Healthcare Inspectorate Wales Annual Report 2022-2023

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our goal is

To be a trusted voice which influences and drives improvement in healthcare

Our values

We place people at the heart of what 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

We have set four strategic objectives through which we deliver our goal of influencing and driving improvement in healthcare.

01

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services

02

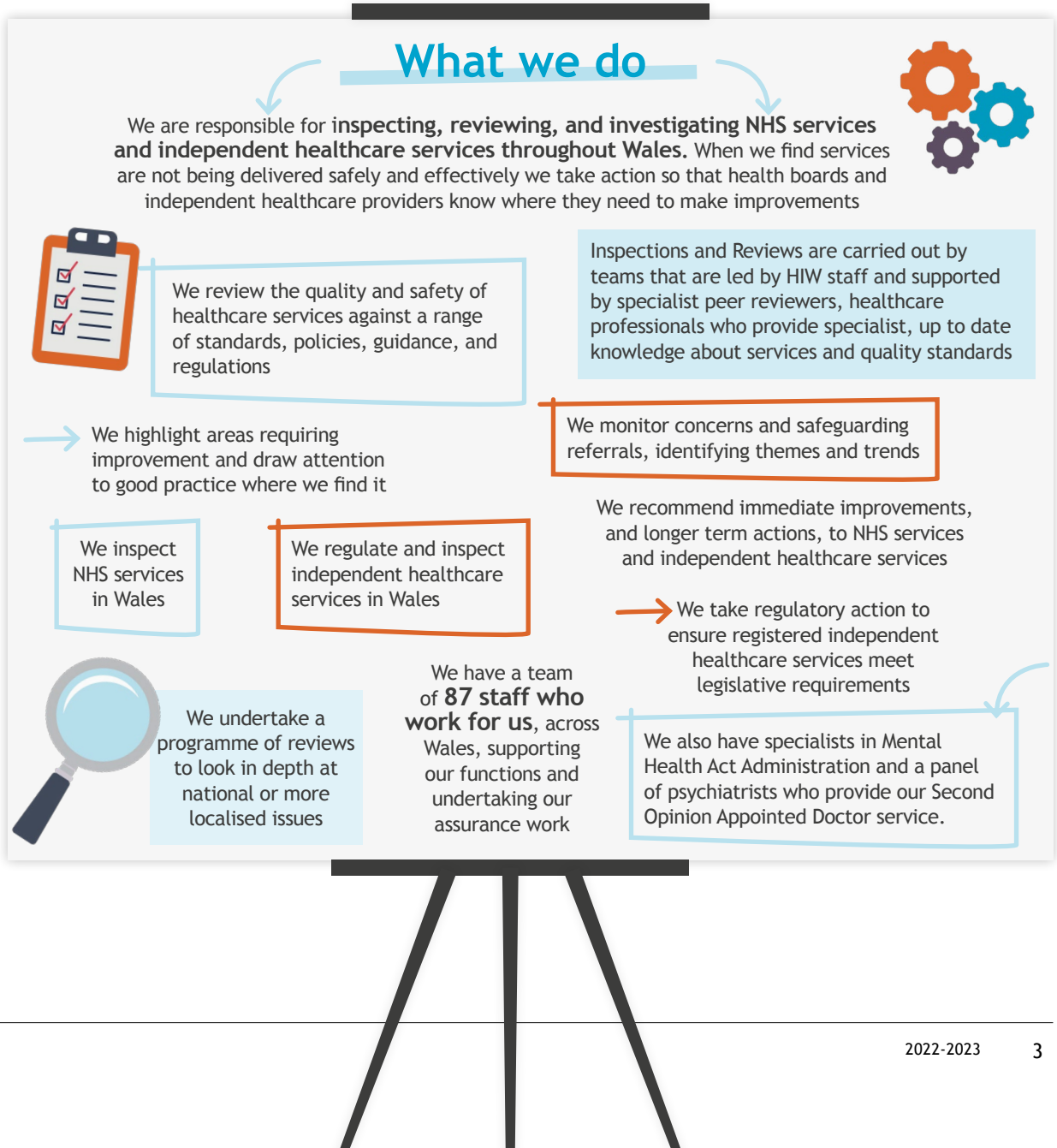
We will adapt our approach to ensure we are responsive to emerging risks to patient safety

03

We will work collaboratively to drive system and service improvement within healthcare

04

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities



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Foreword

Alun Jones
Chief Executive

Welcome to our Annual Report for 2022 – 2023. This Summer marked the 75th anniversary of the National Health Service (NHS), and most people living in Wales today will not have known a time without this institution.

A key milestone this year was the introduction of The Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Act aims to strengthen the overall focus on delivering quality services, and improving engagement with the population across Wales, both in terms of better understanding their needs and improving openness and honesty when things do not go right. The key focus of HIW's work, is to provide an independent view and assessment of the quality and safety of healthcare services. During 2022 – 2023, we have aligned our approach to seeking assurance in preparation for taking account of how well healthcare services are embedding their responsibilities against the duties of the Act.

This report sets out our key findings from the regulation, inspection, and review of healthcare services in Wales. It outlines how we carried out our functions across Wales, seeking assurance on the quality and safety of healthcare services through a range of activities including inspections and review work in the NHS, and regulatory assurance work in the independent healthcare sector. It provides a summary of what our work has found, the main challenges within healthcare across Wales and provides our view on areas of national concern.

In providing an independent view of healthcare services, we seek to contribute to an understanding of the risks and challenges that are preventing services from operating effectively and impacting on the quality of care being delivered to patients.

This has once again been a turbulent year for healthcare services in Wales. Whilst there are initiatives in place to help support healthcare services cope with unrelenting demand,

> **"Whilst patients may well have been satisfied with the staff providing their care, they were not satisfied with the long waits and difficulty in getting treated by services in a timely manner."**

our work during this year did not find evidence of these making a clear and significant difference to services at the front line. Increasingly, we have needed to make in year changes to our programme of work to enable us to undertake inspections in the areas of highest risk. Whilst patients may well have been satisfied with the staff providing their care, they were not satisfied with the long waits and difficulty in getting treated by services in a timely manner. Whilst staff continued to describe their passion for working with people and supporting people with care, they were not satisfied with the immensely pressured environments of work they find themselves in on a daily basis.

Our role covers the regulation and inspection of independent healthcare services in Wales. These services represent an area of growing importance, where innovations in science and technology mean the frequent development of new treatment options and services, many of which are offered by the independent healthcare sector. Many of the specialist mental health care beds in Wales are provided by independent healthcare providers. The sector cares for some of the most vulnerable patients in Wales, dealing with high levels of risk and complex needs. Our work over this time has sought to challenge the sector to ensure that the standards and quality provided are in line with their regulatory responsibilities and provide a quality service to the patients they care for.

Our work within NHS acute hospitals has shown the intense daily pressure in patient admission areas and on inpatient wards. Within Emergency Departments across Wales, we have noted overcrowding, long waits for triage and long waits for treatment, plus ongoing delays in being admitted into the most appropriate beds. Our work over this period has also shown that within General Practice and Dentistry, access to NHS services remains a matter of real concern to patients. When we refer to access, we are describing the ability to source appointments and/or to be registered as a patient with either a GP or Dentist. Once patients are in direct receipt of care and treatment from the NHS, either within Primary or Secondary care services, they consistently told us how well they felt they were being cared for and recognised the professionalism of staff. Through our work we have once again seen a highly skilled and committed workforce, delivering care with compassion and innovation. The workforce of the NHS remains its biggest asset and building on the many positives, with staff, will remain central to navigating the challenges that lie ahead.

We have found one clear issue throughout our work, which is, that at any junction in the care and treatment pathway of a patient, there is huge potential for delay, a pause in treatment, and an overall introduction of risk that is not there at other times. Our work within mental health, for example, has found that this is the case when patients with a diagnosis and care and treatment plan are moving from one part of the service to another.

We have also continued to find that inefficiencies in record keeping and in record keeping systems introduce unnecessary risk into the continuity and quality of patient care.

Three key themes to have arisen from our concerns monitoring service, which takes calls and information from members of the public, are the difficulty in accessing a regular dentist and getting any dental care; difficulty in getting an appointment with a GP; and difficulty in accessing mental health services. This feedback from members of the public is highly concerning and is an early warning of future public health challenges which must be heeded.

Our objectives are ambitious and through them we aim to make a difference to the people of Wales by contributing to improvements in healthcare. In this report you will find some examples of how we have used our work to further this aim. I am proud of the organisation I lead, and the contribution we can make to healthcare in Wales.

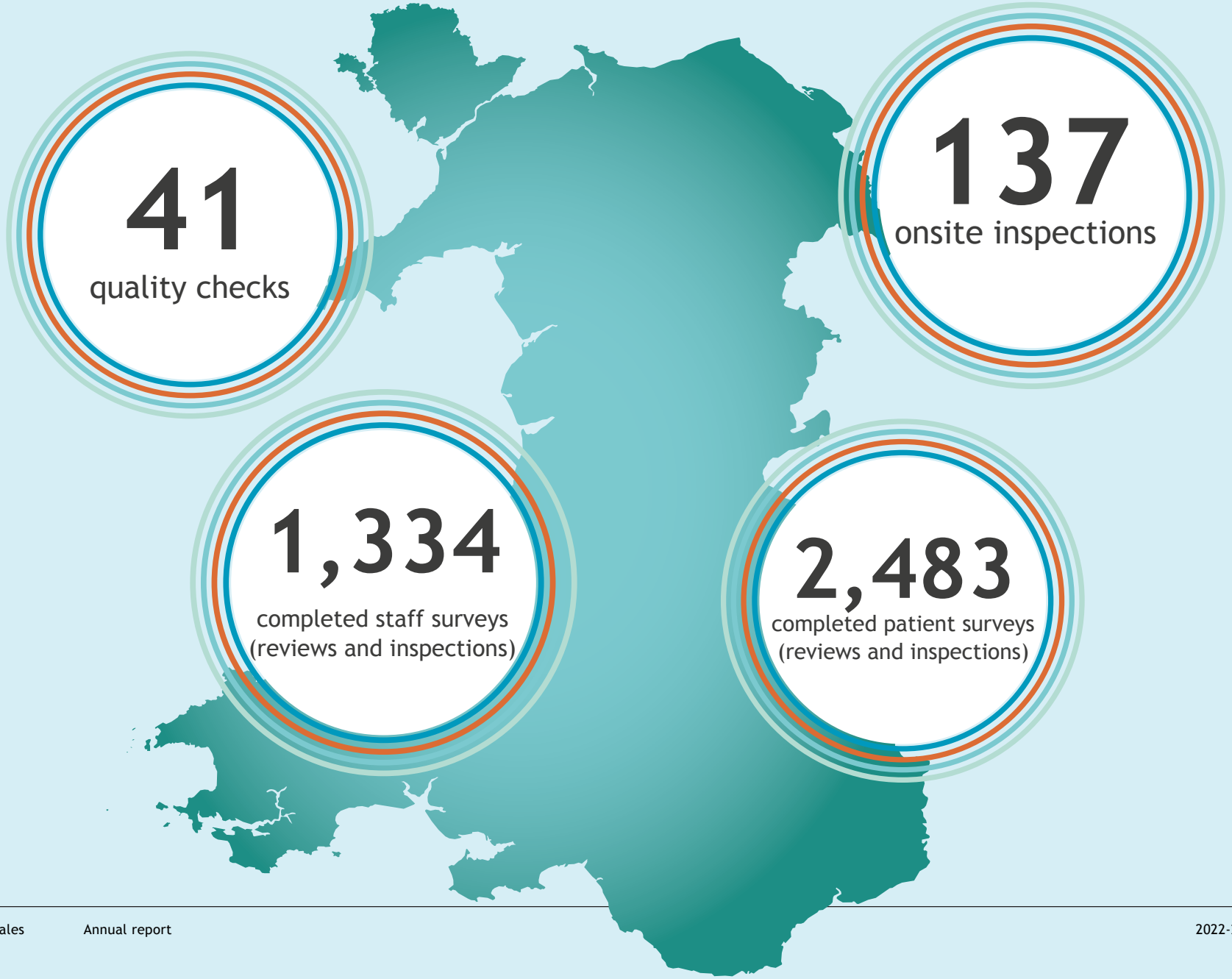
Now, more than ever, healthcare in Wales needs continued innovation, and a vision and understanding of what works and what does not. We have a clear role in illustrating, through our work, what good quality looks like within services and where we find issues with quality we will continue to shine a light on these, pushing services to put them right.

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

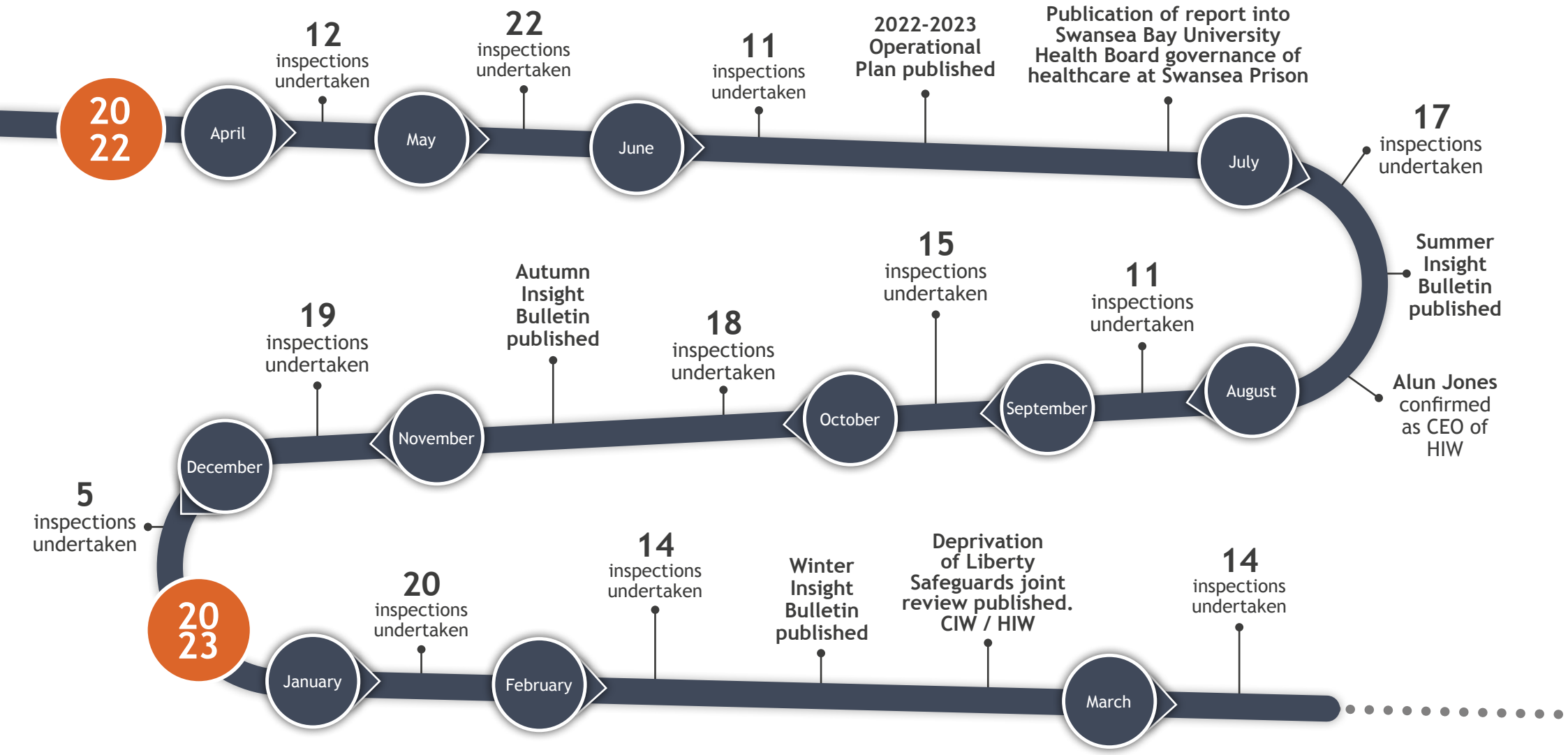
Alun Jones

Chief Executive
Healthcare Inspectorate Wales

HIW in Numbers


41
quality checks
137
onsite inspections
1,334
completed staff surveys
(reviews and inspections)
2,483
completed patient surveys
(reviews and inspections)

Timeline of our work



Engagement and Collaboration

Engagement

Speaking and listening to people who use healthcare services and who work within healthcare services is a key priority for us, and something that we are also committed to improving on. By listening to people who use and work in services, we can better understand what matters to people and can gain a greater understanding of the culture within a service and insight into the experience patients receive.

Across our inspection, quality check and review work, 4,677 people gave us their views on the care they had received, or the service they were working within.

Of the 4,677 separate responses, 4,107 related to our inspection activity and 570 related to our review work.

We heard from:

2,633 patients overall

1,826 staff overall

99 Carers / family members

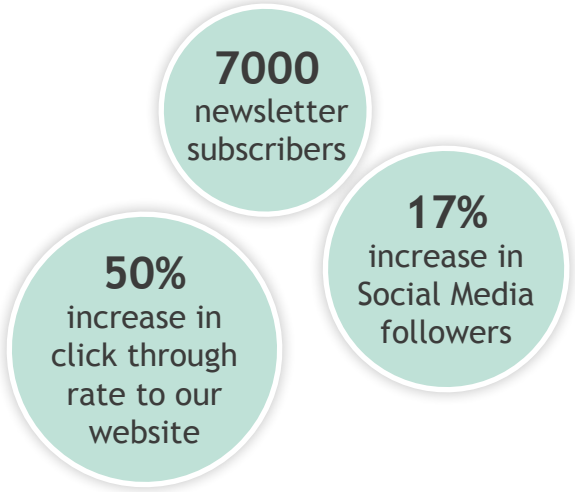
During our inspection and review work we ask patients to tell us about the care they receive by completing a short survey. When we are able to speak to patients in person during onsite visits, we gather views directly. We are also now using videos on our social media channels to help explain and promote our work.

In February 2022, we launched on LinkedIn and in our first year we have reached 7k users. This channel is providing a useful additional avenue for engagement with healthcare professionals. We have continued to use Twitter and Facebook to engage widely with social media users about our work, encouraging people to click through to our website where they can find out more about our work and role in Wales. We have seen a 50% increase in people clicking through to our website from our social media posts. We aim to post varied and interesting content across all three social media channels, posting 1.5k times during the year and seeing a 17% increase in our followers.

This is not our only means of engagement, in the spring of 2022, we launched our new Insight Bulletin. This is a quarterly update which we issue electronically to over 7000 subscribers on our mailing list. Within this we summarise our work from the quarter, and in summer 2022, added a new Learning and Insight section to the bulletin, providing us with a central area to share themes and learning emerging from our work.

We implemented a new approach to report writing in April 2022 which involves publishing a public summary and a full detailed report for the setting. We also updated our report writing style, removing duplication, and making the content easier to read.

In early 2022, we launched our HIW Stakeholder Advisory Group. Membership of the group is made up of a wide range of organisations who work with and represent people with protected characteristics. We are immensely proud of this group and it has continued to strengthen during the year. The group has influenced the way in which we ask patients for feedback during inspections and reviews and has challenged us to think more critically about the way in which our work is both designed and delivered so that we are able to capture as diverse a range of views as possible. The group is one of the ways in which we are working towards our strategic priority of better understanding the quality of healthcare being delivered to people and communities as they access, use and move between healthcare services.



Collaboration

We place considerable importance on collaboration and joint working with other organisations. The added insight and expertise we can draw on when we collaborate with others increases the impact of our work. The provision of healthcare is complex and sharing intelligence with partners enables us to gain insight and experiences that, with our organisational resources alone, we would not be able to achieve.

During 2022-2023, we hosted two Healthcare Summits, attended by regulatory and improvement bodies for healthcare across Wales. Healthcare Summit meetings take place bi-annually to enable discussion between audit, inspection, regulation, and improvement bodies.

They provide an interactive forum for sharing intelligence on the quality and safety of healthcare services provided by NHS Wales. The meetings enable us to foster close working relationships, and share intelligence between participating organisations as we all play our respective roles in driving healthcare improvement in Wales.

During the year we continued to work closely with our partner, Care Inspectorate Wales (CIW). In February 2023 we jointly published our report into the use of Deprivation of Liberty Safeguards (DoLS) in Wales. The Safeguards apply to people over the age of 18 in hospitals or care homes, who cannot consent to treatment or care.

Since 2019, we have been part of Joint Inspections of Child Protection Arrangements (JICPA), working alongside Care Inspectorate Wales (CIW) plus Estyn; Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation) to carry out this work.

In 2022-2023, we continued this work and published our findings of a review of the multi-agency arrangements in Denbighshire for responding to cases of abuse and neglect.

The report outlines our findings about the effectiveness of partnership working and the work of individual agencies in Denbighshire.

In common with many areas across Wales, we found the challenges in recruitment and retention of staff across key agencies in Denbighshire was impacting on the arrangements for safeguarding children. This is made more difficult by the high levels of demand and increasing complexity of children's needs.

We found there are systems and relationships in place to facilitate effective partnership working where a child is at risk of harm. Partners are working to a shared ethos of safeguarding children at different levels of vulnerability. Organisational leaders have a shared vision with a positive approach to regional safeguarding arrangements.

This clear strategic commitment has resulted in the commissioning of a sufficient range of effective local services to support children and families.

Assurance and Inspection Findings NHS Services

Acute Hospital Inspections

In 2022 – 2023, we carried out 19 acute hospital inspections across Wales.

We visited all Health Boards and Trusts where inpatient care is provided.

Our work showed that in general, the demand for inpatient beds and having enough staff to manage the high number of patients was a significant challenge.

The numbers show that we did more of our work in unscheduled care areas compared to scheduled care. The reason we did this was because of the complexity and overall higher risk level in these areas. Across these pieces of work, we needed to use our Immediate Assurance process in 58% of the inspections (11 out of 19). This is a highly concerning figure and demonstrates that at present, acute inpatient healthcare carries the highest level of risk in services across Wales. This figure is currently higher than we found in our inspections of mental health services, an area of healthcare which historically tends to see very high levels of patient risk. This latest finding indicates that mental health services are tackling the risks they face more successfully and strongly suggests that within inpatient acute care, more needs to be done to tackle risk, and quickly.

In the previous year, we introduced our Service of Concern process for the NHS. In 2022 – 2023, we considered 13 NHS services through this process which involves increased scrutiny of the issues identified through inspection and intelligence. In May 2022, we designated the Emergency Department at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board as being a Service Requiring Significant Improvement (SRSI) which is a service with the most significant levels of risk.

Our findings on a national level, from our assurance and inspection activity were:

Huge demand for services continues

Compliance with mandatory training remains mixed and in general, across Wales, there are challenges in ensuring the workforce keep this up to date

The quality of the discharge planning process needs to be improved

Reducing risks within the inpatient environment is something that needs to be improved on. For example, we continue to find medicines unsecured, harmful substances not locked away and equipment not maintained as regularly as needed.

In 2021-2022, our work found evidence of significant pressures in the emergency care system. In 2022-2023, our overall summary is the same and if anything, pressures have increased. These pressures mean that we have seen overcrowded emergency departments, delays in ambulance handover of patients, long waits for triage and long waits for treatment to start. This of course, is not the finding in all instances, but the cases where we saw delay represent the majority rather than the minority. The challenge for staff working at the front line within these emergency and urgent care areas is enormous and the impact on them is equally huge.

The challenge within planned care areas differs in that there are huge challenges in getting patients discharged to more appropriate placements, or back home with support. There are often delays in this due to shortages in social care staff and social workers to assess discharge needs. Patients frequently stay in hospital beds for a long time after they are medically fit to leave because of the unavailability of support services.

When patients are able to be seen and treated by emergency and urgent care services, then admitted and cared for as inpatients, and discharged as soon as they are medically fit, the outcomes for them are far more positive then when they are delayed at each stage of their journey. The delays being experienced lead to adverse patient outcomes in the form of deconditioning, higher risk of hospital acquired infections, loss of social networks and, the initial assessment of support needs on discharge no longer being accurate and needing to be repeated due to a change in condition.

This year, once again, we found that in planned care areas, such as oncology and cardiac wards, where the staff have more control over admission and can provide more patient centred care, there were fewer areas requiring improvement.

Although responses we received to our staff questionnaires indicated low staff morale, particularly related to challenges around staffing numbers and high demand for services, this did not generally seem to impact on the experience patients had of staff. Patients told us staff were kind and compassionate.

Our inspections continued to note low levels of compliance with mandatory training for staff. Mandatory training plays a key role in ensuring staff can provide safe and effective care to patients.

The case studies demonstrate two of our pieces of work from 2022-2023 relating to acute hospitals in the NHS. This work, challenged services and health boards to look for different ways of doing things when outcomes for patients could be improved.

CASE STUDY

National Review of Patient Flow a journey through the stroke pathway

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. Our national review of Patient Flow continued during 2022 - 2023 to explore this.

At a time when the NHS in Wales has continued to deal with significant pressure, staff shortages and huge demand for beds, the review explored the challenge of trying to provide timely care to confirmed stroke patients when resources are under such demand.

In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. National reviews are deep dive pieces of work which enable us to explore a service, care pathway, or department in depth.

During the period from April 2022 to the end of March 2023, we gathered evidence about the care and treatment provided to patients on the stroke pathway across Wales, undertaking nine site visits in total. The site visits involved our review team consulting with health boards in Wales including the Welsh Ambulance Service Trust (WAST), reviewing the processes in place from calling an ambulance to arrival at an emergency department, to admission when patients were receiving inpatient care and through to discharge.

The review found a high demand for inpatient beds and complexities involved in discharging medically fit patients from hospitals which led to the acute hospital system in Wales operating under extreme pressure. Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections or deterioration whilst awaiting discharge. The bottleneck at the point of discharge has a knock-on impact on emergency departments, ambulance response times, inpatient care, planned admissions and overall staff wellbeing.

CASE STUDY

Inspection of Maternity Services, Glangwili Hospital, Hywel Dda University Health Board

HIW completed an unannounced, onsite inspection of the maternity unit across three consecutive days in November 2022, this included the antenatal and postnatal wards, the midwifery led unit, the labour ward and the triage assessment area. Inspectors found the maternity care provided had improved since HIW's previous inspection in 2019, but there were still some areas which required attention.

We found staff were committed to providing a high standard of care to patients. There were many examples where the inspection team witnessed staff being compassionate, kind and friendly to patients and their families. Most patients we spoke to told us they were happy and receiving good care at the hospital. Inspectors also noted that there were good arrangements in place to provide patients and families with bereavement support. We considered the quality of management and leadership, and the culture of the workforce, to be very good.

Staff were encouraged and supported to become involved in quality improvement projects to enhance the care provided, and to aid their ongoing development. Staff were positive about the support and leadership they received and described a positive culture around reporting and learning from incidents. Inspectors noted that the leadership team were visible, supportive, and very engaged with the staff. There was dedicated and passionate leadership displayed by the Head of Midwifery, who was described as energetic, approachable, supportive and visible. There was also a focus on staff wellbeing, including good welfare support and team building activities. Improvement had also been made to collaborate with other health boards effectively.

Some women on the post-natal ward indicated that when they required pain relief, it was not always given in a timely manner, or they were not given an explanation as to why they could not receive the medication. The health board must ensure that there is efficient, safe, and timely administration of pain relief for patients.

Inspectors evidenced improvements had been made regarding security measures to ensure babies were safe and fully protected within the hospital. However, on the first night of the inspection, inspectors noted that the cupboards containing patient records were unlocked and the doors were open. Inspectors immediately raised this with senior management and the cupboard doors were subsequently locked. Management must ensure staff are locking medication fridges and cupboards containing patient records when not in use. We also found that not all staff were compliant with mandatory training and that management needed to ensure rotas are reviewed to ensure there is sufficient resourcing.

Some staff we spoke with raised a concern in relation to the variance of responsiveness of consultants to an emergency when requested by junior doctors and midwives. This was also echoed by comments made in the staff survey we undertook.

We found that there had been significant improvements made since our previous inspection in 2019. There were well-defined systems and processes in place to ensure that the hospital focussed on continuously improving its services. This was achieved through a rolling programme of audit and an established governance structure, which enabled key/ nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

Ongoing improvements need to focus on staff compliance with the clinical room processes, such as medication fridges being consistently locked when not in use and cupboards containing patient records being always locked.

General Practice

During 2022-2023 we carried out 20 pieces of assurance work to GP practices across Wales. nine of these used our remote Quality Check methodology and 11 were onsite inspections. We needed to use our immediate assurance process in 30% of these inspections (6 out of 20 pieces of work).

This inspection year marked our first using our newly refreshed General Medical Practice (GP) methodology. The updated methodology considers the wider primary care landscape including referrals and signposting to other services.

GP practices are under significant pressure and are facing unprecedented demand. Long wait times at Emergency Departments and on long waiting lists for treatment are increasing the pressure on GP services. We used our immediate assurance process, reflecting high risk to patients, on more occasions during 2022 – 2023 compared to the previous year.

We found a range of issues such as:

- Incomplete safeguarding records and poor follow up of concerns
- Checks of emergency equipment and drugs not completed
- No DBS checks on staff including administrative and reception staff
- Medicines not safely stored
- Medication fridge temperature checks not completed
- Poor compliance with mandatory training including safeguarding, CPR and infection prevention and control
- Out of date equipment including sterile sutures, sterile gloves, urine sample collection packs, minor surgical operations packs and needles, some of which were dated 2006.

20 pieces of assurance work

11 Onsite Inspections

9 Quality Checks

Our patient experience surveys regularly conclude that staff treat patients with dignity and respect, but around a quarter of patients tell us they struggle to access an urgent appointment.

Difficulty in accessing GP appointments was one of three clear themes to come out of our HIW Concerns service during 2022-2023.

The effects of delayed appointments on patients encompass physical health, emotional well-being, and overall healthcare experiences.

Delayed access to medical care can lead to worsened health conditions. Conditions that could have been treated effectively with timely intervention might deteriorate, resulting in prolonged suffering, increased complications, and potential long-term consequences. Chronic conditions may worsen, requiring more complex interventions and leading to avoidable hospitalisations.

Patients who struggle to obtain appointments often experience heightened anxiety and stress. The uncertainty of not knowing when they can see a doctor can exacerbate existing mental health conditions or trigger new ones. This emotional toll can further impact their ability to cope with health issues and make informed decisions about their care.

Frustrated by the inability to secure timely appointments, some patients may resort to using emergency services for non-urgent issues. This strains emergency departments and diverts resources away from patients with genuine emergencies.

It is crucial that leaders within this area consider the repeated concern from patients who are unable to access the service and consider what else can be done to alleviate the pressure on GP services.

Mental Health

We look at how NHS mental health and independent mental health care services meet and comply with a range of professional standards and guidance, including the Mental Health Act 1983 and the Independent Healthcare (Wales) Regulations 2011.

During 2022 – 2023 we undertook 20 pieces of work to mental health care services across Wales. Out of these, 16 were onsite inspections to inpatient units, 3 inspections of Community Mental Health Teams (CMHT's) and one larger piece of review work to Cwm Taf Morgannwg Mental Health service. Across these 20 pieces of work, we used our immediate assurance process on seven occasions, this represents 35% of the work where issues found at inspection and review carried the most immediate risk to patients.

A positive area across the majority of our inspections was the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving.

Patients who are in an acute and/or challenging phase of their illness may require a degree of effective observation to ensure that their safety and the safety of others is protected. Staff must deliver a holistic plan of care in the least

restrictive way, balancing this with a risk-based approach. In four of our visits to hospitals, within health boards, we identified a lack of managing aggression/physical intervention training for staff, including bank staff. This is a significant issue because well trained staff decrease the incidents of patients and staff being injured during a restraint.

We found that patient records did not always evidence episodes of patient restraint accurately, and observational charts were not always being kept up to date.

There was also lack of staff training and guidance in this area, and during one inspection, a complete lack of any patient engagement for extended periods of time.

We found little improvement to the following areas, despite raising these in 2021-2022:

- workforce challenges – issues with recruitment and retention of staff
- medicines management – a range of issues with the storage, administration and audit
- patient observations – lack of effective recording, training of staff and the timely review of policies/procedures
- patient information – lack of information available for patients on key topics
- risk assessments and care planning documentation – including risk assessments not completed and lack of a timely review
- environment of care – a lack of audits and the management of environmental ligature risks
- governance - a lack of audit and oversight of key areas including training.

Difficulty accessing mental health services was a key theme to emerge from our HIW Concerns team which hears directly from members of the public. We repeatedly heard of the difficulty in getting support from mental health services and of the poor outcomes for patients who have not received the level of support that was needed.

The inability to access mental health services can lead to the deterioration of mental health conditions. Individuals grappling with anxiety, depression, bipolar disorder, or other mental health issues may experience worsening symptoms in the absence of proper care and support. This deterioration can impact all aspects of life, from work and relationships to physical health.

Without timely intervention, individuals facing mental health challenges are at a higher risk of experiencing crisis. Delayed access to mental health services can extend recovery times for individuals dealing with mental health disorders. Early intervention is often crucial in managing and alleviating symptoms. Protracted delays in receiving treatment may prolong suffering and hinder the individual's ability to regain stability and functioning. Mental health challenges affect not only the individual but also their families and communities.

CASE STUDY

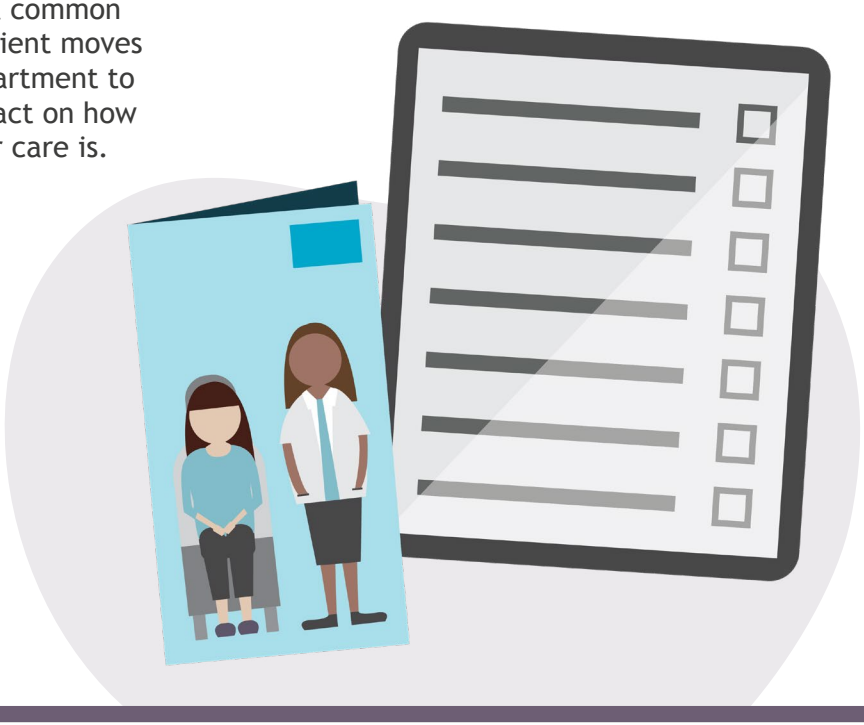
Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

We reviewed the discharge arrangements for adult inpatients on mental health wards in Cwm Taf Morgannwg University Health Board (CTMUHB) from adult (18-65) inpatient mental health units. The decision to undertake the review was made as a result of intelligence indicating significant concerns about the health board's mental health services. This included serious incidents, issues identified through previous HIW inspections, and concerns reported to HIW by patients, the public and staff whistle-blowers.

The review focussed on the quality and safety of discharge arrangements for adults discharged from inpatient mental health units into the community. The review considered the relevant policies and procedures in place, an evaluation of patient records, and information gained through interviews with a range of staff who worked within the health board's mental health services.

As a result of the review, HIW made 40 recommendations for improvement. Some patient safety concerns were of such significance, the health board was issued with an immediate assurance letter, following which, it was required to submit an immediate improvement plan to HIW.

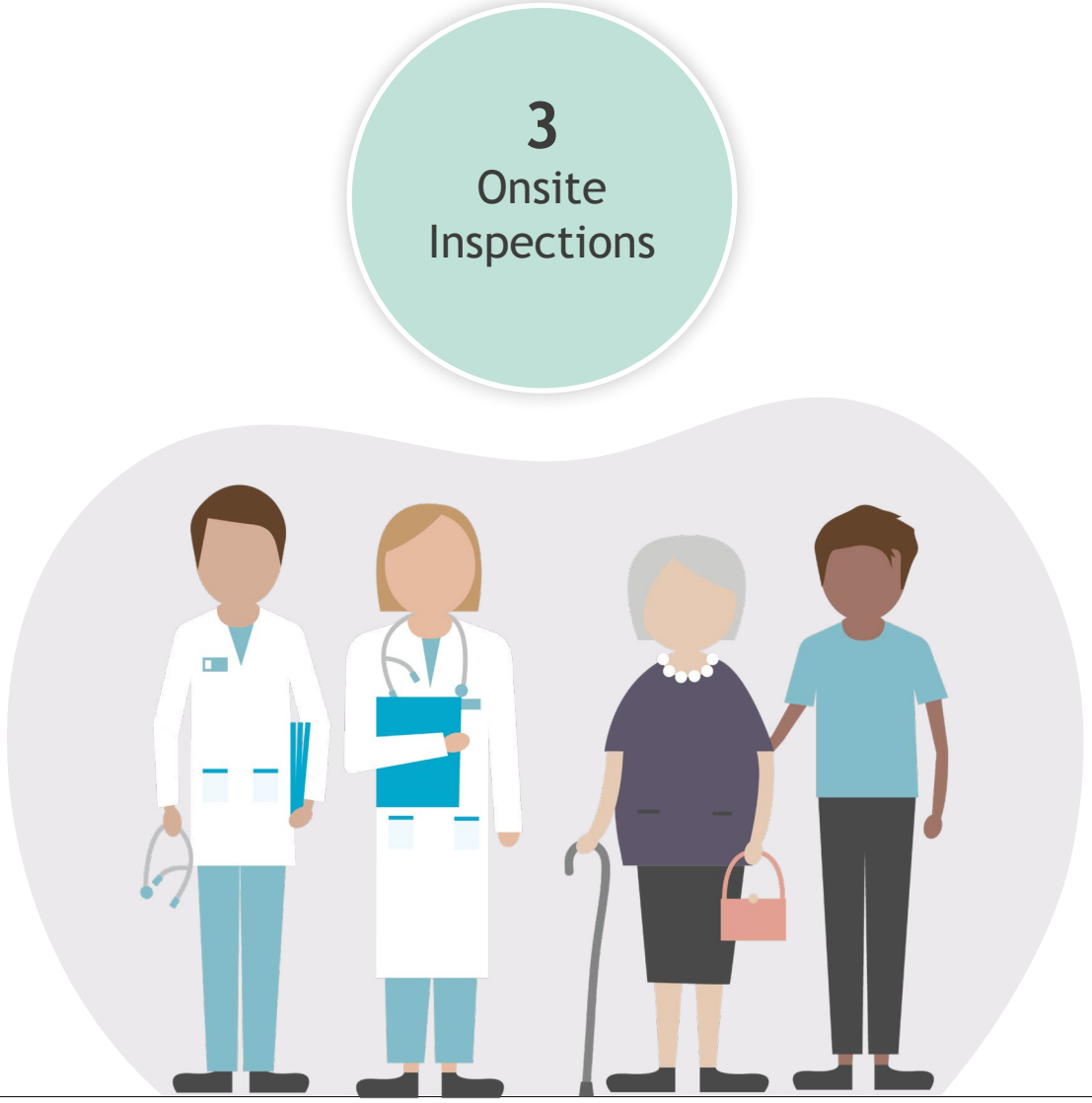
We found evidence of highly complex systems which made the delivery of timely and effective patient care more challenging. As with our National Review of Patient Flow, a common thread was that at the point a patient moves from the care of one team or department to another, there is a significant impact on how timely and well co-ordinated their care is.



Learning Disability Services

HIW undertook three inspections of facilities providing learning disability services. Within these inspections, we noted a range of positive findings including, staff interacting and engaging with patients appropriately and patients being treated with respect and dignity. In addition, there was a range of suitable community-based activities available for the patient group. However, we did find that staffing numbers were not always at a level which met patient needs.

Although this was a small number of inspection visits, we did find issues of concern in one of the three services inspected. There were risks to patient safety within this unit due to ligature risks not being managed appropriately.



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

Medical ionising radiation is used in many healthcare settings, including dental practices and widely within hospital care. It is used to diagnose injuries and illnesses as well as being a form of treatment, for example x-rays and radiotherapy treatment.

It is a highly technical area of healthcare, that used carefully and in accordance with the regulations has huge benefits but there is potential for harm if it is not used safely.

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation and they set out the responsibilities of those undertaking the procedures which use ionising radiation. Within the regulations, these individuals are called duty holders and will comprise of the employer, referrer, IR(ME)R practitioner and operator. Their responsibilities are to meet safety standards and ensure radiation protection, for example, minimising unintended, excessive, or incorrect medical exposures.

During 2022-2023 HIW completed eight IR(ME)R inspections, covering the three modalities of medical exposures. These inspections also covered both NHS and independent hospitals.

HIW was assisted in these inspections by a member of the Medical Exposures Group (MEG), which is part of the UK Health Security Agency (UKHSA), acting in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys.

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. Radiology areas were good at letting patients know of waiting times and any delays in being seen, patients told us they appreciated this. During our IR(ME)R assurance activity we continued to meet experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R. There was a need to improve the written procedures governing the use of ionising radiation and required against the regulations in this area.

We heard from some staff who felt there were insufficient numbers of them to do their job well and to achieve a good work-life balance. We also heard that they did not always feel listened to by management when they raised this. Although more generally, staff told us they felt very well supported in their work by senior management and the wider organisation.

Dental Practices

During 2022-2023, we undertook 74 pieces of assurance work to dental practices across Wales. Out of these, 44 pieces of work were conducted onsite at the practices, where a HIW team including a qualified dentist working as HIW dental peer reviewer, spent time examining the practices, policies and procedures which governed the way each practice was run. We also conducted 30 quality checks which are our remote method of seeking assurance, first developed at the height of the COVID-19 pandemic. The composition of work represented a huge shift back to our teams carrying out onsite inspection work. The 44 onsite pieces of work in 2022-2023 compares to just 9 undertaken onsite in 2021-2022.

Difficulty in accessing dental appointments and securing a regular dentist was one of three key themes to emerge from our HIW Concerns service this year. Securing timely access to dental care is a critical component of overall health and well-being, yet the difficulty in obtaining dental appointments has become a pressing concern with far-reaching consequences. Factors such as limited availability of dental providers, high demand for services, and changes to dental contracts have all impacted patients' ability to access timely dental care and treatment.

Evidence clearly identifies that delayed or infrequent dental appointments can lead to the progression of oral health issues. What might initially be a minor dental concern could develop into a more complex problem, requiring more invasive and costly treatments. Oral health is closely interconnected with overall health. Dental issues such as gum disease have been linked to systemic conditions like heart disease, diabetes, and respiratory problems.

Delayed access to dental care can result in prolonged discomfort and pain for patients. Toothaches, gum sensitivity, and other oral pain can significantly impact daily life, affecting eating, speaking, and even sleeping. The physical discomfort can also contribute to emotional stress and reduced quality of life.

Frustration over delayed dental appointments can lead some patients to seek relief through emergency dental services or hospital emergency departments. This not only strains healthcare resources but often also results in only temporary measures rather than comprehensive treatment.

Regular dental appointments provide opportunities for oral health education and preventive guidance. When patients are unable to access these appointments, they miss out on valuable information about maintaining proper oral hygiene, which can further contribute to deteriorating oral health.

Across all 74 pieces of work, we used our Immediate Assurance process on 6 occasions. This means that in 8% of our work to dental practices in 2022-2023, we came across concerns which had the highest level of risk to patient safety and therefore needed action to be taken and assurance of this action provided to HIW within 48 hours.

We also made a substantial number of recommendations for improvement. The key themes emerging from our dental inspections are described below:

We identified a number of key themes through our dental inspection and assurance activity:

Environmental:

- A poor standard of cleanliness in decontamination areas. In some practices HIW Inspectors uncovered ineffective decontamination processes, including inadequate cleaning of instruments and ineffective use of 'dirty/clean' pathways.
- We reported inappropriate storage of items in clinic and decontamination rooms such as food and cleaning materials, including high numbers of clinical fridges containing non-clinical items such as food and out of date medication. Practices should ensure there are procedures in place to reduce the risk of contamination and to support good standards of infection prevention and control.
- There were numerous examples of practices not undertaking audits of their work. Audits offer an opportunity to review the consistency and quality of care and treatment that is provided to patients, and they are a quality improvement tool, which can provide many benefits and support better practice.
- A number of practices did not have a system in place which ensured all risk assessments were being kept up to date. We noted that some fire risk assessments were out of date and fire drills were not being carried out and evidenced. Risk assessments are an important management tool, which help to keep patients and staff safe and should be reviewed and updated regularly to reduce risks.
- During some inspections, we highlighted the poor maintenance of first-aid kits, emergency drugs and resuscitation equipment – some included out of date items posing a significant risk to patients.

Staffing:

- The majority of dental practices needed to improve their documentation when recording staff training and evidencing that all staff had completed mandatory training sessions.
- Annual appraisals, clinical supervision and staff meetings were often overlooked. We recognise these aspects have been challenging to maintain at times during the COVID-19 pandemic, but practices must continue to prioritise this to support their staff.

General:

- Through our assurance work, inspectors did note practices had out of date or incorrect information on informative literature including patient care leaflets. Practices should conduct regular audits of materials to ensure the information available to patients and staff is relevant and accurate.

Assurance and Inspection Findings Independent Healthcare

HIW's role in the independent healthcare sector in Wales is to register and regulate independent healthcare services. The independent healthcare sector encompasses a huge variety of services, from acute hospitals, mental health hospitals, to independent clinics and laser services. Many dental practices in Wales are also independent healthcare services, providing private dental healthcare, or a mix of NHS and private dentistry.

Independent healthcare services must register with HIW, and once they are successfully registered, they will be subject to ongoing regulation which is done through inspections and checks that providers are meeting the requirements of their registration, complying with the relevant regulations and providing a safe service.

During 2022 – 2023, HIW registered 53 independent healthcare providers. This number included new dental practices and new laser clinics. In total, we had 21 additional services registered with us by the end of the year.

Once registered, any changes a service intends to make to their conditions of registration, requires an application to vary what they are registered to provide. An application to vary a registration will not automatically be approved. Each application involves scrutiny by HIW as to the appropriateness of the proposed changes. During 2022-2023, HIW processed and approved a total of 24 registration variations.

In addition to this, all independent healthcare services have a manager who goes through a registration process to enable them to run a service. In 2022-2023, HIW processed and approved 88 new managers of independent healthcare services.

Registration activity:

53 new providers registered

24 variations of registration approved

88 new registered managers approved

During the 2022-2023 period, we responded to intelligence which suggested there were 24 unregistered providers, across a range of different service types, operating services they were not registered to provide. We followed up each of these cases, requiring the provision of services was stopped until a registration with HIW had been successfully processed.

Where inspections or intelligence indicate serious concerns in registered services, we monitor them through our Service of Concern process. We monitored 26 independent healthcare services through this process during 2022-2023. Whilst not all of these were designated as a Service of Concern, they were all subject to increased scrutiny which triggered follow up assurance and inspection work as required.

In order to check that registered services are continuing to meet the requirements of their registration, and providing a safe, quality service to patients, HIW undertakes a programme of inspection work each year.

In 2022 – 2023, we undertook a total of 31 individual pieces of assurance work to independent healthcare settings. This figure can be broken down further into:

Eight inspections to independent mental health services and 74 dental practice inspections were completed. These are discussed elsewhere in the report.

Our Immediate Assurance process was used in two of seven inspections to independent clinics, a rate of 29%. Improvements required included carrying out a health and safety risk assessment; ensuring evidence of cleaning schedules is recorded, and improving infection, prevention and control arrangements. Recommendations were also made at some independent clinics to improve the feedback process with patients, ensuring that feedback is actively sought and reviewed, and ensuring that complaints procedures are up to date and readily available in the event patients need to use them.

We carried out one inspection to a non-acute independent hospital. This was to PCP Cardiff, a drug and alcohol detoxification and rehabilitation service providing residential treatment on a private basis. Patients receiving treatment there were very complimentary of the staff and the care they were receiving. We found that the service was not adequately managing the risk of ligature and needed to improve medicines management procedures. We issued a non-compliance notice, requiring remedial action within 48 hours of our inspection in order to rectify this. The service was receptive to our findings and complied with the urgent improvements required.

Hospices

Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured.

During 2022 – 2023, we completed:

3

Onsite inspections to hospices in Wales comprising both adult only hospices and one hospice providing care to children. All three are provided by the independent healthcare sector.

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Without exception, we found evidence of positive interactions between staff, patients and their families and carers. The care provided was tailored and clearly person centred. Care plans were updated regularly and evidenced changes in condition and any treatment changes. Families and carers who provided us with feedback were very positive about the experience of care being provided, and the support they were being given.

We did find across all three inspections, that the equipment and medication kits for dealing with medical emergencies needed to be better maintained and kept updated. These kits are used in for example, an adverse reaction to medication. All three services were highly receptive to our findings and have addressed this.

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

During the year 2022-2023, we conducted 19 onsite inspections to laser and IPL registered providers across Wales.

From these 19 inspections we identified non-compliance with relevant regulations in six cases. This means that in 32% of these inspections, we found laser and IPL providers were not meeting all the requirements they need to comply with in order to meet the requirements of their registration. The issues we found required us to use our Immediate Assurance process and request urgent action.

These included, using machines which they were not registered to use, treating patients outside of the age range they were licensed to treat and having no first aider.

The regulations under which laser and IPL providers are required to operated are specific and require them to comply with a number of areas in order to demonstrate their fitness to provide these services. We found a number of areas where we were repeatedly making recommendations for improvement through these inspections. In general, these related to the governance arrangements for these services. Good governance helps to ensure services are safe for the public to receive. Laser and IPL providers should therefore ensure they are familiar with their responsibilities against the regulations. The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

In a number of cases we found that the correct documentation, such as written policies and procedures were not available, or were not kept up to date. Staff training records and recruitment records also needed improving in some cases. The provision of a first aider, appropriately trained first aiders and an up to date first aid kit were also recommendations made in a number of these inspections.

19
onsite
inspections

Findings from Concerns, Investigations and Notifications

Three key themes have come through our concerns:

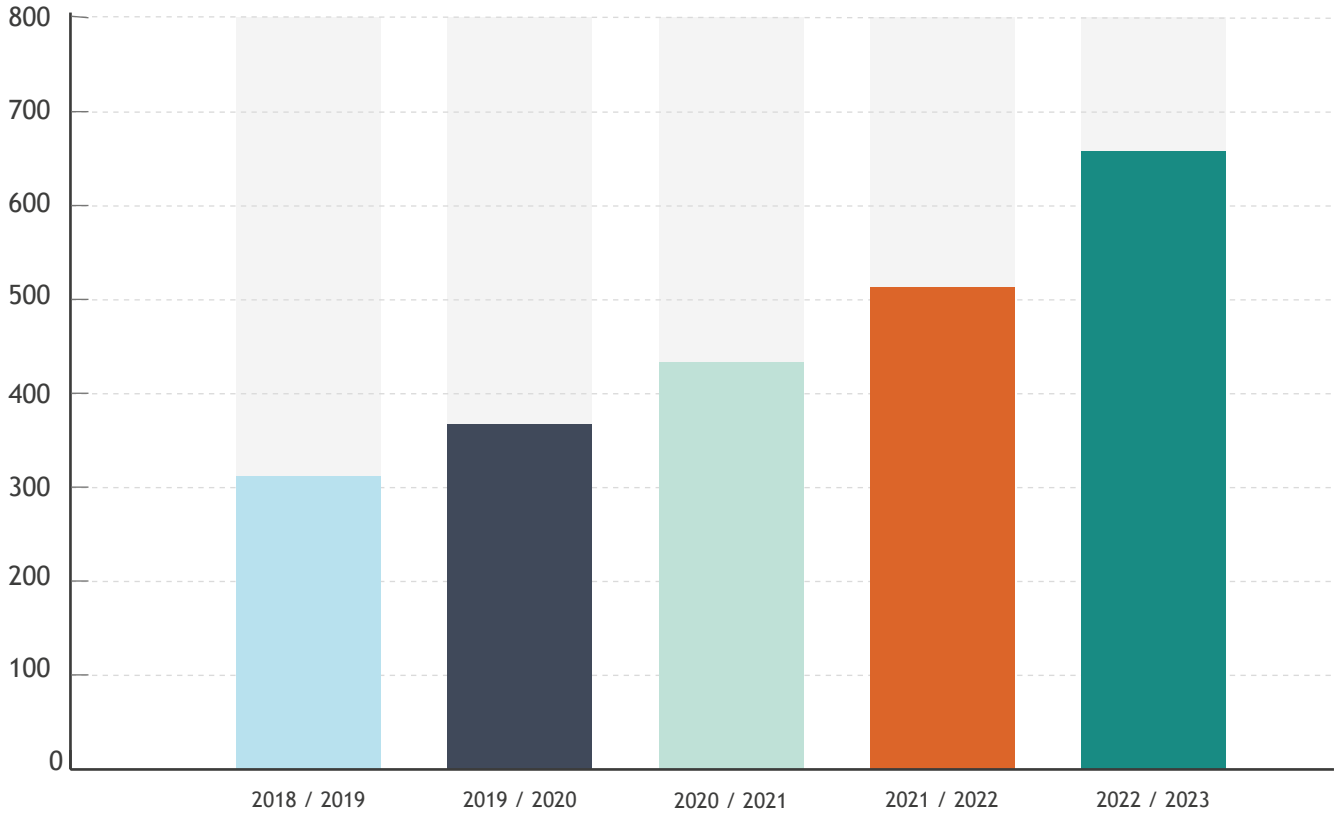
- Access to GP appointments
- Access to dental appointments / care and treatment
- Mental Health appointments and access to services

Complaints play a crucial role in identifying issues and fostering improvement within the healthcare sector. Feedback, often conveyed through complaints, provides valuable insights into areas of concern, inefficiencies, and lapses in quality. These grievances shed light on both systemic and individual problems, ranging from administrative processes to clinical care standards. By addressing and analysing complaints, healthcare organisations can pinpoint recurring patterns, root causes, and potential risks.

The concerns we receive provide an important opportunity to identify problems within a healthcare service. The intelligence received from these concerns enables an evaluation of risks to be identified and conceptualised. Consequently, HIW places significant importance on the intelligence received from concerns and uses it to drive its inspection and assurance activities.

As an organisation HIW is committed to managing concerns fairly, efficiently, and effectively. In total we received 659 concerns from 1st of April 2022 to 31st of March 2023. This represents an increase of 145 concerns compared to the previous year which equates to a 28% increase in the number of concerns received. Over the last 5 years we have seen a 111% increase in the number of concerns received.

The last 5 years of numbers of concerns

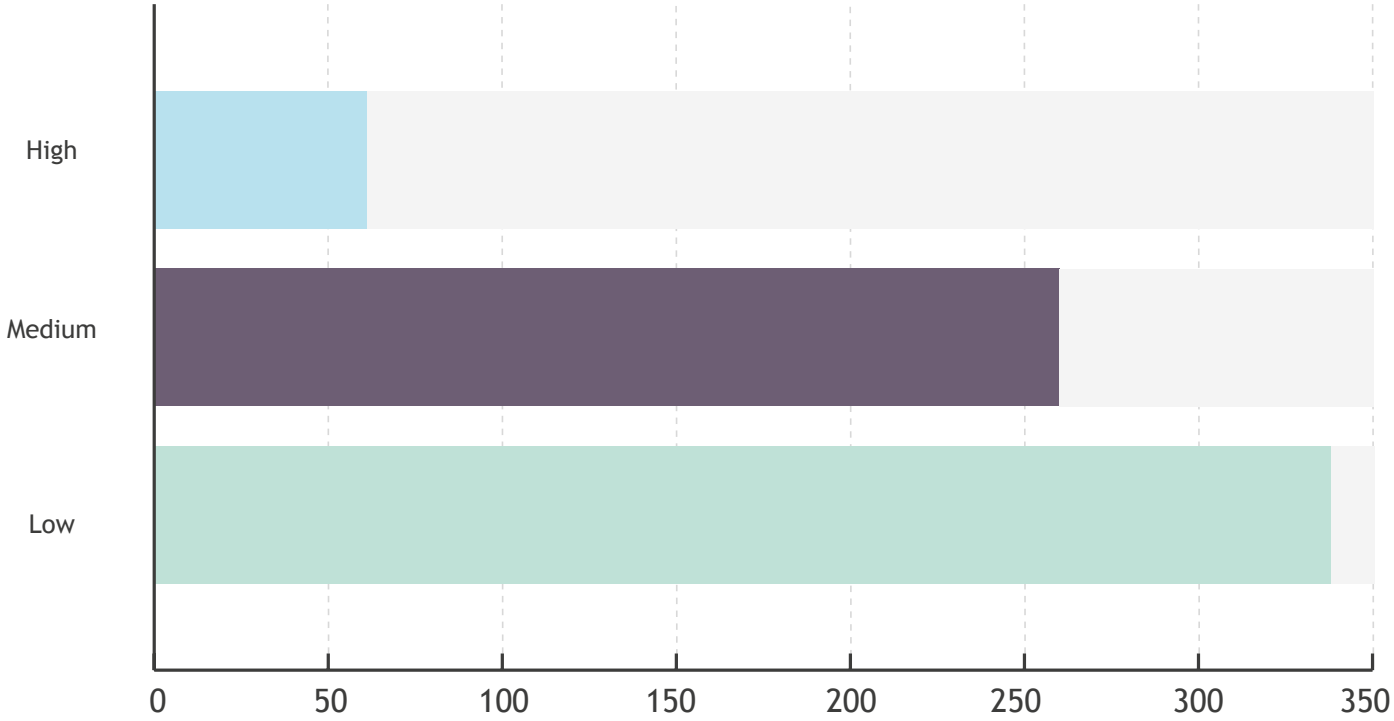


High-risk concerns require immediate action and response within 2 working days, either by HIW or another agency. Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days. Low-risk concerns are those concerns that are generally dealt with by way of signposting towards NHS Putting Things Right processes or the respective local complaints process for independent health providers, with responses being be actioned within 7 working days

The number of high risks concerns received has increased considerably over recent years.

We have experienced a **258%** increase in the number of high-risk concerns received compared with 2021-2022

Risk level of concerns received



HIW responds immediately to all high-risk concerns. This can be in the form of immediate escalation to the health boards / trusts or independent healthcare settings. In addition, some high-risk concerns require the immediate intervention via safeguarding structures or the police.

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

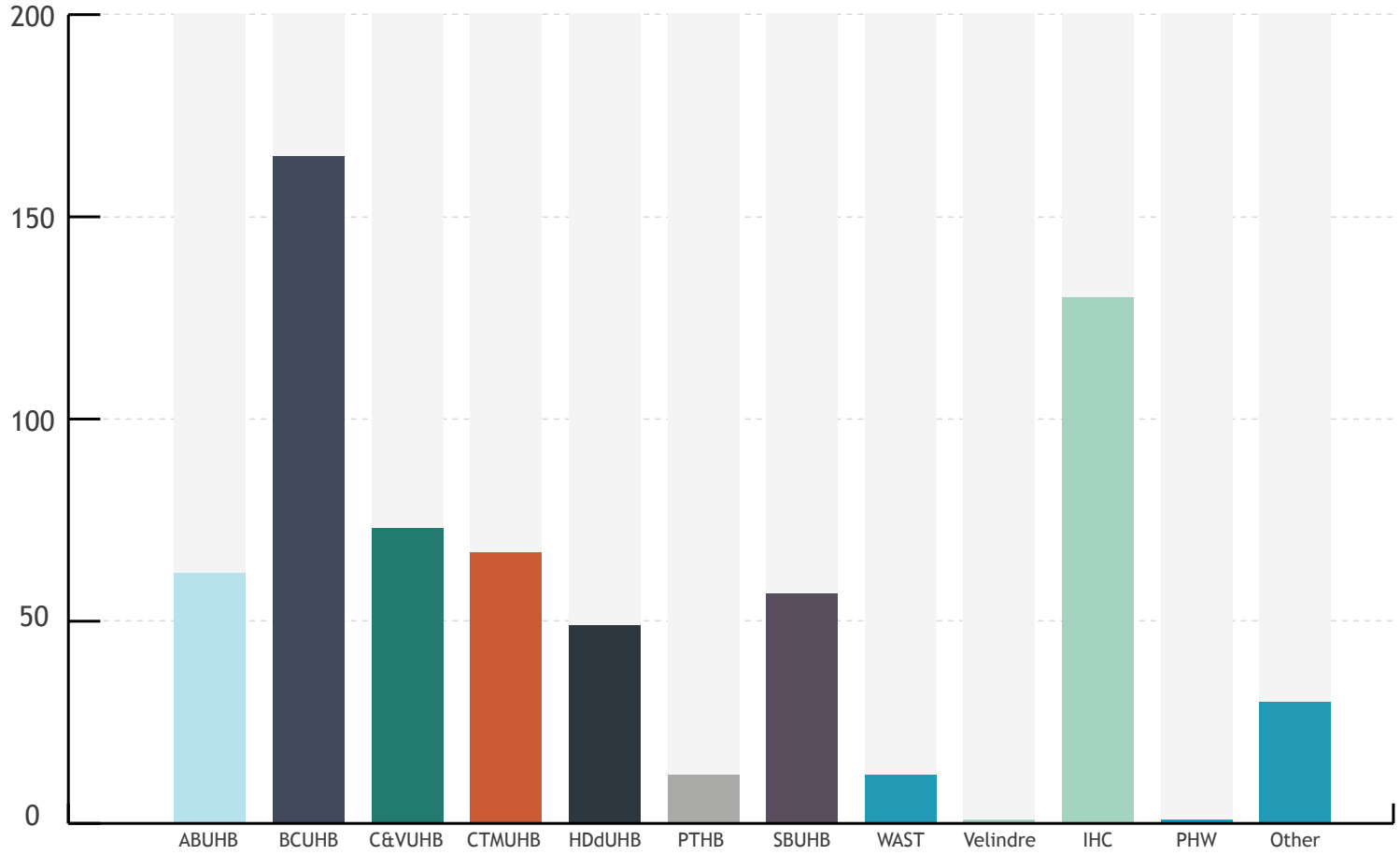
PHW
Public Health Wales

Velindre
Velindre University NHS Trust Welsh

WAST
Ambulance Services NHS Trust

IHC
Independent Healthcare

Location of concerns



Whistleblowing Concerns

25 received for 2019-2020

100 received for 2020-2021

61 received for 2021-2022

133 received for 2022-2023, an **85% increase compared** to previous year.

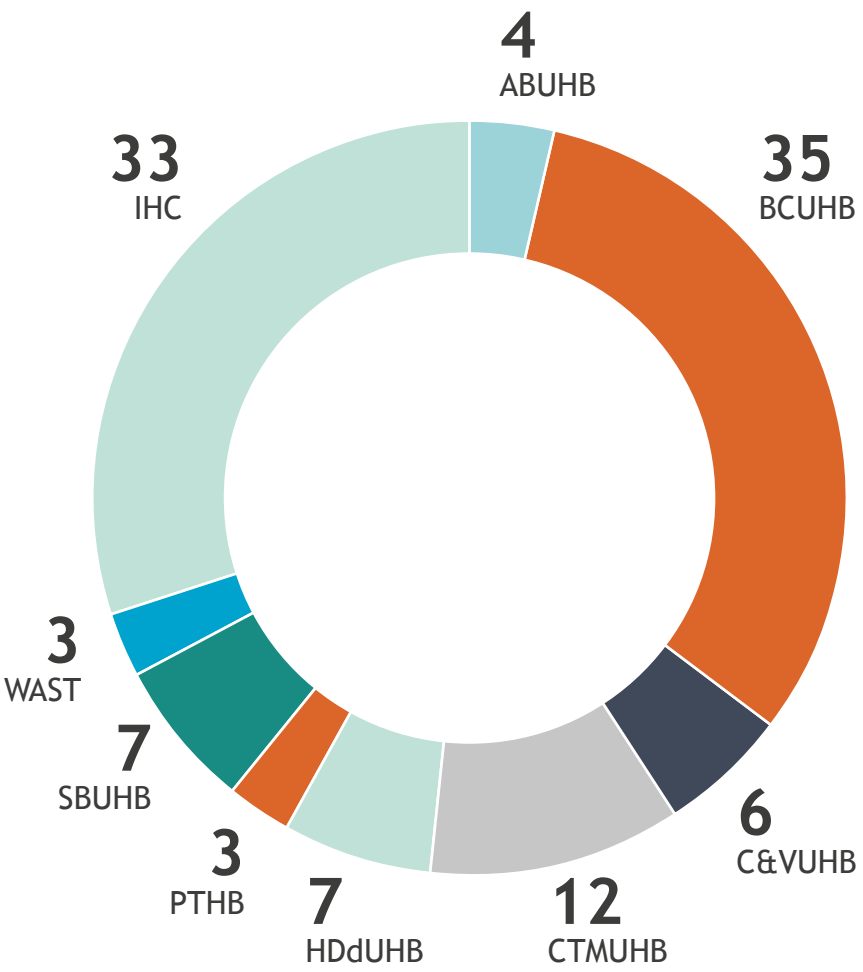
What is whistleblowing?

Whistleblowing is the term used when someone who works in or for an organisation wishes to raise concerns about malpractice, wrongdoing, illegality, or risk in the organisation. These concerns can affect patients, the public, other staff, or the organisation itself.

Whistleblowing applies to raising a concern within the organisation as well as externally, such as to a regulator like HIW. HIW has a special role for people who are thinking about "blowing the whistle" about concerns they have about wrongdoing in healthcare in Wales. HIW is a "prescribed body" under the whistleblowing laws, so employees, former employees, temporary agency staff or contractors who bring us concerns about their employer's activities can have some protection for their employment rights.

All healthcare professionals must follow their professional code of conduct and we would always recommend that they raise their concern within their own organisation first. However, if they feel unable to do this, or have already gone through this route, we will listen to the concern and explain how we can help. We may need to pass on the information they give us to another organisation or regulatory body if it is more appropriate for them to investigate the concern.

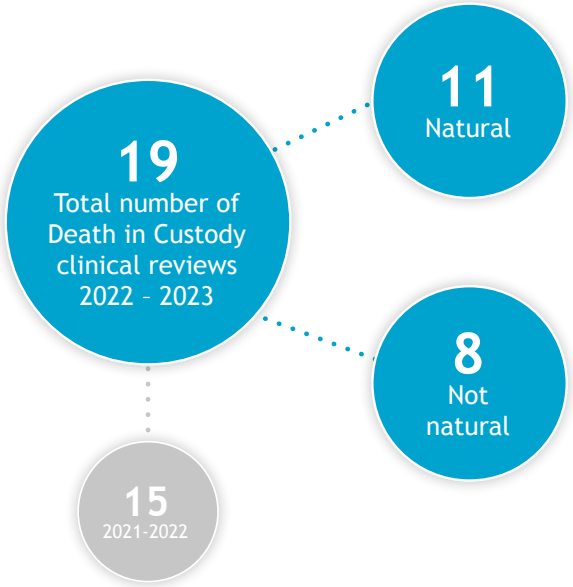
Location of Whistleblower 22/23



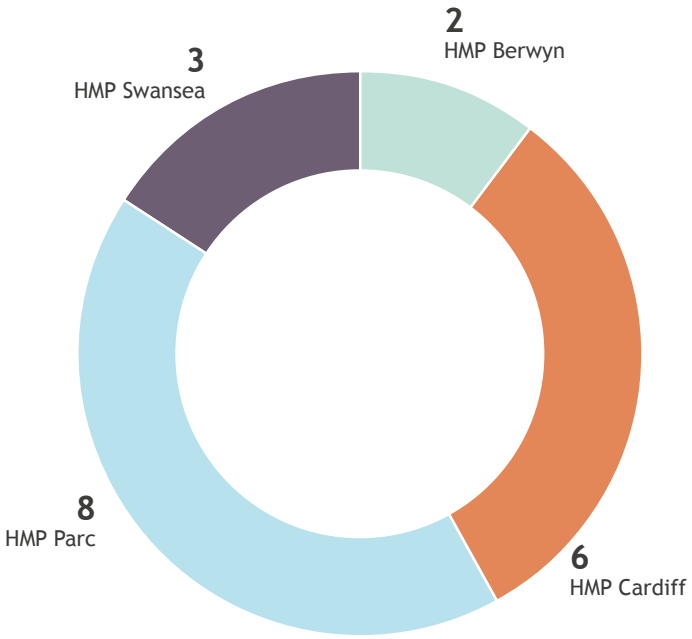
Death in Custody

Every death that takes place in a prison or other authorised location in Wales is subject to an examination by the Prisons and Probation Ombudsman (PPO). HIW assists these inquiries by conducting a clinical review of each death that occurs in a Welsh prison or other authorised location.

The fundamental goal of our clinical reviews is to assess and evaluate the level of care and medical treatment given to inmates while they in a prison or other authorised location. We aim to evaluate whether the care and treatment provided was equitable to what a person in the community could expect to receive.



Location of death:



Common Theme

A common theme identified in our reviews is the failure of prison healthcare staff to record a full set of baseline observations (vital signs) during the very early healthcare screening appointment that prisoners will have on, or shortly after arrival.

Having a comprehensive set of observations for a prisoner at the start of their incarceration is crucial. These measurements offer important insights into the body's functioning, helping healthcare professionals detect any changes. When a prisoner becomes unwell, regular clinical observations also need to be taken so that abnormalities can be spotted, and deterioration can be recognised and acted on. When this does not happen, there can be poor outcomes for patients.

Notifications

Independent healthcare providers are required to inform us of significant events and developments in their service submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.

The total number of regulatory notifications received in this reporting period is 1,847. This figure includes notifications against the following set of regulations:

- Independent Healthcare Regulations (IHC)
- Private Dentistry Regulations (DR)
- IRMER Regulations

A breakdown of the grand total shows the following number of notifications against each of the regulations:

IHC Regulations
1,713

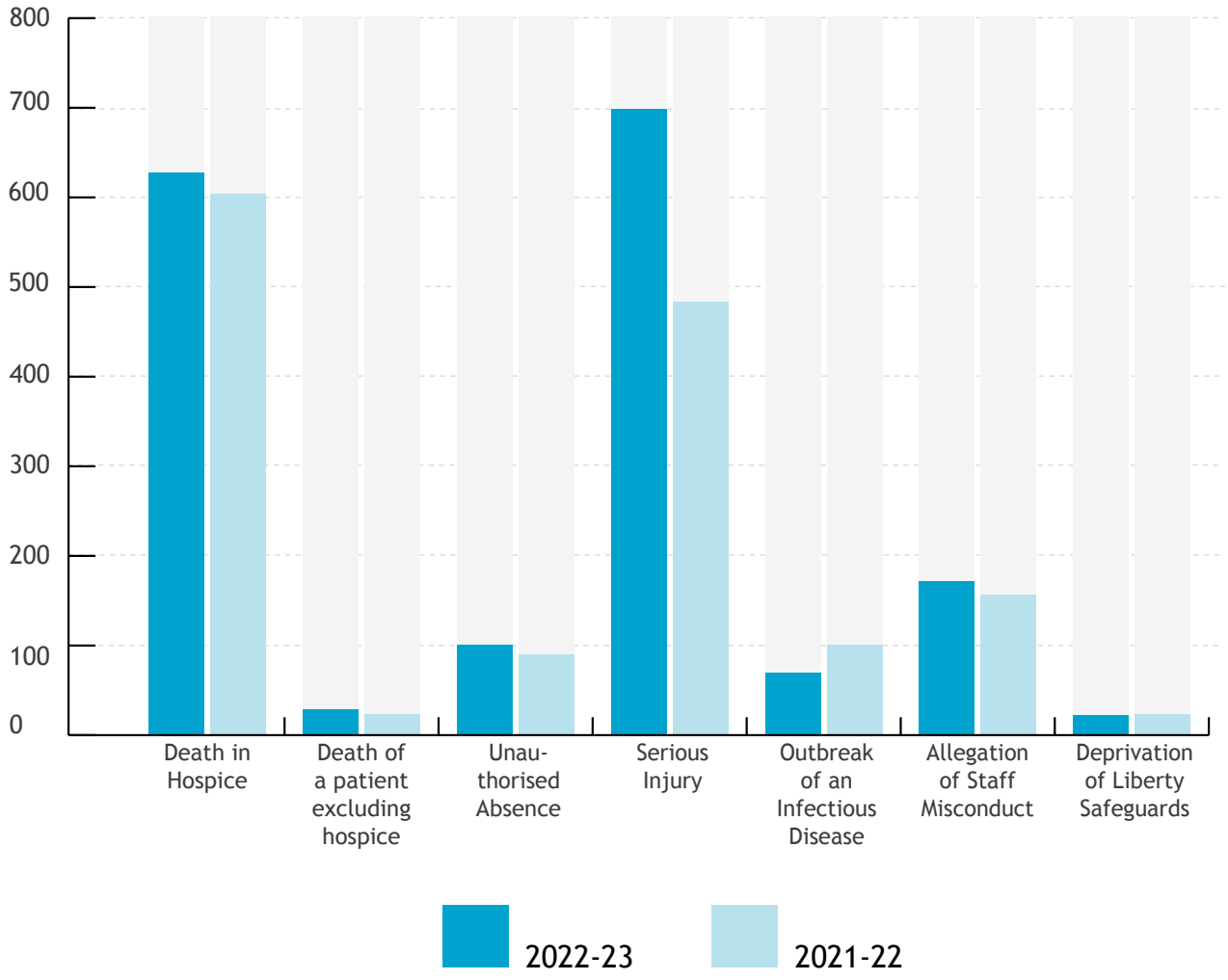
Private Dental Regulations
32

IRMER Regulations
102

Each regulation has its own reporting threshold. IHC Regulation 30/31 includes the following categories:

- **Death in Hospice**
- **Death of a patient excluding hospice**
- **Unauthorised Absence**
- **Serious Injury**
- **Outbreak of an Infectious Disease**
- **Allegation of Staff Misconduct**
- **Deprivation of Liberty Safeguards**

The graph shows a breakdown of the number of notifications received against each category and provides a comparison to the same reporting period last year.



Private Dentistry Regulation

Includes the following categories,

Serious Injury

Outbreak of Infectious Disease

Allegation of Staff Misconduct

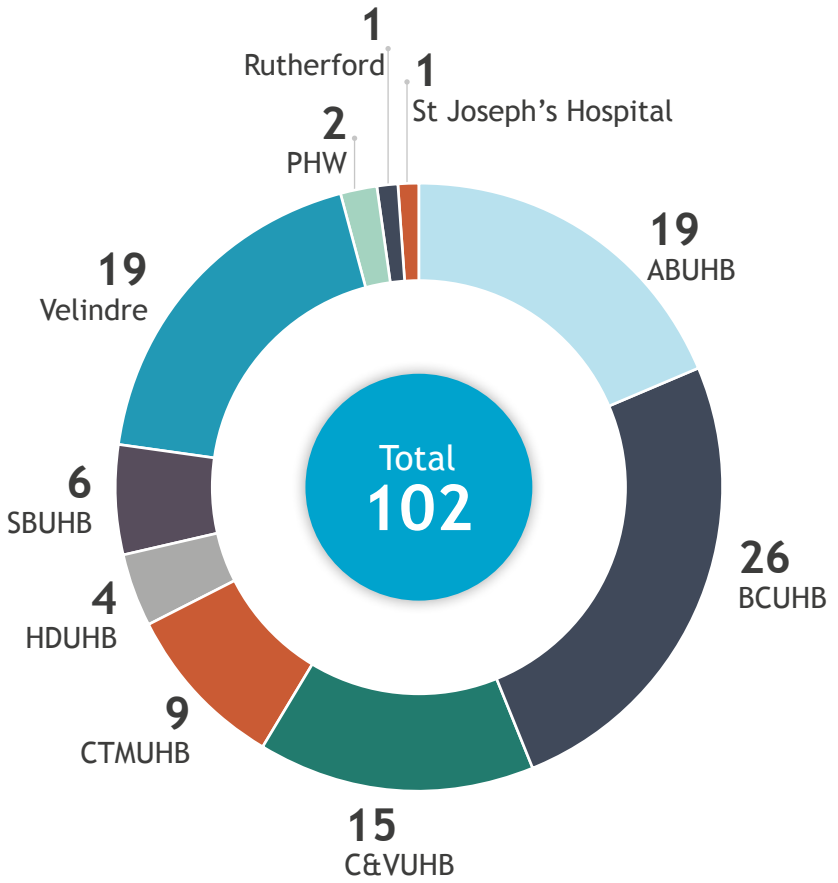
Death of a Patient

Category	2022-23	2021-22
Serious Injury	2	6
Outbreak of an infectious disease	30	147

There has been a significant reduction in the number of notifications received, mainly in the number of outbreaks of infectious diseases reported. This significant drop in the number of Outbreaks of infectious diseases is due to the COVID-19 pandemic.

IRMER

The chart below shows a breakdown of the number of notifications received against the IRMER regulations for this reporting period.



Safeguarding

256
Significant drop in the number of referrals received

In 2021/2022 we received 404 referrals

128
NHS

125
Independent Healthcare

3
Other

NHS

	Financial Abuse	Neglect	Physical Abuse	Psychological / Emotional Abuse	Sexual Abuse	Grand Total
Aneurin Bevan University Health Board		11	4			15
Betsi Cadwaladr University Health Board	2	25	13	2	3	45
Cardiff and Vale University Health Board		2				2
Cwm Taf Morgannwg University Health Board		24	8	3		35
Powys Teaching Health Board		6	7		4	17
Swansea Bay University Health Board		7	2			9
Welsh Ambulance Service NHS Trust		5				5
Total	**2**	**80**	**34**	**5**	**7**	**128**

Independent Healthcare

	Financial Abuse	Neglect	Physical Abuse	Psychological / Emotional Abuse	Sexual Abuse	Grand Total
Aberbeeg Hospital			1			1
Aderyn					1	1
Cefn Carnau Hospital		3	7			10
Coed Du Hall			2			2
Heatherwood Court Hospital		7	1	1	1	10
Hillview Hospital		4	4	3		11
Llanarth Court		11	13	6	4	34
New Hall			1	2		3
Nuffield Health The Vale Hospital		1				1
Rushcliffe Independent Hospital (Aberavon)			1			1
St Peter's Hospital		5	11	3	1	20
Ty Cwm Rhondda				2		2
Ty Grosvenor	1	14	7			22
Ty Gwyn Hall	2		4	1		7
Total	3	38	51	17	6	125

Three of the referrals were in relation to settings not regulated or inspected by HIW.

Second Opinion Appointed Doctor (SOAD) Service for Wales

HIW operates the SOAD service for Wales, employing registered medical practitioners to approve some forms of treatment for patients who are detained under the Mental Health Act. Ultimately, the role of the SOADs is to safeguard the rights of patients who are detained under the Mental Health Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether the patient has capacity to consent.

They must be satisfied that the patient's views and rights have been taken into consideration. After careful consideration of the patient and approved clinician's views, a SOAD has the right to change the proposed treatment. For example, a SOAD may decide to authorise only part of the proposed treatment or limit the amount of treatment which can be given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. Approved clinicians refer cases to HIW seeking a SOAD opinion. Case reviews are requested in the following circumstances:

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

Total Number of SOAD cases dealt with by HIW in 2022 - 2023:

694

Medication:
640 requests related to the certification of medication

ECT:
42 requests related to the certification of ECT

Both:
12 requests related to the certification of both medication and ECT

By comparison, during 2021-2022, HIW dealt with 759 requests for a SOAD review.

Medication:
640 requests related to the certification of medication

ECT:
42 requests related to the certification of ECT

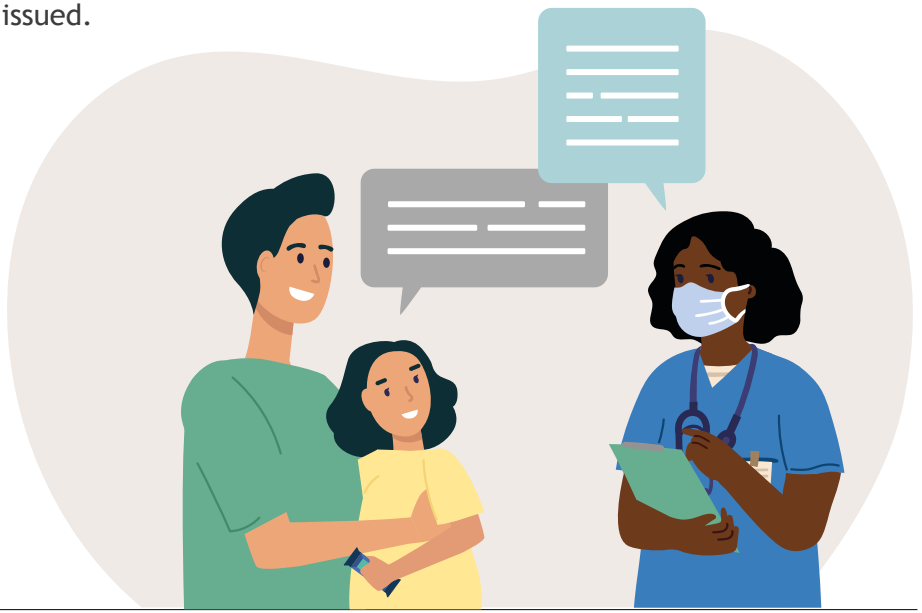
Both:
36 requests related to medication and ECT

Review of Treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the seventh consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are routinely reviewed by our lead SOAD for Wales on a monthly basis. There was a delay in the timeliness of the review of treatments in 2022-23, this was due to a vacant Lead SOAD position. However, all cases have now been reviewed with appropriate action taken where applicable.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continues to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.
- There were a few instances where T3 forms were being utilised instead of the appropriate CO forms, due to temporary methodology guidance implemented during the COVID Pandemic. These have now been rectified and refreshed guidance has been issued.



1 The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.
The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

Our Resources

The table shows the number of full or part time posts in each team within HIW during 2022-2023.

Team	Posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence and Methodology	14
Clinical Advice (including SOAD service)	6
Corporate Services (including business support)	18
Strategy, Policy and Engagement	7
Total	**87**

For 2022-2023 we had a budget of approximately £4.3m.

We have posts equivalent to approximately 87 full-time equivalent staff. We currently have a panel of over 200 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have 44 Patient Experience Reviewers and Experts by Experience.

Finance

The table shows how we used the financial resources available to us in the last financial year to deliver our work in 2022-2023.

HIW staff continue to be our most important resource. A programme of learning and development opportunities has once again been designed and delivered in accordance with feedback from staff. We have refreshed our internal People Forum which provides a strong and valuable source of feedback to senior HIW managers on staff matters and organisational development.

We have continued to recruit into specialist peer reviewer roles, and increased our pool of patient experience reviewers. This has strengthened our access to up to date clinical expertise and provided additional resource who can engage directly with patients during inspection work.

Our electronic Customer Relationship Management (CRM) system is now well established and providing valuable data supporting the work of all teams across HIW.

	£000'S
HIW Total Budget £	£4,372,000

Expenditure	
Staff costs	4,176,468
Travel and Subsistence	26,225
Learning & Development	29,854
Non staff costs	80,210
Translation	59,834
Reviewer costs	405,761
ICT Non CRM costs	16,810
Depreciation of assets	8,000
Total expenditure (a) £	4,803,162

Income	
Total income from Independent Healthcare (b) £	528,239
Total Net Expenditure (a-b) £	4,274,923

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