess how patients were being managed by the three Emergency Medical Services Clinical Contact Centres (EMSCCC's), once a request for an ambulance is received, to the point where the ambulance arrives at the scene. The review also considered how staff working within the EMSCCC's are resourced, trained and supported to undertake their roles.

Overall, our review highlighted that processes were in place which aim to provide safe and effective care to patients. However, we identified issues that were negatively affecting the ability of the service to respond to demand. In addition, we had concerns in relation to staff vacancies, and the training, development and support provided to staff, to enable them to undertake their roles effectively and appropriately.

We published our report in September 2020.

Inspection Findings

NHS Hospitals

In 2019-2020 we conducted 38 hospital inspections across Wales including three community hospitals. 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.

Patients continued to praise the dedication, kindness and compassion shown by staff at all our inspections. Despite very busy settings, almost all our inspections concluded that patients were treated with dignity and respect, in nearly all aspects of their care. We saw numerous examples of good multidisciplinary team working, which contributes to patient experience, and also efficient treatment and discharge.

"Fantastic staff. Lovely food. No job is too much for the staff." – Patient – Cardiff and Vale health board

Leadership at ward and service level is fundamental to the delivery of effective care for patients. The vast majority of our inspections noted supportive management and effective leaders. However, this was not always the case, and on a small number of occasions staff told us that the leadership culture needed to improve in order to help them carry out their role. Protected time available for nursing staff to complete training and appraisals also remains an issue. It is vital that the longer term benefits of good leadership and ongoing training are recognised fully in all settings.

"I am very happy and grateful to my ward manager for all the support she gives to me and to the other members of the teams. She is here for support using professional and personal matters. She always goes that extra mile to support staff." – Staff – Hywel Dda health board

We inspected four emergency departments as part of our inspection programme, which included two follow-up visits to check that recommendations from previous visits had been addressed. All of these inspections noted significant waiting times for patients and issues with access to timely care. Staffing levels and the number of people presenting at and emergency department are obvious factors in the challenge of balancing service capacity and demand. However, our work is increasingly highlighting the need to improve patient flow through hospital sites in order to relieve pressure on emergency departments.

"Sometimes I go home in tears due to the stressful shift as I can't do everything I need to do, with patients rammed in everywhere, and many stuck on the back of an ambulance outside" – Staff – Swansea Bay health board

"I feel at times I am unable to give efficient patient care and deal with their needs, due to the ever-growing demand on ED" – Staff – Swansea Bay health board

We check the cleanliness and hygiene of all the wards and areas we inspect, and rarely note any issues. However, in stark contrast to previous years, we unfortunately noted visibly dusty and dirty environments in three of our inspections, where cleaning schedules were regularly incomplete. We also noted a decline in one specific site.

Inspection Findings

We inspected an emergency department in 2017 and noted how clean the premises were and the housekeeping staff were commended. However, a new inspection of the same site in 2020 found visible dirt, heavy layers of dust and equipment not being cleaned between patients. We escalated our concerns to the health board and were content with the action taken to rectify these issues. General cleanliness of ward areas is a basic requirement for infection prevention and control and this can pose a significant risk to patients.

Three of our inspections were of paediatric units. We developed new patient questionnaires so we could collect the views of children and young adults at these sites. We saw excellent examples of the use of play therapists helping children through medical procedures, and individual play plans for patients staying on the ward for a prolonged period of time. However, we noted in two of these inspections that the layout of the ward made maintaining privacy and dignity for all patients difficult. One example of this included patients and parents having to walk through separate boys and girls bedded areas to get to the garden area. We made recommendations for improvements to the layout and these were included in an upcoming investment of the unit.

"I enjoy playing games around the table" – Patient – Hywel Dda health board

All the staff here were incredible, it was my son's first time in hospital and a terrifying experience for all, they were reassuring, helpful and kind hearted, making a very difficult time so much easier' - Patient's carer – Hywel Dda health board

When inspectors considered how well our previous recommendations had been implemented, we were glad to see the majority of our findings implemented and sustained. However, a minority were not fully implemented, and, disappointingly, we continue to see the same issues in many of our inspections, particularly around medicines management and the safe storage of medicines. An example of this includes IV fluids and controlled drugs being left in open areas and not locked away.

Insufficient checks and poor maintenance of resuscitation equipment was also a common theme. We expect health boards to proactively share the findings of our inspections across other wards and hospitals so they can learn from the experiences, and check if other sites need to make similar improvements. More effective systems need to be in place to ensure this is done robustly.

Inspection Findings

GP

This year we undertook 25 inspections of general practices spread over all seven health boards in Wales. Each inspection considered how the practice met the Health and Care Standards.

We found that patients were being treated in a dignified manner, and staff were respectful, polite and professional. We observed a welcoming environment in the majority of GP surgeries, with high standards of cleanliness across all seven health boards. During inspections, we saw evidence of effective leadership with inclusive and cohesive management teams in place. Overall, patients told us they were happy with the level of care they received.

However, in 2019 – 2020 there continued to be issues with booking appointments to see a healthcare professional. Patients told us about poor telephone booking systems, long wait times to see a doctor and short opening hours of surgeries, with many patients suggesting evening or weekend appointments should be available.

This year we issued 15 Immediate Assurance letters; almost a threefold increase compared with previous years. This means that we wrote to the practice immediately following the inspection, requesting that urgent remedial actions were taken in order to maintain patient safety.

Immediate improvements were required in eight practices on staff employment and Disclosure and Barring Service (DBS) checks. These are criminal record checks that most employers carry out on new staff. We noted these checks had either not been undertaken for all current staff, or records could not be found. DBS checks are required for all staff who work in healthcare, at different levels and are a vital part in assuring patients are safe.

"Lovely staff. Great doctors. Let's face it, we are lucky we have such good GPs and not reliant on locums with the nation struggling to recruit and maintain" – Patient, Hywel Dda health board

"Great staff, always obliging. Excellent, caring team" – Patient, Powys health board

Inspection Findings

We observed that immediate improvements were needed in maintaining resuscitation equipment in four practices. We found equipment that was out of date or not calibrated, and checks on the resuscitation equipment were not always being undertaken. This equipment is necessary in the event of a patient emergency and checks are required to ensure it is always working.

Immediate improvements were also required in maintaining immunisation records for staff, in particular Hepatitis B, in five sites. Practices should be able to provide evidence that all staff are sufficiently protected from the virus.

"The care has always been first class at this surgery. However, the constraints of the 5 minute appointment; the difficulty of maintaining consistency in seeing the same doctor, the anxiety of being able to get an appointment all mean that what was once a solid and reassuring service is threatened" – Patient, Hywel Dda health board

We found that the majority of practices had robust record keeping processes in place for patient records. However we did note that some practices did not have a clear system in place to manage referrals. For example we noted one practice that could not confirm if patient referrals were being sent to the correct department, or had been processed in a timely way.

In comparison to previous years there was a general improvement around signposting information available to patients in the waiting areas of practices. There were leaflets and posters available for patients on staying healthy and information on common ailments. There was also a clear improvement in relation to displaying information about how to make a complaint and the NHS Wales Putting Things Right process.

"Difficult to get through by phone. Possible not enough lines" – Patient, Cardiff & Vale health board

Inspection Findings

Dental

In 2019-2020 we continued to work with our dental peer reviewers to check patients were receiving dental care and treatment in line with professional guidance and relevant legislation, including the Health and Care Standards and the Private Dentistry (Wales) Regulations 2017.

We inspected 68 general dental practices which included 5 follow-up visits to check that recommendations from previous visits had been addressed.

We saw that most practices had dedicated facilities for the cleaning and sterilisation (decontamination) of dental instruments as recommended by the Welsh Health Technical Memorandum (WHTM) 01-05 guidance. However, our peer reviewers identified a range of improvements relating to infection prevention and control (IPC) during inspections. The most common issues identified were inconsistent checking and testing of autoclaves, evidence of required IPC training not being available, and the need to undertake routine audits of infection control arrangements. Dental practices must regularly monitor and assess their compliance with best practice infection prevention and control procedures to ensure standards are maintained.

Whilst we subsequently received assurances in a timely manner, it is frustrating that the majority of issues requiring immediate attention were the same as those identified in 2018-19. It is important for dental practices and health boards to ensure that learning from our inspection findings and reports is applied robustly and disseminated effectively. More effective and proactive arrangements must also be put in place to monitor and ensure compliance with relevant regulations and professional standards.

Findings

We inspected dental practices in every health board in Wales except Powys and the findings were generally good. We found that staff understood their roles and responsibilities and it was clear they worked hard and were committed to ensuring patients received a good quality service while under their care.

The patient comments we received during our inspections were almost always positive, and we found that most practices now have established processes in place to actively engage 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. This allows patients to understand how their engagement has shaped the service being provided.

We saw that most practices had dedicated facilities for the cleaning and sterilisation (decontamination) of dental instruments as recommended by the Welsh Health Technical Memorandum (WHTM) 01-05 guidance. However, our peer reviewers identified a range of improvements during inspections, and dental practices need to ensure they regularly monitor and assess their compliance with best practice infection prevention and control procedures.

Inspection Findings

The arrangements and processes in place to promote and protect the welfare and safety of staff, children and adults were robust and we frequently found good practice within this area. Checking that staff are aware of and understand their responsibilities under the new Wales Safeguarding Procedures 2019 will be a future area of consideration for our inspectors.

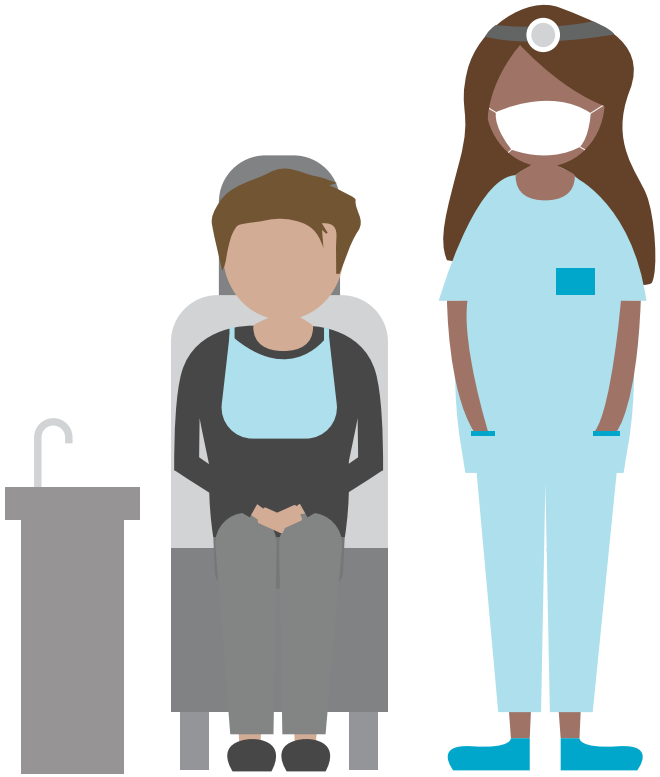
"The staff are very kind and caring. Also the staff are very friendly and always offer the best advice for the protection of my gums and teeth. Overall fantastic dental practice." Patient, Swansea Bay health board

The quality of patient records was variable. Some practices were maintaining excellent patient records that were clear, legible and contained all relevant information regarding discussions held about treatment options, costs, risks, benefits and how patient consent was obtained. However, a poor standard of record keeping was the issue most often raised in Immediate Assurance letters and Non-Compliance Notices. It is vital that dental practices make use of audit and peer review to help ensure patient records are accurate and comprehensive.

We found that staff were generally being supported in their roles by good management and governance arrangements and had access to the appropriate training and continuing professional development opportunities in order to fulfil their roles and responsibilities. Our inspectors will continue to expect dental professionals to be able to demonstrate their own compliance with their professional obligations.

One of the most common significant issues we identified across our inspections was in relation to the lack of suitable arrangements in place to protect patients and staff in a medical emergency. Dental practices must ensure that emergency drugs and resuscitation equipment are available in line with the Resuscitation Council (UK) guidelines and that documented checks are being undertaken weekly to ensure they remain in date and safe to use.

"In my opinion this is the best dental practice I have ever used. I cannot think of any way they can improve their service." Patient, Betsi Cadwaladr health board



Inspection Findings

Mental Health and Learning Disabilities

During 2019 - 20 HIW undertook 13 inspections to NHS hospitals including a Children and Adolescent Mental Health Services (CAMHS) unit, a medium secure unit, a learning disability service, a Psychiatric Intensive Care Unit (PICU) and elderly care services. We also undertook three Community Mental Health Team inspections across Wales.

In relation to independent healthcare inspections we undertook 15 visits, including one learning disability hospital, medium secure units and a CAMHS unit. Two of these visits were made to the same CAMHS unit and a further two of these visits were made to the same independent provider. As part of these visits HIW continues to monitor 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

HIW identified many positive areas during its work. Staff interacted and engaged with patients respectfully and good team working was observed with dedicated and motivated staff. We also found that patients were provided with a good range of therapies and activities and some good examples of care and treatment plans.

In some instances it was clear that Health Boards and Independent Providers had implemented a number of changes following previous inspections and implemented least restrictive models of care. We also found evidence of some effective governance arrangements which were having a positive impact on the care delivered.

However, HIW made a significant number of recommendations to individual Health Boards and requirements for improvement to registered independent providers of care. We continued to identify a range of failings in the maintenance and refurbishment of wards and in some cases this was having a detrimental effect on patient care, privacy, dignity and patient safety. The outdated design of some clinical environments also impacted upon patient privacy and dignity.

Inspection Findings

We observed a range of verbal interactions that varied considerably between staff, and between staff with patients, and unfortunately some were not appropriate One example was when a member of existing staff was orientating a new employee to the hospital, they stated that the patients would be in prison if there was no Mental Health Act. Some other key issues identified were; poor morale amongst the nursing and care staff, issues with physical health monitoring, and inadequate personal alarm systems when alerting staff from other wards.

The quality of care plans varied considerably. In some cases we could not find a care plan to address significant risks to the patient that had been identified; this was very concerning in relation to the safety of vulnerable patients. Training in a number of key areas was also not given to staff, including; the Mental Health Act, the Mental Capacity Act, risk management, patient observations, eating disorders, learning difficulties including autism and attention deficit hyperactivity disorder (ADHD), and a range of mandatory training. In addition shared learning from inspections across the Health Board's was not taking place.

During this year we again identified significant issues in relation to effective medicines management. Issues included;

- stock value errors
- missing witness signatures in the Controlled Drugs (CD) book
- reasons for PRN medication (pro re nata / as required) being administered not always recorded
- out of date information on depot injection dates
- water damaged bandages
- fridges and drawers with medication were not locked
- a lack of a robust system with the pharmacy for ordering and delivery of emergency medication
- lack of a process to ensure that the reporting of unsatisfactory medication fridge temperatures is addressed immediately
- a lack of patient details on Medication Administration Records (MAR)
- inadequate arrangements in place to promptly return or dispose of unrequired medication
- prescribed medication not authorised by the corresponding consent to treatment certificate
- controlled drugs cupboards are not used to store inappropriate items.

In addition policies relevant to the use of medication and clinic rooms were not always up to date and staff did not always have access to these.

A key part of the mental health visits that HIW undertakes is to fulfil its responsibilities to monitor the Mental Health Act 1983 on behalf of the Welsh Ministers who have specific duties that they are required to carry out in law. HIW publishes a separate, more detailed report on the findings from these visits and this includes a section on how the Act is being implemented. The report considers how individual health boards and independent registered providers discharge their duties so that the Act is lawfully and properly administered throughout Wales.

As part of our role in monitoring the use of the Mental Health Act we continued to identify many examples of good practice with the implementation and documentation of the Act and it was apparent that there was a good level of governance and audit. In the vast majority of instances, legal documentation to detain patients under the Mental Health Act was compliant with the requirements of the legislation and there were comprehensive records for the administration of the Act.

Patient records stated that patients had been informed of their rights in line with Section 132 of the Act. Records evidenced that appeals against detentions were held within the required timescales and medication was provided to patients in line with Section 58 of the Act. In relation to Consent to Treatment, treatment certificates were kept with the corresponding MAR Chart. This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of section 58 of the Act.

Inspection Findings

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

- The MHA administrator should consider improved levels of communication with external teams, for example to ensure that patients have their Mental Health Review Tribunals and managers hearings in accordance with the timescales afforded by the Act
- Significant improvements are required around the admissions process, specifically around the appropriateness of patient detention - detention papers had not all been completed correctly to detain patients at the hospital
- In one example a CO2[5] form had not been completed for one of the patients following their transfer to the hospital. This meant that there was no evidence to confirm that the patient had consented to the transfer and their treatment more broadly
- In another visit, when each set of statutory documentation was reviewed, there was no record of the capacity to consent to treatment assessment by the patient's responsible clinician. In addition, there was no record of regular review of treatment
- In one example a patient's consent to treatment certificate was over three years old and there was no evidence that this had been reviewed
- In some instances, consent to treatment certificates that no longer authorised treatment were not clearly marked to indicate to staff that they were no longer valid
- Section 17 Leave authorisation forms that no longer authorised leave, were not clearly marked to indicate to staff that they were no longer valid
- Insufficient staff within the Mental Health Act department
- A lack of detention papers in current patient records.

[5] A CO2 form indicates that the patient has consented to the treatment plan

Inspection Findings

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

Our inspections of seven independent hospitals this year delivered positive findings with no immediate patient safety issues identified. As a result we did not need to issue any non-compliance notices.

We found strong and visible management and leadership on all our inspections, and it continues to be an area where few recommendations were made. Overall we observed clear processes and procedures to support the delivery of safe and effective care. Patients told us that they were happy with the experience and service they had received and patient records were completed to a high standard in general.

However, we did identify some issues in relation to documentation and risk assessment. We found examples where pre-assessment documentation needed to be strengthened with sufficient detail, including the recording of cognition, safeguarding and any religious beliefs. Some risk assessments needed to be more robust and followed-up at appropriate intervals with individualised patient detail. All risk assessments must be completed and / or reviewed at the time of admission and stored alongside patient notes.

Settings were also reminded to ensure that staff complete all aspects of mandatory training and that up-to-date records of this are maintained by setting.

Despite infection prevention and control being of a good standard overall, it was an area where we made a range of recommendations. These included appropriately maintaining environments to enable effective cleaning, for example remedying chipped, rusty or porous surfaces. The number and location of hand washing sinks and clinical waste bins needs to be considered and a reminder for staff to adhere to handwashing guidelines, and settings must replace or make use of disposable curtains if needed.

"Very helpful and caring staff providing excellent care"
Patient, Independent Hospital

Inspection Findings

Independent Clinics and services providing 'prescribed techniques'

Independent clinics are establishments within which services are provided by private medical practitioners, without the facility of overnight beds.

'Prescribed techniques' are services, such as IVF (in vitro fertilisation), termination of pregnancy, and circumcision, provided by settings which are registered with us as an independent hospital. This also includes dental hospitals providing treatment under general anaesthesia.

We conducted seven inspections this year and continued to find high levels of patient satisfaction for independent clinics and services across Wales. It was pleasing to note that no immediate patient safety issues were identified and as a result we did not need to issue any non-compliance notices.

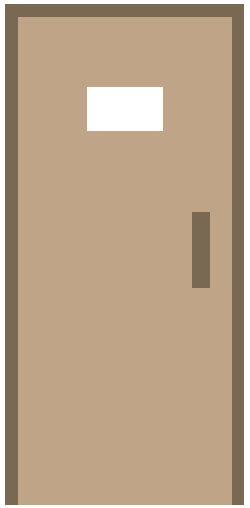
On all clinic inspections we found clean and well-maintained environments and arrangements were in place to ensure patients received care and treatment in a safe and effective way.

However, we did identify a small number of regulatory breaches. Registered providers must ensure that DBS checks are conducted to an appropriate level and mandatory staff training is completed with up-to-date records. Also, visits by the responsible individual must take place at least every six months with a report on the conduct of the service being produced following the visit.

Recommendations for improvement included ensuring patient records are maintained to a high standard, particularly the organisation of records, legibility and procedures for countersignatures; improved availability of health promotion material; and the outcomes and changes made as a result of patient feedback must be displayed for patients to view.

The use of chaperones was again identified as an issue. Registered providers must take meaningful action to ensure that the offer and use of chaperones is recorded.

In relation to services providing prescribed techniques, patient feedback on all inspections was positive, and settings were clean and tidy with suitable infection prevention and control arrangements. However, we did identify a regulatory breach at one setting regarding maintaining patient records in line with professional standards.



Inspection Findings

Class 3b/4 lasers and Intense Pulsed Light (IPL)

This year we undertook 27 inspections of these settings compared with 15 in the previous year. We found patients generally received safe and effective care from staff who had the appropriate skills and knowledge to deliver treatments.

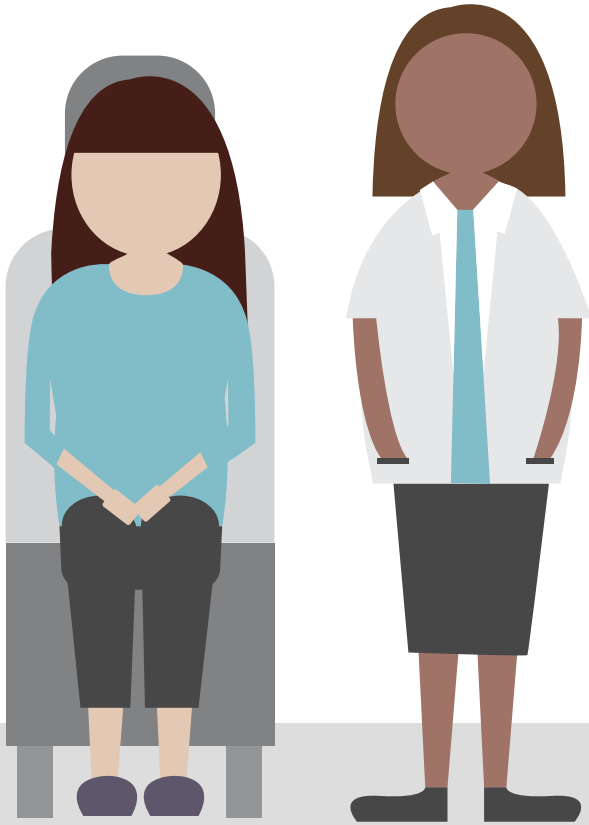
In general, we were assured that:

- Informed consent was being obtained because patients received the right information about their treatment in ways that they could understand
- Patient notes and records were being maintained to a good standard to show that patients were being provided with individualised care
- The laser and IPL machines used by settings to provide treatments had been serviced and calibrated to ensure they performed safely and as expected.

We noted that more settings were using social media as a way of collecting patient feedback. Settings must also ensure feedback is sought from those patients least likely to provide online feedback.

We identified some common improvements in line with professional guidance and standards that needed to be made by settings. These included:

- Better fire precautions, such as weekly documented fire alarm tests and the completion of regular fire risk assessments
- More regular checks of first aid kits to ensure contents remain in date and safe to use
- Documenting cleaning schedules to demonstrate that infection control arrangements are being followed
- Ensuring staff receive appropriate safeguarding training to promote and protect the welfare and safety of children and vulnerable adults
- Having up to date medical treatment protocols drawn up by an expert medical practitioner to set out the procedures to follow to ensure treatment is delivered safely.



Inspection Findings

Although the number of non-compliance notices we issued this year was small, we found that, as in previous years, settings still need to be more proactive in ensuring they comply with the regulations and their conditions of registration with HIW. In particular:

- Key documents such as the Patients' Guide and Statement of Purpose must include all the relevant information and be regularly reviewed
- Policies must be detailed and outline the relevant arrangements in place to ensure staff are aware of their roles and responsibilities
- Background checks must be undertaken on staff members to ensure they are fit to work at the setting to help protect patients against the risk of abuse
- Local rules that detail the safe use of the laser or IPL machine must be reviewed at least annually by a relevant laser or IPL expert.

Enforcement

We have continued to take action when we have been made aware of unregistered providers, taking necessary steps to clarify whether registration is required, and taking them through that process. Where we have identified providers who have not co-operated we have taken stronger steps and in relation to one specific provider we commenced a criminal investigation. During the past year, 14 potential unregistered providers were identified and nine are in the course of being registered, the remainder are at various stages of our enforcement process.

We have also continued to use our Service of Concern process in relation to registered services. This process is used in instances where we have identified significant concerns about services which may impact upon patient safety, typically arising from an inspection visit and any subsequent non-compliance issues. A service is given this formal designation as a consequence. During the past year, four services have been escalated to this status and have been managed in accordance with our enforcement process, with civil actions such as imposition of conditions on registration being implemented in response.

Inspection Findings

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

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

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

During 2019-2020 HIW completed three IR(ME)R) inspections, this is lower than usual due to operational difficulties towards the end of February and the onset of the Coronavirus pandemic in March 2020. These circumstances also meant that only two of the three modalities of medical exposures were covered (radiotherapy and diagnostic imaging) with nuclear medicine not being covered this year.

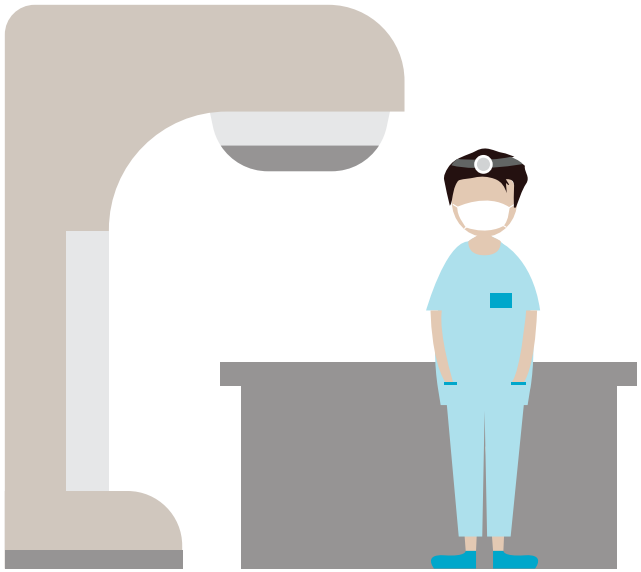
Findings

During our inspections we asked patients to rate their experience; overall patients were highly satisfied with the service they had received. In our inspection of the radiotherapy department at Velindre Cancer Centre patient comments were particularly positive in their praise for the approach taken by staff working there.

Overall compliance with the regulations was good, with policies and written procedures required under IR(MER)2017 being available and up to date. Discussions with staff demonstrated that awareness of their responsibilities in line with IR(ME)R) was also generally good. It was also positive to see that senior staff were very receptive to our inspection activity and demonstrated a willingness to make improvements as a result of our findings.

Half of the recommendations for improvement that we made related to patient experience issues. We found that the services we visited could do more to provide patients with better information on the following areas:

- Availability of Welsh language services and promoting the Active Offer[6]
- Waiting times
- Who to contact should they have any issues following their examination / treatment
- How to raise a concern about the service they have received and how the Community Health Council can support them in doing so.



[6] An 'Active Offer' means providing a service in Welsh without someone having to ask for it. The Welsh language should be as visible as the English

Inspection Findings

The recommendations we made in terms of safe care and leadership / management were specific to the site we inspected with no themes arising. The only exception to this was the need to ensure that all medical and non-medical exposures are justified and that the individual practitioner justifying each exposure can be identified. This is a particular problem with out of hours services provided through an outsourced all-Wales contract arrangement. This contract provides a radiology reporting service which includes, in some instances, out of hours justification of specified examinations and associated clinical evaluation. This is an all-Wales issue so all health boards need to ensure this issue is addressed.

Whilst there were no themes arising from the recommendations themselves, there was a clear theme in the actions proposed by services in response to our recommendations. Overwhelmingly the response was to increase audit and governance activity to ensure that the service is able to identify these issues for themselves and not rely on inspection by the regulator to identify areas of non-compliance. The need to improve governance and oversight of IR(ME)R compliance was identified as a key issue in our 2018-19 inspection programme. We would encourage all health boards and trusts to continue to focus on this and learn from each other.

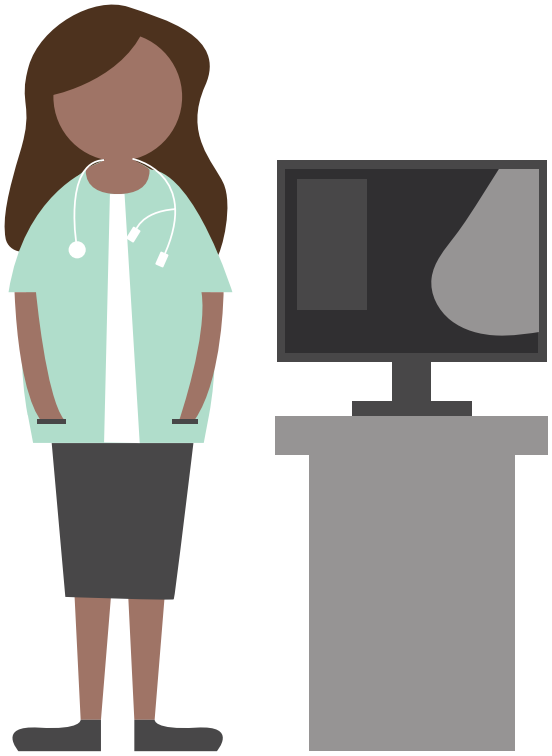
At the request of the UK Government an international team of senior safety experts conducted an Integrated Regulatory Review Service (IRRS) peer review mission from 14 to 25 October 2019. The purpose of this mission was to evaluate the UK's regulatory framework for nuclear and radiation safety against the IAEA safety standards.

This was the fourth IRRS mission that the UK has hosted since IRRS programme began in 2006 and the first full scope mission which addressed both nuclear and radiation safety. The radiation safety element brought the use of ionising radiation for medical reasons into scope for the first time.

HIW fully engaged with this review both during the initial self-assessment exercise and being interviewed by the review team during the mission itself. Overall, the review team were complimentary of the arrangements in place for monitoring compliance with IR(ME)R and did not make any recommendations with regards to our inspection methodology. However, they did recommend that all UK regulators for IR(ME)R should adopt a frequency based approach to inspection. This will mean an increase in the number of inspections per year as we seek to achieve the following frequency based approach:

- Radiotherapy services will be inspected every four years
- Nuclear medicine facilities will be inspected every six years
- Hospitals with diagnostic imaging services will be inspected every 10 years.

Overall the IRRS mission was a valuable learning experience for UK regulators which enabled us to self-diagnose improvements required for our own policies and procedures. It's also brought the four UK regulators much closer together and created a mechanism for sharing learning and practise across the UK.



Inspection Findings

Offender Healthcare

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 death in custody reviews critically examine and evaluate the systems, processes and quality of healthcare services provided to prisoners during their time in prison or Approved Premises.

In 2019-2020, HIW was commissioned to conduct 14 clinical death in custody reviews on behalf of the PPO. Half of these were located in HMP Parc, Bridgend. HMP Swansea had the minority of deaths in custody with only one case.

Again this year, our death in custody reviews established that, in general, the care provided to prisoners in Wales was equitable with the expected level of care in the community. In each of our reviews we identified improvements and highlighted good practice.

We noted that referrals to specialities were, in general, done in a timely and efficient manner. In addition, medication management and routine reviews of prisoners' medication were undertaken in a satisfactory manner.

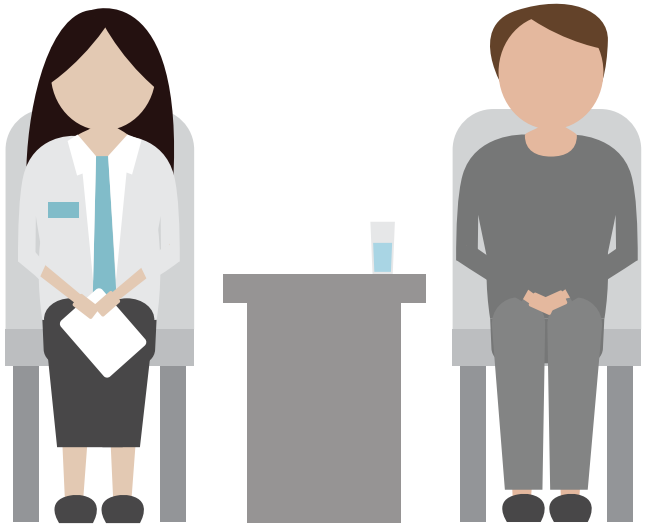
We also identified the need for improvements within our reviews. For example, we noted that improvements in clinical auditing practices were required. Clinical audit should be an intrinsic part of quality management within prison healthcare services, as it promotes positive outcomes and increases patient safety.

Mental health / dementia service provision was also highlighted as requiring improvement within our death in custody reviews. We recommended prisoners with dementia should have access to local specialist mental healthcare in a timely manner.

Prison Inspections

HMI Prison Inspections 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 2019-2020, we attended two HMIP inspections at HMP Parc near Bridgend. The inspections were for the adult prison population and the youth offending institution based at HMP Parc.



Inspection Findings

The inspection reports found the following good practice:-

- Initial health screening was undertaken promptly and effectively in reception, with appropriate onward referral to other services when necessary. Secondary screening was routinely offered, and take-up and recording had improved over the last 12 months
- The prison had a coherent approach to health promotion. The healthcare team utilised a calendar of events reflecting national programmes, and health promotional information was displayed throughout the prison
- There was a specialist assisted living unit for prisoners diagnosed with learning difficulties, and this provided an excellent level of care and support
- The presence of two dedicated nurses on the children's unit enabled effective continuity of care and helped to build caring and trusting relationships with the children.

The inspection also identified some areas for improvement particularly in the following areas:

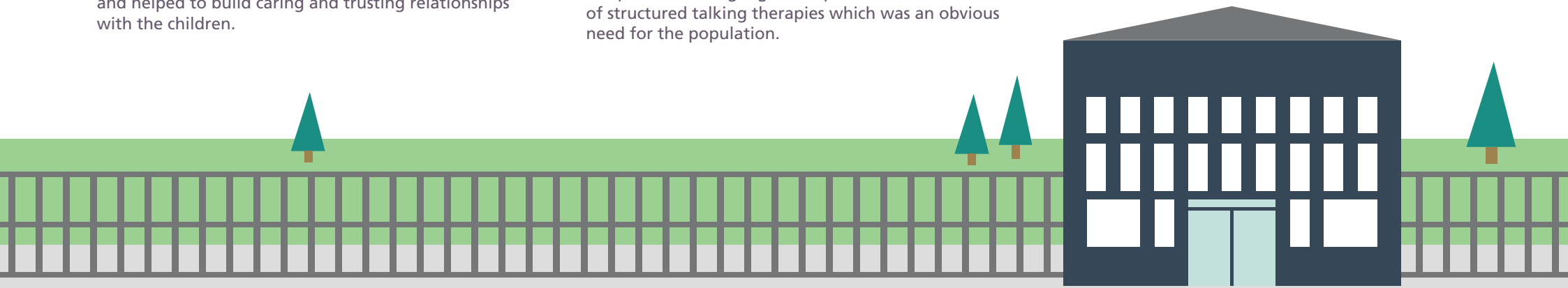
- The demand for mental health services was high and service provision did not meet demand. Although the support available for mild to moderate problems had improved, the range of specialist interventions and support for prisoners with more complex needs was inadequate and too many patients waited too long to access existing services
- Vulnerable prisoners in one unit could access only a single weekly dentist session, which could have resulted in them facing delays in receiving urgent care
- Child and adolescent mental health services did not deliver a suitable range of assessments, treatment and interventions for children at Parc. Psychology based interventions were no longer delivered, there was no speech and language therapist and no evidence of structured talking therapies which was an obvious need for the population.

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 in depth reviews also involve an assortment of other partner agencies including Estyn and Care Inspectorate Wales.

In February 2020 HIW participated in an inspection of the Youth Offending Services in Cardiff and evaluated the healthcare services and provisions provided to young people.

The full report was due to be published at the end of July 2020 and the report will found on HMI Probation's website.



Local Health Boards and NHS Trusts

Aneurin Bevan UHB

Overall, we observed staff providing safe and effective care, whilst treating patients with dignity and respect. The majority of patients we spoke with were happy with the care they received. We were pleased to see evidence of effective multidisciplinary working across the inspections, particularly in our Hospital inspections.

One of the key challenges for the health board, recognised in last year's Annual Report, is the sharing of learning between services, and finding similar issues across our inspections. Whilst it is encouraging to see many examples of good practice, it is disappointing that this does not appear to be shared and implemented across the health board. An example of this is on our Mental Health inspections, where we found good application of the Mental Health Act in County Hospital, yet we found poor application of the Act in Maindiff Court. We also raised this issue at a similar inspection in November 2018.

Additionally, we have previously raised concerns with the quality of record keeping within settings, and it was disappointing to find a number of improvements required in this area across a number of services.

The findings from our GP inspections were broadly positive. The majority of patients we spoke with were happy with the care they received, and we observed staff treating patients with dignity and respect. Practices were aware of their responsibilities in promoting peoples' rights and ensuring services are accessible to all patients, and all practices were well managed. However, we did issue two Immediate Assurance letters following two of these inspections, both in respect of checking emergency equipment. We subsequently received sufficient assurance from the health board on these issues.

We inspected three hospitals as part of our National Review of Maternity Services. We observed professional and kind interactions between staff and patients, and care was provided in a dignified way. Most patients we spoke with were positive about the care they received. It was pleasing to see good processes in place for the management of clinical incidents, which is a good example of sharing good practice across all sites. Specialist Midwives were appointed across all three hospitals, and we found evidence of good multidisciplinary team working. However, we found improvements were required to infection prevention and control processes in two of our inspections. We issued an Immediate Assurance letter following one inspection regarding the safety of babies on the ward; the checking of emergency equipment; and monitoring drug fridge temperatures. We subsequently received sufficient assurance from the health board on these issues.

Aneurin Bevan UHB

We inspected two NHS Mental Health settings in 2019-2020. It was pleasing to see evidence of good team working between staff and hearing patients speak positively about the care they received. There was a good focus on individualised care, and both settings had strong links with the local community. We also found that there were established processes in place to ensure that staff safeguarded vulnerable adults and children. Unfortunately, we found improvements were required to how medicines are managed to ensure medication remained within acceptable temperature ranges, which is something we also identified in one of our hospital inspections.

We inspected 13 dental practices in 2019-2020. It was pleasing to see that patient feedback was sought and acted upon and that there was evidence of good management and leadership. However, in over half of our inspections, we identified improvements required to the standard of clinical record keeping, which is particularly disappointing as this area was identified as a theme requiring improvement in the 2018-19 Annual Report.

We will be tracking compliance with our recommendations during 2020-21 to ensure learning is shared and recommendations are acted upon.

Aneurin Bevan UHB

Hospitals

- ✓ Overall, safe and effective care was found
- ✓ Staff treated patients with dignity and respect
- ✓ Most patients said happy with care received
- ✓ Good evidence of multi-disciplinary team working
- ✓ Good levels of patient privacy on wards
- × Issues with infection control and prevention measures
- × Checks on emergency equipment
- × Record keeping
- × Medicines management

Mental Health

- ✓ Dedicated and motivated staff
- ✓ Patients complimentary about care received
- ✓ Good team working
- ✓ Good individualised care
- × Medicines management
- × Application of the Mental Health Act

GP

- ✓ Overall, safe and effective care was found
- ✓ Staff treated patients with dignity and respect
- ✓ Good access to patient information
- ✓ Practices were well managed
- ✓ Good communication between staff
- × Policies and information on chaperones
- × Staff training records
- × Record keeping
- × Checking emergency resuscitation equipment

Dental

- ✓ Patient feedback was regularly sought and acted upon
- ✓ Practices were overall clean and well maintained
- ✓ Evidence of good management and leadership
- × Medical devices and equipment
- × Storage and security of waste
- × Standard of clinical record keeping

Local Health Boards and NHS Trusts

Betsi Cadwaladr UHB

Overall, inspections of the health board throughout 2019-2020 have been positive. We found dignified, individual care being provided by staff within the inspection settings. However, it was a concern that some issues highlighted in the previous year continue to be evident.

One of the main challenges seen within the Emergency Departments inspected was the flow of patients into appropriate services within the hospitals. This had a detrimental effect on the running of the departments and achieving the Welsh Government waiting time target.

Within the six GP practices inspected during 2019-2020, we were concerned to see many issues relating to safe and effective care and governance and leadership. However, patients generally reported that they were treated with dignity and respect by the staff.

Two Non-Compliance Notices were issued as a result of the eight dental inspections carried out. However, two practices visited had no areas for improvements to recommend which was pleasing to see.

It was pleasing to find evidence of effective person centred care and holistic planning in our hospital, mental health and CMHT inspections. It was also reassuring to see that none of the mental health inspections resulted in us issuing an Immediate Assurance letter.

We found that care planning and documentation was of a good standard within the hospital, mental health and CMHT inspections, however, we did recommend that learning from audits, concerns and incidents needed strengthening. These findings were also evident in the inspections carried out during 2018-19.

Overall, across all inspections, staff were very positive about the areas they worked within, however improvements were required to strengthen training and staff retention.

During 2019-2020 we inspected the entirety of the health board's acute and community birthing units within maternity services. It was pleasing to see improvements within the acute maternity inspections and clear sharing of learning was evident, with excellent communication between the acute services. However, we were concerned to find within the three community birthing units, there were issues across all of the three healthcare standard domains. Despite these issues, feedback received from the women using the units was very positive about their care and experience.

In light of the health board remaining in special measures, it is imperative that the drive to implement improvements and share recommendations continues and traction is not lost.

Betsi Cadwaladr UHB

Hospitals

- ✓ Good evidence of person-centred care and staff engagement
- ✓ Safe and effective care demonstrated across the range of inspections
- ✓ Good arrangements in place in maternity to provide women and families with bereavement and perinatal mental health support
- × Poor infection prevention and control compliance in some areas
- × Learning from audit, concerns and incidents
- × Overall governance and leadership within the community birthing units

Mental Health

- ✓ Positive feedback from service users regarding staff engagement and person centred care planning and provision
- ✓ Clinical auditing, reporting and escalation processes good within CMHT Care
- ✓ Established governance arrangements that provide safe and clinically effective care
- × Provision of information available for patients
- × Safe and effective medicines management
- × Assessing of ligature risks
- × Staff training, recruitment and retention

GP

- ✓ Patients treated with dignity and respect and engaged throughout care
- ✓ Good evidence of robust record keeping
- ✓ Staff within all inspections happy within their roles
- × Infection prevention and control measures require strengthening
- × Staff personnel records review required to ensure compliance is clearly documented such as DBS, immunisations and training compliance
- × Safeguarding meetings are regularly held, documented and learnt upon

Dental

- ✓ Good mechanisms for obtaining and responding to patient feedback
- ✓ Suitable range of health promotion and oral hygiene material
- ✓ Appropriate adult and child safeguarding training
- × Use of clinical audits to be expanded, particularly smoking cessation and antimicrobial prescribing
- × Infection prevention and control measures require strengthening
- × Sharps bins to be wall mounted

Local Health Boards and NHS Trusts

Cardiff and Vale UHB

Overall, our inspection findings within the Health Board were positive. Where improvement was required, all clinical boards have responded in a constructive manner and with good engagement. Throughout each inspection, staff interaction with inspection teams was very good, and the ongoing engagement from Health Board leadership teams has also been positive.

Patients were on the whole very positive about the care, treatment and services provided by the Health Board. Staff also provided positive feedback in relation to the support and leadership provided by senior department and Health Board managers. There were effective multidisciplinary team working practices, which were noted as being positive and enabling.

We visited four hospitals and inspected seven departments, and maternity services at University Hospital of Wales (UHW) was inspected as part of our National Review of Maternity Services. Overall, we observed professional and compassionate interactions taking place between staff and their patients. All inspections identified that patients' privacy and dignity was maintained by staff, and staff were striving to deliver safe and effective care.

The Health Board consistently regards external and internal scrutiny as a positive means for learning and for continuous improvement. Shared learning across the health board has been evident in most areas. It was pleasing to note that the HIW follow-up inspection of the Assessment Unit and Emergency Unit demonstrated significant improvement in many areas following the issues found in last year's inspection.

We were unable to undertake our planned CMHT inspection within North West Cardiff, due to the Covid-19 pandemic. Our Mental Health Unit inspection within Hafan Y Coed revealed a number of issues which were negatively impacting on the patient experience, and which may impact on the safety of patients. A number of issues HIW identified during the inspection in 2019, were again identified this year.

The Health Board must reflect on its own assessment of the arrangements that were in place following last year's inspection at Hafan Y Coed, and why more action was not taken in relation to the action plan, leading to issues again being identified during this year's inspection.

Overall, in our three GP inspections, we found that staff were focused on providing safe and effective care to patients. There was generally a good standard of record keeping, and each practice was well led with good staff and team interactions. We did identify some areas for improvement particularly in relation to policies and procedure updates, and Disclosure and Barring Service (DBS) checks were an issue in some practices.

We undertook 15 dental inspections this year, and we found that staff were focused on providing safe and effective care to patients, and overall patients were happy with the care received. There were generally good management processes in place across the services. However, we did find that some improvements were required with documentation in patient records, clinical audit activity, and with the checks, storage and location of emergency equipment.

Cardiff and Vale UHB

Hospitals

- ✓ Overall, each inspection was generally positive and identified safe and effective care
- ✓ Positive patient experiences were identified across all inspections
- ✓ Good evidence of multi-disciplinary working on all inspections
- ✓ Good leadership and management across all inspections
- × Checking of resuscitation equipment in two departments
- × Availability of hand sanitizing facilities in all clinical areas
- × Timely personal annual development review
- × Timely compliance with mandatory training

Mental Health

- ✓ Dedicated staff teams committed to providing high standards of care
- ✓ Good staff/ patient interaction and engagement, with dignity and respect
- ✓ Care records maintained to a good standard
- ✓ Good leadership on both wards, with positive staff and patient feedback
- × Patients' legal status and consent to treatment certificates were not always present within their drug charts
- × Patients often 'sleeping out' of their designated ward, on to other wards
- × Poor staff training compliance
- × Appropriate patient access to the Hafan Y Coed garden area

GP

- ✓ Overall, each inspection was generally positive and identified safe and effective care
- ✓ Good patient feedback
- ✓ Well maintained and clean premises
- ✓ Good medicines management process
- × Disclosure and Barring Service checks
- × Improvements to policy and procedures
- × Obtaining timely access to appointments

Dental

- ✓ Overall, patients were happy with the service received
- ✓ All practices had staff trained appropriately in resuscitation
- ✓ Good staff induction process
- ✓ Good compliance with staff annual appraisals
- × Clinical audit activity and use of peer review
- × Frequency of checks, storage or location of emergency equipment
- × Clinical record documentation
- × Storage and security of waste

Local Health Boards and NHS Trusts

Cwm Taf Morgannwg UHB

This has been a hugely challenging year for the health board, one that started with the publication of the report on maternity services at Cwm Taf University Health Board by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives identifying a number of serious concerns and service failures. The findings of the maternity report led to these services being placed under Special Measures, whilst the health board's overall status was also escalated to Targeted Intervention.

Partly in response to this report, as well as our own concerns over governance and risk management, a joint review of governance arrangements was initiated alongside Audit Wales. This review highlighted a number of fundamental deficiencies in the health board's quality governance arrangements. We were concerned that these weaknesses were compromising the health board's ability to adequately identify and respond to problems that may arise with the quality and safety of patient care. We also identified the urgent need for improvements to strengthen existing arrangements, organisational structures and roles, in addition to addressing a number of issues relating to the culture of the health board. In particular we felt that leadership arrangements for quality and patient safety within the health board need to be strengthened and broadened, and that there were gaps in key governance arrangements associated with the management and identification of risk, and the provision of information to support effective scrutiny by the board and its committees.

The health board accepted these findings in full and have produced a positive response to the recommendations. What is now important is that the health board continues with its progress along the improvement pathway. The scale of the challenges to improve quality and patient safety governance is not to be underestimated and will require focused and sustained commitment by the health board.

In terms of our own inspection activity during the year, we have noted some improvements in comparison with last year's programme of work. Our annual report last year noted concern about a lack of organisational learning from previous inspections, in particular around mental health services. This year our inspections of mental health services have demonstrated that several of the issues previously highlighted by us have been, or are in the process of being addressed. It is clear that staff are committed to providing the best care that they can. Nonetheless two of our three inspections identified Immediate Assurance issues, the most significant of these highlighting concerns over safe care and the reporting of incidents.

Cwm Taf Morgannwg UHB

In relation to our inspections of hospitals this year, these were all focussed upon maternity services aligned to our broader National Review of Maternity Services. As such we inspected each maternity unit within the health board. Broadly our inspections found that women were overwhelmingly positive about their care and experience of using maternity services. We also found that generally staff were interacting positively and that there was evidence of strong midwifery leadership. These are all positive elements and evidence of the work the health board has undertaken in relation to maternity services.

However, we also found a number of Immediate Assurance issues across our maternity inspections, with several of these being similar across sites. Whilst many of these issues were also found across Wales, it is nonetheless clear that there is still much work to be done to ensure consistency of standards across the health board's maternity services.

We found Non-Compliance issues at one IR(ME)R inspection last year. It was positive to note therefore that this year's inspections found no significant issues, with good compliance evidenced against the regulations. It is important that these improvements are sustained.

We will continue to monitor the health board closely and will be tracking progress against the recommendations of the joint review during 2020-21.

Cwm Taf Morgannwg UHB

Hospitals

- ✓ Women and their families were positive about their care and treatment
- ✓ We observed professional and kind interactions between staff and patients and we saw care provided in a dignified way
- ✓ Arrangements were in place to provide women and families with bereavement and perinatal support
- ✓ Staff were generally positive about the support they received from managers and we saw strong midwifery leadership
- × Checking of emergency resuscitation equipment
- × Medicines management including the safe storage of drugs
- × Measures to be strengthened to ensure the risk of baby abduction is mitigated
- × Security of patient records
- × Induction of labour medication prescribing

Mental Health

- ✓ We saw staff interacting and engaging with patients respectfully
- ✓ Some facilities were well maintained and created a pleasant environment of care
- ✓ Staff committed to providing dignified care
- ✓ A range of dementia care initiatives
- × Poor clinical documentation and risk management
- × Experience and skill mix of staff, alongside staffing levels
- × Medicines management, including the safe storage of drugs
- × Mandatory training compliance rates
- × Embedding of clinical audits
- × Incidents not being documented, recorded or reported adequately

Cwm Taf Morgannwg UHB

GP

- ✓ Positive and friendly interactions between staff and patients
- ✓ Clean and tidy environments
- ✓ Evidence of a strong teams, and a commitment to make improvements
- × Need to strengthen arrangements around maintaining a register of all clinical staff hepatitis B immunisation and immunity status
- × Strengthen employment check arrangements when recruiting new staff
- × Ensuring that complaints are recorded and assessed appropriately, including demonstrating actions taken as a result
- × Improving websites to ensure that they reflect the services on offer

Dental

- ✓ Patients told us they were happy with the service provided
- ✓ Patients had appropriate ways to provide feedback to the service
- ✓ There was patient information readily available within the services
- × Improvements to clinical records required, including alcohol and smoking advice, medical histories, recall and BPE recording

IR(ME)R

- ✓ Compliance with IR(ME)R 2017 Regulations was good
- ✓ Department was being well managed and comments from staff indicated that they felt supported by senior staff
- ✓ Feedback received from patients indicated that they were highly satisfied with the services provided within the department
- ✓ Senior staff were very receptive to our inspection and demonstrated a willingness to make improvements as a result
- × Ensure patients are routinely being provided with information in regard to the risks and benefits of undergoing their examinations
- × Ensure staff consistently undertake patient identification checks and pregnancy status enquiries prior to exposure to ionising radiation
- × Promote the availability of Welsh speaking staff working within the department to help deliver an 'Active Offer'[7]

[7] An 'Active Offer' means providing a service in Welsh without someone having to ask for it. The Welsh language should be as visible as the English

Local Health Boards and NHS Trusts

Hywel Dda UHB

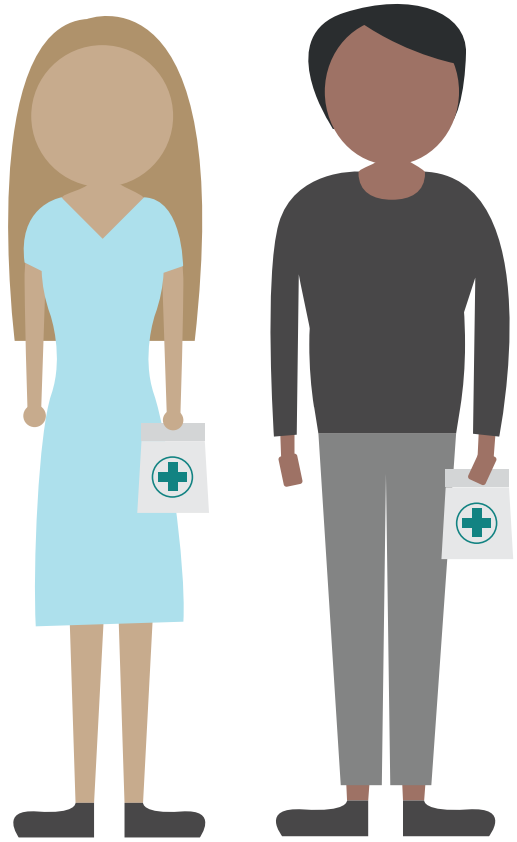
Overall, patients were extremely positive about the care, treatment and services provided by Hywel Dda University Health Board. Staff provided positive feedback in relation to the support and leadership provided by senior ward and hospital managers. Multidisciplinary effective working practices were also noted as being positive and enabling.

Unfortunately again this year themes have been identified which have been reported in previous annual reports that continue to be problematic areas for the Health Board. In particular medicines management was again noted as an area requiring improvement.

We visited six hospitals and inspected ten wards. Three hospital inspections were visited as part of our National Review of Maternity Services. Overall our inspections found that women were overwhelmingly positive in relation to their experiences of using maternity services. We observed professional and compassionate interactions taking place between staff and patients. During our inspections of maternity services we observed evidence of effective leadership. However, we also identified a number of Immediate Assurance issues across our maternity inspections, with several of these being similar across sites. Some of these issues were also found across Wales. It is acknowledged however, that there is work to be done to ensure consistency of standards across the health board's maternity services.

We undertook one learning disability inspection and one mental health inspection. It was pleasing to report that no Immediate Assurance letters were issued. In both inspections it was identified that the care, support and treatment provided was undertaken in a dignified and respectful manner.

HIW also undertook an inspection of a Community Mental Health Team located in Llanelli. We found the quality of care and engagement to be generally good and service users were mainly positive about the support they received. We found that a multidisciplinary approach was in place for assessment, care planning and review and that service users and their families were involved, where appropriate, in the process. During the inspection we highlighted concerns in relation to Disclosure and Barring Service (DBS) checks and aspects of medication management. Our concerns were dealt with under our Immediate Assurance process.



Hywel Dda UHB

Overall, in our four GP inspections we found that practices were focused on providing safe and effective care to patients. Record keeping was noted as being completed to good standards. We did identify some areas for improvement particularly in relation to human resources practices. Specifically we identified that Disclosure and Barring Service (DBS) checks were not undertaken in a robust and comprehensive manner.

In our dental inspections, we noted that surgeries generally provided safe and effective care to their patients in a professional and committed manner. Patients were largely very positive on the services provided. Some areas for improvement were identified which included mandatory training for staff and robust recruitment processes.

During all of our inspections and contacts with the health board it is important to note that dealings have been positive and enabling. This has been demonstrated in our interactions with ward based staff and the senior executive team. Where recommendations / Immediate Assurances have been highlighted, the Health Board has looked to remedy any issues at the earliest possible opportunity. Hywel Dda University Health Board is to be commended on its approach to improving standards of care and patient safety. The health board has developed a culture of openness and transparency and senior executives are to be commended for adopting this approach.

Hywel Dda UHB

Hospitals

- ✓ Staff were committed to providing high quality care to patients
- ✓ We saw professional and kind interaction between staff and patients, and care was delivered in a dignified manner
- ✓ Good multidisciplinary team (MDT) working.
- ✓ Generally, staff were positive about the support they received from managers
- × Medicines management including the safe storage of drugs
- × Checking of emergency resuscitation equipment
- × Staff compliance with statutory and mandatory training
- × Documentation, including risk assessments
- × Hygiene and infection control practices

Mental Health

- ✓ Patients were provided with a good range of therapies and activities
- ✓ Good team working and motivated staff
- ✓ Promotion of patient centred care to aid recovery
- ✓ In-depth and individualised care plans
- ✓ Good out of hours provision and Mental Health Act Administration in our CMHT inspection
- × Capacity of its adult inpatient mental health service
- × Audit and governance arrangements
- × The provision of information and literature on the wards for patients
- × Staff compliance with statutory and mandatory training
- × Improvements to medicines management including the safe storage of drugs needed on our CMHT inspection
- × DBS checks on staff not completely adequately on CMHT inspection

Hywel Dda UHB

Community Mental Health

We inspected the Llanelli Community Mental Health Team

- ✓ Service user and carer engagement
- ✓ Multidisciplinary working and links with other agencies
- ✓ Out of hours provision
- ✓ Mental Health Act Administration
- × Medicines management including the safe storage of drugs
- × DBS checks on staff
- × Psychology waiting times
- × Training on Social Services and Well-being Act for health board staff

GP

- ✓ Patients were treated with dignity and respect
- ✓ Good standard of record keeping
- ✓ Good range of health promotion information and initiatives
- ✓ Support from senior management
- × Completion of Disclosure and Barring Service checks
- × Greater provision of bilingual information
- × Medicines management including the safe storage of drugs
- × Compliance with statutory and mandatory training

Dental

- ✓ Surgeries were maintained to a high standard
- ✓ Arrangements were in place for infection prevention and control
- ✓ Patients were provided with enough information to make an informed decision about their treatment
- ✓ Patients were able to provide feedback regarding the care and treatment they received
- × Improved implementation of Delivering Better Oral Health guidelines and ensure evidence is recorded within patients' records.
- × Ensure clinical patient records are maintained to an agreed professional standard
- × Compliance with statutory and mandatory training

Local Health Boards and NHS Trusts

Powys THB

Overall, inspections in Powys Teaching Health Board throughout 2019-2020 were mostly positive. We found dignified, person centred care being provided by committed staff across all inspection settings, as was demonstrated during inspections in 2018-19.

We inspected one GP practice in 2019-2020 where patients generally reported they were treated with dignity and respect by the practice team. We saw evidence of good team working amongst the practice staff. Improvements were required to ensure that staff employment records were up to date, including pre-employment checks and training information. A programme of clinical audit was required to ensure the practice regularly reviewed its activities.

It was pleasing to find evidence of effective multidisciplinary working in our hospital, mental health and CMHT inspections. In particular, the level of integration between health and social care within the CMHT was very positive, in contrast with a CMHT inspection within the health board the previous year. It was also positive to find improvements in the waiting times for patients being able to access psychology services within the CMHT.

We also found that care planning and documentation was of a good standard, with the majority of records we looked at being completed in detail and person centred.

We did, however, find areas for improvement with some aspects of Mental Health Act documentation across a number of settings. This is an area where there were similar findings in our 2018-19 CMHT inspection.

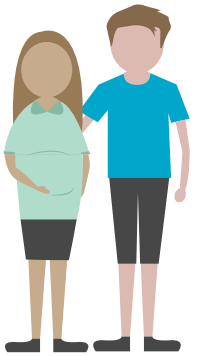
Across our hospital, mental health and CMHT inspections we found there were supportive governance and audit processes in place. There were, however, some areas where this could be improved, such as ensuring policies and procedures were reviewed in a timely manner, to ensure staff have access to the most appropriate and up to date information to support them in their practice. It was also disappointing to find, in one mental health inspection, that improvements identified during a 2017 inspection had been identified again in this inspection cycle.

Generally, staff reported there to be a good team-working environment and felt supported by their managers and colleagues. We found that the Health Board continues to have difficulties in recruiting to vacant positions. However, the health board was proactively advertising to attract candidates into these roles. Despite these difficulties, we found that there were appropriate staffing levels across settings, to support the delivery of a good standard of care.

Whilst we saw effective discharge planning across settings, we found that due to the lack of social care placements and /or social care engagement, patients' discharge from hospital settings could often be delayed.

It was disappointing to find a number of estates issues across a range of services within the Health Board, which were in need of addressing to ensure a safe environment for patients. Consideration must also be given to the ward layouts in some of the mental health wards. We found that the ability of staff to be able to provide care in a dignified way was negatively impacted due to double occupancy rooms and shared bathroom facilities.

We inspected six birth centre units across the health board, and whilst we generally found these to be positive, there were some inconsistencies in the process used for water birth pool evacuations. Also, we found that some supporting equipment used in such an emergency was not available in all units. This resulted in an Immediate Assurance letter to the Health Board to take urgent remedial action. We were assured by the action taken.



Powys THB

Hospitals

- ✓ Patients received dignified and respectful care, from committed staff
- ✓ Multidisciplinary team working
- ✓ Identification of patients requiring additional support with their needs i.e. butterfly scheme and identification for those needing support with eating and drinking
- ✓ Overall, good governance, audits and clinical review processes in place
- ✓ Checks on emergency equipment
- × Environmental issues
- × Consistent use of a pain assessment tool
- × Ability of the health board to recruit into vacant positions
- × Completion of areas within Mental Health Act documentation
- × Impact of lack of social care provision on discharge planning
- × The need to ensure that policies and procedures were reviewed and up to date

GP

- ✓ Patients treated with dignity and respect
- ✓ Supportive team working environment
- ✓ Patients fully aware of the reasons for prescribed medication
- ✓ A clean and tidy clinical environment
- × The need to implement a programme of clinical and quality audits
- × Staff personnel records to be maintained appropriately, including employment and training information
- × Formal staff communication, to include team meetings and clinical staff meetings to disseminate information appropriately

Powys THB

Mental Health

- ✓ Patients received dignified and individualised care, including care plans from committed staff
- ✓ Multidisciplinary team working across the services, and good level of integrated working shown in the CMHT
- ✓ The use of distraction techniques, rather than resorting to restraint as a method within the hospital
- ✓ Whilst not across the two hospital wards, we found examples of noteworthy practice that could be shared (use of a patients' council and 'This is me' document)
- ✓ Timely process for screening new referrals within the CMHT
- ✓ Significant reduction in the waiting time for patients to access psychology services within the CMHT(from 2 years to 2/3 months)

- × Physical layout of hospital wards with some patients sharing rooms and bathrooms, had an impact on the ability of staff to always provide care in a dignified manner
- × Patient discharge arrangements were impacted due to the involvement and availability of social care providers
- × Policies and procedures were in need of reviewing as many were out of date
- × Ability of health board to recruit into vacant positions
- × Environment in Bronllys hospital
- × Significant problems with the IT system used for patient records, resulting in staff not always having timely access to records (Immediate Assurance was issued for this)
- × Accuracy and completion of Mental Health Act documentation
- × Some arrangements for dealing with patient emergencies within the CMHT, such as availability of Section 12 doctors, availability of local in-patient beds and timely and secure transport for patients to hospital
- × Range of specialist training for staff and compliance with mandatory training within the CMHT

Local Health Boards and NHS Trusts

Swansea Bay UHB

In general, across all settings, patients were very positive about their care and treatment. Patients were treated with dignity and respect by a professional staff group. Staff kept patients informed about their care allowing them to make informed choices.

We saw good team work in action across settings and a desire to learn from inspection activity and make improvements. However, there is a need to strengthen governance arrangements to promote learning across settings.

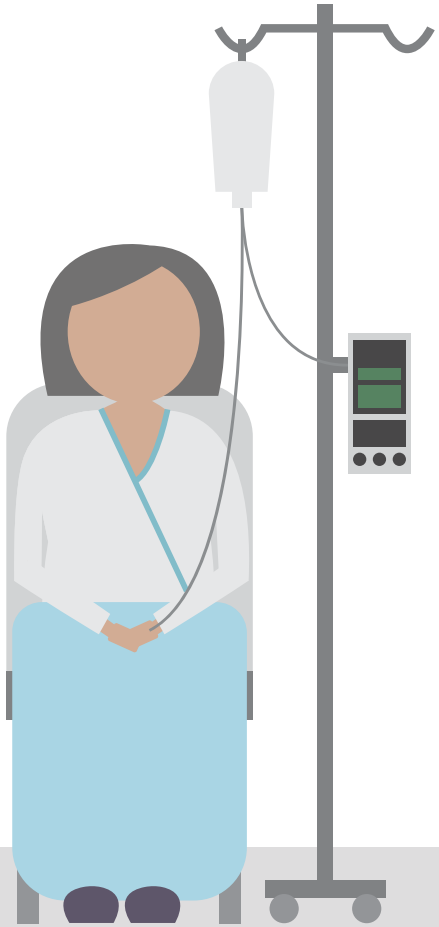
In some settings, we spoke to staff who felt unsupported when raising concerns and following clinical incidents. Along with a reported lack of senior and executive staff presence in operational areas.

The Health Board have made significant positive steps in its pre-employment checks after the Kris Wade review. A working group has been set up to ensure compliance in all settings across the health board with a continuous programme of monitoring and audit

We inspected two maternity units in Swansea Bay as part of our national review of maternity services across Wales. These were at Singleton and Neath Port Talbot hospitals.

On the whole both inspections were positive. Feedback from patients was very positive and complementary about the care, treatment and support provided by staff.

Most recently a pre Covid-19 inspection of the Health Board's Emergency Department and Acute Medical Assessment Unit in Morriston hospital highlighted significant concerns in a number of areas. A number of Immediate Assurance issues were identified covering management and administration of medication, maintenance of resuscitation equipment, infection prevention and control and assessment times for patients arriving by ambulance. HIW will continue to monitor the health board's progress in dealing with these issues. Full details are published within the report for Morriston ED and AU on our website.



Swansea Bay UHB

Hospitals

- ✓ Safe and robust process on each ward inspected for medicines management
- ✓ Documentation was of a very high standard
- ✓ There were regular and consistent checks of equipment within the birth centre to uphold standards
- ✓ We saw professional and kind interaction between staff and patients, and care provided in a dignified way
- ✓ The ED and AU staff and senior managers consistently demonstrated a commitment to learn from the inspection and to make improvements as appropriate
- × Audit management to ensure consistency and promote sharing and learning
- × All patients should be discharged in a timely manner
- × A review of staffing rotas to ensure that staffing levels are safe and effective to meet the needs of the service
- × Patients were waiting within the three ED waiting areas for excessive periods of time, some up to 15 to 20 hours
- × Patient nutrition and hydration needs were not being met continually within ED

Mental Health

- ✓ We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed that staff interacted with patients respectfully throughout the inspection
- ✓ Staff interacted and engaged with patients respectfully
- ✓ Patients were provided with a good range of therapies and activities
- × The health board must review its mental health service provision to ensure the environments of care are developed, to reflect current and future provision of mental health care.
- × The environment of care for staff to manage the safety of the wards
- × The layout of the clinic rooms and storage of medication
- × Record keeping and the completion of clinical documentation

Swansea Bay UHB

GP

- ✓ Arrangements for managing patient referrals
- ✓ Clinical peer review and support
- ✓ The practice was trialling new methods of information sharing and preventative healthcare by using an app for patients
- ✓ A range of services available to patients including information on health promotion as well as regular clinics for ongoing conditions
- ✓ Comprehensive business continuity and emergency plans in place
- × Establish chronic disease management clinics
- × Some areas of patient record keeping
- × The practice was not able to provide evidence of Hepatitis B immunity for all clinical staff. We saw that records for some staff, but not all
- × Location of equipment for blood pressure, height and weight monitoring was behind reception desk and did not support patient confidentiality.
- × Some staff members unaware of location of the defibrillator and resuscitation equipment was missing an ambubag to assist breathing
- × Medication not always securely stored

Dental

- ✓ Staff were supported and had the necessary training to deliver their roles efficiently
- ✓ The environment provided clinical facilities that were well-equipped, maintained and visibly clean and tidy
- ✓ Very high levels of patient satisfaction
- ✓ Patients were being provided with the right information to make informed decisions about their treatment
- ✓ Comprehensive risk assessments were in place to ensure the premises and clinical facilities were fit for purpose
- ✓ Clinical staff were registered to practice with the General Dental Council and had received the necessary training for their roles and responsibilities
- × Record additional information in the patient notes, for example ongoing medical history
- × The practice must ensure that checks are undertaken of emergency drugs and equipment on a weekly basis
- × The practice must ensure that suitable paediatric pads are available within the emergency kit
- × Decommissioned equipment needs to be removed by the health board or practice
- × Clinical records need to include ongoing consent

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

Public Health Wales

We undertook a review of PHW to assess how Breast Test Wales ensures the breast screening process is managed in a timely manner, for women who have an abnormal screening mammogram.

Throughout the review, the organisation was both open and helpful. This included providing HIW with a range of information, and helping to facilitate sending a survey to capture the views and feedback from women.

The survey was sent to all women who had been recalled to attend an assessment clinic for further tests and investigation during October to December 2019, and who went on to receive a benign outcome i.e. a cancer was not identified. The results from the survey were very positive, with most women rating their overall experience as excellent. Also, we received many comments from women who praised the professionalism and caring nature of the staff.

Velindre NHS Trust

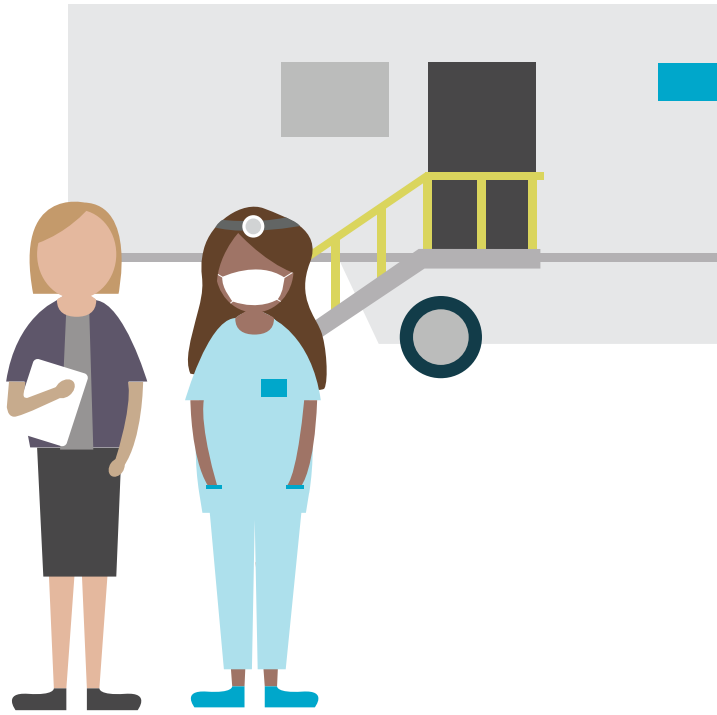
Velindre continues to be a relatively small organisation offering specialist cancer treatment and hosting the Welsh Blood Service. Through our routine discussions and meetings, patients consistently report they are treated very well by the staff in Velindre.

Velindre was found to have sufficient arrangements in place to promote the safety and wellbeing of patients when HIW inspected the radiotherapy department. It also reports only a small number of serious incidents and no public concerns about the services provided were reported to HIW.

The main challenges for Velindre are around the environment and the infrastructure. The trust is currently working to replace a dated ICT system, planning and building a new cancer centre in Cardiff, and streamlining their cancer services to be more integrated and focusing on a home-based care model. Whilst this will be a great benefit to patients when completed, the care provided to patients during this transition needs to be maintained.

Velindre is struggling to cope with a very high demand on its services. Waiting times and timely access to services are a challenge. This is being addressed by the replacement of older radiotherapy machines and increasing the workforce capacity.

HIW also identified a need for Velindre to improve its provision of Welsh language speaking staff and communicating effectively with patients around delays and the complaints procedures. Velindre accepted these recommended improvements and has put action in place to make sure it is meeting the expectations of the 'Active Offer' and providing live updates about any changes to waiting times.



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

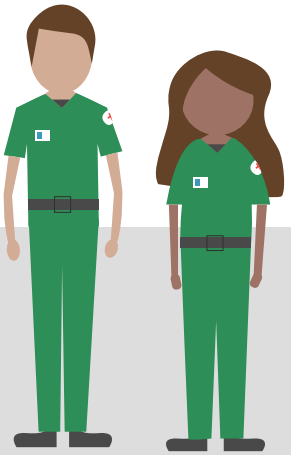
Welsh Ambulance Service NHS Trust

Throughout 2019-2020, WAST was having serious issues with handover delays and community waiting times. During the first months of winter, performance against response times were particularly poor. However, this is partially due to an increasing number of red, high priority, calls, and also longer wait times for ambulances outside emergency departments. Handovers between ambulances and hospital staff are frequently delayed, and the proportion being handed over within 15 minutes has been declining throughout 2019-2020. This is not something WAST can resolve alone, and it must work with health boards to address.

While this is a whole system issue, WAST have some ability to take this forward. Welsh Government is aware of this issue, and trying to work more closely with the poorest performing hospitals and health boards to resolve these issues. This does seem to be having some impact, with performance starting to rise again through the end of the winter 2020 period.

Temporary emergency measures were put in place at different sites across Wales, with some accepting patients into corridors and others establishing temporary buildings on hospital sites. This has helped reduce pressure on ambulance services, but HIW has raised concerns about the care being provided to patients in corridors and issued challenges to the health boards for the implementation of these practices.

Over this year, HIW has been undertaking a review of WAST's patient management arrangements, with a focus on the processes for managing calls within their Clinical Contact Centres. More information on this review can be seen on page 21.



Our Resources

Our people

The table below shows the number of full or part time posts in each team within HIW during 2019-2020.

Team	Whole time posts
Senior Executive	4
Inspection, Regulation and Concerns	36
Intelligence, Partnership and Methodology	14
Strategy, Policy and Communication	5
Clinical advice (including SOAD service)	4
Business support	18
Total	**81**

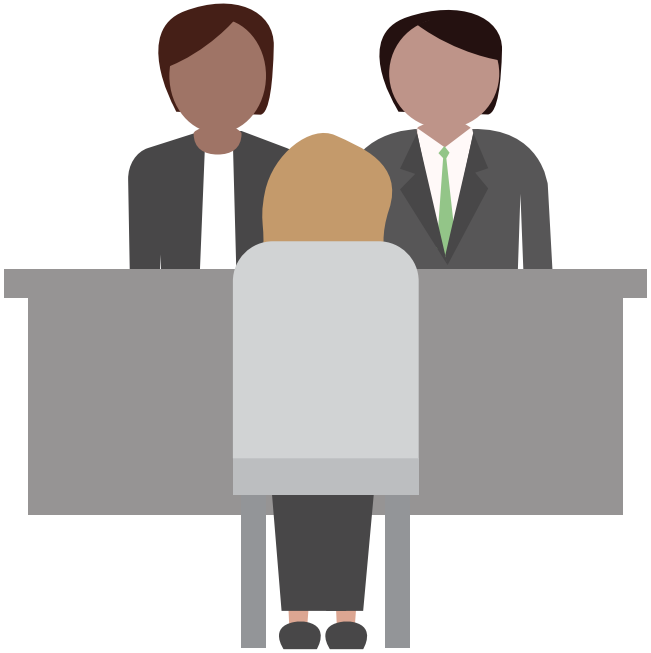
Following a successful recruitment campaign launched towards the end of 2018, we welcomed 10 new staff to our inspections and reviews team in 2019. This was a key priority for us in order to build organisational capacity across our core functions.

We have also recruited into other key areas of the organisation, including strengthening our Clinical Advice team, which has taken the total number of posts in HIW to 81.

We rely on the input of peer and lay reviewers to assist in the delivery of our inspection and review programme. Peer reviewers are health professionals who use their knowledge and expertise to ensure our work is based on current practice and experience. Voluntary lay reviewers play an important role in helping strengthen the voice of patients in the way health services are reviewed.

We currently have a panel of over 250 peer reviewers, having held a number of recruitment exercises during 2019-2020, in order to meet the demand of our increased programme of inspections and national reviews. This included a Lead GP Peer Reviewer, a number of GP Peer Reviewers, Midwife Peer Reviewers and Consultant Obstetrician Peer Reviewers.

We also undertook an evaluation of our voluntary lay reviewer role, in line with the commitment in our Operational Plan, and have decided to replace this role with two paid roles – Patient Experience Reviewer and Expert by Experience. This highlights the importance we place upon assessing patient experience through talking to patients and inviting them to complete questionnaires on our inspections.



Our Resources

Finances

The table on the right shows how we used the financial resources available to us in the last financial year to deliver our 2019-2020 Operational Plan.

	£000's
HIW Total Budget	**4529**
Expenditure	
Staff costs	3912
Travel and Subsistence	102
Learning & Development	26
Non staff costs	103
Translation	84
Reviewer costs	637
Capital ICT costs	157
Total expenditure (a)	**5021**
Income	
Independent healthcare	251
Private dental registrations	239
Legal fees	11
Total income (b)	**500**
Total Net Expenditure (a-b)	**4521**

Commitment Matrix

The following table is a list of the objectives HIW set for itself for 2019-2020, 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	During 2019-2020 we completed: Independent Health Care Services • 26 New Registrations • 17 Changes of Registered Managers • 10 Changes of Responsible Individuals • 16 Variations of HIW Registration Conditions Private Dental Practices • 22 New Registrations • 25 Changes of Registered Managers • 6 Changes of Responsible Individuals • 2 Variations of HIW Registration Conditions

Commitment Matrix

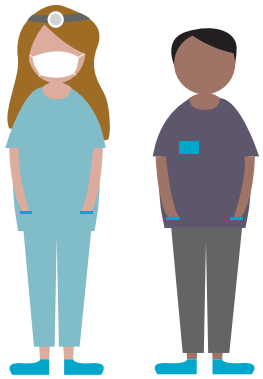
What we said	Measured by	Outcome
Deliverable 2 Conduct a programme of visits to suspected unregistered providers • As required Deliver a programme of inspections in independent settings • Approximately 27 laser • Approximately 19 non-laser excluding mental health	• Number of visits undertaken • Number of inspections undertaken • Number of reports published • 3 months following inspection	We undertook one unannounced visit to a suspected unregistered provider We carried out 27 inspections of services providing laser or IPL treatments We carried out 14 inspections of independent services (excluding laser/IPL and mental health). This was slightly lower than planned due to inspections cancelled in March 2020 due to coronavirus and because of in-year de-registrations.

Commitment Matrix

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 2019-2020 we received 367 concerns from the public or staff. Of these, 229 related to NHS settings or services and 131 to independent healthcare services registered with HIW. We also received 7 concerns in 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. These Regulation 30/31 notifications continue to be managed in line with our process and dealt with effectively. In total we received 1,157 Regulation 30/31 notifications received. They are as follows: • Death in Hospice – 597 • Death excluding Hospice -10 • Unauthorised absence – 137 • Serious injuries – 280 • Allegation of staff misconduct - 120 • Outbreak of Infectious Disease – 2 • Deprivation of Liberty Safeguards (DoLS) – 11

Commitment Matrix

What we said	Measured by	Outcome
Deliverable 4 Undertake a broad inspection programme in the NHS informed by intelligence and an assessment of risk including approximately • 31 general hospital inspections • 36 GP inspections • 75 dental inspections • 5 IR(ME)R inspections • 6 surgical services inspections • Of these inspections 23 include an element of follow-up from previously conducted inspections	• Number of inspections undertaken	We carried out 150 inspections • Hospitals – 38 • NHS Mental health units - 13 • CMHT- 3 • GP - 25 • Dental - 68 • IR(ME)R - 3 • Surgical – 1 (included in hospital inspection figures above) • Follow-up – 13 (included in above figures)



Commitment Matrix

What we said	Measured by	Outcome
Deliverable 5 Continue our programme of national thematic reviews including: • National Review of Crisis Care in Mental Health • National Maternity Services Review • National Review of Care Pathways for elderly people in Wales: Focus on Falls • National Review of the prevention and promotion of • Independence for older adults (over 65) living in the community. • Local review - Breast Test Wales, PHW • Local Review - Patient Management Arrangements within Clinical Contact Centre's - Welsh Ambulance Service Trust	• Publication of terms of reference of each project • Publication of individual hospital reports, and for local and national reviews, final reports	During the year we published: • Review of Integrated Care: Focus on Falls We started work on two National Reviews: National Maternity Services Review, Phase One - 15 hospital and 10 birth units were inspected, and each report published. A National report of phase one will be published in the Autumn 2020. National Review on Crisis care in Mental Health, Phase One. A Phase One report will be published in the Winter 2020/21. We started work on two Local Reviews: Local Review of how breast screening processes are managed in a timely manner for women who have an abnormal screening mammogram, within Breast Test Wales. Local Review of the patient management arrangements in Clinical Contact Centre's within WAST.

Commitment Matrix

What we said	Measured by	Outcome
Deliverable 6 Conduct a high level review of each NHS body through • Further development of the Relationship Management function • Producing an Annual Statement for each Health Board and NHS Trust	Publication of health board and NHS trust annual statements	2019-2020 annual findings were presented at board meetings and board development days for Health Boards and NHS Trusts by Relationship Managers. In arriving at the annual report health board summaries, Relationship Managers considered: • findings from our 19-20 inspection and review programme • intelligence gathered through attendance at a number of key health board meetings such Quality & Safety meetings and one to one meetings with key health board personnel • concerns received through our concerns process • meetings with external partner organisations such as the Audit Wales and Community Heath Councils.
Deliverable 7 Undertake a programme of inspections in NHS and independent mental health settings including approximately • 15 NHS mental health units • 14 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 28 inspections of mental health and learning disability units: • 13 NHS mental health units • 14 independent mental health hospitals • 1 independent learning disability hospital units We carried out 3 Community Mental Health Team inspections.

Commitment Matrix

What we said	Measured by	Outcome
Deliverable 8 Provide a Second Opinion Appointed Doctor service for about 1000 SOAD requests	• Key Performance Indicators	We received 1017 requests for a SOAD and 958 SOAD visits were undertaken.
Deliverable 9 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	In November 2019 we produced a new Publication Policy outlining our approach to publishing inspection report and reviews. Publication dates of all routine inspection reports are published on our website 10 weeks in advance. The Publication Schedule can be found here: www.hiw.org.uk/publication-schedule

Commitment Matrix

What we said	Measured by	Outcome
Deliverable 10 To actively share our findings and recommendations with stakeholders, service providers and the public to influence and drive improvements in health care. In particular in relation to: • Hospital Inspections • GP Practices • Dental Practices • Mental Health Act Annual Monitoring Report • Deprivation of Liberty Safeguards (DOLS) • IR(ME)R • Lasers • HIW Annual Report	Publication and dissemination of our findings in a number of ways including: • Learning events • Learning bulletins distributed • Case studies of good practice distributed • Improved website content • Inclusion in our monthly stakeholder newsletter	We hold regular workshops with Community Health Councils and quarterly summits with NHS and independent healthcare sector In March 2020, we issued our first quarterly peer reviewer newsletter Following the publication of our Falls Review, which included a suite of different pathways, we held two learning events with stakeholders We have supported improvements to our website in 2019 – 2020 including: • Consistent naming convention for all published reports on our website • Registration information and registered providers • Updated SOAD information • Extension of our publication schedule to include publication dates 10 weeks in advance. We share links to all published reports with 4339 subscribers every month in our stakeholder newsletter.
Deliverable 11 Continue our joint inspection work with UK agencies • Approximately 16 death in custody reviews with the Prison and Probation Ombudsman • Up to 3 joint reviews with HMI Prisons and HMI Probation	• Number of inspections undertaken	We carried out 14 death in custody investigations. We undertook 3 joint inspection with HMI Prisons and HMI Probation.

Commitment Matrix

What we said	Measured by	Outcome
Deliverable 12 Continue our joint work with other UK and international agencies on joint inspections and influencing best practice	• Participation in joint work • Consolidation of key findings and emerging themes on youth services from Inspection Wales members.	We undertook a joint review of governance and risk management of Cwm Taf Morgannwg University Health Board alongside Audit Wales. We took part in a joint inspection process, with partner organisations such as Care Inspectorate Wales (CIW), Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Her Majesty's Inspectorate of Probation (HMIP) and Estyn. This was undertaken as a Joint Inspection of Child Protection Arrangements (JICPA) in December 2019. This inspection was of the Aneurin Bevan University Health Board (ABUHB). Whilst we did no undertake any specific joint work on youth services, we are planning follow-up on our review of healthcare services for young people (published in March 2019) by seeking an updated response to our recommendations. We worked with CIW on the National Review of Prevention and Promotion of Independence for Older Adults (over 65) Living in the Community. These individual reports were published during 2019 and 2020. We worked with CIW on the Deprivation of Liberty Safeguards – Annual Monitoring Report for Health and Social Care 2018-19. This report was published in August 2020.

HIW Governance Glossary

Decision making and business management

Senior Leadership Group (SLG)

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

Business Group

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

Workforce Planning and Finance Comittee

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

Risk & Escalation Committee (REC)

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

Advise and make recommendations

Methodology Change Panel (MCP)

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

Digital Design Panel (DDP)

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

People Forum

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

Review Steering Board (RSB)

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

HIW Governance Glossary

Engagement with staff and external organisations

Stakeholder Reference Groups

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

Relationship managers (RMs)

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

Concerns / notifications meetings

The aim is to monitor / escalate any concerns or notifications that require action. Its main activity is to create brand new methodology, change existing tools and workbooks as requested and develop guidance / supporting information for all users.

Heads of Branch (HoBs) Meetings

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

Team Meetings

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

People Forum

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

Staff Conferences

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

Education and Public Services (EPS) group meetings

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

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

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

Or via

Phone: **0300 062 8163**
Email: **hiw@gov.wales**
Website: **www.hiw.org.uk**

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

 WG40229 Digital ISBN 978 1 80082 315 0