Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Annual Report

## 2025-2026

Enter

# Contents

# About us

We are the independent regulator of healthcare and the inspectorate for NHS services in Wales. Our role is to check that healthcare is safe, effective, and meets the needs of people and communities.

### Our purpose

We check the safety and quality of healthcare across Wales.

### Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

### Our values

Our values shape our work every day and ensure people remain at the heart of everything we do.

## We are:

- **Independent:** we are impartial, deciding what work we do and where we do it.
- **Objective:** we are reasoned, fair and evidence driven.
- **Decisive:** we make clear judgements and take action to improve poor standards and highlight the good practice we find.
- **Inclusive:** we value and encourage equality and diversity through our work.
- **Proportionate:** we are agile and we carry out our work where it matters most.

Our four strategic priorities set out how we will work towards our vision of a future where healthcare in Wales is safe, effective, and high-quality for everyone.

## 1. Putting People First

**We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.**

## 2. Learning and Working Together

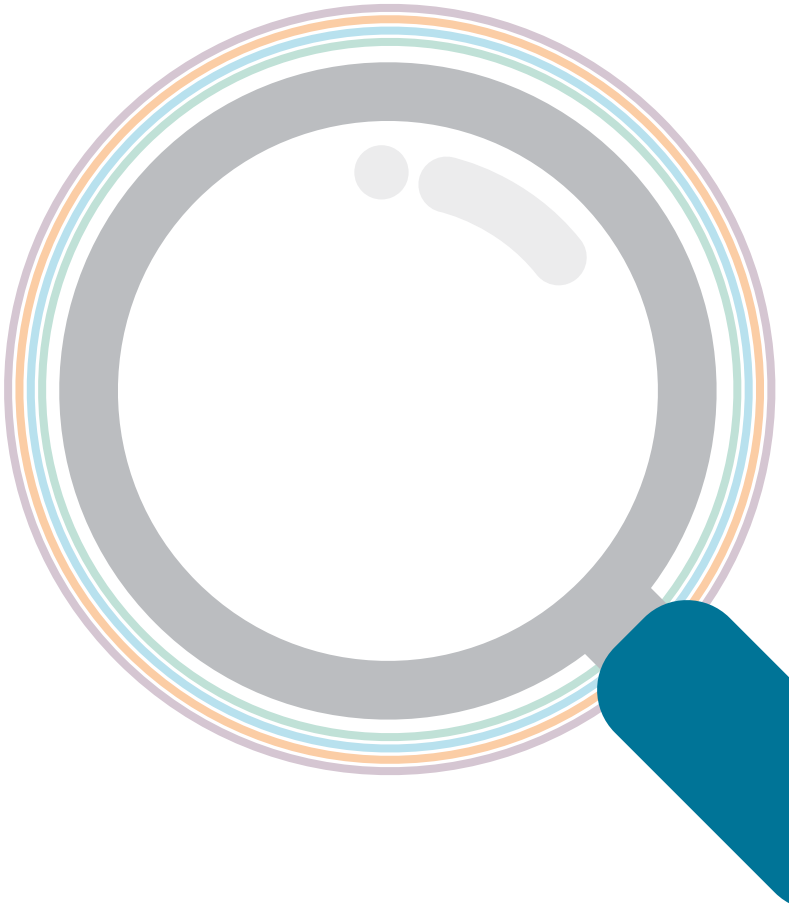
**We will collaborate with partners to share learning and drive lasting improvements.**

## 3. Investing in Our People

**We will ensure our people feel supported, valued, and empowered.**

## 4. Taking Action That Matters

**We will take action to improve the quality and safety of healthcare for the future of Wales.**



This report reflects activity delivered against the priorities and objectives set out in **HIW's Strategic Plan 2022–2025**, which governed the period covered by this report.

# What we do

**Register, regulate and inspect** independent healthcare services, taking enforcement action where standards are not met.

**Monitor concerns and safeguarding referrals,** acting swiftly where risks are identified.

**Inspect NHS services** across Wales to ensure quality, safety, and effectiveness.

**Recommend improvements,** both immediate and long-term, to strengthen care across independent and NHS sectors.

**Undertake reviews** to explore key issues in depth and drive improvement.

**Take regulatory enforcement action** to ensure independent healthcare providers meet legislative requirements.

# 01 Foreword

**Alun Jones**
**Chief Executive**

**Welcome to our Annual Report for 2025 to 2026.**

> **"There is much to recognise in the commitment of the workforce and the delivery of compassionate care. At the same time, there are persistent challenges that affect the quality, safety and experience of services. These challenges are not new. They are recurring themes from our inspections, concerns we receive, and wider system insight."**

Healthcare in Wales is changing. Demand is growing, services are evolving, and people rightly expect safe, high-quality care wherever they access it. Against this backdrop, Healthcare Inspectorate Wales (HIW) provides independent assurance on the quality, safety and experience of healthcare across Wales.

Over the past year, our work has included 216 onsite inspections and direct engagement with thousands of people across Wales, including 4,407 survey responses from patients, families and carers, and 1,628 responses from healthcare staff. These insights provide an important, real-world understanding of how care is delivered and experienced.

We have seen a continued rise in reported concerns, with 783 received this year alone. This reflects growing awareness and confidence in people speaking up about their experiences and provides important insight and intelligence into the pressures facing healthcare services.

This report is not only a summary of our work. It provides a clear and evidence-based view of how healthcare services are working, where improvement is being made, and where further action is required. It is intended to support those delivering healthcare, those responsible for oversight, and those shaping policy, by setting out the current position and the issues that require focused attention.

## A clear picture of sustained pressure

NHS healthcare services across Wales continue to operate under sustained pressure. Demand remains high, and patients are experiencing varying levels of access to care across Wales. Sub-optimal patient flow through the system continues to reduce available capacity within urgent, emergency and planned care settings. Workforce challenges remain evident across services, affecting both resilience and the sustainability of care delivery.

Meanwhile, difficulties in accessing primary care contribute to increased demand elsewhere in the system, and workforce constraints impact on the consistency and reliability of care across different settings.

The concerns raised with us reflect this wider picture. We continue to see increasing complexity, with many concerns involving

multiple parts of the system. Themes such as access to care, delays in treatment, mental health provision, and workforce pressures are recurring.

These same issues have been identified through wider system insight. They are well understood. What remains a significant concern is the slow pace at which improvement is being delivered and the extent to which improvements are sustained over time. As Wales enters a new period of government, there is a clear expectation that change is delivered more quickly and that improvements translate into lasting benefits for patients.

## The strength of the workforce

Across our work, we continue to see high standards of compassion and professionalism from healthcare staff. Patients are often treated with dignity and respect, and we regularly see staff going above and beyond to improve and support patient care. This remains a significant strength within the system.

However, the quality of care cannot depend on commitment alone. Workforce challenges, reliance on temporary staffing, and pressures on training and development, are affecting the stability and sustainability of services.

Over time, this creates risk for both patients and staff. Supporting the workforce and creating the conditions for sustainable care delivery must remain a central focus.

## Taking action where standards are not met

We have continued to take a responsive and proportionate approach, focusing on areas of greatest risk and responding to emerging issues as they arise. This year has seen increased levels of escalation activity across NHS services and enforcement activity within the independent healthcare sector. Where standards have not been met in independent healthcare services, we have taken action to protect patients, including restricting or suspending services where necessary.

Within NHS services, structured escalation arrangements are being used more actively to manage risk and support improvement, helping to ensure that issues are identified early and addressed. Whilst services often respond positively to our findings, the recurrence of issues remains a concern. Improvement is not always embedded or maintained, and this must be addressed if meaningful progress is to be achieved.

## Independent healthcare: New risks and challenges

The independent healthcare sector in Wales continues to expand and change.

There has been growth across a wide range of services, including private primary care, aesthetic treatments and other health and wellbeing services. This brings increased choice for patients. However, our work highlights ongoing risks, particularly where new providers enter the market without a full understanding of the standards required to deliver safe care.

Alongside this, we have seen a significant increase in registration activity, with 705 cases received compared to 528 last year, while the total number of registered services increased from 746 to 771. Between April 2023 and March 2026, over half of all net growth in registered services came from independent clinics and medical agencies. These services increased from 42 to 78 over the period, a rise of almost 86%. This reflects a significant shift in the nature of independent healthcare provision in Wales, with increasing numbers of services delivering private medical consultations, diagnostics, weight management, wellbeing and aesthetic treatments.

This growth brings both opportunities and challenges. As the sector expands, so too does the need for effective regulation to ensure patients receive safe, high-quality care wherever they choose to access healthcare. The registration and regulation of services play a key role in making sure providers are safe to operate, and that there is ongoing oversight of the care people receive.

The increasing use of services such as weight management, wellbeing and aesthetic treatments is creating new regulatory challenges and exposing limitations in a framework designed for a very different healthcare market.

We continue to identify issues relating to unregistered services and unsafe practice, particularly in areas such as aesthetic treatments, where there is increasing use of higher-risk treatments.

The pace of change in the sector is increasingly exposing the limitations of the current regulatory framework. As healthcare delivery evolves, regulation has not always kept pace.

We welcome developments in other parts of the UK to strengthen safeguards in areas such as non-surgical cosmetic procedures and aesthetic treatments, recognising the need for regulation to keep pace with changing models of care. As the independent healthcare sector continues to evolve, it is important that the regulatory framework in Wales is fit for purpose, provides effective safeguards for patients and maintains public confidence in healthcare services. We have raised our ongoing concerns with government officials and look forward to engaging positively on a way forward.

## Mental health: A national priority

Mental health estates remain one of the most persistent concerns identified through our work. Across both NHS and independent services, we continue to see dedicated staff providing compassionate care to some of the most vulnerable people in society. However, the most significant and longstanding concerns relating to the care environment are found within parts of the NHS mental health estate.

The condition and suitability of some NHS mental health facilities continue to raise concerns about safety, privacy, dignity and the ability to provide truly therapeutic care. Patients experiencing severe mental ill health are often at their most vulnerable. They deserve care in environments that promote recovery, preserve dignity and support their wellbeing.

While many independent mental health services generally operate from more modern and well-maintained environments, some challenges remain across all sectors. However, too many NHS services continue to operate from buildings that were not designed for modern models of care and which, in today's healthcare system, would be difficult to regard as acceptable.

The need for investment and improvement is well understood. The challenge now is delivering change at the pace required. Without sustained action, there is a risk that patients and staff will continue to be let down by environments that do not reflect the standards of care that Wales should aspire to provide.

## The opportunities ahead

As Wales enters a new period of government, there is an opportunity to address some of the long-standing challenges facing healthcare services. The evidence set out in this report provides a strong and independent assessment of the current position, highlighting where focused action is required and where the pace of improvement needs to accelerate.

This report reflects the final year of delivery under **our previous strategy**. **Our Strategy for 2026-2030** sets out a bold vision for how we will strengthen our role as an independent and influential voice, with a continued focus on quality, safety and improvement across healthcare services for the people of Wales.

Next year, we will take forward a major programme of work to transform how we gain assurance and inspect maternity and neonatal services in Wales. This will introduce a more joined-up approach, with a stronger focus on whole care pathways, supporting more consistent oversight of quality and safety across services. This work will also help to shape how we inspect complex, high-risk NHS services in the future, ensuring our approach continues to reflect the realities of modern healthcare delivery.

## The state of healthcare in Wales

This report provides a clear message about the state of healthcare in Wales.

There is much to recognise in the commitment of the workforce and the delivery of compassionate care. At the same time, there are persistent challenges that affect the quality, safety and experience of services. These challenges are not new. They are recurring themes from our inspections, concerns we receive, and wider system insight.

Sustained effort, clear accountability and coordinated action will be required across the system in order to address these challenges. Against this background, HIW will continue to provide independent assurance, highlight both good practice and areas of concern, and use its voice to drive improvement.

## A thank you

I would like to thank the people of Wales who continue to share their experiences with us. These voices are central to our work and ensure that attention is focused where it matters most.

I would also like to thank the team at HIW. Their professionalism, dedication and commitment underpin the impact of our work and our ability to improve healthcare for the people of Wales.

If you have any comments on this report or our work, please do get in touch.

*Alun Jones*

**Chief Executive**
**Healthcare Inspectorate Wales**

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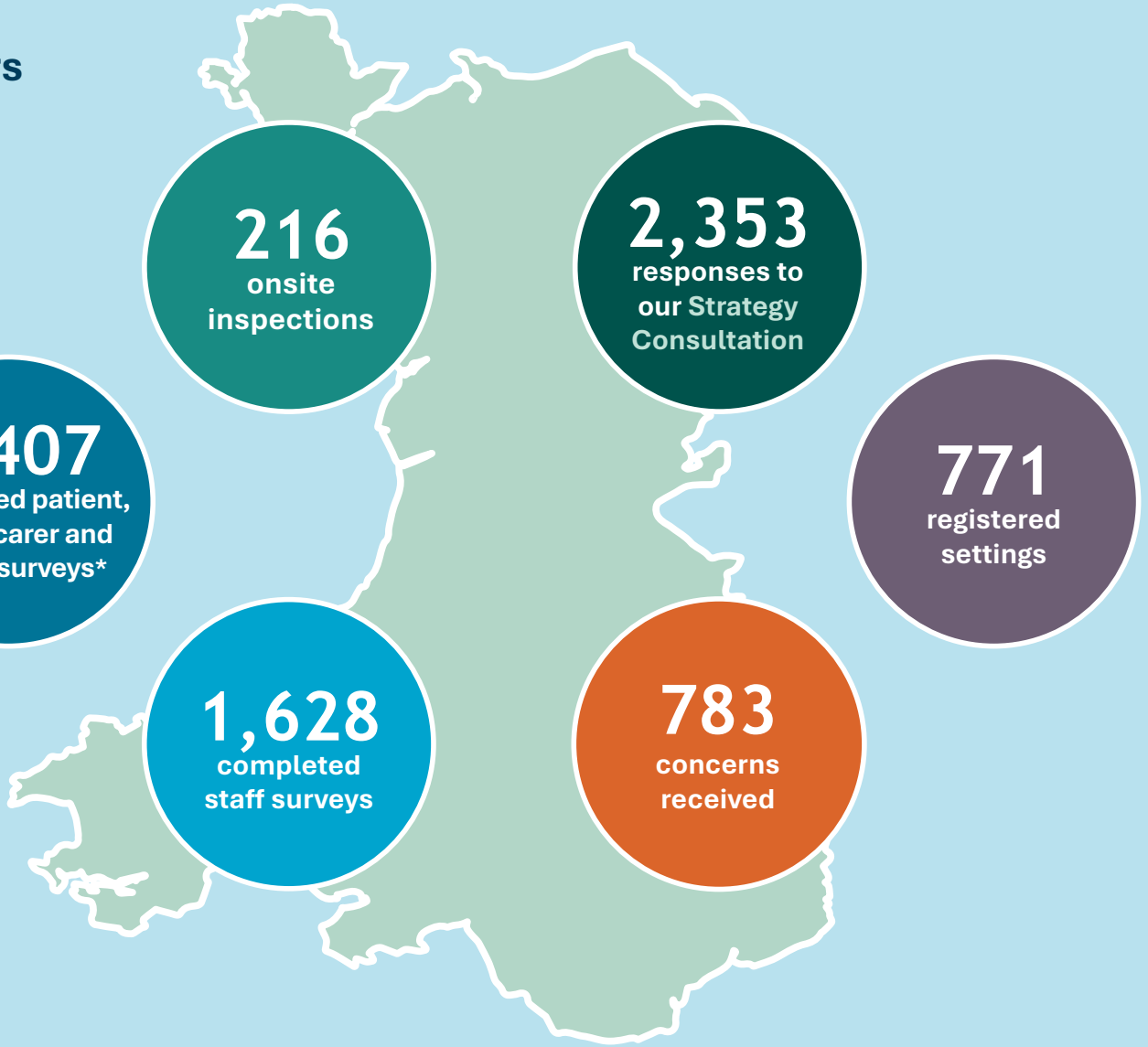
# HIW in numbers

## 2025–2026 in Numbers




**30%** increase in overall patient responses.
The highest number of responses originates from GP and dental inspections.

# A timeline of our activity

## 2025

### April

**11 inspections undertaken**

### May

**17 inspections undertaken**

- Improvements noted at Ysbyty Cwm Cynon's Dementia Care Unit
- Position Statement on Corridor Care
- We've published our Operational Plan 2025–2026
- Maternity Services at Neath Port Talbot Hospital Birth Centre praised but areas for further improvement
- Caution issued to provider using unregistered laser services

### June

**16 inspections undertaken**

- Inspection Identifies Strengths but Improvements Required at Ysbyty Gwynedd's Maternity Unit
- Promoting Mental Health and Wellbeing at the 2025 Show
- Caution Issued to Provider Using Unregistered Laser Services
- Joint inspection identifies Pembrokeshire's child protection strengths and challenges amid rising demand

### July

**22 inspections undertaken**

- Care praised but further improvements require attention at a specialist mental health unit in Cardiff
- Emergency Care Under Pressure: Staff praised despite ongoing challenges at Ysbyty Gwynedd
- Registration Cancelled for Private Dental Practice in Anglesey

### August

**13 inspections undertaken**

- Position Statement on the Swansea Bay Maternity Support Group Family-Led Review of Maternity Services
- Caution issued to provider using unregistered laser services
- Positive Culture and Inclusive Maternity Care Praised at Glangwili, with Areas for Improvement
- Insights from Our Inspections: Key Themes in GP Practices

### September

**17 inspections undertaken**

- Help Shape HIW's Strategy 2026–2030 – Consultation Now Open
- Birth Centre praised for individualised care and strong leadership, with areas for improvement identified

## October

### 14 inspections undertaken

- Healthcare Inspectorate Wales calls for safe, dignified, and effective health care
- Insights from Our Inspections: Key Themes in Dental Practices
- Insight Bulletin – October 2025 issued

## November

### 18 inspections undertaken

- Inspection of Royal Glamorgan Hospital's Emergency Department Reveals Progress and Ongoing Challenges
- Mental Health Services in Wales: Ongoing Challenges and Opportunities for Improvement
- Healthcare Inspectorate Wales and Care Inspectorate Wales conclude assurance check of Torfaen learning disability services

## December

### 12 inspections undertaken

- Thank you for having your say on our Strategy for 2026–2030!
- HIW Inspection Highlights Compassionate Care at Bridgend Maternity Unit Alongside Areas for Improvement
- Bronglais Hospital Emergency Department Staff Praised for Compassionate Care Despite Significant Operational

## 2026

## January

### 28 inspections undertaken

- Inspection identifies strong patient centred care alongside areas for improvement at a Mental Health Unit in Abergavenny
- Inspection Highlights Some Positive Changes but Ongoing Challenges in Ysbyty Gwynedd's Mental Health Unit
- Healthcare Inspectorate Wales and Care Inspectorate Wales conclude assurance check of Carmarthenshire learning disability services
- Inspection finds dedicated staff at Swansea mental health wards amid ongoing safety and dignity issues

## February

### 18 inspections undertaken

- Inspection Identifies Positive Practice But Clear Areas for Improvement at Carmarthen Mental Health Wards
- Position Statement on National Assurance Assessment of Maternity & Neonatal Services
- Listening to Wales: What You Told Us in Our Strategy Consultation

## March

### 30 inspections undertaken

- Annual Report: Deprivation of Liberty Safeguards (DoLS) in Wales 2024–2025

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# Regulating independent healthcare

# At a glance: Our activity this year

We are responsible for registering and regulating independent healthcare services to ensure they are safe, effective, and person-centred.
We carried out 137 inspections across a wide and growing range of services, from private dental practices and cosmetic laser clinics to independent hospitals and mental health units.

Regulation provides assurance that services meet clear standards for safety, quality and governance. It also ensures that when care falls short, action can be taken to protect people and drive improvement.

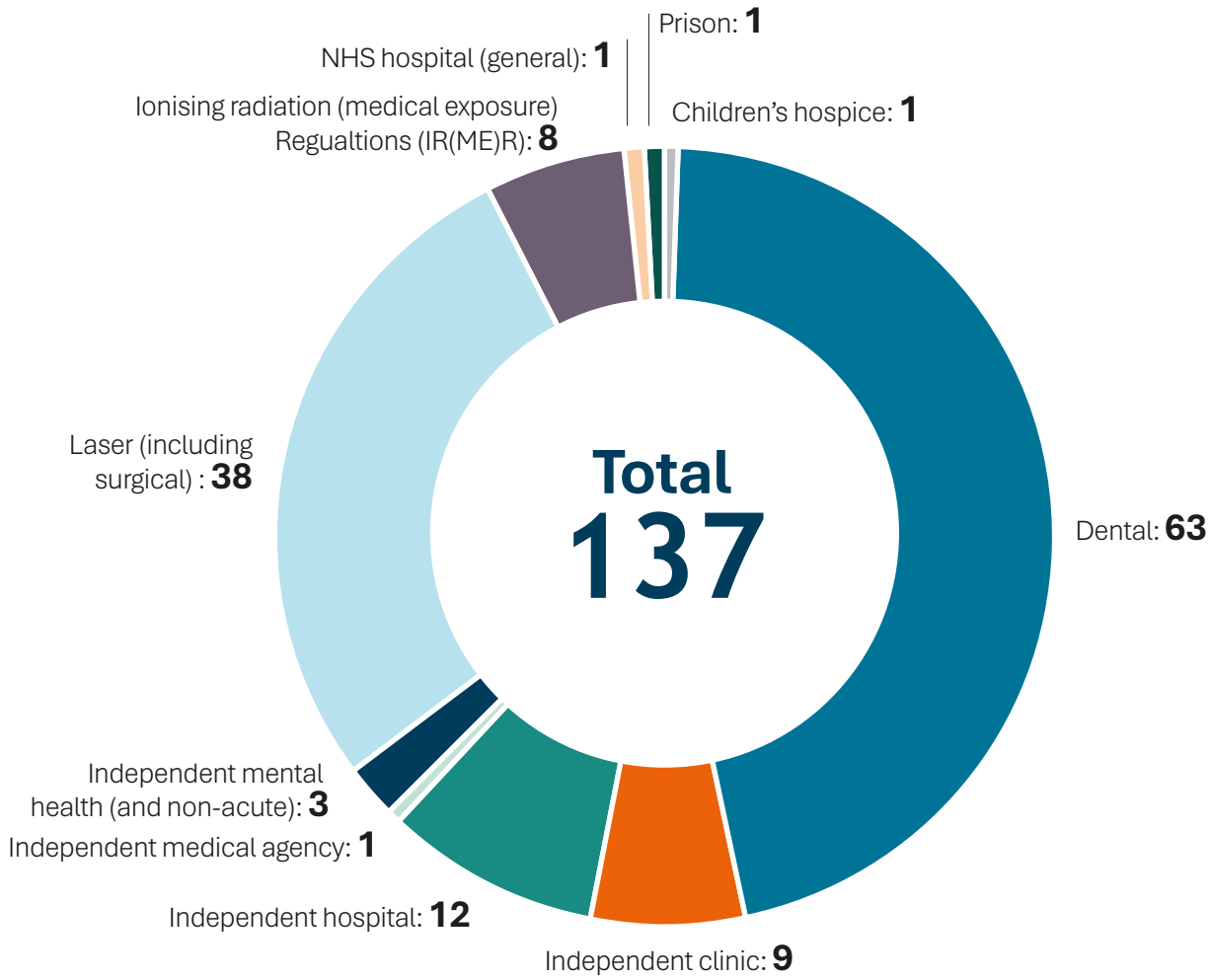
## A diverse and evolving sector

Many independent services operate alongside NHS care. For example, some independent hospitals provide treatment for NHS-funded patients with complex needs, and many dental practices offer a mix of NHS and private care. We have seen growth in services offering elective treatments such as laser procedures, weight management, and menopause support. As this sector grows, it can become more difficult for people to understand which services are regulated and what safeguards are in place. This makes clear, visible regulation increasingly important.

## Balancing innovation and safety

From HIW's perspective, this sector brings both opportunities and challenges. Independent providers often bring flexibility and innovation, which can benefit patients, but only when supported by strong governance, clear accountability, and a commitment to continuous quality, safety and improvement. Innovation can improve choice and access, but it must not come at the expense of safety. Regulation plays a key role in maintaining this balance and ensuring that standards are routinely applied.

## Independent healthcare (IHC) inspections




## Our role as the regulator

Our inspections are designed not just to identify risks, but to help providers improve. We regulate services to ensure they meet the standards required by law and deliver care that is safe, respectful, and responsive to people's needs.

This includes assessing whether services are safe to operate before they are registered, monitoring them over time, and taking action where standards and legislative requirements are not met.

As the sector continues to grow and diversify, HIW remains committed to making sure that everyone in Wales, regardless of where they receive care, can expect high-quality, dignified, and safe healthcare.

# Registration highlights

This year, our registration activity increased significantly, reflecting continued growth and change across the independent healthcare sector in Wales.

**705** **registration cases received**
(up from 528 last year)

**285** **applications granted**

**75** **not granted**
(35 returned, 40 withdrawn)

**Total registered services**
increased from
**746** to **771**

**57** **services deregistered**
during the year

There has been significant growth in the independent healthcare sector. Applications in this area have increased substantially, with new independent healthcare services accounting for around 75% of all applications received

Between April 2023 and March 2026, over half of all net growth in registered services came from independent clinics and medical agencies alone. These services increased from 42 to 78 over the period, a rise of almost 86%.

This reflects a significant shift in the nature of independent healthcare provision in Wales, with increasing numbers of services delivering private medical consultations, diagnostics, weight management, wellbeing and aesthetic treatments. These shifts can increase choice for people accessing care, but they also create new challenges where services are not captured by the scope of existing regulatory frameworks which were designed for a very different healthcare market.

**Independent clinics and medical agencies** increased from

58 to 78

a one-third rise in the year and almost double since April 2024.

Applications for independent clinics have tripled since 2023/24.

**Within dental services, the shift towards private provision continues:**

Private-only services increased from

21% to 26%

The proportion of practices offering NHS services has fallen from

86% to 74%

over two years.

**This increase in activity has driven a rise in operational demand:**

Over 40%

more on-site registration visits

35%

increase in registered manager interviews.

**We received** 271

registration enquiries, continuing an upward trend.

These enquiries often come from new providers entering the market.

**There were mixed trends across service types:**

**Dental practices** decreased slightly from

513 to 510

**Laser/IPL services** increased from 121 to 125 although growth has slowed

**Independent hospitals** increased from

28 to 31

For people using these services, registration is an important safeguard. It shows that a provider has been assessed against required standards, and that there is ongoing oversight of the care being delivered.

This work highlights an ongoing gap in legislation. Some services, particularly those led by non-medical professionals such as nurses or pharmacists, do not currently require registration, even when undertaking similar activities to regulated providers.

# Independent hospitals, hospices and clinics

We inspect and regulate independent healthcare services in Wales to ensure they meet the legal requirements set out in the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011, and the National Minimum Standards for Independent Health Care Services in Wales. Inspections are a key part of our role in protecting patients and promoting high-quality care across a growing and diverse sector.

We aim to inspect independent hospitals every two years and clinics every three years. Hospices are also regularly reviewed, though we may visit any service more often if concerns are raised or there are significant changes.

## Independent hospitals and hospices

In 2025-2026, we completed two inspections of independent hospitals and two inspections of adult hospices.

Overall, our assurance and inspection work indicated that services were providing safe and effective care, with positive feedback from patients, carers and staff. Patients told us they felt well supported, and we observed staff interacting with patients in a kind, respectful and dignified way.

We saw strong multidisciplinary working, with staff teams committed to delivering compassionate, safe and effective care.

Feedback reflected this positive experience, with one patient describing the hospice as *"like being surrounded by a big warm hug."*

We did not identify any immediate risks to patient safety during these inspections. Most findings related to minor areas for improvement, including:

- keeping patient guides and Statements of Purpose up to date
- ensuring risk assessments are fully completed and follow-up actions clearly recorded
- strengthening audit processes to ensure actions are completed and learning is embedded.

These findings show a sector that is generally performing well, with established systems and a strong culture of care. However, services must continue to focus on maintaining up-to-date documentation, strengthening governance processes, and ensuring that improvement actions are sustained.

## Independent clinics

There are a wide range of independent clinics in Wales providing specialist services. In 2025-2026, we carried out 9 inspections of independent clinics, including cosmetic clinics, termination of pregnancy centres, and drug and alcohol rehabilitation services.

Overall, most services treated patients with dignity and respect. Consultations were carried out in private, and staff demonstrated professional and appropriate behaviour.

However, many of these settings are small and locally run. Governance arrangements are often less developed and can rely on a small number of individuals. This makes services more vulnerable where leadership capacity, oversight or formal processes are limited.

We identified patient safety issues in three inspections (33%), a higher rate than in hospitals and hospices, which generally have more established governance systems. While smaller services may find it more difficult to keep pace with regulatory requirements, compliance remains essential.

**Patient safety issues included:**

- providing services outside of their conditions of registration
- incomplete medication records
- lost health records
- lack of Basic Life Support training and inaccessible defibrillators
- poor cleanliness and gaps in maintenance or calibration of medical equipment.

**Other common areas for improvement included:**

- documentation and record keeping
- governance and policy development
- environmental maintenance
- accessibility and communication support.

These findings highlight that, while many clinics provide compassionate and respectful care, positive patient experience must be supported by robust governance, clear policies, accurate records and safe clinical systems. Regular inspection remains essential, both to identify immediate risks and to support compliance and continuous improvement.

Across Wales, the independent healthcare sector continues to expand, particularly in areas such as private GP services and cosmetic treatments. This growth provides greater choice for patients but also increases the complexity of the sector. The range of treatments available can make it harder for people to understand whether a service is properly registered or whether practitioners are appropriately qualified.

**We encourage anyone seeking independent healthcare in Wales to:**

- check that the provider is registered with HIW
- read our most recent inspection reports
- confirm that their chosen clinician holds the appropriate qualifications for the treatment they are offering.

This is especially important in areas where regulation continues to evolve. Our role is not only to inspect and regulate services, but also to help the public make informed choices and stay safe.

# Dental practices

Dental services in Wales continue to play a vital role in community healthcare. Our inspections this year show that many practices are providing safe care and positive patient experiences. However, there are still areas where improvement is needed, particularly around governance, record keeping, and managing clinical risk.

We remain committed to a balanced approach that combines robust oversight with practical support. Our inspections are designed not only to identify risks, but also to help practices make timely and sustainable improvements. As the dental landscape continues to evolve, our role in maintaining standards and supporting improvement remains essential.

**Over the course of 2025–2026, HIW carried out 63 inspections of dental practices across Wales.**

**8 inspections** resulted in Non-Compliance Notices, issued where there were significant risks to patient safety requiring immediate action.

**4 practices** were urgently suspended following enforcement action.

**1 practice** had its registration cancelled following continued enforcement activity linked to a 2024/25 inspection.

Many issues were resolved during inspection visits, reflecting a supportive and collaborative approach. These included removing expired medicines, addressing gaps in stock control, managing environmental risks, and taking unsafe equipment out of use.

Overall, most practices were clean, well maintained, and provided safe clinical environments. Patients described staff as friendly, respectful and professional, and reported being treated with dignity and involved in decisions about their care.

We also saw examples of good practice and innovation. Some practices worked with local schools to promote oral health, while others introduced small but impactful changes to improve patient experience and access. These included quieter appointment times for neurodivergent patients, flexible opening hours, improved communication tools, and better appointment management through short notice lists. Patient feedback highlighted the positive impact of care, with patients reporting a significant improvement in their confidence when attending appointments.

However, our inspections also identified areas of concern that require continued focus.

# Key areas for improvement

## Infection prevention and control

We identified risks in some practices relating to decontamination processes and the handling of clinical instruments. These issues pose potential risks to patient safety and require effective controls.

## Clinical records and audit

Record keeping remains an area where improvement is needed. We found that medical histories were not always updated, and examinations, risk assessments and treatment decisions were not always recorded. Key clinical information, including checks on gum health, was sometimes missing, and standards varied between clinicians within the same practice. In some cases, practices did not have structured audit programmes or were not using audit findings effectively to improve care. Consistent records and robust audit processes are essential for safe and effective care.

## Governance and workforce

We found inconsistencies in how governance systems were applied. Policies were not always regularly reviewed or version controlled, and systems to monitor staff training and maintain accurate records were not always in place. Recruitment checks, including references and employment history, were sometimes incomplete.

Practices must ensure governance systems are actively used and routinely reviewed to provide clear assurance that risks are being managed.

## Immediate risks and safety issues

Some inspections identified serious risks that required escalation. These included environmental safety issues, gaps in equipment maintenance and servicing, and risks linked to incomplete or inconsistent clinical records. These issues highlight the importance of regular checks and proactive risk management.

## Welsh language provision

The provision of Welsh language services was variable. While information was often available in both English and Welsh, it was not always actively used in practice. The recording of patient language preferences was fragmented, and services were not always offered proactively in Welsh. We would like to see providers take a more proactive approach to understanding and meeting patients' Welsh language needs, ensuring people can access care and information in their preferred language wherever possible.

## Context and future focus

During 2025–2026, the dental sector operated in a period of uncertainty as preparations were made for the introduction of the new NHS dental contract. Practices have worked to understand the changes required, recognising that this represents a significant shift in how services are delivered. As the contract comes into force in April 2026, we will continue to monitor its impact on care delivery and patient experience.

## Remembering Ali

We pay tribute to Ali, a highly respected colleague and Clinical Dental Lead at HIW. Since joining in 2014, Ali made a significant contribution to dentistry in Wales, leading inspections, supporting peers, and helping shape regulatory approaches that prioritise patient safety and quality. He was known for his fairness, professionalism and commitment to improvement, as well as his warmth and generosity. Ali's impact on colleagues and the wider dental community was profound, and he will be greatly missed.

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

Our regulatory responsibilities in independent healthcare include the registration and inspection of services offering laser and Intense Pulsed Light (IPL) treatments. These non-surgical procedures are typically used for cosmetic or skin-related purposes, such as hair removal or treating acne or pigmentation.

While many providers are committed to delivering a good service, our inspections continue to show that some underestimate the time, expertise and systems required to meet the legal standards needed to ensure safe, high-quality care.

These services must comply with specific regulations to minimise risks, particularly burns and eye injury, and to ensure safe environments for both patients and staff. As the independent regulator, our priority is to ensure services are safe, well-run and respectful of people's dignity.

During 2025–2026, laser and IPL providers continued to have the highest proportion of urgent Non-Compliance Notices across the sector. Nearly a quarter of services (9 out of 39) required urgent action to address risks to patient safety, with providers expected to respond within a short timeframe.

# Key safety concerns

## Fire safety

Several services lacked adequate fire risk assessments and staff training to respond effectively in an emergency.

## Safe use of equipment

Some providers did not have appropriate treatment protocols or local safety rules in place and had not engaged professional advice to ensure treatments were delivered safely.

## Staff training

In some services, staff did not have up-to-date training in key areas affecting patient safety, including first aid.

## We also commonly found:

- Incomplete patient records and treatment registers
- Equipment not being serviced or maintained correctly
- Insufficient systems to ensure staff training remained up to date
- Limited evidence of effective governance to monitor quality and meet regulatory requirements.

These findings highlight that, while many patients have positive experiences, laser and IPL treatments carry inherent risks, and not all providers have the necessary safeguards in place to minimise them. Our inspection reports provide important information to help people make informed choices when considering these services.

HIW remains committed to holding providers to account and supporting them to understand their responsibilities, because everyone in Wales deserves safe, high-quality care.

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# Taking action through escalation and enforcement

# At a glance: Our activity this year

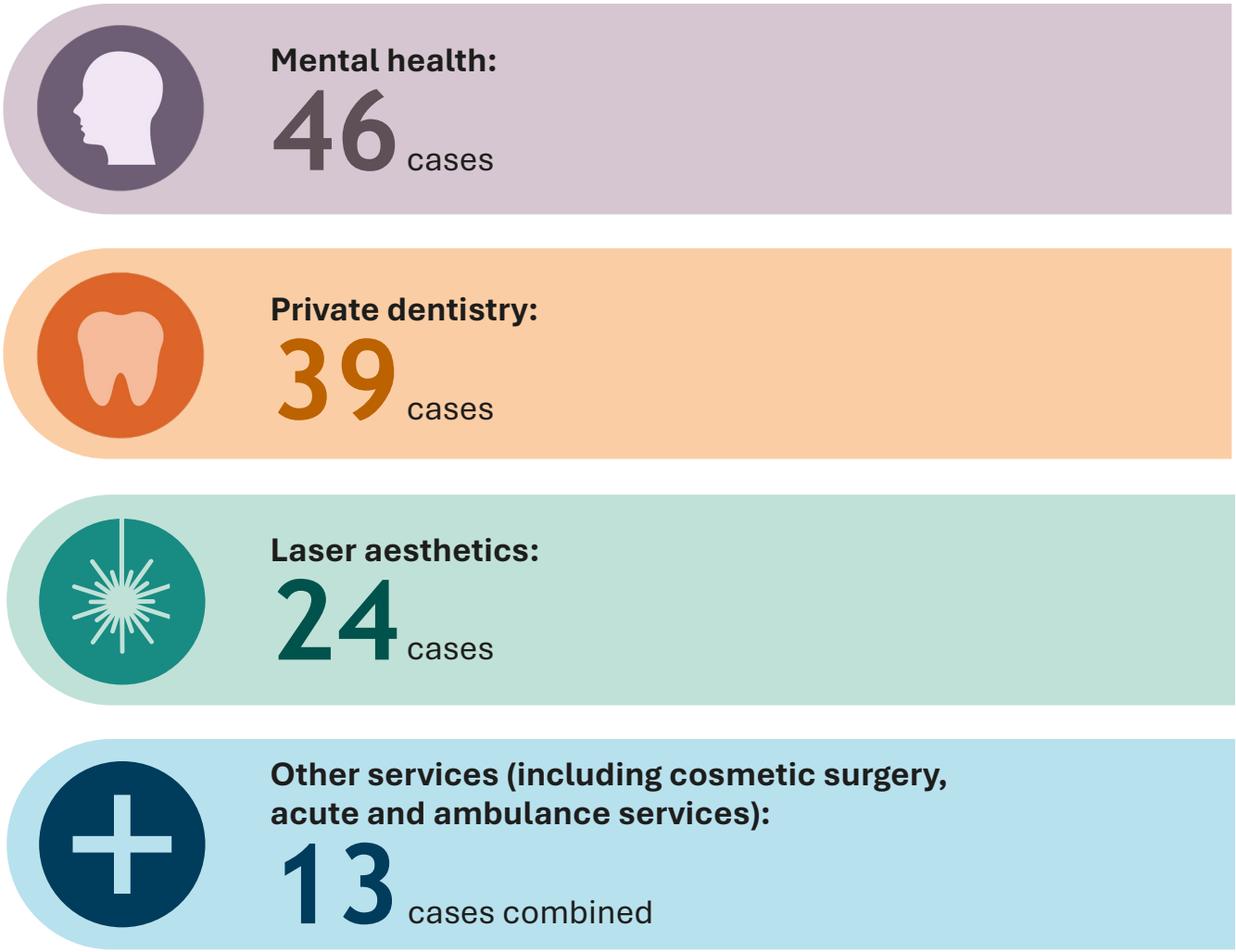
The Escalation and Enforcement Team leads HIW's response to serious risks across NHS services, independent healthcare and private dentistry in Wales. We work with NHS organisations through structured escalation processes to seek assurance and support improvement. In the independent healthcare sector, we use our powers under the Care Standards Act 2000 to take action where services fall short of regulatory standards. This includes suspending services, imposing conditions, designating providers as Services of Concern (SoC), cancelling registrations and pursuing criminal investigations where appropriate.

The SoC process remains a key escalation pathway when there is a significant risk to patient safety or persistent non-compliance. It applies across both NHS and independent healthcare services and involves structured meetings, targeted monitoring, and coordinated action to drive improvement or, where required, restrict services to protect the public. For NHS organisations, escalation through this process can lead to a **Service Requiring Significant Improvement (SRSI)** designation where risks are not addressed.

In 2025–2026, no NHS services were escalated to SRSI. However, NHS services continued to be actively managed through the SoC pathway, with increasing use of meetings to monitor risk and drive improvement.

Across the year, the team maintained a high level of activity. A total of 26 NHS SoC meetings were held, alongside 122 SoC meetings in independent healthcare, covering private dentistry, mental health, laser aesthetics and other settings. While independent healthcare continues to account for the majority of activity, NHS escalation activity remained at similar levels to the previous year, while independent sector meetings declined.

**The distribution of independent healthcare SoC activity shows a clear concentration of risk in specific sectors:**




Within NHS services, SoC activity was spread across health boards, with the highest number of meetings recorded in Betsi Cadwaladr University Health Board (7, 27%), followed by Aneurin Bevan and Powys (5 each, 19%), Swansea Bay (4, 15%), Hywel Dda (3, 12%), and Cardiff and Vale (2, 8%).

Monitoring of unregistered providers remained a significant part of enforcement work. The number of providers actively being monitored at any one time increased from 4 in May 2025 to a peak of 13 in August 2025, before stabilising at around 10–11 live cases during late 2025 and early 2026. The majority of these cases related to laser aesthetics services, often accounting for more than three quarters of all unregistered activity.

Overall, activity levels remained high throughout the year, reflecting sustained demand on escalation and enforcement processes rather than short-term spikes.

# Key figures and enforcement activity

## Escalation Activity — NHS Health Boards

**26** SoC Pathway meetings held across NHS services

## Independent healthcare — SoC activity

**122** SoC meetings held across independent healthcare

## Service of Concern designations

**6** (50%) Unregistered laser aesthetic providers

**5** (41.7%) Private Dentistry meetings

**1** (8.3%) Laser Aesthetics meetings

## Enforcement Activity

**5** services suspended:
- 4 private dental practices
- 1 laser aesthetics provider

**2** registrations cancelled:
- 1 dental practice (following urgent enforcement action)
- 1 laser aesthetics provider (failure to notify HIW of closure)

**5** simple cautions issued following urgent enforcement action

## Unregistered Providers and Criminal Investigations

- The number of unregistered providers being monitored increased from **4** in May 2025 to **13** in August 2025, before stabilising at around **10-11** cases per month
- Laser aesthetics services account for the majority of unregistered providers **(often over 75%)**
- Ongoing programme of criminal investigations linked to unregistered aesthetic services

# Key themes

Several themes emerged from escalation and enforcement activity in 2025-2026.

## Sustained enforcement pressure in laser aesthetics

Laser aesthetics continues to present the highest regulatory risk. It accounts for the majority of unregistered provider activity, a significant proportion of SoC designations, and a high volume of criminal investigations and enforcement action. This reflects the challenges associated with a rapidly evolving sector, including the presence of unregistered providers and gaps within the current regulatory framework.

## Independent healthcare as the primary source of activity

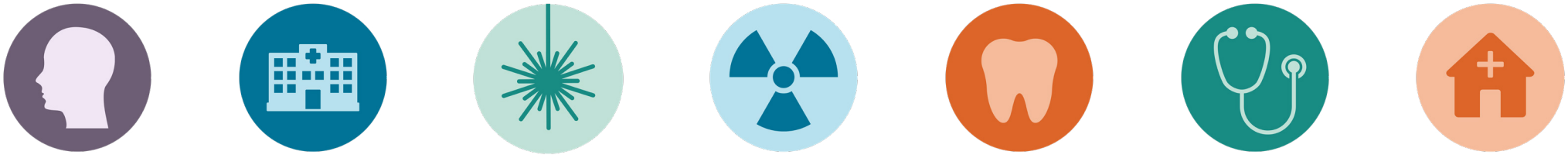
Independent healthcare accounts for significantly higher volumes of escalation activity than NHS services. Within this, mental health and private dentistry together represent 70% of all SoC cases, highlighting where regulatory focus and resource have been most heavily directed.

## Concentration of risk in specific sectors

Concerns are concentrated within a small number of service types; mental health, private dentistry, and laser aesthetics, indicating recurring compliance issues within these sectors rather than system-wide concerns.

## Effective use of the SoC framework

No NHS services were escalated to SRSI during the year despite HIW holding 26 SoC pathway meetings. This suggests that risks are largely being identified and managed effectively through the SoC process, enabling earlier intervention before issues reach the highest level of escalation.



## Ongoing challenge of unregistered providers

The high and sustained level of unregistered provider monitoring, particularly in laser aesthetics, continues to present a significant regulatory challenge, requiring ongoing enforcement and oversight.

## Increased use of enforcement and legal routes

There has been robust use of suspensions, cancellations, criminal investigations, and cautions within the independent healthcare sector. This demonstrates a proactive and increasingly assertive approach where providers fail to achieve compliance voluntarily.

## Responsive and risk-based regulation

The use of targeted inspections, structured SoC meetings and proportionate decision-making reflects a flexible and intelligence-led regulatory approach. Our work balances enforcement with practical considerations such as system pressures, while maintaining a clear focus on patient safety and quality of care.

Where providers fail to meet required standards, we have used a range of regulatory powers, including suspensions, cancellations, criminal investigations and cautions. These actions demonstrate a firm but proportionate approach, protecting patients while supporting improvement where providers engage and take the necessary steps to achieve compliance.

This year's activity highlights the importance of a risk-based approach, particularly in relation to unregistered providers and recurring compliance issues within higher-risk sectors. Maintaining effective oversight in these areas remains a significant priority.

# A closer look: Enforcement and regulatory action in dental services

In November 2025, HIW inspected two associated dental practices in Pembrokeshire. Both services shared the same Responsible Individual and Registered Manager. Inspections identified significant non-compliance across both locations, raising serious concerns about patient safety and service quality.

Key issues included poor cleanliness standards, gaps in staff training and competence, failures in decontamination processes, and missing risk assessments required to meet regulatory standards. These findings pointed to wider governance and oversight failures across both sites.

HIW took urgent enforcement action, suspending both services to prevent further risk to patients. This decisive step ensured that services could not continue operating while unsafe and set clear expectations for improvement.

Following the suspension, the provider took action to address the issues, including improvements in infection prevention, staff capability, and governance arrangements.

Subsequent reinspection confirmed sufficient progress, and the suspensions were lifted, allowing services to resume.

This case also demonstrated the importance of multi-agency working. HIW informed the General Dental Council, Fire and Rescue Service, and the relevant health board, ensuring wider system oversight.

The case highlights how timely enforcement can protect patients while also supporting improvement. It shows the importance of clear escalation pathways, robust follow-up, and ensuring that improvements are sustained before restrictions are lifted.

05

# Assessing the quality, safety and experience of NHS care

# At a glance: Our activity this year

The NHS continues to operate under sustained and complex pressures, including rising demand, patient flow challenges and workforce constraints. Despite these pressures, our inspection and assurance work found that compassionate, person-centred care remains a significant strength, with patients describing staff as caring, respectful and committed. While we continue to see the impact of system pressures across services, we also identify clear opportunities for improvement in the quality, safety, experience and leadership of care.

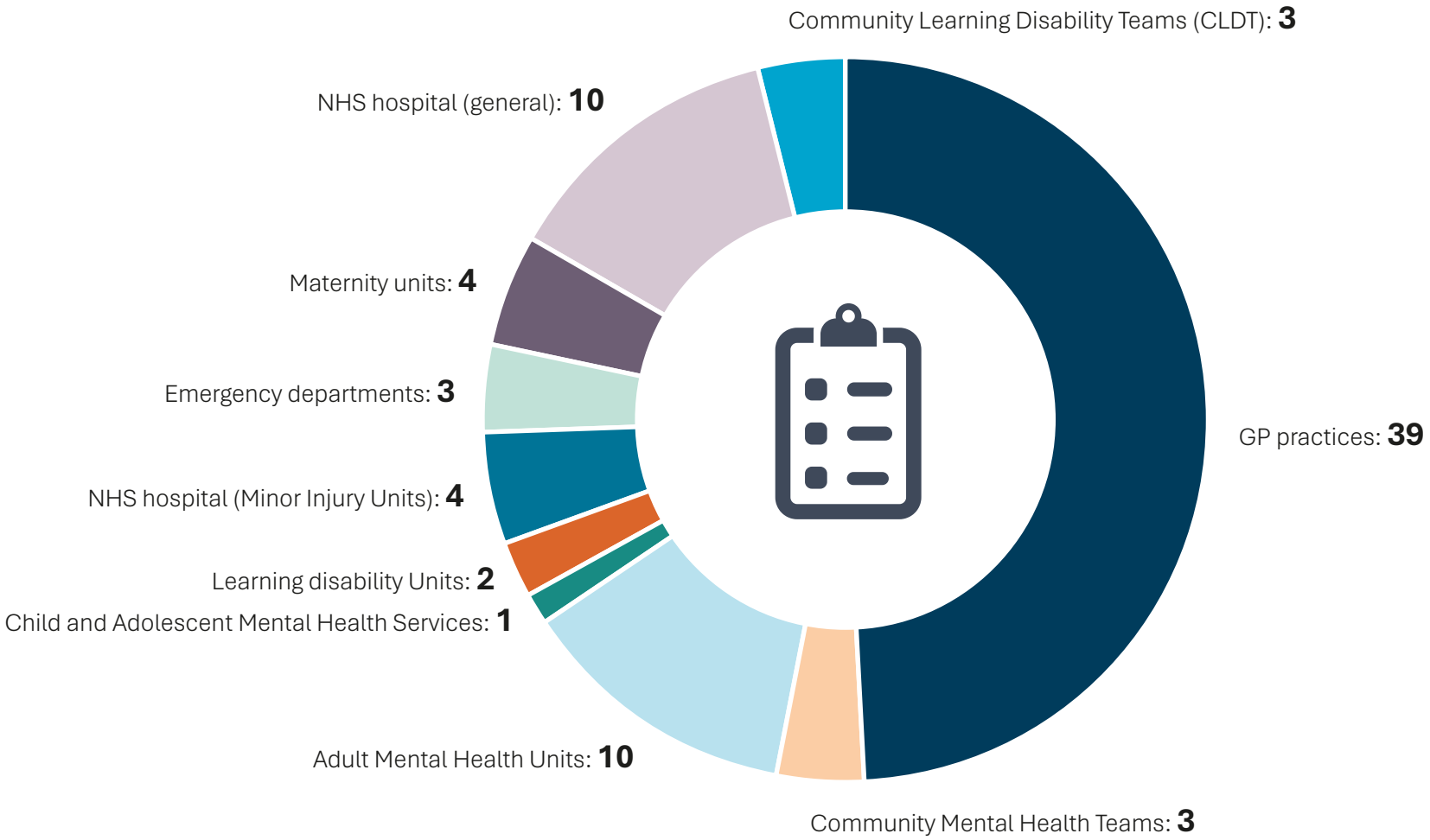
In 2025–2026, our NHS Assurance work continued to provide independent oversight of the quality, safety and experience of healthcare services across Wales. We undertook a broad programme of inspection and assurance activity across general practice, mental health, general hospital services, emergency care and maternity services. This work provided insight into both patient experience and the effectiveness of governance, safety and leadership arrangements across settings.

Across all services, we identified recurring concerns relating to governance, risk management and the application of core safety processes, including medicines management, training compliance, documentation and environmental safety. While improvement action is often taken following inspection, many issues continue to recur, indicating that improvements are not always embedded or sustained.

Overall, our work highlights a healthcare system supported by dedicated staff but facing significant operational pressures. Stronger oversight, proactive risk management and whole-system working will be essential to delivering sustainable improvement and ensuring patients receive safe, effective and equitable care.

We carried out 79 inspections across primary care, community, and hospital settings, and concluded three national and joint reviews, with further follow-up work underway.

# NHS Inspections



# What we found: Key themes and insights

## Mental health: Compassionate care constrained by system pressures

Across mental health and learning disability services, we found that patients were treated with dignity, compassion and respect. Staff commitment, multidisciplinary working and examples of visible leadership supported person-centred care, often aligned with the Mental Health (Wales) Measure 2010, which aims to improve access to mental health support, care planning and advocacy.

However, these strengths continue to be constrained by persistent system pressures. Workforce challenges, including vacancies, reliance on temporary staff and gaps in mandatory training, affected the consistency and timeliness of care. We also identified variation in care planning, risk assessment, access to therapeutic activity and medicines management.

The quality of the care environment remained a significant concern. Ongoing issues with estate maintenance, environmental risk management and the suitability of facilities meant some settings did not meet expected standards for privacy, dignity or infection prevention. In some cases, the physical environment directly affected patient safety.

Inspection activity identified recurring safety concerns, including unmitigated ligature risks, weaknesses in medicines governance, gaps in infection prevention and failures in equipment checks. While action was usually taken following an inspection, the repeated nature of these issues indicates that core safety processes are not always effectively implemented in day-to-day practice.

Governance arrangements were in place but often lacked the rigour needed to identify, escalate and resolve risks effectively. In some services, known issues had not been fully addressed, indicating limited progress in delivering sustainable improvement.

Strengthening leadership accountability and oversight is essential to ensure safe and sustainable care.

**Further details about our work in mental health settings are included in a dedicated section later in this report.**

## General practice: Positive care under increasing pressure

We completed **39 GP inspections**

received feedback from **1,799 patients** and **399 staff**

Patient experience remained **broadly positive**

Most patients reported that they were treated with dignity, respect and compassion and felt involved in decisions about their care. Staff responses were also positive, with most reporting that they felt appropriately trained and confident in the care being delivered.

However, our findings highlight increasing pressure across general practice. Demand continues to exceed capacity in many areas, particularly in rural communities and areas of higher deprivation. This is affecting access, staff morale and the consistency of service delivery.

Access to services was a key concern. While most patients were able to contact their practice, fewer were able to secure timely urgent or routine appointments. Patients reported ongoing challenges with telephone access, delays and unclear triage processes. Although some practices have introduced local solutions, these are not always applied, resulting in variation in access and experience.

During some inspections, we also identified weaknesses in core safety processes, including infection prevention and control, medicines management and emergency preparedness. Workforce assurance arrangements were variable, with gaps in recruitment checks, training compliance and staff oversight.

Clinical care remained generally good; however, variation was identified in areas such as the use of chaperones and the quality of record keeping. Governance processes were not effective in supporting proactive risk management or sustained improvement, with inconsistencies in documentation, audit processes and policy implementation limiting assurance that risks were being identified and managed proactively. These findings indicate that, while care remains compassionate and clinically sound, consistency and reliability remain a challenge.

## General hospitals: System pressures affecting flow

Across general hospital services, patients were generally treated with dignity and respect, with staff supporting involvement in care and maintaining patient independence. However, this was not the case across all services.

System pressures affecting patient flow and discharge were a key theme. Delayed discharges, often linked to limited community capacity, contributed to longer stays and reduced flow through services. In some cases, this was compounded by delays in clinical decision-making and therapy input.

The care environment varied. While some areas were well maintained, others were affected by overcrowding, use of surge capacity and environmental issues that impacted patient privacy, dignity and safety.

Infection prevention arrangements were generally in place, but environmental standards were variable.

Workforce pressures were evident, including staffing shortages, skill mix challenges and gaps in training. While positive team working and ward-level leadership were often observed, concerns remained about staff morale and the visibility of senior leadership.

We also identified variation in communication, risk assessment and escalation processes, alongside inconsistent Welsh language provision and promotion of the Active Offer. Although these were often addressed at the time, their recurrence indicates that core processes are not always routinely applied.

## Emergency care: Sustained pressure and patient flow challenges

Across emergency departments and minor injury units, patients were generally treated with dignity and respect, with positive feedback on staff behaviour and communication.

Our inspections found that minor injury units generally provided timely, patient-centred care, supported by effective multidisciplinary working. However, emergency departments continue to face significant operational pressures. Delays in patient flow and extended waiting times remain a challenge, with overcrowding and the use of corridor care affecting patient privacy and dignity in some settings.

The care environment was generally clean, but space constraints and waiting area pressures remained. While systems for medicines management and equipment safety were in place, they were not always applied, with risks identified in stock control, equipment checks and documentation.

Workforce pressures, including staffing shortages and fatigue, were evident. Safeguarding processes were in place, but variation in risk assessment and oversight remained.

Welsh language provision was supported in some areas but not consistently, with limited recording of language preferences and variable application of the Active Offer.

Overall, while compassionate care remains a strength, sustained system pressures continue to impact the consistency and reliability of care delivery. Health boards must strengthen oversight, ensure core processes are routinely applied, and take a whole-system approach to improving patient flow to ensure patients receive safe and timely care.

## Maternity services: Person-centred care but ongoing concerns

Our work across maternity services found that women were treated with dignity, compassion and respect, supported by committed staff delivering person-centred care, often in challenging circumstances.

There were positive examples of innovation, including digital tools, multilingual information and approaches to improving understanding of safety and escalation. As digital systems continue to be introduced across Wales, we saw examples of governance arrangements supporting effective infection prevention and control, good quality record keeping and the use of digital systems to strengthen oversight of quality and risk.

However, workforce pressures remained a significant challenge, particularly in relation to staffing capacity, skill mix and reliance on temporary staff. These pressures affected the continuity and timeliness of care, and in some cases, limited the ability of services to meet the expected standards.

Variation was identified in key clinical processes, including maternity triage arrangements, escalation processes and compliance with mandatory training, such as obstetric emergencies and foetal monitoring. As these processes are critical to the early identification and management of risk, inconsistency in their application reduces reliability of safety processes across services.

While care was frequently described as compassionate and supportive, communication was not always clear or timely, and variation remained in the application of equality principles, including the Welsh language provision. Although digital approaches are supporting improvement in some areas, implementation remains variable and is not yet providing sustained assurance across services.

Overall, strong professional commitment continues to underpin maternity care. However, variation in workforce resilience, governance and the application of core safety processes persists, indicating that improvements are not yet embedded or sustained. Strengthening leadership oversight and ensuring the reliable implementation of critical processes will be essential to improving outcomes and delivering safe, high-quality and equitable maternity care.

# A closer look: Maternity services at Glangwili General Hospital, Hywel Dda University Health Board

An unannounced inspection of maternity services at Glangwili General Hospital in May 2025 found a well established service delivering compassionate, person centred care. This was supported by a committed multidisciplinary workforce. Women and families reported positive experiences, describing staff as kind, professional and responsive. Inspectors observed care being provided in a calm, clean and welcoming environment, where dignity and privacy were respected.

The service demonstrated a strong approach to individualised and inclusive care. Women and families were actively involved in decisions about their care and supported to make informed choices based on their preferences. Inspectors identified positive practice in the use of bilingual health promotion materials, access to translation services, and targeted support for diverse groups. This included a maternity passport for neurodiverse individuals and outreach activity with marginalised communities. Access to a patient experience midwife and a Birth Reflections service strengthened how the service gathered and responded to feedback.

From a safety and governance perspective, effective systems were in place to support safe and clinically effective care. These included regular audit activity, daily care planning and multidisciplinary review of incidents.

The service showed a positive and psychologically safe culture. Staff reported high levels of satisfaction, felt confident to raise concerns and described strong support from colleagues and leaders. Inspectors also noted effective multidisciplinary working, including within theatre settings and in the management of risk.

The inspection also identified areas where greater consistency is required. These included the need for earlier reporting of national incidents in line with Welsh Government policy, more consistent use of structured handover processes such as Situation, Background, Assessment and Recommendation (SBAR), and further strengthening of audit arrangements to clearly demonstrate learning and impact. Improvements were also needed in mandatory training compliance, particularly in safeguarding, and in ensuring effective approaches to medicines management and equipment checks.

Where improvement work had already taken place, progress was evident since the previous inspection in November 2022. For example, documentation relating to nutrition and hydration had improved, with fluid balance charts now completed to a high standard. This reflects focused work to develop a maternity-specific approach and shows the service's ability to respond to findings and translate improvements into practice.

Overall, this inspection found a service with a strong culture, positive patient experience and effective core systems. However, greater consistency in the application of governance and assurance processes is needed. Continued focus on embedding these improvements will be important to ensure risks are identified, escalated and addressed across the service.

# NHS key themes and learning across services

Across all services, several themes emerged.

**Compassionate, person-centred care remains a clear strength**, with patients reporting positive interactions with committed and professional staff.

**System pressure continues to affect services differently,** with patient flow challenges in hospitals and access pressures in general practice.

**Variation in the quality of care remains a key issue**, with patients not always experiencing the same standards of care across services.

**Core safety processes are not embedded**, particularly in medicines management, training, documentation, risk assessment and infection prevention and control.

**Governance and assurance remain variable**, limiting early risk identification, learning and sustained improvement.

**Environmental and infrastructure issues affect care delivery**, including estate condition, overcrowding, privacy and unsuitable care environments.

**Workforce pressures continue to affect service delivery across all settings**, affecting consistency, timeliness and sustainability of care.

**Welsh language and equality remain variable across services**, with differences in support for language needs and the delivery of the Active Offer.

**Whole-system working is essential**, as key challenges such as flow, access and workforce cannot be addressed in isolation.

# Ensuring safe use of ionising radiation in healthcare

Ionising radiation plays a vital role in modern healthcare. It is used in:

- **diagnostic imaging –** such as X-rays and CT scans to view internal structures
- **radiotherapy –** to treat conditions such as cancer
- **nuclear medicine –** which uses small amounts of radioactive material to diagnose or treat a range of conditions.

As these procedures involve exposure to radiation, they must be carefully controlled to protect patients and staff. This is set out in the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R), which define how radiation is used safely in medical settings, including roles, responsibilities, patient information and monitoring.

HIW is responsible for monitoring compliance with IR(ME)R in Wales. In 2025-2026 we inspected eight NHS and independent healthcare settings that use ionising radiation. Inspections are announced in advance and include a self-assessment by the provider. This allows inspection teams, supported by technical experts from the UK Health Security Agency (UKHSA), to focus on the environment and how procedures are carried out in practice.

As part of this programme, we also asked the UKHSA Medical Exposures Group to review reports of significant accidental or unintended exposures (SAUEs) submitted between 1 April 2024 and 31 March 2025.

## What we found in 2025–2026

Overall, our inspections found that services across Wales delivered safe care, with patients reporting positive experiences.

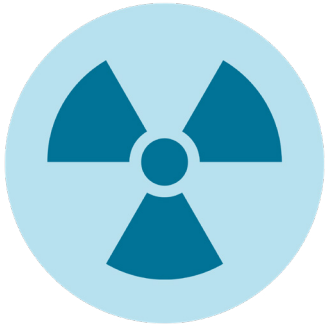
Patients told us they were treated with dignity and respect, felt well informed, and were involved in decisions about their care.

**We observed:**

- engaged and professional staff, with strong patient communication
- effective leadership within radiology and imaging services
- positive cultures, with services open to feedback and committed to improvement.

Survey feedback and patient comments reinforced this, with patients describing services as welcoming, professional and reassuring.

We also identified examples of innovation. In one service, radiologists were using an Artificial Intelligence (AI) stroke evaluation tool to support initial triage. This acted as an early indicator to identify patients who may require urgent treatment, before full clinical review by a radiologist. However, we found that Employer's Procedures had not been updated to reflect this use of AI, which could lead to ambiguity about roles and responsibilities.



## Areas for improvement

While overall care was positive, we identified several areas where further work is needed to strengthen consistency, governance and compliance.

## Diagnostic Reference Levels (DRLs)

DRLs are used to help monitor and optimise radiation doses for patients undergoing imaging procedures. One inspection identified a significant weakness in the process for establishing and reviewing DRLs. There was no clear evidence of how DRLs were approved or how actions from Medical Physics Expert advice were implemented. Services must ensure clear processes are in place to define, monitor and act on DRLs to maintain safe exposure levels.

## Governance and referral pathways

We identified inconsistent governance arrangements where IR(ME)R activities sit outside core radiology departments, particularly across multi-disciplinary pathways. This includes variation in referrer compliance and communication processes. As services become more complex, stronger governance and clearer accountability are required.

## Employer's Procedures (EPs)

There was variation in how the role of the IR(ME)R employer was understood and applied in practice. Employer's Procedures were not always regularly reviewed or aligned with actual practice. EPs must be clear, up to date and implemented, particularly following recent regulatory changes.

## Audit and learning

We saw variation in clinical audit programmes and how learning from incidents is used. Some services need to strengthen audit arrangements, including clear schedules, follow-up actions and feedback mechanisms to ensure continuous improvement rather than compliance alone.

## Clinical and equipment governance

Opportunities remain to strengthen systems for equipment governance, including maintaining accurate inventories and ensuring quality assurance processes are in place. Services must also ensure full alignment with updated IR(ME)R requirements, including those relating to training and employer cooperation.

## Good practice

We identified examples of person-centred innovation. One service created a child-friendly waiting area, including interactive activities and a pictorial book developed by staff to explain imaging procedures to children. This initiative, recognised by the British Nuclear Medicine Society, helped reduce anxiety and improve understanding for younger patients.

# A closer look: Compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)

A previous inspection of a national screening service found that it was not fully compliant with IR(ME)R regulations. There were concerns about the lack of clear procedures, protocols and quality assurance arrangements needed to support safe practice.

HIW issued an Improvement Notice under the Health and Safety at Work etc. Act 1974. Since then, we have worked closely with the service at both strategic and operational levels to support improvement. The provider responded positively, taking action to strengthen governance and safety processes, and the notice was lifted within a short timescale.

This case highlights HIW's approach to regulation. We take decisive action where risks are identified, but we also work collaboratively with providers to support improvement and achieve sustainable compliance.

# Making an impact through reviews

We publish a range of reviews and other reports every year.

National reviews help us to evaluate how healthcare services in Wales are delivered.

In 2025–2026, our review programme tackled some of the most sensitive and complex areas of care, with a focus on consistency, collaboration, and compassion.

## Follow-up: Supporting the mental health needs of children and young people

In November 2024, we published **our joint review with Estyn and Care Inspectorate Wales (CIW)** examining how healthcare, education and children's services support the mental health needs of children and young people.

During 2025–2026, we undertook a stage one follow-up by reviewing updated improvement plans from health boards, local authorities and regional partnership boards.

We found that:

- most actions assigned directly to health boards were reported as completed
- just over half of actions requiring joint working between organisations were completed
- all organisations demonstrated progress across key areas.

It was encouraging to see examples of strengthened practice and improved ways of working. However, progress was more variable where joint action is required, reflecting the challenge of delivering coordinated improvement across organisational boundaries.

We will continue to monitor progress and are planning a stage two follow-up in autumn 2026 to assess whether improvements have been sustained and are making a difference for children and young people.

# Follow-up: Vascular services, Betsi Cadwaladr University Health Board

As part of our stage two assurance work following **our 2023 vascular services review**, we undertook further follow-up activity with Betsi Cadwaladr University Health Board.

The initial response provided by the health board did not provide us with sufficient assurance, and further clarification and evidence were requested. A Service of Concern meeting, as part of our formal escalation process to address risks to quality and safety, was held in January 2026, where the health board set out its progress and improvement plans in detail.

Following this, we saw evidence of:

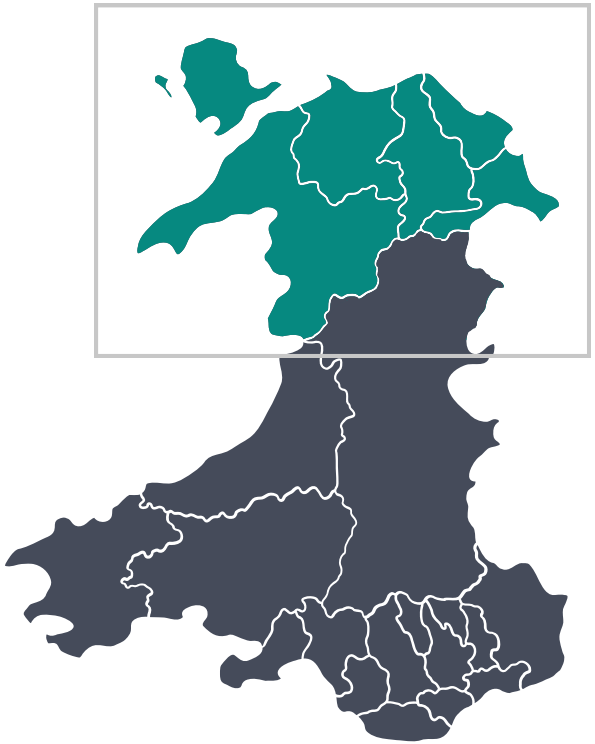
- clearer governance arrangements
- defined leadership responsibilities
- improved structures for clinical audit, oversight and learning.

However, overall assurance remains partial. While the health board has established more structured plans and monitoring arrangements, much of this work is still in development or at an early stage of implementation. There is currently limited evidence that these actions have led to sustained improvement in patient outcomes, service consistency or staff experience.

The health board must now demonstrate that improvements are:

- fully implemented across all services
- consistently applied in practice
- supported by clear evidence of impact on safety, quality and outcomes.

HIW will continue to seek assurance through ongoing engagement and scrutiny, including reviewing progress against planned actions and evidence of sustained improvement. Overall, our follow-up work this year shows that progress is being made, but that improvement is not always delivered at scale or maintained over time.



Sustained focus, strong leadership and effective partnership working continue to be essential in ensuring that improvements are delivered at pace and maintained over time. HIW will continue to use its review programme to provide independent challenge, monitor progress and support system-wide improvement.

06

# Mental health in Wales: Our findings and impact

# At a glance: Our activity this year

Mental health and learning disability services across Wales continue to face significant and sustained pressures. These pressures are particularly evident within NHS services, although independent providers also face challenges in delivering safe, effective and person-centred care. From HIW's perspective, this remains one of the most complex and high-risk areas we inspect and regulate. It requires strong leadership, safe environments, a skilled workforce and a continued focus on improvement across the whole system.

## What we did in 2025–2026

During the year, HIW carried out

**31** **onsite inspections** across mental health and learning disability services in Wales,

including

**19** **NHS settings**

and

**12** **independent healthcare settings**

Our programme covered a broad range of services, including:

- Community Mental Health Teams (CMHTs)
- Community Learning Disability Teams (CLDT), undertaken jointly with Care Inspectorate Wales
- NHS learning disability inpatient services
- Child and Adolescent Mental Health Services (CAMHS) inpatient setting
- A wider programme of inpatient mental health inspections across NHS and independent providers.

Our inspections focused on patient experience, the delivery of safe and effective care, and the strength of leadership, governance and oversight. Across services, patients described staff as caring and supportive, and we saw many examples of compassionate, person-centred care.

# What we're seeing across Wales

**Across the services we inspected, there was clear evidence of committed staff, effective multidisciplinary working and generally robust care and treatment planning aligned with the Mental Health (Wales) Measure 2010. Patients described staff as caring and supportive, and we saw many examples of compassionate, person-centred care.**

Mental Health Act arrangements were largely compliant, with patients supported to understand their rights and to access advocacy services. Medicines management systems were generally safe, although issues remain around the consistency and completeness of documentation. Some services also need to improve how information is provided, including the use of accessible formats.

In learning disability services, we saw positive examples of person-centred care, with staff demonstrating a strong understanding of communication needs and applying least restrictive approaches effectively. Families and carers were generally well involved, and care planning reflected individual needs and references. While some improvements were required in areas such as governance, documentation and aspects of the care environment, the quality of direct care was generally positive.

However, these strengths are being delivered within a system facing ongoing pressure. The most significant concern remains the environment of care, particularly within NHS settings. Ageing infrastructure, maintenance issues and delays in addressing known risks continue to affect patient safety, dignity and the therapeutic quality of services. In several cases, previously identified issues had not been resolved, indicating that improvements are not always being delivered at the pace required.

Workforce pressures remain evident across both NHS and independent services. These include challenges in maintaining training compliance, access to specialist roles and achieving the right skill mix.

In NHS settings, reliance on temporary staff and wider system pressures continue to affect continuity of care and access to therapeutic activity. Independent services generally demonstrated more stable workforce models, well-maintained environments and access to structured therapeutic activity. However, some services continued to experience pressures in maintaining staffing levels and responding to increasingly complex needs.

Governance arrangements were generally in place across services. However, weaknesses in documentation, oversight, record keeping and the use of learning from incidents reduced assurance that risks were always being identified and addressed effectively.

Overall, the evidence shows that direct care remains a strength, supported by committed and compassionate staff. However, environmental limitations, workforce pressures and delays in resolving known issues continue to affect the reliability and sustainability of care across Wales.

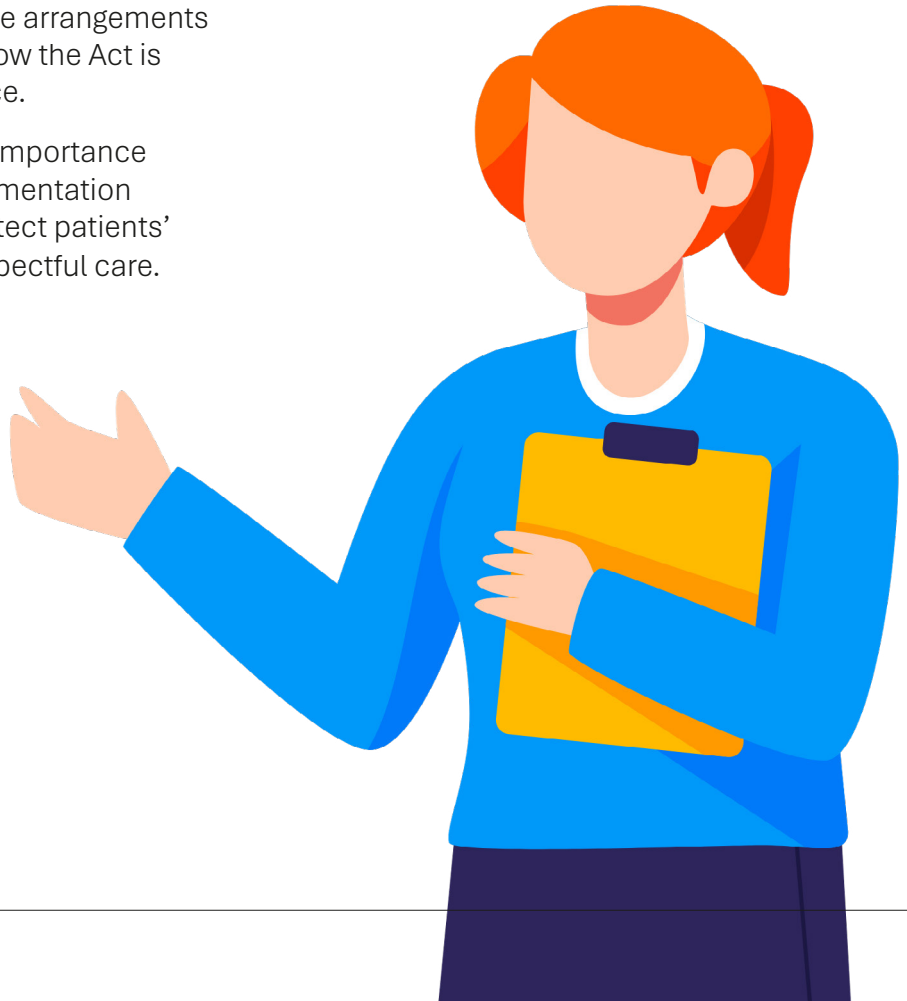
# Monitoring the Mental Health Act

The Mental Health Act 1983 provides the legal framework for detaining and treating people with serious mental health conditions when this is necessary for their safety or the safety of others. As part of our regulatory role, HIW continues to monitor how services apply the Act in practice.

In 2025–2026, our assurance work found that Mental Health Act arrangements were largely compliant, with patients generally supported to understand their rights and access advocacy services. Across the services inspected, there was evidence that legal safeguards were usually being applied appropriately.

However, as in previous years, some areas still require improvement. In particular, services need to ensure that documentation is complete, that information is accessible to patients, and that governance arrangements provide strong oversight of how the Act is applied in day-to-day practice.

These findings reinforce the importance of clear systems, good documentation and ongoing oversight to protect patients' rights and ensure lawful, respectful care.



# Second Opinion Appointed Doctor (SOAD) Service

The Second Opinion Appointed Doctor (SOAD) service is a vital safeguard for patients detained under the Mental Health Act who are unable or unwilling to consent to certain treatments. SOADs are independent consultant psychiatrists who review proposed treatment plans to ensure they are clinically appropriate, lawful and in a patient's best interests. This provides an important layer of external challenge and protection for patients.

HIW continues to manage the SOAD service in Wales, ensuring that robust arrangements are in place to support the timely and effective delivery of independent second opinions. This includes overseeing operational processes, promoting consistency in decision-making, and ensuring that learning from inspections and wider assurance activity informs the service.

## Service activity and delivery

Between 1 April 2025 and 31 March 2026, the SOAD service received 873 requests. Of these:

- 808 related to patients detained in hospital settings (SOAD 1 cases)
- 65 related to patients being treated in the community (SOAD 2 cases)

This represents an increase compared with recent years, while remaining broadly in line with activity seen over the past five years.

The service continues to operate through a hybrid delivery model, combining onsite and remote assessments, supported by a cohort of around 14 active SOADs across Wales. While remote certification remains an important part of service flexibility and timeliness, onsite assessments continue to be regarded as best practice wherever possible because of the additional value they provide in patient engagement and assurance.

Work has also continued to strengthen the digital systems supporting the service. Enhanced security measures for the digital operating model are being tested and implemented to improve resilience, information governance and efficiency.

## Service development and improvement

During the year, several steps were taken to strengthen consistency and quality in SOAD practice. This included the introduction of a revised SOAD toolkit, with updated guidance and practical resources to support SOADs in carrying out their statutory role.

The annual training programme was also delivered, with a particular focus on peer review, reflective practice, and thematic sessions on the use of Electroconvulsive Therapy (ECT), a treatment used in certain severe mental health conditions where a controlled electrical stimulus is applied under anaesthetic to improve symptoms. These were identified as priority areas to support consistency in decision-making and reinforce good practice.

In addition, HIW carried out a comprehensive audit of SOAD certifications from the previous reporting period. Findings were shared with the SOAD cohort to promote learning and continuous improvement, particularly in relation to documentation standards and the consistency of reasoning within certification decisions.

HIW also continued to discharge its responsibilities under Section 61 of the Mental Health Act 1983, reviewing the administration of treatment to detained patients. These reviews found generally high levels of compliance with statutory requirements. Where issues were identified, these were mainly minor administrative errors, and these were followed up with providers to ensure appropriate remedial action.

## Challenges and forward look

A significant challenge for the service continues to be the recruitment and retention of SOADs. Despite ongoing efforts, the current cohort has not been expanded, which continues to place pressure on service capacity and resilience. This challenge is likely to become more pressing with the anticipated impact of Mental Health Act Reform (2025), which is expected to increase demand for SOAD services.

Looking ahead to 2026–2027, the focus will be on strengthening capacity and resilience, progressing actions to address recruitment challenges, and ensuring readiness for any increase in demand. Further work will also continue to improve the digital delivery model, integrate into practice learning from audit and training, and promote consistency and quality across SOAD decision-making.

Overall, the SOAD service continues to provide an essential safeguard within the mental health system in Wales, helping to protect patient rights and ensuring independent scrutiny of significant treatment decisions.

07

# Concerns, investigations and notifications

# Concerns: Our activity this year

We are committed to managing concerns fairly, efficiently and effectively. Concerns raised with us about the quality, safety and experience of healthcare services are a vital source of intelligence that help us identify risks, highlight areas of good practice and drive improvement across healthcare services in Wales.

## Why concerns matter

Much of our work in responding to concerns takes place outside the public spotlight. While this activity is less visible than inspections or published reports, it is a critical part of how we hold organisations to account.

Through concerns, we may identify early warning signs of risk, seek assurances from providers and, where needed, escalate issues to protect patients.

This intelligence directly informs our inspection programme, assurance work and wider regulatory decisions.

We also continue to see increasing complexity in the concerns raised. Many involve multiple services, higher levels of risk and require more direct follow-up. In 2025–2026, we sought further assurance from services in around 30% of concerns received, reflecting the seriousness of issues being reported.

## How we respond

We act quickly on high-risk concerns, seeking immediate assurances from healthcare providers and taking further action where necessary.

All concerns about the quality, safety or experience of healthcare services are triaged according to risk, with clear target times for HIW's response to the person raising the concern:

- **High-risk concerns** require immediate action and a response from HIW within 2 working days.
- **Medium-risk concerns** require a response from HIW within 5 working days and may involve direct engagement with the provider.
- **Low-risk concerns** are typically signposted to local complaints processes, with a response from HIW within 7 working days.

Where concerns indicate potential risks to patient safety or quality of care, we may seek assurances directly from the provider. High-risk concerns may require immediate assurance, while medium-risk concerns would typically require a response from the provider within 5 working days.

## Concerns at a glance

In 2025–2026, we received 783 concerns, an increase of 40 compared to the previous year and continuing a strong upward trend over time.

Concerns received over the last six years:

- 2020–2021: 434
- 2021–2022: 514
- 2022–2023: 659
- 2023–2024: 614
- 2024–2025: 743
- **2025–2026: 783**

This sustained increase reflects greater public awareness, confidence in raising concerns, and ongoing pressures within healthcare services.

**783 concerns received**

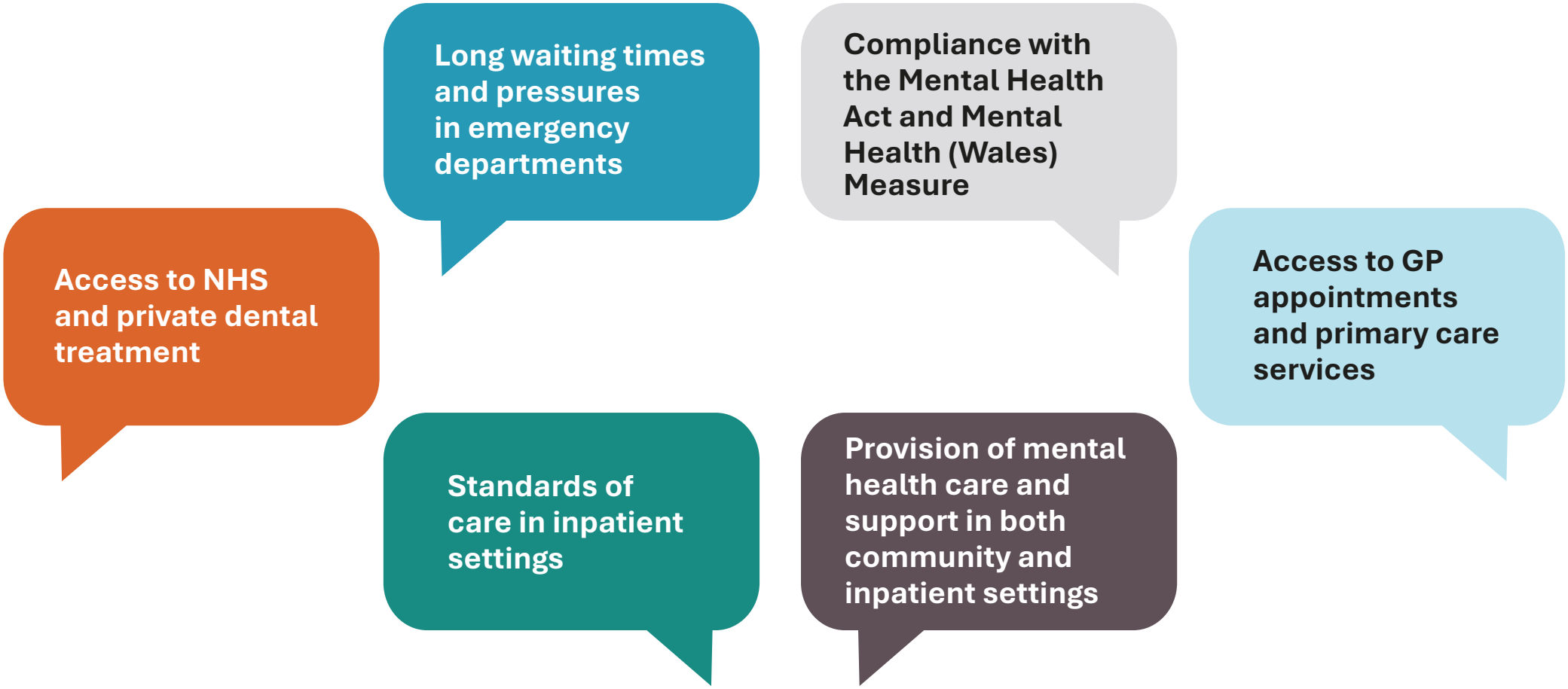
## What the concerns were about

| | |
|---|---|
| 115 | Betsi Cadwaladr University Health Board |
| 110 | Swansea Bay University Health Board |
| 110 | Independent healthcare |
| 96 | Aneurin Bevan University Health Board |
| 87 | Hywel Dda University Health Board |
| 85 | Cwm Taf Morgannwg University Health Board |
| 80 | Cardiff and Vale University Health Board |
| 52 | Dental |
| 20 | Powys Teaching Health Board |
| 17 | Other |
| 5 | Welsh Ambulance Services University NHS Trust |
| 2 | Public Health Wales |
| 2 | Velindre University NHS Trust |
| 2 | NHS Wales |

Note: The figures shown represent the number of concerns received by HIW during 2025–2026. Health boards serve populations of different sizes and provide services across different geographical areas. As a result, these figures should not be used to compare organisations directly or interpreted as a measure of performance.

## What people told us

The most common themes raised in concerns during the year included:




These themes reflect wider system pressures and highlight where patients are finding it most difficult to access timely, safe and effective care.

# Whistleblowing: Speaking up for safety

**Whistleblowing plays a vital role in protecting patients and improving services. It allows staff to raise concerns about unsafe practice, poor quality care, or organisational culture where they may not feel able to do so internally.**

As a prescribed body, HIW has a key role in receiving and acting on these concerns. Staff come to us not only to report immediate risks, but also to highlight deeper issues relating to governance, leadership and culture.

In 2025–2026, we received 117 whistleblowing concerns, a small decrease from the previous year of 120.

These concerns mostly related to:

- staffing levels, turnover and skill mix
- staff conduct and clinical practice
- environment and infection prevention and control
- culture, including bullying and discrimination
- standards of care and treatment
- leadership, support and governance arrangements
- lack of action following concerns being raised.

We take all whistleblowing concerns seriously and may seek assurances or share information with other regulatory bodies where appropriate.

# Regulatory notifications: Keeping us informed

Independent healthcare providers and private dental services are required by law to notify us of certain incidents. We also receive notifications relating to ionising radiation under IR(ME)R regulations.

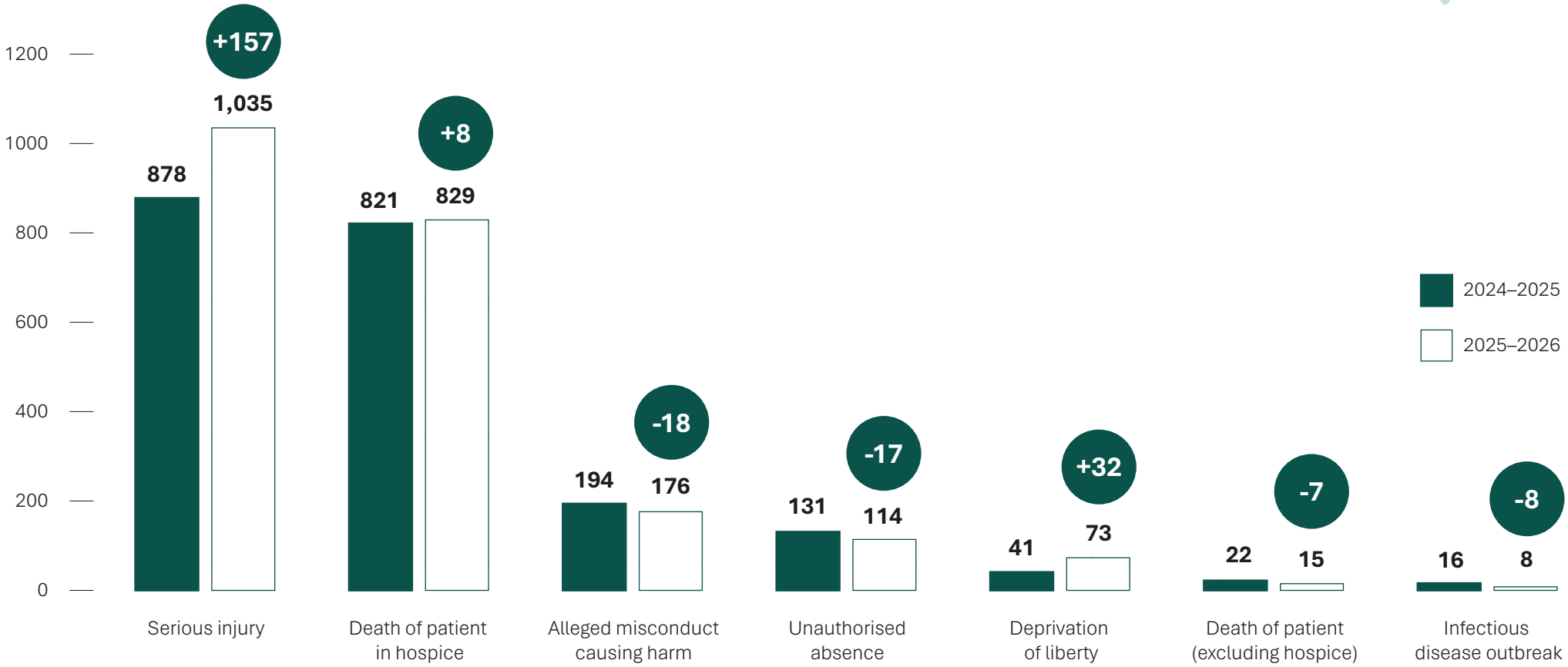
In 2025–2026, we received 2,385 statutory notifications, an increase of 154 (7%) compared to the previous year. This increase was primarily driven by Regulation 30/31 notifications.

**Breakdown of notifications received:**


These notifications are reviewed and assessed to determine risk and whether further action is required. They also provide valuable insight into emerging trends and help inform our inspection and regulatory activity.

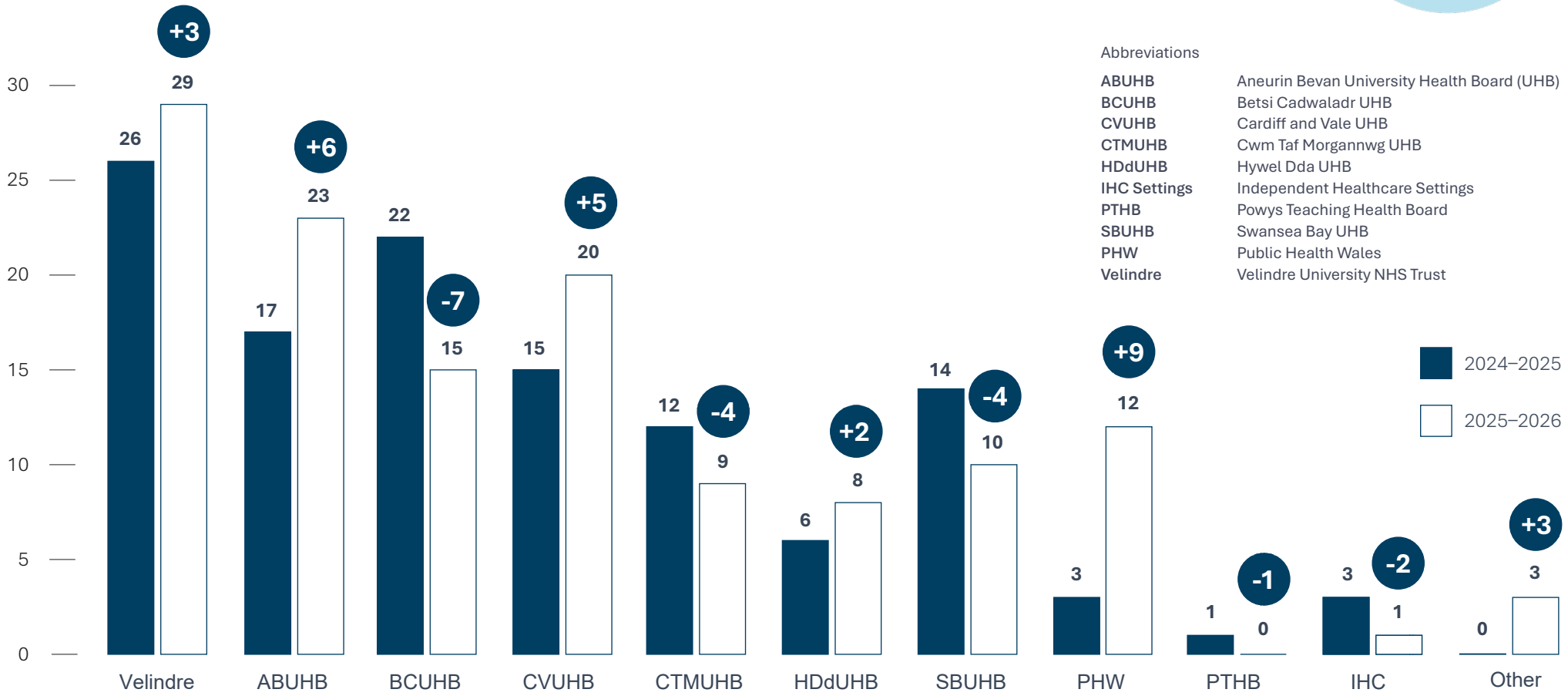
## Regulation 30/31 notifications

Regulation 30/31 notifications increased during 2025–2026, driven primarily by a rise in serious injury notifications, which increased from 878 to 1,035. Notifications relating to deprivation of liberty also increased, while reports of alleged misconduct causing harm, unauthorised absences, infectious disease outbreaks and deaths outside hospices decreased. Death notifications from hospices remained broadly consistent with the previous year.



# IR(ME)R notifications by location

Overall, the number of concerns and statutory notifications received in 2025–2026 increased compared with the previous year. This intelligence remains central to our role, enabling us to identify risks early, target our regulatory activity and support improvements in the quality and safety of care across Wales.

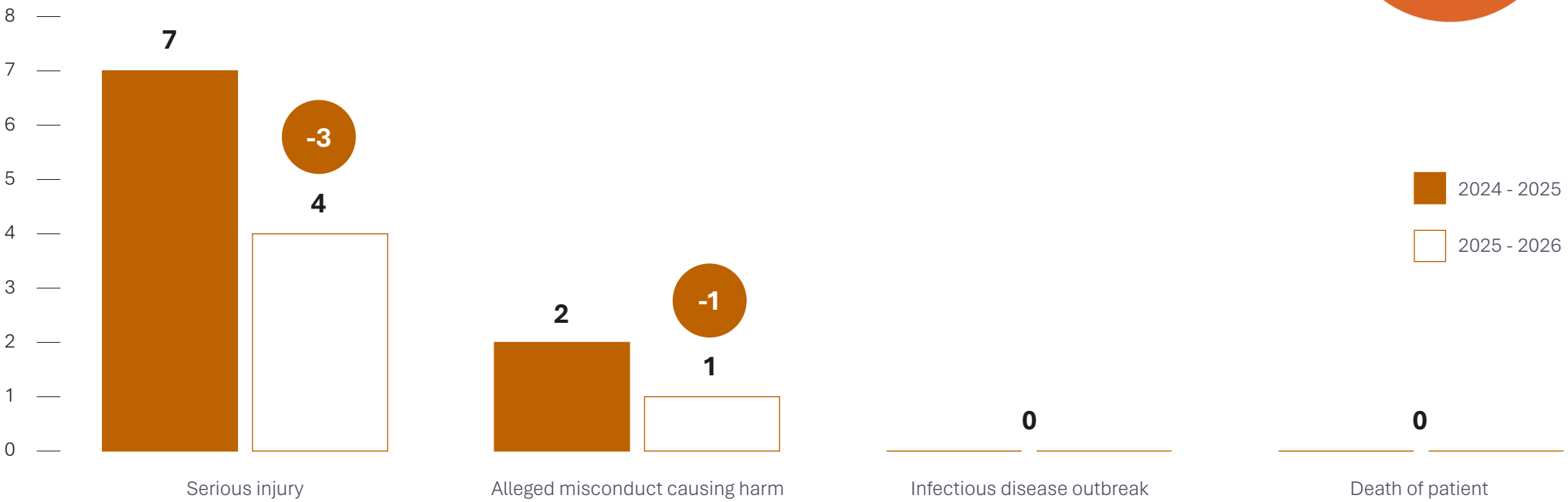



Abbreviations

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

# Private dental notifications

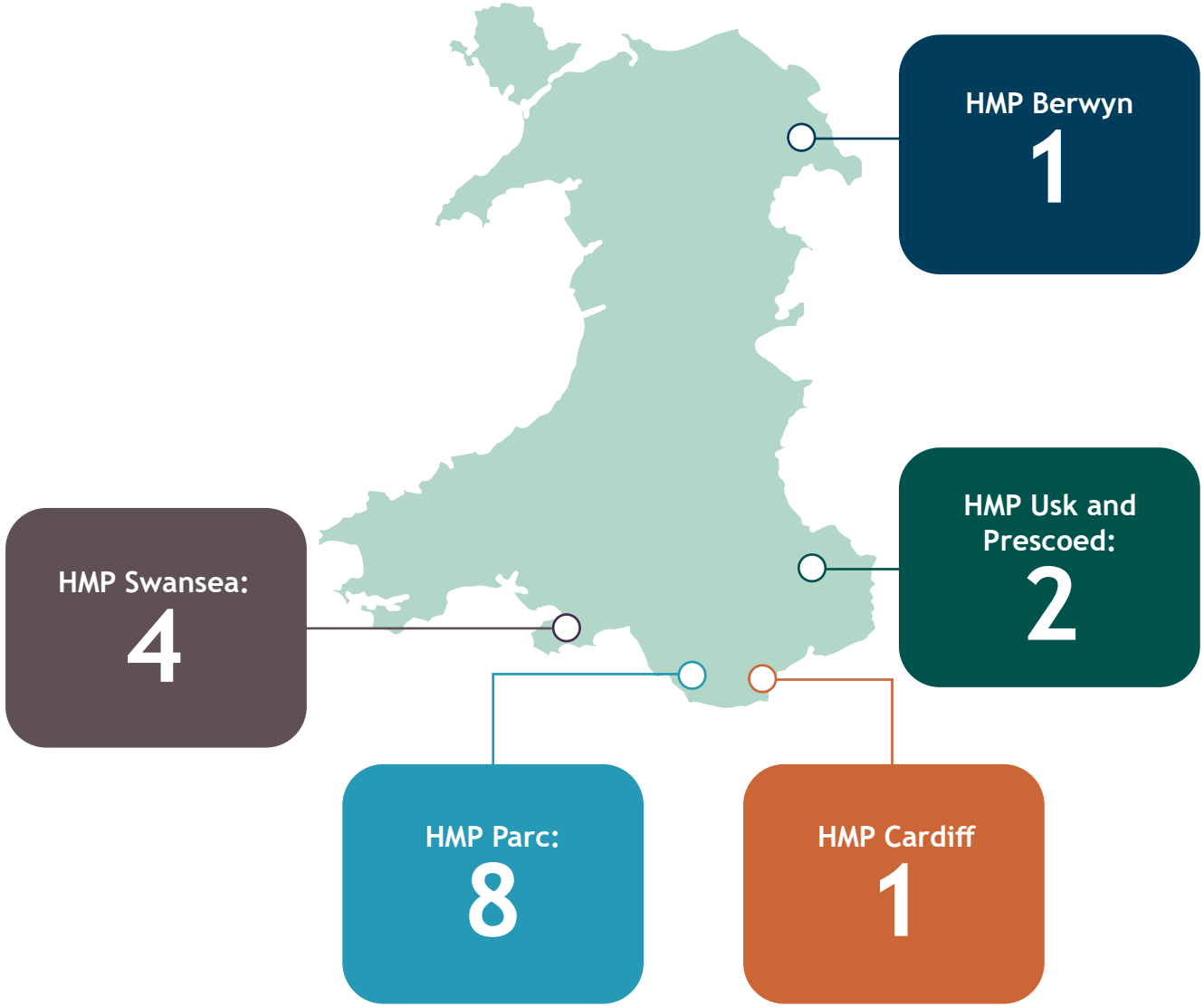
Private dental notifications remained low during 2025–2026. Serious injury notifications decreased from seven to four, while alleged misconduct notifications reduced from two to one. No notifications relating to infectious disease outbreaks or patient deaths were received.



# Death in custody

In Wales, every death in custody is subject to independent investigation by the Prisons and Probation Ombudsman (PPO). As part of this national process, HIW undertakes clinical reviews to assess whether the healthcare provided was equivalent to that available in the community. These reviews focus on the timeliness, appropriateness and continuity of care.

Between 1 April 2025 and 31 March 2026, HIW was commissioned to undertake 16 clinical reviews across Welsh prisons, of which 11 were completed by year end. These were spread across the prison estate as shown in the map.



## HMP Parc: Complex needs and systemic challenges

As in previous years, most reviews were undertaken at HMP Parc. Our findings highlight ongoing challenges in managing individuals with complex and multiple health needs, including chronic physical conditions, mental health issues, substance misuse and frailty.

Several reviews identified concerns in the early stages of custody, including delays or omissions in second-stage health assessments, and gaps in baseline observations and risk assessments. In several cases, there were missed opportunities to respond to deteriorating clinical indicators, such as abnormal test results or significant weight loss.

These findings reflect similar issues to those identified last year, highlighting ongoing challenges in ensuring early intervention and effective management of clinical risk.

There were also ongoing issues in the management of long-term conditions, particularly respiratory and cardiovascular disease, and in the care of frail individuals. Fragmentation between primary healthcare and substance misuse services limited effective information sharing and continuity of care. Delays in accessing clinical information and poor integration between services continued to contribute to gaps in care.

The use of remote GP provision, particularly out of hours and at weekends, was also linked to delays in clinical decision-making and, in some cases, reduced diagnostic accuracy. This highlights the impact that service models can have on the quality and timeliness of care.

## Systemic weaknesses

Across other prisons, our reviews identified a pattern of system-wide issues, many of which mirror those seen in previous years. Individuals often presented with multiple vulnerabilities, including mental health needs, substance misuse and complex physical health conditions. However, care was not always coordinated or proactive.

A key concern was the quality and completeness of clinical documentation. In several cases, important information about health status, risks and clinical history was not fully recorded. This limited the ability of clinicians to make informed decisions and contributed to fragmented care.

We also identified variability in the use of risk assessment processes. In some cases:

- risk assessments were not completed or updated
- clinical decisions, including those related to medication or segregation, were not supported by full assessment
- face-to-face reviews were not always carried out where clinically indicated.

This reflects ongoing inconsistency in the application of safeguarding processes, including the use of Assessment, Care in Custody and Teamwork (ACCT) procedures and other risk management tools.

Oversight of individuals in segregation or restricted regimes was also variable. We identified gaps in:

- regular clinical review
- documentation of welfare checks
- healthcare involvement in decision-making.

These gaps are particularly significant given the vulnerability of this group and reflect concerns identified in previous years.

Across services, we also found limited proactive management of individuals with complex or deteriorating conditions, including those with frailty, self-neglect or multiple co-morbidities. Care plans were not always adapted to reflect changing needs, and escalation was inconsistent, leading to missed opportunities for earlier intervention.

There were also gaps in follow-up after clinical incidents, including falls, head injuries and reported health concerns. In some cases, appropriate monitoring and review were not clearly evidenced, particularly where staffing or access constraints applied. In addition, involvement of specialist mental health and in-reach services was variable at key points of risk.

## Key findings and next steps

**Taken together, our findings highlight continuing weaknesses in:**

- integration between healthcare and custodial services
- the consistency of clinical assessment and decision-making
- proactive identification and management of risk
- oversight of vulnerable individuals, particularly in restricted settings.

While governance structures and clinical processes are generally in place, their effectiveness was mixed in the cases we reviewed, and key issues identified in 2024–2025 persist. This indicates limited progress in addressing underlying system challenges.

**There is a clear need to strengthen:**

- information sharing and coordination across services
- the consistency of clinical assessment, monitoring and follow-up
- multidisciplinary approaches to managing complex needs
- oversight and safeguarding for those at greatest risk.

These findings reinforce the need for a whole-system approach to healthcare, where clinical, custodial and support services work together to ensure risks are identified early and managed effectively. HIW will continue to provide independent scrutiny and challenge to support improvements in the quality and safety of care for individuals in custody.

08

# Engagement and partnerships

# Partnerships

During the year, HIW continued to strengthen its role as a system connector, enabling the sharing and triangulation of intelligence and the identification of emerging risks.

By working closely with partners across healthcare, regulation and government, we have supported collective oversight and improvement in the quality and safety of care across Wales. Through formal agreements and structured engagement, we have supported the sharing and triangulation of intelligence, helping partners to identify emerging risks and develop a collective understanding of system-wide challenges.

## Formal agreements and intelligence sharing

HIW maintains close working relationships with a wide range of organisations. Formal **Memoranda of Understanding (MoUs)** underpin this work, setting out how we share information, manage risks, and coordinate activity.

These agreements support timely intelligence sharing, clear routes for escalating concerns, joint approaches to emerging risks and system pressures, and better alignment of regulatory and improvement activity. Together, they provide a framework for sharing intelligence, escalating concerns and supporting coordinated responses to risks affecting the quality and safety of care.

We regularly review these arrangements to ensure they remain effective and up to date. Between March 2025 and April 2026, HIW established or updated MoUs with the Independent Sector Complaints Adjudication Service (June 2025), the National Institute for Health and Care Excellence (June 2025), and the Royal College of Midwives (September 2025).

In addition, HIW strengthened partnership working through a number of wider agreements, including a strategic agreement with Audit Wales, Care Inspectorate Wales and Estyn (January 2026), an agreement with NHS Wales Performance and Improvement (February 2026), and a joint arrangement with Welsh Ministers, Care Inspectorate Wales and Healthcare Inspectorate Wales (March 2026).

These arrangements strengthen our ability to take a coordinated, system-wide view of quality and safety.

## Engagement with NHS Wales

During 2025–2026, HIW introduced a new NHS Wales Engagement Process to strengthen how we engage with health boards and NHS trusts across Wales.

The process provides a structured approach to engagement between HIW and NHS organisations, supporting regular discussions with senior leaders and strengthening opportunities to share intelligence, explore emerging issues and seek assurance. It complements our inspection, review and

regulatory activity by helping us build a broader understanding of the challenges and risks affecting healthcare services across Wales.

Through this approach, HIW engaged with a range of senior leaders, including Executive Directors of Nursing, Medical Directors and Directors of Therapies and Health Science. Discussions covered key issues such as workforce pressures, service resilience, patient flow, governance, quality and safety risks, infection prevention and control, and wider system pressures affecting urgent and emergency care.

This engagement strengthens HIW's ability to gather timely intelligence, apply constructive challenge and better understand how organisations are responding to risks, pressures and recovery priorities. It also supports a more informed, evidence-based and risk-focused approach to our work.

## National Healthcare Summits

In May and November 2025, HIW convened national Healthcare Summits, bringing together organisations from across audit, inspection, regulation and improvement to share intelligence on the quality and safety of healthcare services in Wales.

The Summits are a key mechanism for triangulating insight from across NHS Wales, enabling partners to develop a collective understanding of performance, emerging risks, and areas requiring improvement. They provide a structured forum for triangulating intelligence from across the system, helping partners to develop a shared understanding of performance, emerging risks and areas requiring improvement. Insight from the summits informs organisational work programmes, supports alignment between partners, and enables coordinated responses to system pressures.

Across both summits, partners identified a set of system-wide challenges:

## Access to care and patient flow

There has been some progress in improving access to healthcare, including the use of virtual appointments and more targeted GP services. However, long waiting times for planned care remain a major concern, with delays in diagnosis and treatment continuing to affect patient safety.

While some health boards have improved emergency care performance, significant pressures remain. Emergency departments continue to experience crowding, ambulance handover delays persist, and difficulties in discharging patients mean beds are not always available when needed. These issues continue to affect the flow of patients through the system.

## Mental health and vulnerable groups

There are examples of positive local work to improve mental health services, including faster access to support in some areas. However, serious concerns remain.

Partners highlighted issues with access to crisis support, the quality of inpatient care, safeguarding arrangements, and support after discharge. There were also concerns about how risks are managed, including gaps in observation, inconsistent discharge planning, and weaknesses in how services keep people safe.

## Quality, safety and governance

The summits identified ongoing concerns about how organisations manage incidents, respond to complaints, and learn from what goes wrong.

Delays in investigating incidents and taking action remain a challenge, and in some cases learning is not followed through effectively. Challenges with data quality, and inconsistent use of the duty of candour, make it harder to clearly understand risks and ensure improvements are made.

## Workforce, culture and leadership

Staffing pressures continue to affect services across Wales. These include difficulties recruiting staff, high levels of sickness absence, and a continued reliance on temporary staff.

In some services, there are concerns about training compliance and reliance on a small number of key individuals, creating risks if those staff are not available. Cultural issues also remain significant in some areas, including concerns about bullying, poor staff engagement, and staff feeling unable to speak up.

## System sustainability and strategic pressures

There are growing concerns about the long-term sustainability of some services. Financial pressures are increasing and were identified as a growing risk to the quality and delivery of care.

A key issue raised was the continued focus on short-term actions to manage immediate pressures, rather than longer-term planning to address underlying challenges and support sustained improvement across the system.

# Clinical insight

Over the past year, HIW's Clinical Team has continued to play a vital role in embedding clinical expertise at the heart of our inspection, assurance and regulatory work. Their contribution has strengthened how we assess concerns, plan inspections and interpret findings, ensuring our work reflects current clinical practice and remains focused on quality, safety and patient experience.

## Use of Peer Reviewers

HIW continues to use clinical peer reviewers to bring frontline expertise and specialist insight into our work. These professionals, who remain active in clinical practice, provide an independent and practical perspective on how care is delivered.

During the year, we further strengthened this approach by identifying and matching the right expertise to specific areas of inspection activity. Peer reviewers have supported a wide range of assurance work, provided external challenge and helped ensure our findings are clinically credible, evidence-based and relevant to the services we review.

Their involvement also helps us stay connected to the realities of service delivery and supports a culture of shared learning and improvement across the healthcare system.

## Providing expert advice

The Clinical Team provided expert advice and challenge across a broad range of inspection and review activity. This includes supporting inspection planning, identifying areas of clinical risk, and reviewing immediate assurance and non-compliance findings to ensure clinical accuracy.

Throughout the year, the team evaluated whether organisational responses and action plans from healthcare services following our inspections provided sufficient assurance, helping ensure that our conclusions are robust and focused on the issues of greatest importance to patients and services.

Throughout the year, the team responded to a wide range of clinical and operational issues, including patient safety concerns, infection prevention and control, safeguarding, governance matters and emerging incidents. This included providing informed clinical input on complex and evolving issues, such as outbreak management and situations requiring detailed professional judgement.

This work enabled HIW to respond in a timely and informed way, ensuring that decisions were supported by sound clinical expertise and a clear understanding of the wider healthcare context.

# Engagement – Listening and learning

Listening to the people who use and work in healthcare services remains at the core of our work. Their experiences help us understand how care is delivered across Wales and where change is needed most.

We build this understanding through every part of our approach. During inspections and reviews, we speak directly with staff, patients and carers, using conversations and surveys to gather real, lived experience. Beyond inspections, we continue to expand how we engage using digital platforms, campaigns, and face-to-face opportunities to reach more people and hear more voices.

**This year:**

**216**
**on-site inspections** carried out

**1,628**
**staff surveys** completed

**4,407**
**patient, carer and public surveys** returned

**2,353**
**responses** to Strategy Consultation

This insight strengthens our findings, challenges assumptions and drives improvement. People's voices are not just captured; they actively shape our work and influence change across healthcare services.

## Raising awareness and building public confidence

During 2025–2026, we continued to publish inspection reports and key findings, with many attracting regional and national media coverage across major outlets. This included both live and recorded interviews, helping raise awareness of HIW's role and reinforcing public confidence in independent scrutiny.

We have also strengthened our digital presence and reach, ensuring more people understand who we are and how we work.

**Our latest engagement data shows:**

**50%**
of the public now recognise HIW, up from 47% in 2024

**19%**
of people became aware of HIW through online sources or websites

**23%**
through radio

**20%**
through social media

This growing visibility is important as it supports transparency, reassures the public that services are independently monitored, and encourages providers to maintain high standards of care.

## Accessible, inclusive and impactful engagement

We are continuing to build an approach to engagement that is accessible, inclusive and reflects the diversity of communities across Wales.

**During 2025–2026, we have:**

- Strengthened our digital offer, including expanding use of video, animation and new platforms to reach wider audiences.
- Continued to improve accessibility across our website and publications, with a sustained focus on clear language and inclusive formats including Easy Reads.
- Increased the use of web-based content instead of PDFs to make information easier to access and keep up to date.
- Developed internal guidance and tools to support staff in producing accessible, inclusive content.

We are also exploring new ways to engage, testing different channels, formats and approaches to ensure we are reaching people in ways that work for them.

## Learning and insight that drives improvement

We continue to strengthen how we share learning from our work to support improvement across healthcare.

- Our **Insight Bulletins** continue to reach a growing audience, sharing key findings, risks and examples of good practice.
- Engagement with our News and Insight Bulletins has increased, showing strong interest in our work and findings.
- We have expanded digital content and improved how we present insights online, making them clearer and easier to use.

By making our insight more accessible and practical, we are helping providers, policymakers and the public understand what good care looks like and where improvement is needed.

## Being visible, building trust

We are more visible than ever, with increased participation in national events, stakeholder forums and public engagement opportunities.

**This year, we:**

- attended major national events such as the Mental Health and Wellbeing Show, and professional conferences
- engaged directly with healthcare professionals, stakeholders and the public
- promoted our work and increased awareness of opportunities to get involved, including peer reviewer roles.

We also refreshed our exhibition materials to ensure they are engaging, inclusive and environmentally sustainable reflecting our values in both design and delivery.

## Engagement highlights

- **8.1% increase in new social media followers**
- **29k video views across platforms (+437% from 5.4k last year)**
- **1.6k social media posts published (+14.3% from 1.4k last year)**
- **833k impressions across social media (+24.4% from 670k last year)**
- **556k website views (+8.8% from 511k last year)**
- **180 inspection reports and 38 news items published**
- **13 press notices issued**
- **9k+ newsletter subscribers**
- **48 editions of our internal newsletter 'Connect' shared with staff**

# Championing Equality, Diversity and Inclusion (EDI)

We remain committed to ensuring our work reflects the diversity of the communities we serve. Our **Joint EDI Strategy (2024–2028)** with **Care Inspectorate Wales (CIW)** continues to guide this work, aligning with Welsh Government priorities and strengthening collaboration across inspectorates.

## Why EDI matters

People's experiences of healthcare are shaped by their identity, background and circumstances. By recognising this, we can better assess whether services are accessible, respectful and responsive.

## What we have delivered this year

- **Embedding EDI in inspections:** Equality and inclusion considerations are now built into inspection processes, including accessibility, language, disability and digital exclusion.
- **Improving how we use data and insight**: We are strengthening how we capture and analyse equality data to identify trends and risks across the system.
- **Strengthening engagement with diverse communities:** We have increased engagement with organisations representing underrepresented groups to better understand lived experience.
- **Developing our workforce:** Staff have taken part in EDI learning and development, alongside dedicated sessions focused on lived experience.
- **Internal EDI Champions Group:** Continues to provide leadership, challenge and oversight, ensuring EDI is embedded across our work.

These actions are helping us build a more inclusive organisation and improve how we engage with people, providers and partners.

## Working with our Stakeholder Advisory Group

Our **Stakeholder Advisory Group (SAG)** continues to play a critical role in shaping our work.

The group brings together organisations representing a wide range of communities across Wales, helping us better understand the needs, experiences and barriers faced by diverse groups. This ensures our work reflects the issues that matter most to people and communities.

This year, the group has:

- expanded its membership, strengthening representation from diverse communities
- contributed to our Strategy 2026–2030 consultation and wider engagement activity
- provided insight on accessibility, inclusive communication and lived experience.

## How the group is shaping our work

The group plays an active role in influencing how we plan, deliver and improve our work. Their input has helped us to:

- **design and improve our engagement approaches, ensuring they are accessible and reach a wider range of people**
- **strengthen how we capture and interpret lived experience, particularly from underrepresented groups**
- **shape our priorities and areas of focus, including where we direct our assurance and improvement activity**
- **improve how we communicate, making our content clearer, more inclusive and easier to understand**
- **identify potential inequalities and barriers, helping us challenge where services may not be meeting people's needs**

Their insight helps us better understand where healthcare services are working well, and where improvement is needed, particularly for those most at risk of poorer experiences or outcomes. Their input helps ensure our work is informed by real experiences and that our approach remains inclusive, relevant and focused on improving healthcare for everyone across Wales.

# Welsh language – The Active Offer

We are committed to making the Welsh language a natural, visible and integral part of how people experience healthcare in Wales. For many people in Wales, particularly children, older people, people with dementia, those with learning disabilities and people experiencing mental ill health, being able to communicate in Welsh is not simply a matter of preference. It can be fundamental to dignity, understanding, participation in care and wellbeing.


## Strengthening how we assess and influence Welsh language provision

This year, we have taken a more structured approach to assessing Welsh language provision through our inspection work. This includes:

- routinely reviewing how services deliver the Active Offer, including communication, signage, patient information and staff visibility
- checking whether services ask and record patients' language preference, which remains a key area for improvement
- including Welsh language considerations in inspection questions and findings, ensuring they inform our recommendations and follow-up work.

We are also supporting national progress by sharing clear evidence from inspections on how services enable people to receive care in their preferred language.

## What we are seeing

Our inspection findings show a mixed picture:

- There is strong practice in some services, where Welsh is used confidently, bilingual information is visible, and patients are actively supported to speak Welsh.
- While we continue to identify positive examples of the Active Offer in practice, our findings show that access to Welsh-language services remains variable. Too often, provision depends on individual staff members rather than being effectively built in to organisational systems, workforce planning and service delivery.

Through our wider engagement and strategy consultation, we also heard that:

- access to Welsh-medium care is not always reliable in practice
- the Active Offer is not consistently delivered
- barriers include workforce capability, confidence and training.

Through our inspections and engagement work, people continue to tell us that whether or not they get to receive care in their preferred language affects their ability to understand information, express concerns, participate in decisions and maintain their dignity. This can be particularly important when people are at their most vulnerable.

## Driving improvement across the system

We are using these insights to strengthen expectations and drive improvement. We are:

- highlighting the need for services to embed the Active Offer consistently, not just in principle but in day-to-day practice
- reinforcing the importance of recording language preferences from the outset of care
- supporting a stronger focus on Welsh language workforce planning, ensuring services have the skills needed to meet patient needs.

We continue to identify and share positive examples, including:

- staff proactively offering services in Welsh
- clear use of bilingual materials
- improved visibility of Welsh-speaking staff.

At the same time, we are clear where improvement is required, particularly where Welsh language provision is variable, not visible, or not fully integrated into systems and processes.

## Our commitment

We will continue to strengthen how we assess, report and follow up on Welsh language provision. This includes being more visible, more consistent and more proactive in highlighting where change is needed. People should not have to rely on chance to receive healthcare services in Welsh. The Active Offer should be a routine feature of care across Wales, not something dependent on individual staff, local enthusiasm or good fortune. While progress is being made, our work shows there is still some way to go before Welsh language provision is fully embedded across the healthcare system.

By doing this, we aim to ensure that the Welsh language is not an add-on, but a core part of safe, high-quality and person-centred care across Wales.

In addition, all of our public-facing communications continue to be fully bilingual, and we have strengthened how the Welsh language is embedded across our public engagement work.

We also publish key communications bilingually and support staff to build confidence and understanding through initiatives such as Cornel Cymraeg (Welsh Corner) within our internal staff newsletter.

09

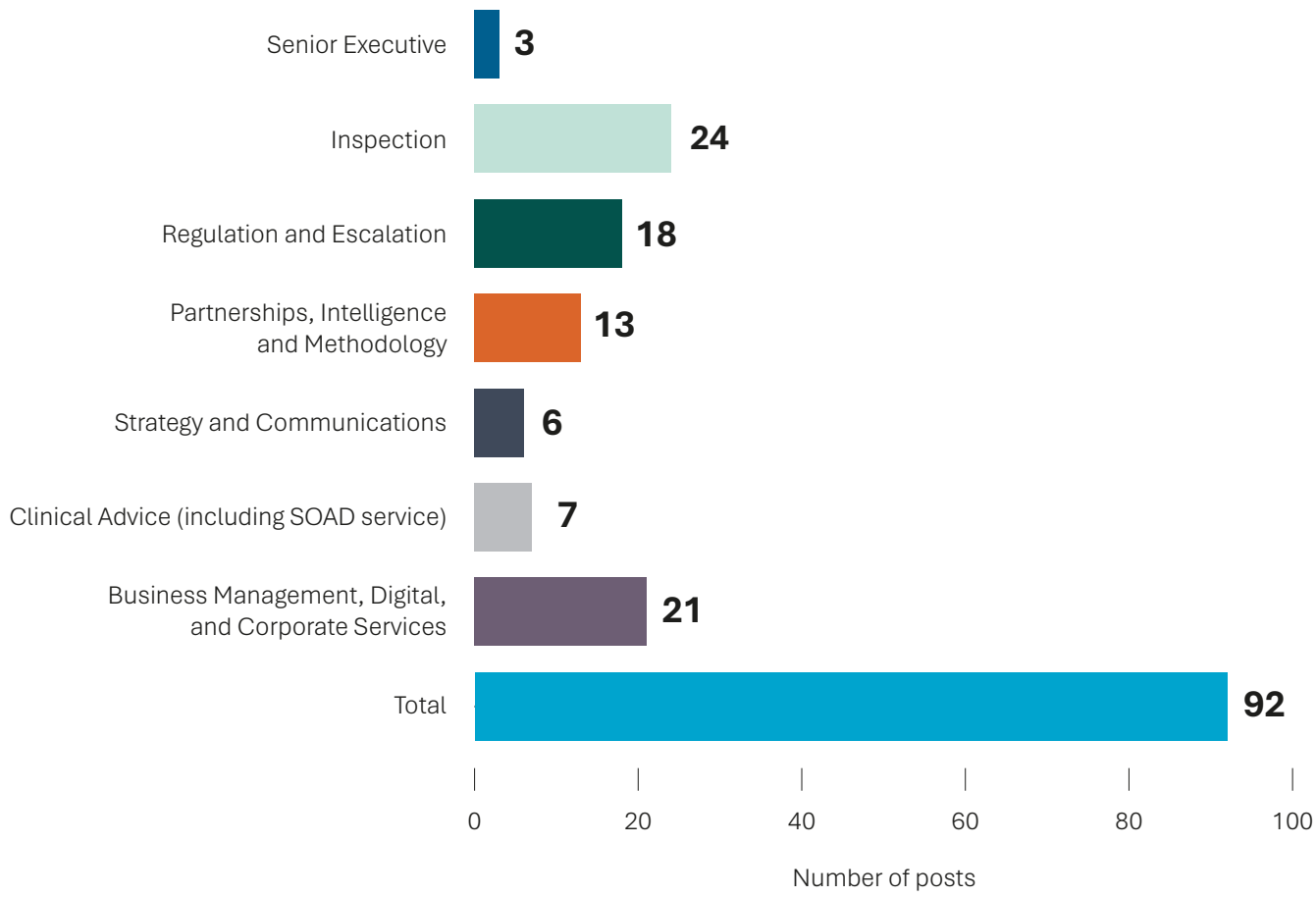
# Our resources

Our people remain our most important resource. In 2025-2026, we continued to invest in a comprehensive programme of learning and development opportunities, shaped directly by staff feedback. This was complemented by a series of Lessons Learnt exercises, enabling us to reflect on our work and continuously improve.

Our internal People Forum was reviewed and strengthened. It remains a valuable and credible source of feedback, providing senior HIW managers with insight on staff experience and supporting organisational development.

We are supported by a strong pool of specialist expertise. This includes over 150 Peer Reviewers with clinical backgrounds, alongside our Mental Health Act Administration specialists and a panel of psychiatrists delivering our Second Opinion Appointed Doctor (SOAD) service. In addition, our 44 Patient Experience Reviewers and Experts by Experience play a vital role in assessing care through direct engagement with patients.

Our Customer Relationship Management (CRM) system migrated to updated software in early 2026 and continues to generate valuable data, supporting the work of teams across HIW.



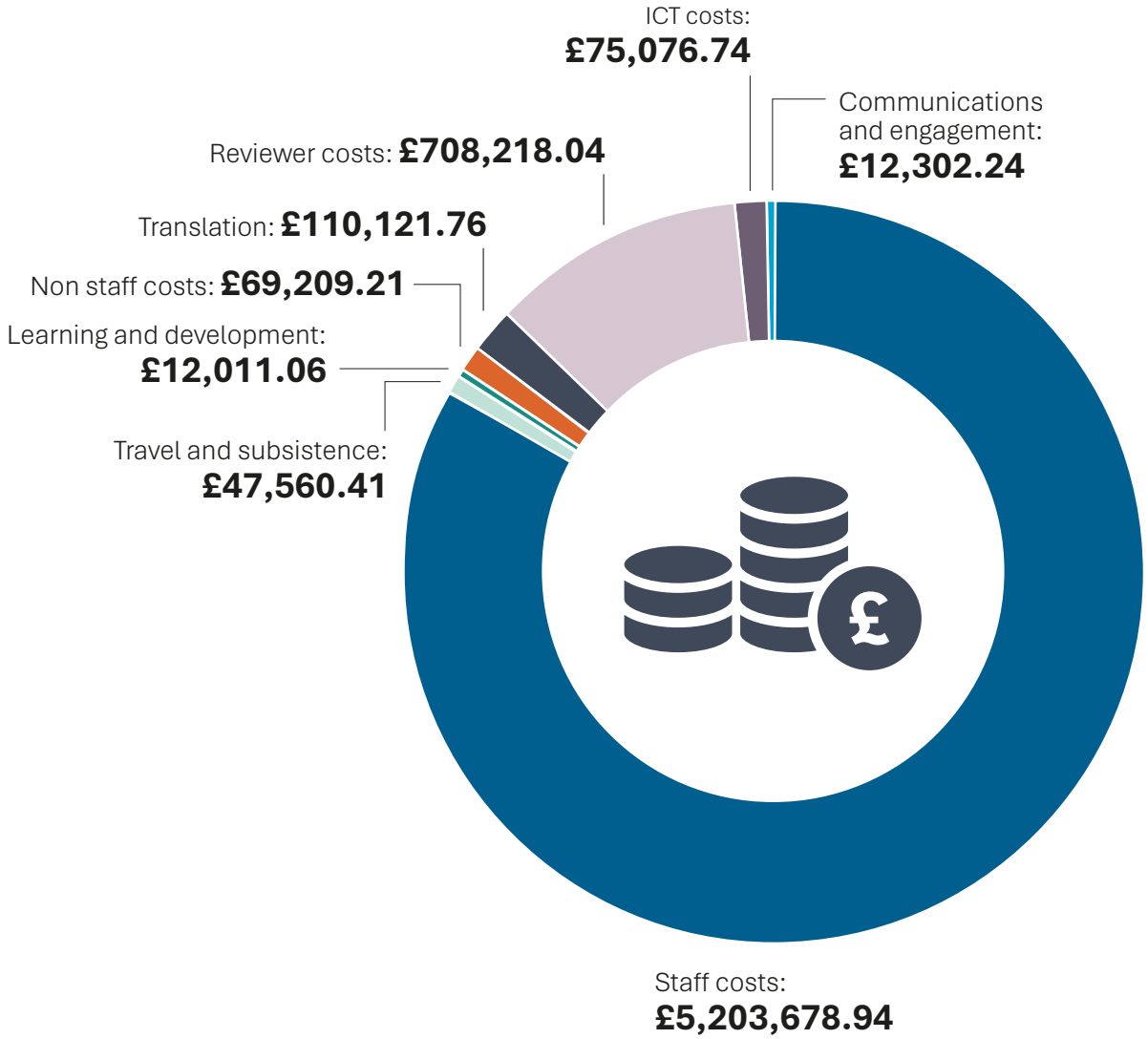
## Finance

For 2025-2026 we had a budget of approximately £6.2m, which includes fee income from our regulatory role in the independent sector. The table below shows how we used the financial resources available to us in the last financial year to deliver our work in 2025-2026.

**Total expenditure (a)**
**£6,238,178**

**Income from independent healthcare (b)**
**£580,350**

**Total net expenditure (a – b)**
**£5,657,827**



Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Contact us

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: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