Prif Weithredwyr a Chadeiryddion
Byrddau Iechyd ac Ymddiriedolaethau GIG Cymru
Drwy e-bost

15 Hydref 2024

Annwyl Brif Weithredwr a Chadeirydd,

EMBARGO: Arolygiaeth Gofal Iechyd Cymru (AGIC)
Diweddariad: Adroddiad Blynyddol 2023 – 2024

Hoffwn roi gwybod i chi y bydd AGIC yn cyhoeddi ei Hadroddiad Blynyddol 2023-2024 am 00:01 ddydd Iau 17 Hydref 2024. Mae copi o'r adroddiad wedi'i atodi. Bydd allfeydd y cyfryngau yn cael copi dan embargo ddydd Mercher 16 Hydref 2024.

Mae'r adroddiad hwn yn nodi canfyddiadau allweddol ein gwaith o reoleiddio, arolygu ac adolygu gwasanaethau gofal iechyd yng Nghymru. Mae'n amlinellu sut y gwnaethom gyflawni ein swyddogaeth ledled Cymru, gan geisio sicrwydd am ansawdd a diogelwch gwasanaethau gofal iechyd drwy amrywiaeth o weithgareddau, yn cynnwys arolygiadau a gwaith adolygu yn y GIG, a gwaith sicrwydd rheoliadol yn y sector gofal iechyd annibynnol. Mae'n rhoi crynodeb o ganfyddiadau ein gwaith, y prif heriau a wynebir ym maes gofal iechyd ledled Cymru, a'n barn am feysydd o bryder.

Mae ein hamcanion yn uchelgeisiol a thrwyddynt, ein nod yw gwneud gwahaniaeth i bobl Cymru drwy gyfrannu at welliannau i ofal iechyd. Yn yr adroddiad hwn, byddwch yn gweld enghreifftiau o'r ffordd rydym wedi defnyddio ein gwaith i fynd ar drywydd y nod hwn. Rwy'n falch o'r sefydliad rwy'n ei arwain, ac o'r cyfraniad y gallwn ei wneud at ofal iechyd yng Nghymru.

Os hoffech drafod unrhyw ran o'r adroddiad ymhellach, mae croeso i chi gysylltu â'ch Rheolwr Cydberthnasau yn AGIC neu gysylltu â mi yn uniongyrchol.

Yn gywir

Alun Jones
Prif Weithredwr
Arolygiaeth Gofal Iechyd Cymru

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Chief Executives and Chairs
NHS Health Boards and Trusts Wales
Via Email

15 October 2024

Dear Chief Executive and Chair,

EMBARGO: Healthcare Inspectorate Wales (HIW)
Update: Annual Report 2023 – 2024

I would like to inform you that HIW will be publishing its 2023-2024 Annual Report at 00:01 on Thursday 17 October 2024. Please find a copy of the report attached. Please note media outlets will receive a copy under embargo on Wednesday 16 October 2024.

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 function 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 concern.

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.

Should you wish to follow up on anything contained within the report then please get in touch with your HIW Relationship Manager or me directly.

Yours sincerely

Alun Jones
Chief Executive
Healthcare Inspectorate Wales

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Annual Report

2023 - 2024

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

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

We will:

Focus on the quality of healthcare provided to people and communities as they access, use, and move between services.

We will:

Adapt our approach to ensure we are responsive to emerging risks to patient safety.

We will:

Work collaboratively to drive system and service improvement within healthcare.

We will:

Support and develop our workforce to enable them, and the organisation, to deliver our priorities.

What we do

We inspect NHS services in Wales. We regulate and inspect independent healthcare services in Wales

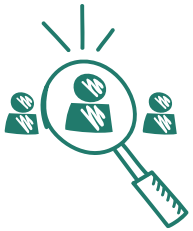
We undertake a programme of reviews to look in depth at national or more localised issues

We monitor concerns and safeguarding referrals

We take regulatory action to ensure registered independent healthcare services meet legislative requirements

We recommend improvements, immediate and longer term, to NHS services and independent healthcare services

We have a team of 87 staff who work for us, across Wales, supporting our functions and undertaking our assurance work



We have a team of specialist peer reviewers who we continually recruit to provide specialist, up to date knowledge about services and quality standards

We have specialists in Mental Health Act administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service

We have a panel of Patient Experience Reviewers and Experts by Experience to capture the voice of patients out on inspection

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01.

Foreword

Foreword

Alun Jones
Chief Executive

Each year Healthcare Inspectorate Wales (HIW) publishes an annual report setting out the key findings from the regulation, inspection, and review of healthcare services in Wales.

We seek to drive improvement by understanding the risks and challenges that are preventing services from operating effectively and impacting on the quality of care being delivered. We have continued to take an independent, balanced, and risk-based approach to our work. In delivering our assurance activity we have highlighted areas of improvement and good practice and have proactively shared key findings and themes to support and drive service improvement.

People are at the heart of everything we do, and listening to those who use and work within healthcare services across Wales remains a critical area of our work. By obtaining feedback on services, we can gather meaningful insight to better understand what matters to people. To reinforce our commitment to this area, I am pleased to say that earlier this year, in collaboration with Care Inspectorate Wales (CIW), we published a strategic statement of intent in relation equality, diversity, and inclusion (EDI). The statement is part of our commitment to developing an Equality, Diversity and Inclusion Strategy, which will ensure EDI is embedded throughout our work, helping us to understand the challenges communities face when accessing health and care services.

I am also immensely proud of the work of our newly established Stakeholder Advisory Group, which continues to provide valuable insight, reflection and direction for our work. Membership of the group is made up of a wide range of organisations which work with and represent people with protected characteristics.

The group has influenced the ways and methods by which we seek feedback from patients and has challenged us to think more critically about the way we work to further understand and embed EDI.

In a small country like Wales, collaboration with partner organisations is essential, and during this period we have led two Healthcare Summits of healthcare inspection, regulation, audit, and assurance bodies. The Summits highlighted the ongoing challenges in the Welsh healthcare system, which include workforce issues, access to services and the timeliness of care.

Overall, patients told us they were pleased with the care they received and that they valued the work and commitment of staff. Furthermore, our inspection and review work has shown a high standard of healthcare being delivered to most patients. We have also seen that innovation within the NHS, including the provision of a range of options for patients who require urgent and out of hours care, has helped the system to respond to very high demand. However, it was clear from our hospital inspections that there are times when the demand on services greatly exceeds capacity. This can lead to delays in providing urgent care and patients in Wales are often experiencing excessive delays in relation to planned care.

We acknowledge health boards in Wales continue to face challenges in the delivery of healthcare. However, it is critically important that whilst addressing their strategic and financial challenges, leaders in our health services do not lose sight of the need to provide safe, effective, and patient-centred care.

Our work has provided an insight into the impact of delays in patients being discharged from hospital in Wales. The challenges around delayed discharge are wide ranging, and unnecessarily long stays in hospital due to delayed discharge can place patients at risk. Our work within NHS hospitals has highlighted the reoccurring issue of poor patient flow, with intense daily pressures around patient admission and bed management. Within Emergency Departments across Wales, we have noted overcrowding, long waits for triage and long waits for treatment or admission into the most appropriate beds. The challenge is a complex one, especially in relation to health and social care service interaction, but our work has identified areas where settings can do more to tackle this sustained challenge.

Through our inspection and assurance work within GP practices, it was clear services are continuing to face significant pressure post-pandemic, due to practice closures, staff shortages and long hospital waiting lists for treatment.

Our national reviews have helped us to evaluate how healthcare services across Wales are delivered. Our reviews are often large scale and see us collaborating with other organisations to collectively come together, to pool our experience, insight and knowledge. Our work has focused on complexities involving some of the most vulnerable people within our communities, including investigating child protection arrangements, and how difficult medical decisions are being made in Wales such as ‘do not attempt resuscitation’ (DNACPR).

Our role in the independent healthcare sector in Wales is to register and regulate services. The independent healthcare sector encompasses a huge variety of services, from acute hospitals and mental health hospitals through 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. Our work in relation to dental practices has highlighted issues around capacity and demand and how these impacts on the ability of patients to access timely care.

We place significant importance on the intelligence received from concerns and use it to drive forward and inform our inspection and assurance work. The main themes emerging from our concerns during this period were access to appointments for mental health, GP and dental care, increasing demand in emergency departments and low staffing levels.

Where we find service failings or inadequate care we will take action. Due to the severity and number of issues identified through some of our independent healthcare inspections, we have designated settings as a 'Service of Concern' in line with our Escalation and Enforcement processes. We have suspended registrations where serious failings have been identified and have investigated and instigated several criminal proceedings to ensure safe care is being delivered.

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 and our teams, as we continue to work towards our goal of being a trusted voice which influences and drives improvement in healthcare.

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

Alun Jones

02.

2023-2024 in Numbers

2023-2024 in Numbers

172 onsite inspections

2,319 completed staff surveys

5,924 completed patient, family/carer and public surveys

2023

April

- 10 inspections undertaken.

May

- 13 inspections undertaken.
- Insight Bulletin - May 2023 published.
- Joint review of child protection arrangements (JICPA) in Denbighshire.
- Published our Operational Plan.

June

- 12 inspections undertaken.
- Joint review of child protection arrangements in Wales - interim findings published.
- Vascular Services in North Wales are de-escalated as a service requiring significant improvement by HIW.

July

- 21 inspections undertaken.
- Published our Mental Health Monitoring Annual Report 2021-2022.

August

- 15 inspections undertaken.
- Equality, Diversity and Inclusion: A Statement of Strategic Intent published.

September

- 20 inspections undertaken.
- Published our National Review of Patient Flow a journey through the stroke pathway.
- Published our joint review of child protection arrangements (JICPA) in Bridgend.
- Rapid Review of Child Protection Procedures in Wales published.

October

- 18 inspections undertaken.
- HIW hosts European Partnership for Supervisory Organisations 35th Conference in the Welsh Capital.

November

- 17 inspections undertaken.

December

- 4 inspections undertaken.
- Annual Report published.

2024

January

- 14 inspections undertaken.
- Published our Mental Health Monitoring Annual Report 2022-2023.

February

- 14 inspections undertaken.
- Published our joint review of child protection arrangements (JICPA) in Powys.
- Joint Review: Deprivation of Liberty Safeguards (DoLS) published.

March

- 14 inspections undertaken.
- Insight Bulletin - March 2024 published.

03.

Engagement and Collaboration

Engagement

By listening to those who use and work in healthcare services, we can better understand what matters to people to gain greater understanding and insight.

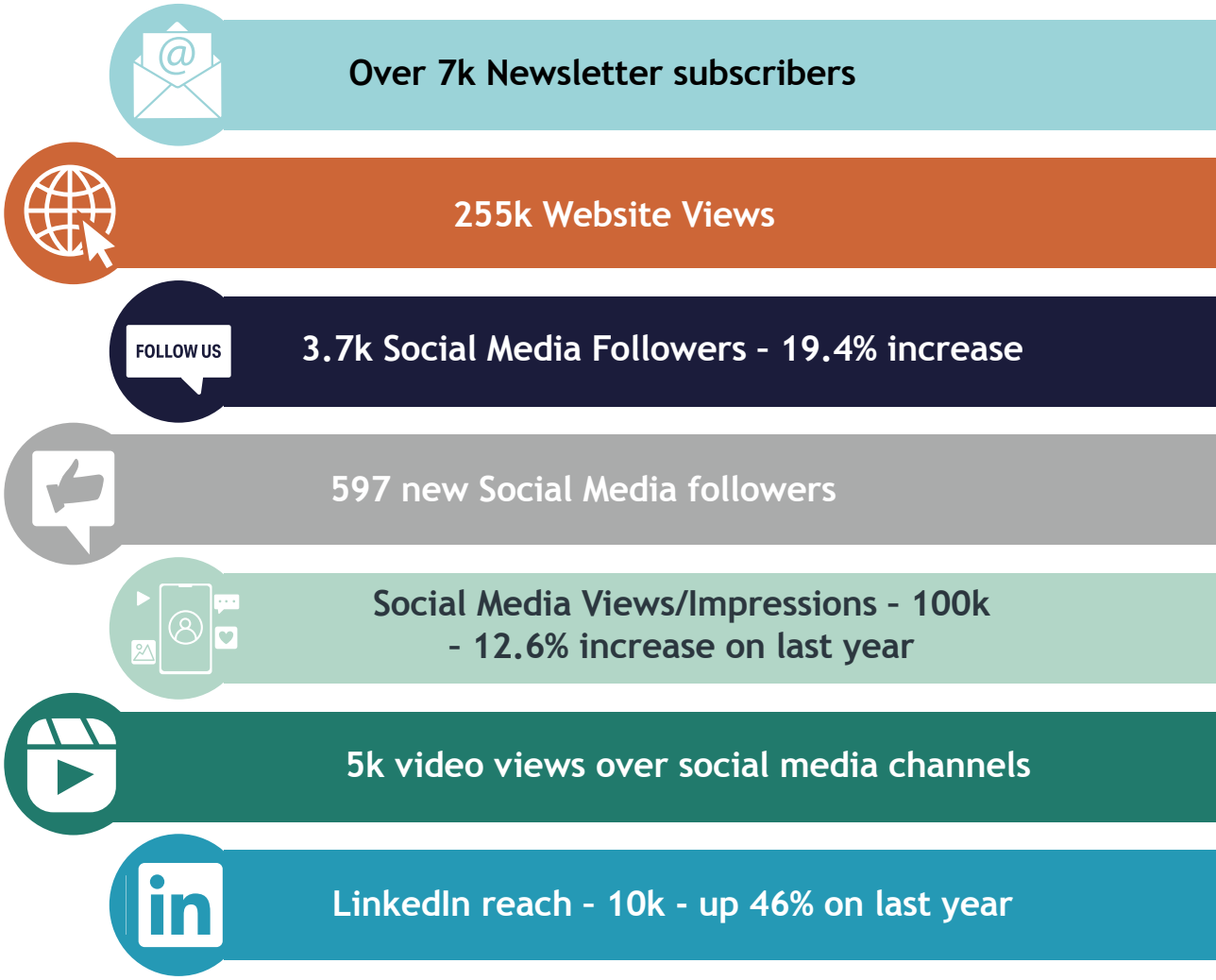
During our assurance work we ask patients to tell us about the care they receive by completing a short experience survey. When able to, we aim to speak in-person with patients during onsite visits, so that we can gather their views directly. We also regularly use our social media channels, alongside targeted newsletters, to raise awareness and obtain further insight.

Across our inspection and assurance work, 8,243 people gave us their views on the care they had received, or the service they work within. Of those responses, 7,695 related to our inspection activity, and 548 related to our review work.

In total we heard from:

- 5,856 patients
- 2,319 staff
- 68 Carers/family members

By obtaining feedback we can better understand, influence, and help drive forward improvement within healthcare services across Wales.



Proactively engaging with our stakeholders remains a priority, and our aim is to ensure engagement outcomes are reflected in our work. Engagement helps us to strengthen our partnership working, ensuring it is fully inclusive and representative. Our goal is to ensure equality, diversity, and inclusion (EDI) is embedded into the work we do, and to consider how healthcare services reach those who face the greatest barriers to accessing quality healthcare.

Engagement is broader and deeper than traditional consultation. It is about how we communicate, involve, listen, respond to and understand people and stakeholders. It is how we help people and conduct informed work by developing relationships to obtain insight; encouraging active participants to discuss and influence the things that matter to them.

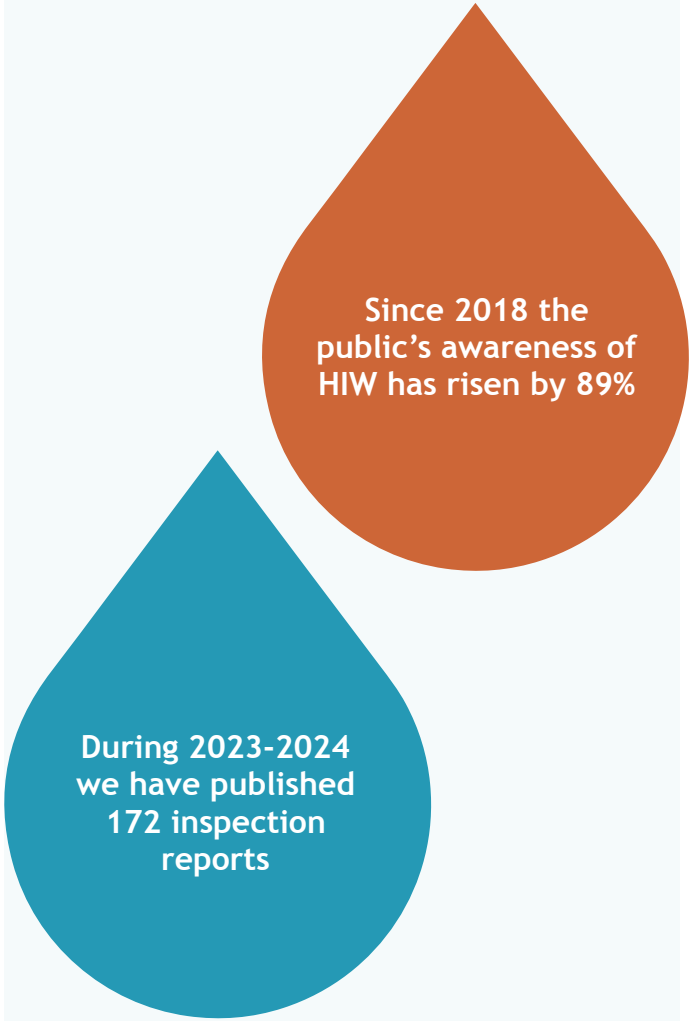
We have continued to use our social media channels to widely engage, and proactively encourage people to click through to our website, where they can find out more information about our work and role.
Our following on these channels has increased and analytics show our social media posts are reaching more people every month. Our public facing website has received 255,000 views during this period, where our social media content is driving click-through rates to key informative pages. We actively ensure our content is fully accessible by conducting regular checks, alongside developing and implementing an Accessibility Guide.

We have continued to issue our quarterly Insight bulletins, which we issue electronically to over 7000 subscribers on our mailing list. The bulletin summarises our work from the quarter and includes a Learning and Insight section, where we share themes and learning emerging from our work. We have also introduced a new Learning and Insight area of our website, where a series of themes and case studies emerging from our assurance work is shared. We believe there is significant value in sharing learning and experiences and want healthcare services to use our findings as a means of driving improvement within healthcare, in line with our purpose of 'maximising the health and wellbeing of people'.

Our Stakeholder Advisory Group continues to make a valuable contribution, providing insight to inform our work. Membership of the group is made up of a wide range of organisations which work with, and represent, people with protected characteristics. We are immensely proud of this group, and membership has grown during the year.

The group has influenced the way in which we ask patients for feedback during our work 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.

During 2023-2024 we have issued 172 inspection reports, some of which led to local and national news coverage including conducting live/pre-recorded interviews with major news providers. Through commissioning research via a national omnibus survey, we know the public's awareness of our organisation is continuing to grow. We know that since 2018 the public's awareness of HIW has risen by 89%, from 27% to 51% in 2023. We also know that in 2023 34% people said TV or radio is how they became aware of HIW, with 17% stating online/websites, and a further 21% stating their awareness came via word of mouth. Through increasing awareness and visibility, we can foster trust and transparency, reassuring the public that care standards are being effectively monitored. It also drives accountability encouraging healthcare providers to maintain high levels of safety and quality.



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. Collaboration also helps us to work beyond the health care sector, taking a wider view of services in the way the that the public experience them.

Equality, Diversity and Inclusion: A Statement of Strategic Intent

During this period, we collaborated with Care Inspectorate Wales (CIW) to publish a joint strategic statement of intent focusing on equality, diversity, and inclusion (EDI). As the independent inspectorates and regulators of healthcare, social care, and childcare in Wales we aim to take action to improve the quality and safety of services for the well-being of the people of Wales. We came together, to pool experience and knowledge, to work on producing a joint EDI strategy which supports both organisations. The statement of intent shows our commitment to publish a joint strategy to provide new opportunities to help reduce inequalities across services.

Healthcare Summits

During 2023-2024, we hosted two Healthcare Summits, to enable discussion between key regulation and improvement bodies in Wales. The Summits, led by HIW were held in May and November 2023, and involved partners from healthcare inspection, regulation, audit, assurance, and improvement bodies. The purpose of the Summit is to provide a forum for sharing intelligence, on the quality and safety of healthcare services provided by NHS Wales.

The key issues identified from the 2023-2024 summits were:

- **Workforce:** there are significant staffing shortages in many areas, especially in maternity services leading to stress amongst the workforce and potential safety issues. There are also concerns regarding the impact on primary care services, due to problems in recruiting and retaining General Practitioners (GPs).
- **Primary Care:** there are challenges for patients accessing GP and dental care appointments. This includes the considerable difficulties patients experience when contacting GPs by telephone.
- **Unscheduled Care:** there are significant concerns around long waiting times and overcrowding within Emergency Departments, due to system wide pressures. These issues include patients attending the Emergency Department, as a result of not being able to access their GP.
- **Planned Care:** although some improvements were seen in the performance figures for planned care, many patients still face very long waits for outpatient appointments and cancer treatments.
- **Maternity and Neonatal Care:** key concerns include staff shortages and lack of compliance with mandatory training.
- **Healthcare Associated Infections (HCAIs):** for some health boards there were concerns around increasing rates of HCAIs. These are infections that patients contracted while receiving medical treatment.

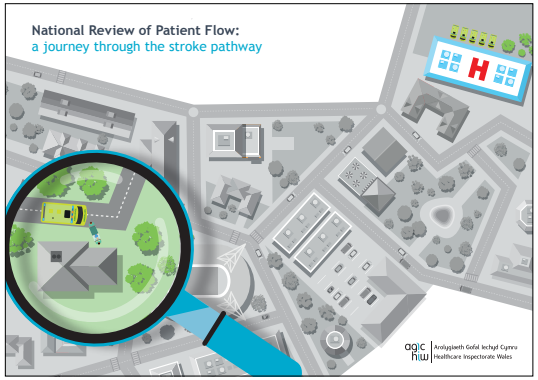
- **Child and Adolescent Mental Health Services:** there are concerns about waiting times for young people awaiting a first appointment, and any following support or treatment. There are also challenges where children transition from child to adult services.
- **Neurodevelopmental Assessments:** there are long waits for children and families waiting for an assessment for conditions such as Autism and Attention Deficit Hyperactivity Disorder (ADHD).

04.

Reviews

Reviews

All of our reviews help us to evaluate how healthcare services in Wales are delivered, and often see us collaborating with other organisations to pool our experience, insight, knowledge and regulatory powers.



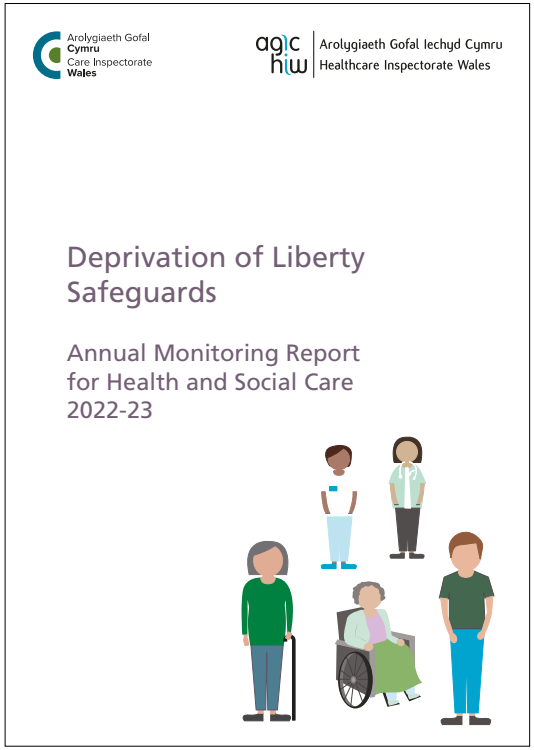
National Review of Patient Flow - A journey through the stroke pathway

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 to explore this during 2022-2023. 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 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 working with health boards and the Welsh Ambulance Service Trust (WAST) and assessing the processes in place from the time an ambulance is called, through to arrival at an emergency department, admission of patients and discharge.

The review found a high demand for inpatient beds and complexities involved in discharging medically fit patients from hospitals leading 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.

The full review was published in September 2023.



Joint Review: Deprivation of Liberty Safeguards (DoLS)

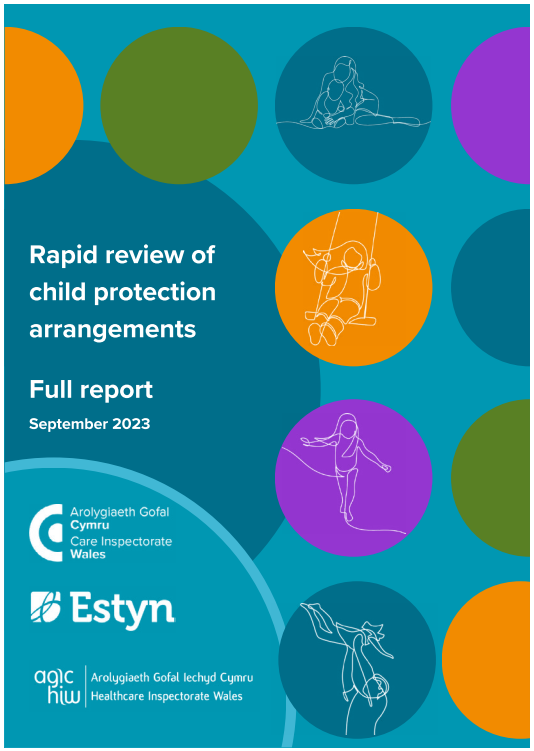
HIW and CIW have a joint role in monitoring the implementation of the Deprivation of Liberty Safeguards (DoLS) and our most recent monitoring report was published in February 2024.

DoLS were developed to ensure people's human rights are protected and maintained, and the care they receive is in their best interests and delivered in the least restrictive way.

The Safeguards apply to people over the age of 18 who cannot consent to treatment or care in a hospital or care home. They provide a legal framework for deprivations to prevent breaches of the European Convention on Human Rights.

The main areas for improvement included:

- There was an 18% increase in the number of DoLS applications assessed by the local authorities compared to the previous year.
- The number of DoLS applications assessed by health boards increased by 32% in 2022-23, compared to figures seen in 2021-22.
- The long delays in allocating, assessing and authorising applications continue to result in many people in Wales being deprived of their liberty, with no legal protection in place and no opportunity to challenge whilst waiting for a decision to be made.
- Many urgent authorisations expire before the required DoLS assessments can be undertaken. Some local authorities and health boards may benefit from reviewing their current procedures for urgent authorisation with managing authorities.
- Most local authorities and health boards are unable to allocate the volume of requests received for further authorisations. All supervisory bodies must ensure people's rights are protected and assessments for all applications are undertaken within stipulated number of days as set out in DoLS Code of Practice.
- The use of conditions by local authorities and health boards varies, with some regions using them more than others. Supervisory bodies should ensure conditions are used where necessary and are focussed on improving outcomes for people including reducing or removing the deprivation.



Joint Rapid Review of Child Protection Arrangements

In November 2022, in response to several tragic child deaths across Wales and England, the Welsh Government requested a multi-agency rapid review of decision making in relation to child protection. HIW contributed to this review which was undertaken jointly with CIW and Estyn.

The purpose of the review was to determine to what extent the structures and processes in place in Wales ensure children's names are appropriately placed on, and removed from, the child protection register (CPR), when sufficient evidence indicates it is safe to do so.

We engaged with four health boards which included:

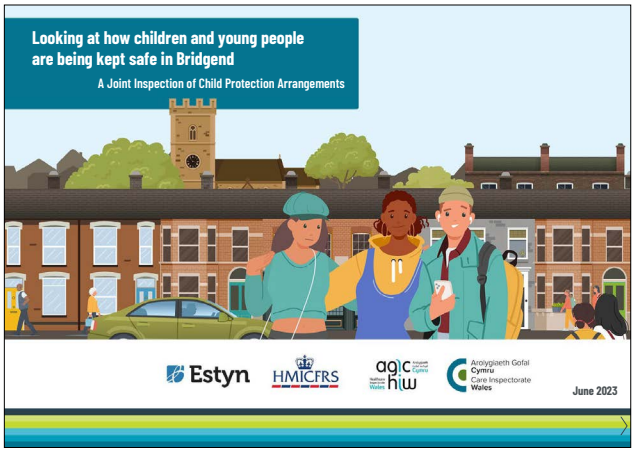
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Swansea Bay University Health Board
- Aneurin Bevan University Health Board

Following the review, recommendations were made across the multi-agency partnerships, but also specifically to healthcare providers.

These included the following:

- The Welsh Government should work alongside health boards to commission a centralised, accessible IT system that is able to capture all health information relating to children, including the location of any non-digitalised records.
- Health professionals must ensure every child has a robust assessment of their health needs, including emerging and potential health needs where there are child protection concerns. Any unmet health needs should be addressed via the care and support protection plan.
- GP practices hold key information in relation to children and their families. In line with Wales Safeguarding Procedures, they must provide a written report for all child protection conferences.

The full report was published in September 2023.



Joint Inspection of Child Protection Arrangements (JICPA)

Together with CIW, His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and Estyn, we conducted a joint inspection of the multi-agency response to abuse and neglect in children.

These took place in:

- January 2023: Denbighshire County Council, which sits within the boundary of Betsi Cadwaladr University Health Board
- June 2023: Bridgend County Borough Council which sits within the boundary of Cwm Taf Morgannwg University Health Board
- October 2023: Powys County Council which sits within the boundary of Powys Teaching Health Board
- January 2024: Cardiff Council which sits within the boundary of Cardiff and Vale University Health Board.

Key findings include:

It was positive to find that local authorities and partners exercised their functions under the Social Services and Well-being (Wales) Act 2014, endeavouring to make a positive contribution to the well-being and safety of children who need care and support.

Overall, systems and relationships were in place to facilitate effective partnership working where a child is at risk of abuse and neglect.

There were, however, areas of child protection which attention is required, including:

- Challenges in sharing information between relevant agencies
- Inconsistencies with the quality of care and support protection plans
- Instability with staffing levels, including an over reliance on temporary agency workers to meet statutory duties
- Inability to regularly access the child protection register (CPR) – both in and outside office hours
- Inadequate attendance at multi-agency strategy meetings to review and make effective conclusions.

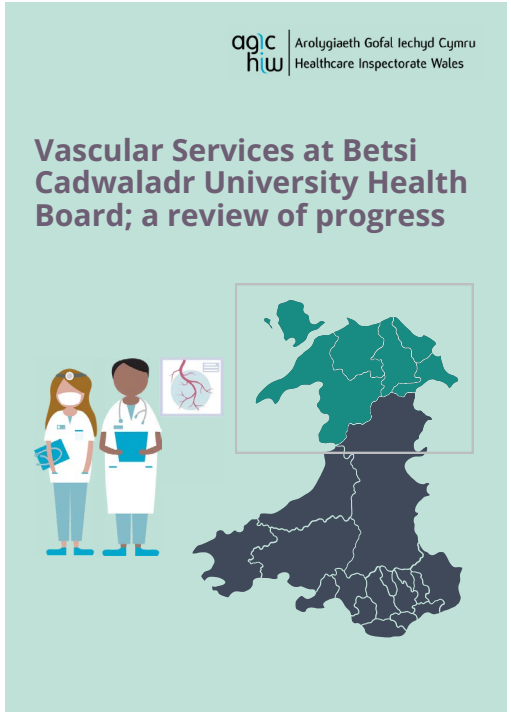
An overview report of themes arising from our JICPA work to date is set to be published in September 2024.

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

In November 2019 we undertook a joint review with Audit Wales of the quality governance arrangements at Cwm Taf Morgannwg University Health Board. The joint report highlighted a number of fundamental weaknesses in leadership, strategic focus, patient safety and risk scrutiny, management of concerns and complaints, and organisational culture. The report included 14 recommendations for improvement.

In May 2021, a joint follow-up review found the health board made good progress on 2019 recommendations despite COVID-19 challenges. However, work was still needed in all areas, so the 14 recommendations remained open.

Our second follow-up review which commenced in March 2023 found the health board had made significant progress in addressing the concerns and recommendations. The report for this follow-up work was published in August 2023. We found a stronger strategic focus on quality and patient safety, with clearer roles and responsibilities compared to 2019. Based on the report, further detailed follow-up was deemed unnecessary. We maintained oversight of ongoing actions through our routine work programs.

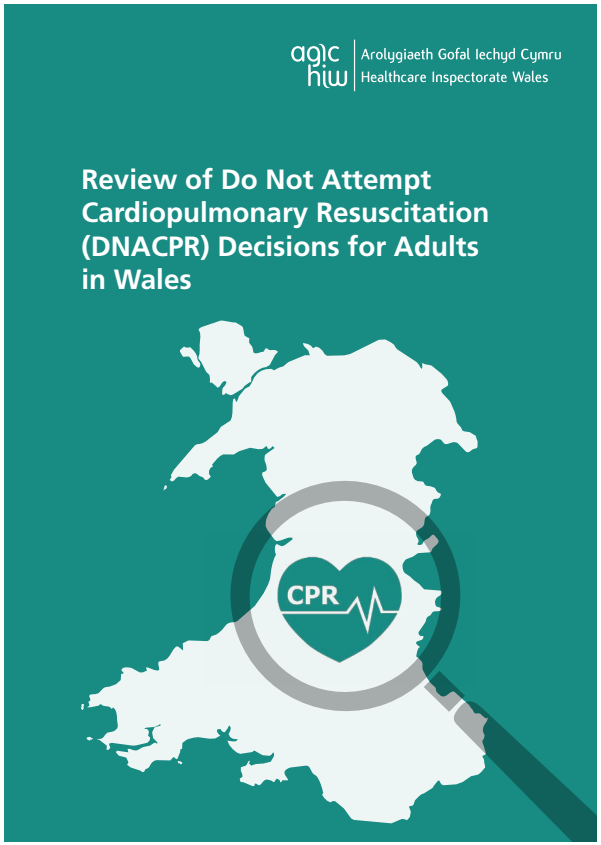


Local Review of the Vascular Service, Betsi Cadwaladr University Health Board

We undertook a local review of vascular services within Betsi Cadwaladr University Health Board. The review set out to consider the progress made by the health board in relation to the findings and the nine recommendations highlighted in the Royal College of Surgeons (RCS) of England Clinical Record Review Report, published in January 2022. Following this review, HIW designated the vascular service as a Service Requiring Significant Improvement (SRSI).

Overall, our review found that efforts had been made by the health board to implement processes and make improvements within its vascular services, with the aim to provide safe, timely and effective care to patients. Satisfactory progress had been made against all nine recommendations made by the RCS review team, and work to address the five urgent patient safety risks was commenced promptly by the health board. This resulted in the service being de-escalated as a SRSI. Our report noted that further work was still required to strengthen some aspects of clinical record keeping.

We published our report Vascular Services at Betsi Cadwaladr University Health Board; a review of Progress in June 2023.



All Wales Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions

DNACPR decisions are an important part of end-of-life care that can ensure a respectful and dignified death. It is therefore imperative that these decisions are handled and communicated sensitively and effectively. In 2023, we commenced a national review considering the arrangements in place across Wales when DNACPR decisions are made for adults. We explored whether DNACPR decisions reflect the priorities of an individual, including their preferences, and whether DNACPR decisions was clearly recorded and communicated between healthcare teams, and to the patient and those close to them.

The report, published in May 2024, found that there are examples of noteworthy practice across Wales regarding the DNACPR decision making process. However, we also identified opportunities to improve, including the need to strengthen the quality of communication with both patients and those close to them, including healthcare teams to clearly document discussions on DNACPR forms.

We found that staff need support and empowerment to hold honest conversations, and patients and families should be encouraged to discuss end-of-life wishes. Health boards and trusts must ensure DNACPR discussion resources are shared and used. Training also needs attention across Wales.

We concluded that closer attention to detail is needed when completing the all-Wales DNACPR form, ensuring it is fully completed and supported by clear, legible records of decision-making and conversations with patients and families.

We hope that our review leads to improvement in this area, particularly so that the right balance can be struck between clinical decision making and respecting the wishes of patients and families.

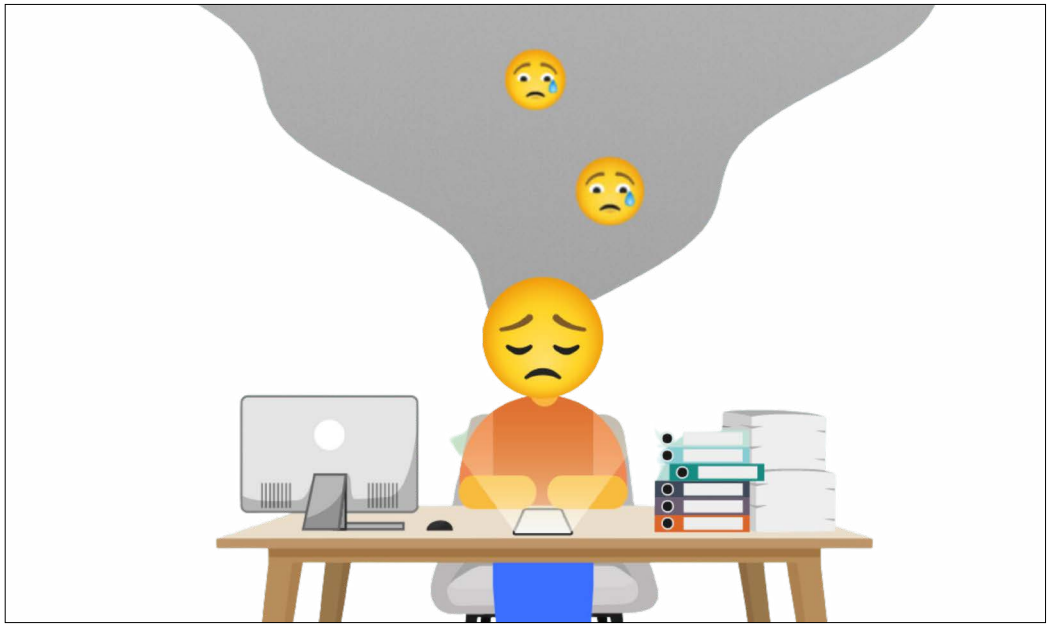
A summary of our findings can be found on our website.

Joint Review: How are healthcare, education, and children's services supporting the mental health needs of children and young people in Wales?

This joint review with Care Inspectorate Wales (CIW) and Estyn commenced during 2023 to consider whether children and young people are receiving timely and effective support for their mental health needs. The review focuses on children aged 11 to 16 in mandatory education and considers the services available to support their mental health needs within healthcare, education, and children's services, before referral to or assessment by specialist CAMHS.

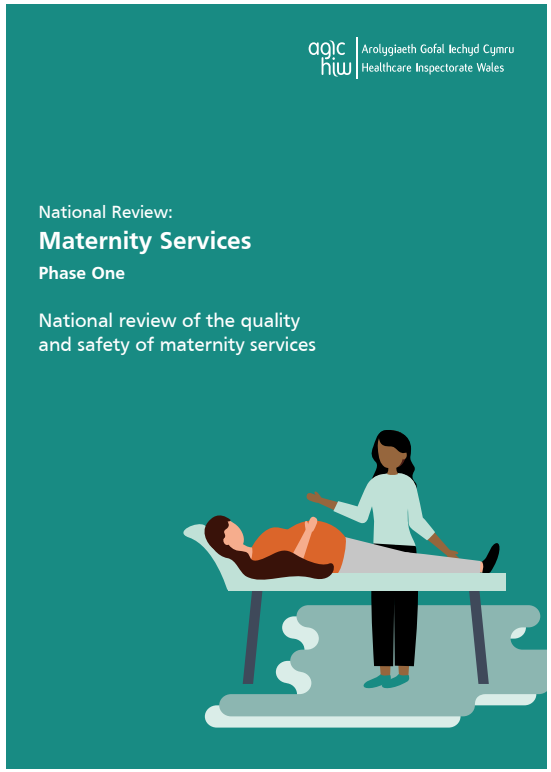
Our research and stakeholder engagement has helped inform the scope of our work to answer the question:

How are healthcare, education, and children's services in Wales supporting the mental health needs of children and young people, as they wait for assessment, or who do not meet the criteria for specialist CAMHS intervention?



Stage one of the review took place between January and March 2024. This stage helped inform the decision on where to undertake further scrutiny during onsite fieldwork in a selection of health board areas.

The report is due to be published in late 2024.



National Review of Maternity Services - A follow-up on improvement plans

In November 2020, HIW published the final report of its National Review of Maternity Services. The report highlighted 32 recommendations for health boards to consider and five for Welsh Government. Each health board and Welsh Government were asked to consider the findings from our review and the recommendations highlighted in the report. All were required to submit an improvement plan to HIW in response to the review's recommendations, to ensure that the matters raised by our review are being addressed.

During 2023-2024, we followed-up on the progress made by health boards in relation to their improvement plans. For this, we considered the details provided to us in our first follow-up, undertaken in February-March 2021, and updates provided to us during June and July 2023.

HIW is currently reviewing the findings from maternity inspections undertaken during 2022-23 and 2023-24, to identify key themes. The findings will be considered in the context of the recommendation made following the national previous national review. This work will be used by HIW to inform any future assurance work and key relevant findings will be shared with Welsh Government in order to support its wider oversight role.

05.

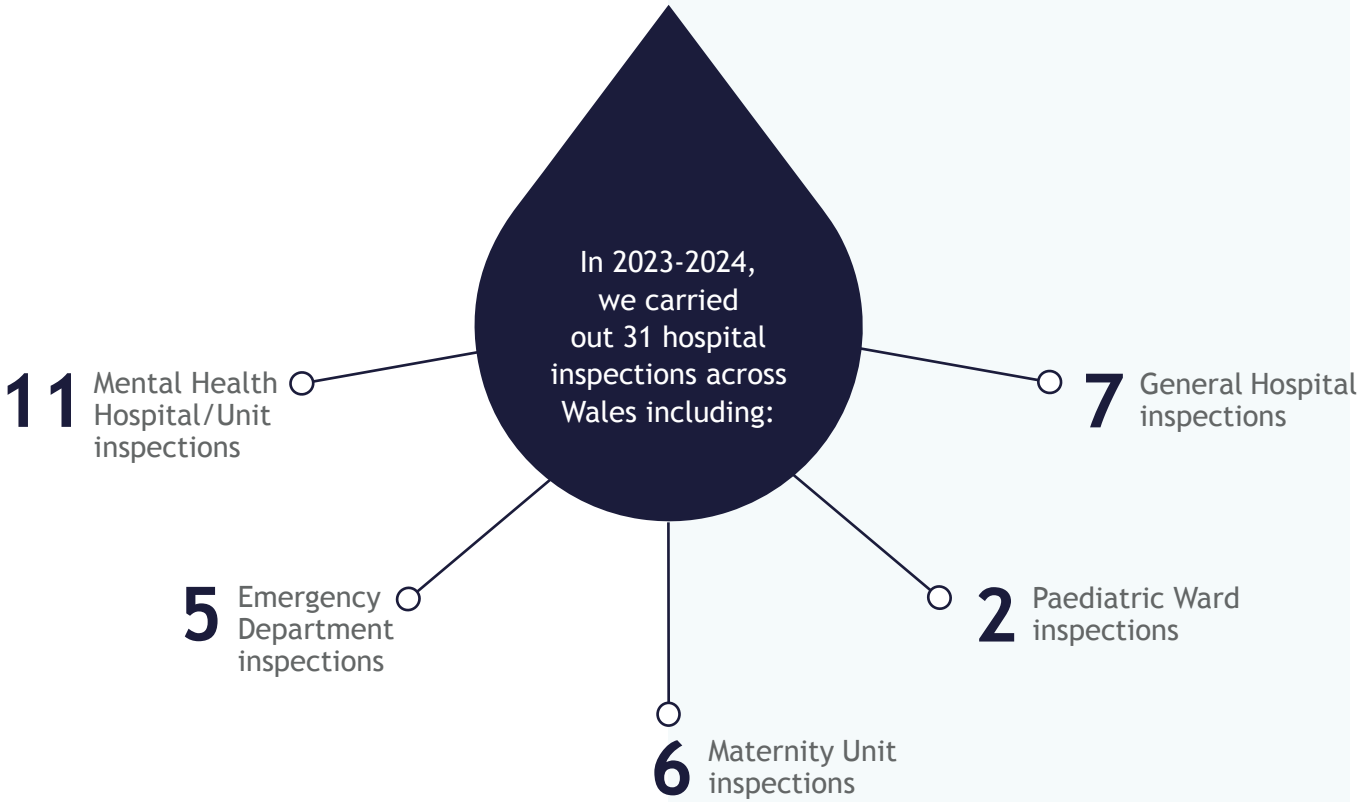
NHS Services

NHS Services

Our Findings

Our work within the NHS showed the demand for inpatient beds and maintaining safe staffing levels to manage the high number of patients remained a significant challenge. Assurance work within acute hospitals has shown the sustained pressure in patient admission areas and on inpatient wards. Within Emergency Departments across Wales, we noted overcrowding and long waits for treatment, alongside delays with patients being discharged. Overall, we found that patients generally received a safe level of care. However, despite efforts by health boards, the patient flow challenges meant that some patients did not receive timely care and treatment and remained in the Emergency Department for longer than expected.

Through our work we have once again seen a highly skilled and committed workforce, delivering care with dignity and compassion. Teams were professional, cohesive, and supportive, with staff working hard to provide patients with a positive experience and good levels of care despite extreme pressures.



Our findings on a national level, once again highlighted:

- Huge demand for services
- Compliance with mandatory training remains mixed and in general, across Wales, there are challenges in ensuring the workforce keeps up to date on training
- The quality of the discharge planning process needs to be improved
- There is an ongoing need to reduce patient safety risks within the clinical environment. For example, we continue to find medicines unsecured, harmful substances not locked away and equipment not maintained as regularly as needed.

Emergency Care

Our work found evidence of significant pressures in the emergency care system. The increased pressure meant that we have continued to see overcrowded Emergency Departments, delays in ambulance handover of patients and long waits for triage and treatment to start. We are continuing to see the effect of poor patient flow due to the volume of patients awaiting discharge. This impacts on the quality of care and patient experience. This manifests in overcrowded waiting rooms, which leads to staff pressure, including:

- Inadequate privacy and dignity for patients
- Low levels of mandatory training compliance
- Poor infection prevention and control
- Incomplete tasks leading to risk
- Lack of risk assessments, poor oversight, and security.

It was positive to see hospitals are bringing in many new initiatives to manage the increased volume of walk-in patients at emergency departments, including environmental changes such as creating larger waiting areas and specialist frailty and dementia services.

Mental health care continues to be an extremely busy area within the delivery of emergency care across the NHS, with all but one of our emergency department inspections noting issues with areas for patients presenting with serious mental health issues. We have observed long waiting times and identified additional areas for improvement to reduce the risk of harms such as potential ligature, for patients with diverse needs.

Maternity Care

We found staff within the maternity wards 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.

Our inspections highlighted the importance of good communication, whether that is through birth choices or pain relief. We have also seen improvements in systems for women and birthing people whose first language is not English.

Through our inspection work within maternity units, we have highlighted how staffing and positive leadership can make a significant difference to the quality of care being provided.

Our inspection and assurance work noted an increase in the provision for women seeking sanctuary and survivors of harmful practice. Whilst this important work could always be strengthened, it was positive to see more staff involved in the delivery and championing of these important initiatives to improve outcomes for women with differing needs.

The case study below demonstrates how a challenged service has looked for different ways of working to prove outcomes for patients.

Case Study of Good Practice - Bronglais Maternity Unit

We conducted an unannounced inspection of the Maternity Unit at Bronglais General Hospital in Aberystwyth, run by Hywel Dda University Health Board. Inspectors completed the inspection across three consecutive days in August 2023, focusing on antenatal, labour, and postnatal care.

During this inspection, we found a dedicated team of staff, who were committed to providing a high standard of care to women, birthing people, and their families. Inspectors witnessed staff at all levels working well as a team to provide a positive experience, that was individualised and focussed on the needs of the women and birthing people they were providing care for.

Responses to our staff survey were positive, and this was reflected in the quality of care we saw.

Staff comments included:

“I truly do feel proud to work for this unit. There’s such a sense of togetherness in our shared vision or providing excellent care for women and families in our community, and everyone takes genuine pride in the service we offer.”

“A great work environment with excellent teamwork and morale.”

“We are able to provide very safe and individualised care to our patients, putting their needs first and ensuring they are part of their care & the decisions that are made. We are able to provide one to one care on a regular basis, and due to being a small team there is often continuity which is not only positive & reassuring for those we care for but for us as staff too.”

Governance and leadership within the unit was highlighted as good practice, which had had a significant positive impact on the wellbeing of staff, and in turn on the quality of patient care and patient experience.

Inspectors observed staff providing kind and respectful care to women and birthing people and their families. When asked, all women and birthing people were positive about their care, the staff, and the maternity environment. We saw evidence that those with communication difficulties were identified and supported to effectively access services through the maternity passport scheme. The scheme can be used for those who are neurodiverse, and those with learning difficulties or any other communication difficulties,. to record communication needs of those receiving care. Inspectors witnessed staff speaking in Welsh and we were told by people using the services that the active offer of Welsh made a positive impact on their care.

Staff were also kept informed through internal newsletters to keep them up to date with new developments and events etc. We also saw evidence of a wide range of teaching and learning opportunities, including lunch and learn sessions.

Staff described a positive culture with good, supportive leadership. A clear management structure was in place with clear lines of reporting and accountability. Managers were visible, approachable, and receptive to feedback. There was a stable midwifery staff team with a strong team ethos and compassionate leadership. It was noted the unit did not experience some of the significant staff shortages that have been experienced elsewhere in UK. A range of supportive initiatives were in place to ensure that more junior staff members are supported by senior staff.

All staff told us they felt they could raise concerns to midwifery staff and consultants.

This was achieved through a number of good cultural and governance processes. We saw a supportive culture around learning from incidents, such as the quick reporting of incidents, including those with no harm. Doctors and midwives led on sharing learning from incidents and communicating next steps widely. Themes were tracked and learning was encouraged through an open and supportive culture. Staff told us there was a culture of 'closing the loop', i.e. always fully responding to concerns and reflecting.

Further examples of good practice included the unit being part of the health board's wider teams and networks, ensuring that the staff members who work in the smaller maternity unit are fully integrated and supported within larger networks.

Through our assurance work across the NHS in Wales we found a number of reoccurring thematic issues, these include:

Staffing

Resourcing and staffing remain an issue for NHS services across Wales. This in turn is often leading to staff burnout, low morale, and a high turnover, subsequently causing a cycle of added pressure on the remaining staff.

Through our work we have seen good practice in some maternity settings where they are more prudent in their approach to workforce planning, including overestimating sick and maternity leave, and planning shift cycles in advance for resilience purposes.

Equipment and Medicines Management

Following recent assurance work, we have reported on a number of issues relating to the availability or equipment and the management of medicines. In some circumstances we have needed to ask the setting to take immediate action to reduce risks to patient safety.

A recurring theme from our work is the availability and access to monitoring equipment for patients. When asked, a significant number of staff told us this is an issue where they work, causing delays and frustration.

Medication management also remains a consistent issue, where we have sought immediate assurance due to insufficient security of medicines, poor monitoring of fridge temperature checks and the poor disposal of out-of-date medicines.

Physical Environment

We regularly see the impact of a lack of capital investment within NHS sites, with many services running within older premises which often require maintenance leading to service accessibility issues and an increased risk to patients, staff, and visitors.

Technology

We have seen improved use of technology in some inspections, where some settings are using digitalised systems to check emergency equipment, including the monitoring of compliance with those checks.

Within some services, compliance with checking of emergency equipment had increased to nearly 100%. This is welcomed by HIW as it is more efficient and has a positive impact on the delivery of safe patient care.

Unfortunately, the poor checking of emergency equipment is still a regular finding throughout our NHS inspections. We have, however, seen good practice where services have demonstrated that innovation through the use of technology is benefiting their governance procedures. For example, using live digital data and information to track and improve patient flow, service user experience and risk monitoring.

Staff Feedback

Responses we received to our staff questionnaires at NHS hospital inspections indicated generally low staff morale. This is particularly related to challenges around staffing numbers and high demand for services.

The majority of staff told us they struggle to meet the demand and want to be able to provide better care. However, this did not generally seem to impact on the experience patients had of staff, who were often praised for their commitment to deliver quality person-centred care.

Patient Experience

Despite the challenges encountered by staff as noted above, overall, patients told us staff were kind and compassionate. They told us staff are making increased efforts to protect their dignity. However, we are concerned about the sustainability of this given the ongoing challenges in healthcare settings relating to the increase demand and staff shortages.

General Practice

During 2023-2024 we carried out 21 inspections of GP practices across Wales.

Our updated General Medical Practice (GP) approach considers the wider primary care landscape including referrals and signposting to other services.

We found GP practices remain under significant pressure post-pandemic and are continuing to face unprecedented demand. Due to practice closures, staff shortages and long hospital waiting lists for treatment the pressure on GP services continues to rise. Our immediate assurance process, which identifies significant concerns or risks, was used for 10 of these inspections.

The immediate assurance issues included:

- Incomplete safeguarding records and poor follow up of concerns
- Checks of emergency equipment and drugs not completed
- No DBS checks on staff including admin/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.

Our patient experience surveys regularly conclude that staff treat patients with dignity and respect, but many patients told us they struggle to access an appointment. Difficulty in accessing GP appointments was a key theme to come out of Concerns raised with us during 2023-2024. The effects of delayed appointments on patients encompass physical health, emotional well-being, and overall healthcare experiences.

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.

Areas of good practice to emerge from our programme of work included:

- Larger centres providing more centralised services, including physiotherapists, social prescribers improving access to services for patients
- Specialist mental health associates to provide more local care
- Cluster paramedics conducting home visits to ease pressures on GPs
- Cluster pharmacists and psychological wellbeing practitioners available to improve outcomes for patients
- Upholding patient rights by using preferred names and pronouns when treating transgender patients
- Generally, a good level of health promotion including the ‘Active Offer’ of different languages

- Additional clinics working out of usual hours for vaccinations, making it easier for patients to access
- Patients told us that they are treated well when they do see a clinician.

Common improvements areas that featured across our inspection included:

- A need for improvements to privacy, especially for patients who need to discuss potentially sensitive matters regarding their health at a reception desk
- Incomplete or outdated risk assessments for physical environments including potential safeguarding risks and fire hazards
- Inadequate checks of emergency equipment
- Inconsistencies in following up when children missed appointments/clinics and potential safeguarding referrals
- Low levels of basic and critical mandatory training including basic life support.

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

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.

During 2023-2024 HIW completed eight IR(ME)R inspections, covering the three modalities of medical exposures. This included four diagnostic imaging departments, one of which was an independent hospital, three nuclear medicine departments, one of which was an independent provider, and one Radiotherapy Department.

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 positive when asked about their experience attending the departments. Patients generally provided good feedback about their experiences. Whilst feedback from staff was generally positive, there were some negative responses and comments from staff relating to low resourcing issues.

There was generally good compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017, within the majority of hospitals. Training records, both mandatory and IR(ME)R training, were good in most departments as well as compliance with the annual appraisal process.

In one department we were told that referral forms for exposures performed during surgical theatre cases were not being completed by the referrer but were completed by the radiographer. This was not in keeping with the requirements of the duty holder role and the responsibility of the referrer.

Whilst employer's procedures, required by IR(ME)R 2017, were generally well written, there were areas identified where these could be further improved.

8
IRMER inspections

Mental Health

During 2023-2024 we undertook a total of 26 mental health inspection visits to in-patient wards and two inspection visits to community services. During the reporting period we undertook onsite inspections to a range of healthcare settings of both NHS and independent hospitals. The wards and services inspected accommodated a range of patients which included:

- Adults with mental health issues
- Older persons
- Learning Disabilities
- Child and Adolescent Mental Health Services (CAMHS)

In relation to community services, we undertook one visit to a community mental health team (CMHT) and one visit to a community learning disability team (CLDT).

During the visits we consider a range of key areas under the three distinct headings of quality of patient experience, delivery of safe and effective care and the quality of management and leadership.

For the NHS we look at how the mental health care services meet the Health and Care Quality Standards 2023. For the independent providers we look at how these services comply with the National Minimum Standards for Independent Health Care Services in Wales 2011 and the Mental Health Code of Practice Wales (revised 2016). For both NHS and independent providers, we consider how these services comply with the Mental Health Act 1983 and the associated Code of Practice, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and the implementation of Deprivation of Liberty Safeguards.

We used our immediate assurance/ non-compliance process on seven occasions. This represents a quarter of our inspections where issues found during an inspection carried the most immediate risk to patients.

A positive area across most of our inspections was the quality of staff and patient interaction. Staff interacted and engaged with patients appropriately and treated patients with dignity and respect. Patients felt they could engage and provide feedback to staff on the provision of care at the hospital they were staying.

In relation to the monitoring of the use of the Mental Health Act we found that patients were legally detained according to guidance and legislation. Overall, the records we viewed were well organised, easy to navigate and contained detailed and relevant information. In addition, we observed that patient rights information was clearly documented with an assessment of patient understanding, in accordance with section 132 of the Act, and good systems were in place to support the automatic renewal of detention.

26
mental health inspection visits

However, we identified several significant issues with the implementation of the Act, including Hospital Manager Hearings not being held in a timely manner, with a delay of 5 months in one instance. In addition, section 17 leave forms had the term 'cancelled' on them instead of 'no longer valid' where leave had been taken, and assessments of capacity had not been conducted and documented before carrying out the care and treatment of patients.

Patients who are in an acute and/or challenging phase of their illness may unfortunately require the use of seclusion for a limited period. In one of our visits where seclusion was being used, we observed that the area being used to seclude the patient did not conform to best practice standards or to the health board policy and procedures for the use of seclusion. Notably, a clock was not visible and there was no temperature control outside the area. The separate toilet facility being used by the patient had not been adapted for high-risk patients and we were concerned over their access to regular periods of fresh air. Lastly, there was no seclusion care plan in place for the patient which contravened the health board policy. In addition, in terms of patient observation; levels of observations had not been updated in care plans since the last care and treatment review meeting.

Unfortunately, in recent years, we have found little improvement in the following areas:

Staff and Patient Safety – issues included ligature risks that had been recommended for anti-ligature work in 2020 but still hadn't been completed, patient call bells were not easily accessible and appropriate for the patient group and staff were not wearing personal alarms.

Workforce challenges – issues with recruitment and retention of staff and the inadequate induction of agency staff.

Medicines Management – a range of issues with the storage, administration and recording of medicines.

Training – a lack of training on key areas including Restrictive Physical Intervention (RPI) training, Mental Capacity Act, manual handling and basic life support.

Patient Information – lack of information available for patients on key topics.

Care Planning Documentation – we were not always assured that the care and treatment arrangements in place were in line with the Mental Health (Wales) Measure 2010.

Risk Assessments – not always completed and the review of them not always timely.

Environment of Care – lack of a structured approach for timely repair, replacement and refurbishment of wards.

Governance – a lack of audit and oversight of key areas of quality and patient safety.

During our inspections we observed committed and determined staff, working hard but clearly under pressure from a shortage of mental health beds.

Delayed access to mental health services had become all too common and this was placing additional pressure on staff and patients.

Timely access to mental health services is crucial to ensure the best care pathway for an individual to achieve the best outcome. Without timely care and treatment, a patient may well experience crisis and risks that could be avoided.

Second Opinion Appointed Doctor (SOAD) Service for Wales

The Second Opinion Appointed Doctor (SOAD) service operates as a hybrid service. When requested by a patient's responsible hospital, the Review Service for Mental Health arranges for an independent doctor, called a Second Opinion Appointed Doctor (SOAD) to provide a second opinion if a patient is not able or willing to consent to their treatment. This is a statutory requirement undertaken by HIW on behalf of the Welsh Ministers.

Our methodology is set out in detail in our guidance to all SOADs and provided to all Mental Health Act Administrators on our website. In addition, we produce a patient information leaflet, also available on our website, for all patients to understand their rights and the role of the SOAD service.

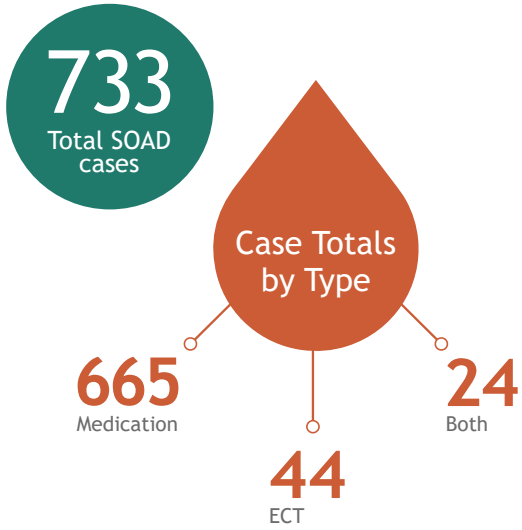
This year we amended our methodology to fully incorporate and utilise the benefits of hybrid methodology that has been in use since 2021.

One of the main changes we have implemented is that whilst SOAD visits should occur in person for the purposes of interviewing the patient for most cases, we have make us of a 'remote first' approach in relation to Community Treatment Order (CTO) cases. All patients are consulted by their clinical team prior to the submission of requests to confirm if they are content for their CTO case to be dealt with on a remote first basis. Patients retain the right, in all cases, to specifically request an onsite visit from a SOAD. Our forms are being updated to reflect these changes and will be published in late 2024. In addition, we are refreshing and redrafting our suite of guidance toolkits on all matters relating to the Review Service for Mental Health (RSMH) services, including the SOAD service. We are currently in the process of consulting with external stakeholders on these revisions and intend to publish our refreshed guidance toolkit suite on our website later in the year.

The SOAD must, and will, use their professional opinion and discretion to consider whether they can safely and confidently certify remotely, and the method of interviewing the patient should always be recorded as part of their reasoning on their Certificate of Consent forms.

Full advice on our methodology is available on our website and is currently being updated to reflect the changes we have made this year.

Total breakdown for SOAD cases between 01/04/2023 - 31/04/2024:

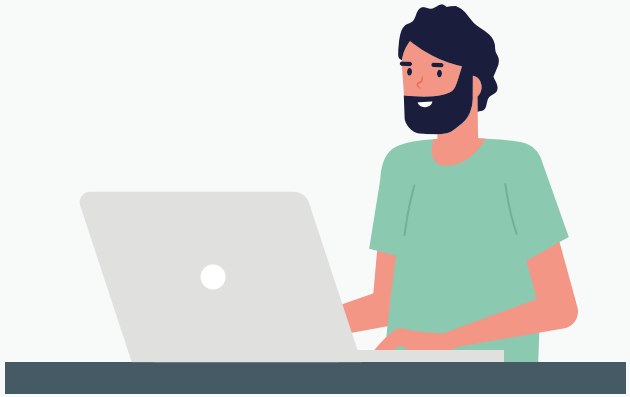


Review of Treatment (Section 61)

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 (MHAA) office for all local health boards and independent settings for the Responsible Clinician to complete. For the eight consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed by our lead SOAD for Wales on a monthly basis. We categorise and identify any compliance issues and use this to identify trends and discrepancies in administration of the Mental Health Act 1983. This process is designed to add an additional layer of patient safety to those being treated under the Act and is in compliance with requirements placed upon HIW as outlined in the Code of Practice (for Wales) revised 2016.

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

- There continue to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting and this resulted in several new SOAD certification requests.
- There remain minor discrepancies in relation to complex issues relating to the patient address as listed on the CO forms. This relates to patients mainly who have no fixed abode. HIW have produced guidance to MHAA's in relation to this subject to minimise these instances.



[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.

06.

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 and mental health hospitals, to independent clinics and laser services. The mental health hospitals provide care for NHS funded patients with complex needs. Many dental practices in Wales are also independent healthcare services, providing private dental healthcare, or a mix of NHS and private dentistry. Consequently, the regulatory sector accounts for a significant proportion of our assurance work.

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

Our Findings:

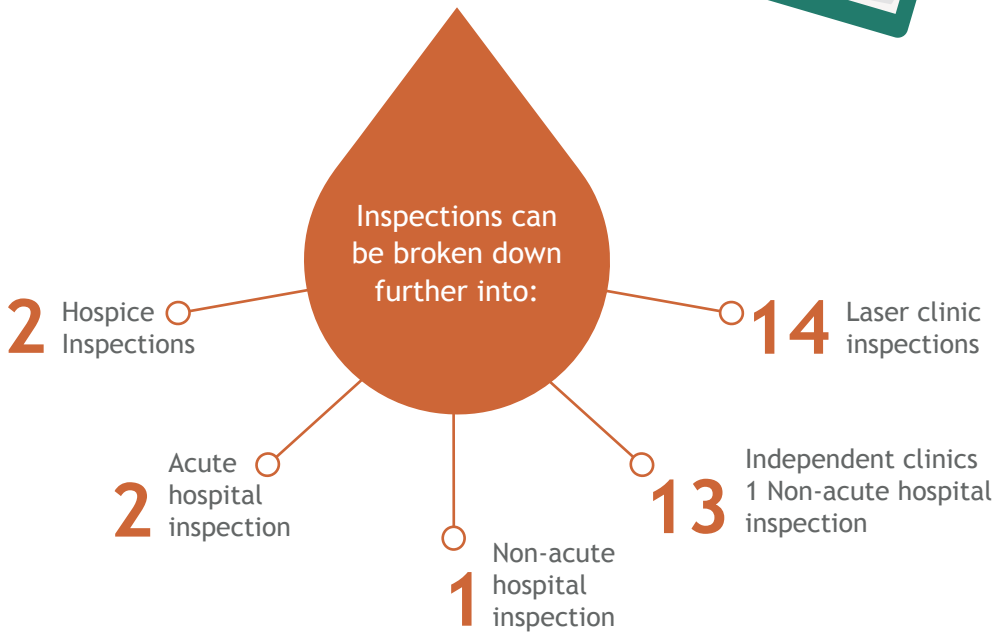
During 2023-2024, HIW completed 266 pieces of work associated with the registration of independent healthcare providers. This involved the registration of 101 new independent healthcare providers. This number included new dental practices and laser clinics.

Once registered, any changes a service intends to make to its conditions of registration, requires an application to vary what it is 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.

In addition to this, all independent healthcare services have a manager who goes through a registration process to enable them to run a service.

During 2023-2024, HIW processed and approved a total of 41 registration variations.

In 2023-2024, HIW processed and approved 124 new managers of independent healthcare services.



To check that 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 2023-2024, we undertook a total of 32 individual pieces of assurance work to independent healthcare settings.

In addition to the above, 13 inspections to independent mental health services and 62 dental practice inspections were completed. These are discussed elsewhere in the report.

Independent Mental Health Services

Throughout our 13 independent mental health inspections, four non-compliance notices were issued. Our broader findings from our mental health assurance work can we found in elsewhere within this report, but we have specifically focused on key areas of non-compliance within this section.

The areas of immediate concern that emerged in relation to non-compliance were:

- Restraints not being appropriately reported and investigated, with insufficient analysis and investigation of the restraints to understand whether they could have been avoided and whether the restraint used was appropriate
- A lack of suitably qualified staff trained in immediate life support, on duty at all times
- Poor statutory recording of consent to authorise treatment administered to patients, along with incorrect type and dosage of medication
- Inaccurate recording of administered medication and a lack of audits to identify where mistakes are made, discrepancies identified and quickly rectified
- Capacity to consent to treatment for patients not being carried out in line with the framework set out in the mental capacity act and the Mental Health Act Code of Practice for Wales
- Areas of some hospitals in a very poor state of repair, requiring a deep clean to adhere to best practice Infection Prevention Control standards, inaccurate and ineffective audits.

13

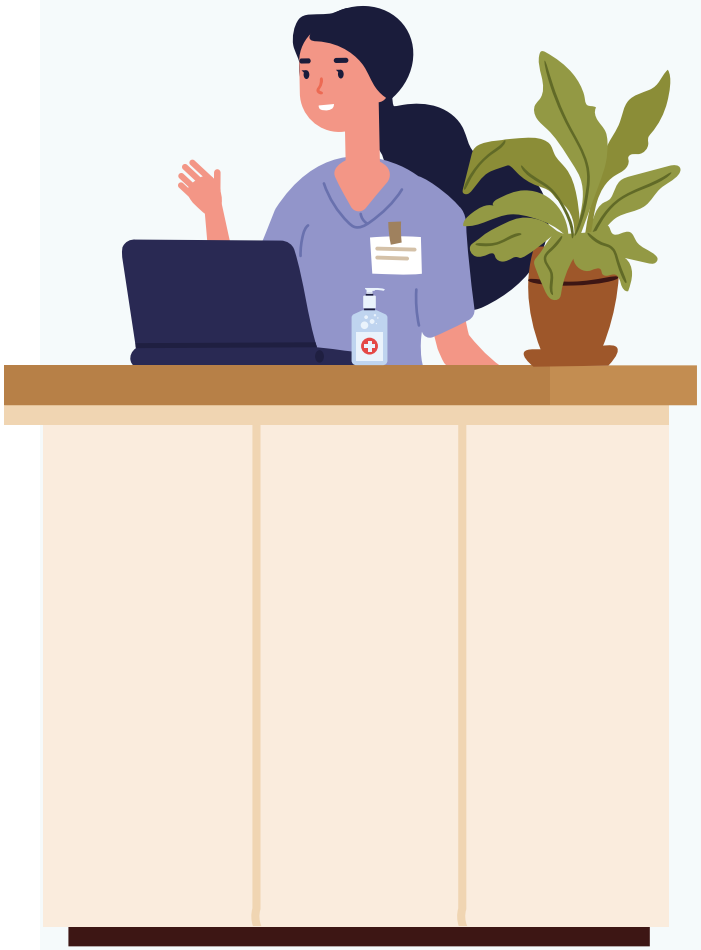
independent mental health inspections

Independent Hospitals, Clinics and Opticians

If, following an inspection, we find that a service provider is compromising patient safety and failing to comply with the terms of their regulatory requirements and registration, we will take immediate action by issuing a non-compliance notice. Through, our hospital, clinic and opticians' inspections four non-compliance notices were issued.

The key areas of immediate concern related to:

- Lack of daily and monthly checks of the emergency resuscitation trolleys
- Poor levels of mandatory staff training including safeguarding and first aid training
- In one inspection, the display of appropriate protocols such as the major haemorrhage protocol was insufficient
- Medical records were not always available for inspection
- The Statement of Purpose document was not updated to include additional services being provided at the setting since initial registration
- Inadequate of checks and audits to ensure expired medication is removed and replaced
- Lack of fitness to work checks including DBS checks for staff
- Lack of fire safety risk assessments, fire safety training, fire safety audits and drills.



Dental Practices

During 2023-2024, we undertook 62 pieces of assurance work to dental practices across Wales, including 15 pre-registration visits. These inspections were conducted onsite at the practices, where a HIW team including a qualified dentist working as dental peer reviewer spent time examining the practices, policies and procedures which governed the way each practice was run.

Access to dental care and treatment continues to emerge as a key theme this year. Factors such as the availability of dental providers and high demand have all impacted the ability of patients to access timely dental care.

Research shows delayed dental appointments can lead to the progression of oral health issues, i.e. a minor concern could develop into a more complex problem, requiring more invasive and costly treatments.

Across all our dental assurance work, we issued urgent non-compliance notices on 11 occasions. This meant we came across concerns which had the highest level of risk to patient safety and therefore needed action to be taken within 48 hours.

We also made a substantial number of recommendations for improvement.

The recommendations included the following themes:

- Low levels of compliance with staff mandatory training including Duty of Candour training in some practices providing NHS services
- Lack of pre-employments checks, such as Disclosure & Barring Service (DBS) checks and arrangements ensuring staff were fit-to-work within a practice
- Inadequate fire risk assessments, fire safety training and drills, arrangements for ensuring equipment relating to fire safety was maintained and stored correctly
- Out of date medication within emergency drugs boxes
- Medication including emergency drugs not being stored securely
- Resuscitation equipment required to be on site was not always readily available
- Inconsistencies with mandatory first aid training for staff, including not always having first aid trained personnel on site
- The equipment used for de-contamination and some treatments were found to be unsafe with no records of servicing or maintenance
- Damaged and unsafe X-ray equipment including no evidence of staff training, maintenance, or servicing
- Lack of audits such as infection prevention and control and clinical audits
- Patient records not being stored securely.

Independent 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 2023-2024, we completed two onsite inspections to adult only hospices in Wales 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.

Families and carers who provided us with feedback were positive about the care being provided, and the support they were being given. Staff were seen to engage positively, and patients told us that staff were kind and caring. We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner. There was a multidisciplinary approach to the provision of care with the staff team committed to provide patients with compassionate, safe, and effective care.

We found that improvement was required in terms of risk assessments and some aspects of auditing infection prevention and control procedures. Inspectors noted a lack of risk assessments including for falls and pressure sores being carried out effectively. We were also not assured all the staff had received updated mandatory training including basic life support.

2
onsite inspections

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

During the year 2023-2024, we conducted 14 onsite inspections to laser and IPL registered providers across Wales.

From these inspections we identified non-compliance with relevant regulations in six cases. This means that in 57% of these inspections, we found laser and IPL providers were not meeting all of the requirements to comply with their registration. The issues we found required us to issue urgent non-compliance notice to ensure immediate action was taken.

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 several areas to demonstrate their fitness to provide these services. We found several 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 several 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 appropriately trained first aiders and an up to date first aid kit were also recommendations made in a number of these inspections.

Other areas of non-compliance were:

- Medical and treatment protocols were not complete or not being adhered to
- Lack of fire safety risk assessments, fire safety training, fire safety audits and drills.
- Settings providing treatment with a laser machine that was not included within the original registration
- Incomplete and inaccurate recording of patient notes and notes not being securely stored
- Electrical appliances had not been PAT tested.
- Staff not having up to date first aid training, not having completed or updated core of knowledge training
- Insufficient Policies and Procedures not adhering to the requirements set out in the regulations
- Lack of a Laser Protection Advisor (LPA) contract, or not having in place an annual review with the LPA and lack of local rules for the devices in use at the setting.

Escalation and Enforcement

The Escalation and Enforcement Team manage and lead all escalation and enforcement activity in relation to NHS, independent healthcare, and private dentistry in Wales. The team investigates and instigates criminal proceedings utilising the civil powers afforded to HIW to regulate registered providers.

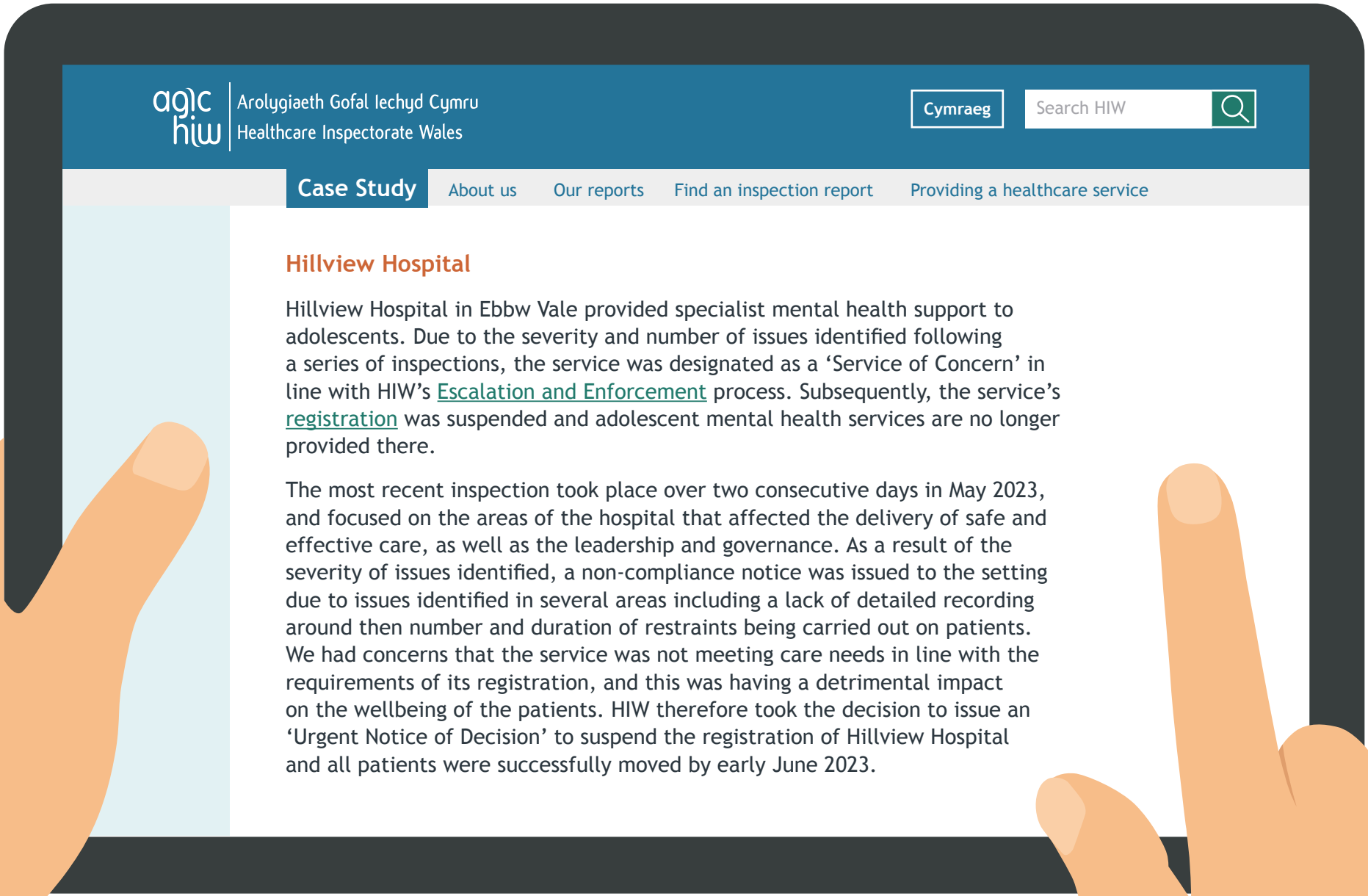
In 2023-2024 the Escalation and Enforcement team held 85 Service of Concern (SoC) meetings with regards to private healthcare and dentistry in line with our escalation procedures. HIW's SoC process is used when there are significant service failures, or when there is an accumulation of concerns about a service or setting.

We encourage the reporting of unregistered providers. This year we have seen an increase in unregistered aesthetic providers being reported, with this informing our enforcement activity. We will continue to raise awareness of the need to register through proactive communications and engagement.

For NHS services, we held 13 SoC meetings during 2023-2024 because of concerns arising from our assurance work. These SoC discussions may lead to a service being designated a Service Requiring Significant Improvement (SRSI), a process we introduced in November 2021 in order to drive focused and rapid action by health boards and trusts to ensure safe and effective care is being provided. During 2023-24, no services were escalated to being a SRSI, however, we de-escalated one service from the SRSI designation. This is referred to within the reviews section of this report.

In total 12 registered settings were designated as a SoC in that period. The team also instigated three criminal investigations during 2023-2024.

9 Independent Health
3 Private Dental
Services with a SoC designation at 31st March 2024:
1 Emergency department
1 Minor injury unit
2 Paediatrics
4 Mental Health
2 Maternity
NHS Services monitored as part of the NHS SoC process in the year 2023-2024:
1 GP
2 other
3 warnings issued
3 criminal cautions issued
3 ongoing
Criminal Investigations / outcomes:
Settings with a Service Requiring Significant Improvement (SRSI) designation at 31st March 2024:
1 NHS Service
Provider Meetings held in 2023-2024:
5 independent healthcare



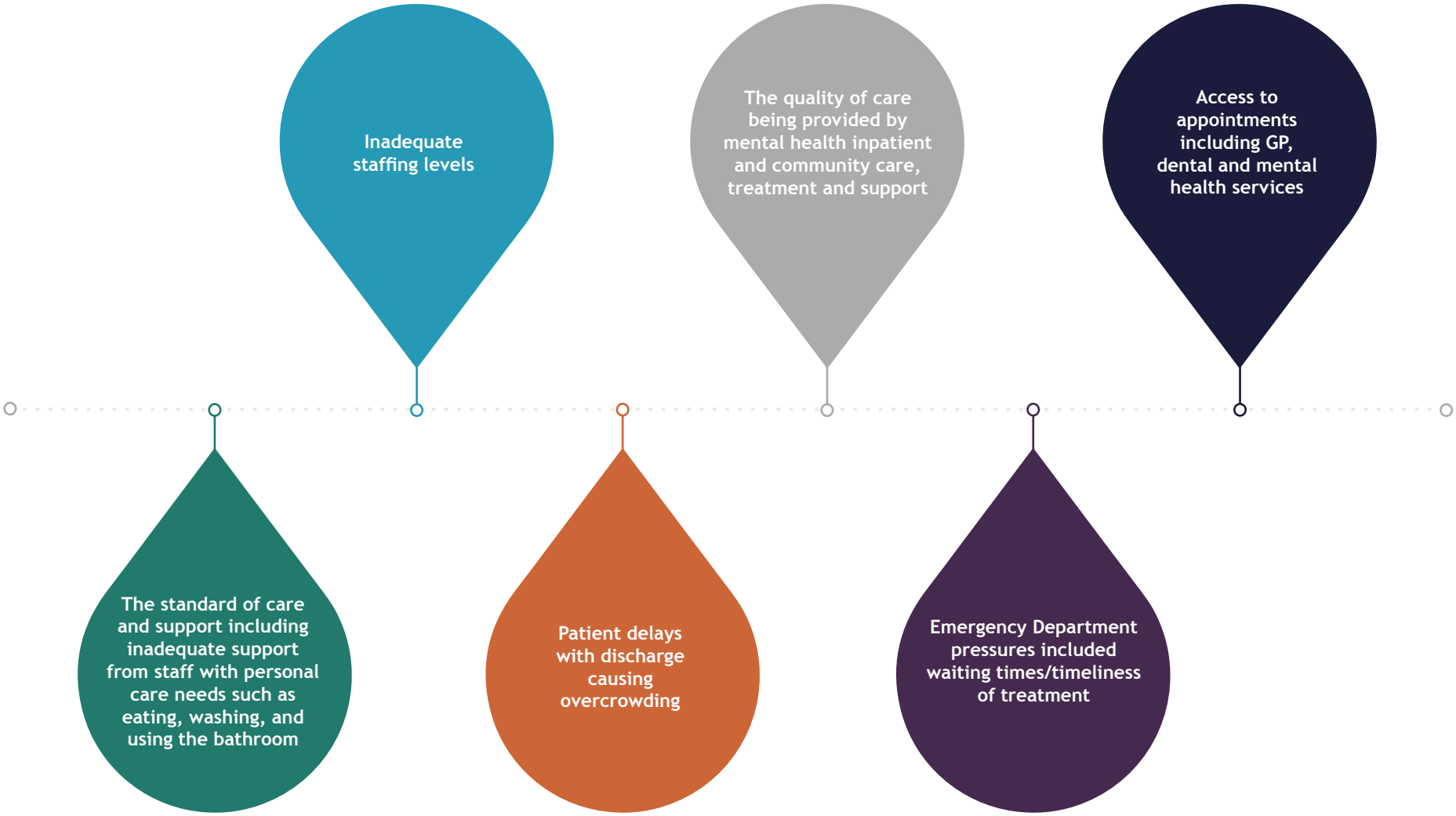
Hillview Hospital

Hillview Hospital in Ebbw Vale provided specialist mental health support to adolescents. Due to the severity and number of issues identified following a series of inspections, the service was designated as a 'Service of Concern' in line with HIW's Escalation and Enforcement process. Subsequently, the service's registration was suspended and adolescent mental health services are no longer provided there.

The most recent inspection took place over two consecutive days in May 2023, and focused on the areas of the hospital that affected the delivery of safe and effective care, as well as the leadership and governance. As a result of the severity of issues identified, a non-compliance notice was issued to the setting due to issues identified in several areas including a lack of detailed recording around then number and duration of restraints being carried out on patients. We had concerns that the service was not meeting care needs in line with the requirements of its registration, and this was having a detrimental impact on the wellbeing of the patients. HIW therefore took the decision to issue an 'Urgent Notice of Decision' to suspend the registration of Hillview Hospital and all patients were successfully moved by early June 2023.

Concerns, Investigations and Notifications

Key themes from concerns received

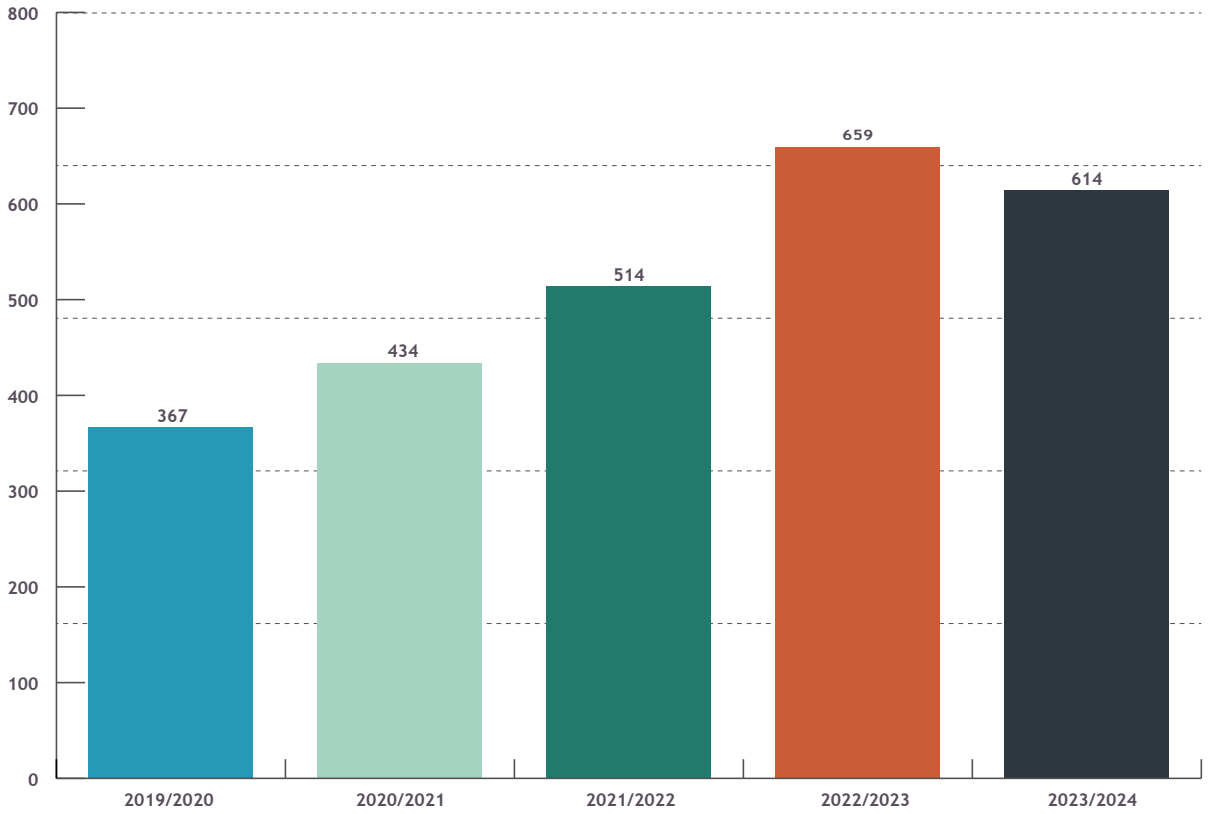


Total number of concerns received by HIW

As an organisation we are committed to managing concerns fairly, efficiently, and effectively. Concerns play a crucial role in identifying issues and driving improvement within the healthcare sector. Feedback, often conveyed through concerns, provides valuable insights into areas of risk, inefficiencies, and lapses in quality. These 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.

Whilst HIW is not a complaints body, the concerns we receive provide an important opportunity to identify problems within a healthcare service. We use this intelligence to inform our assessments of services and steer decisions on the assurance activities we undertake.

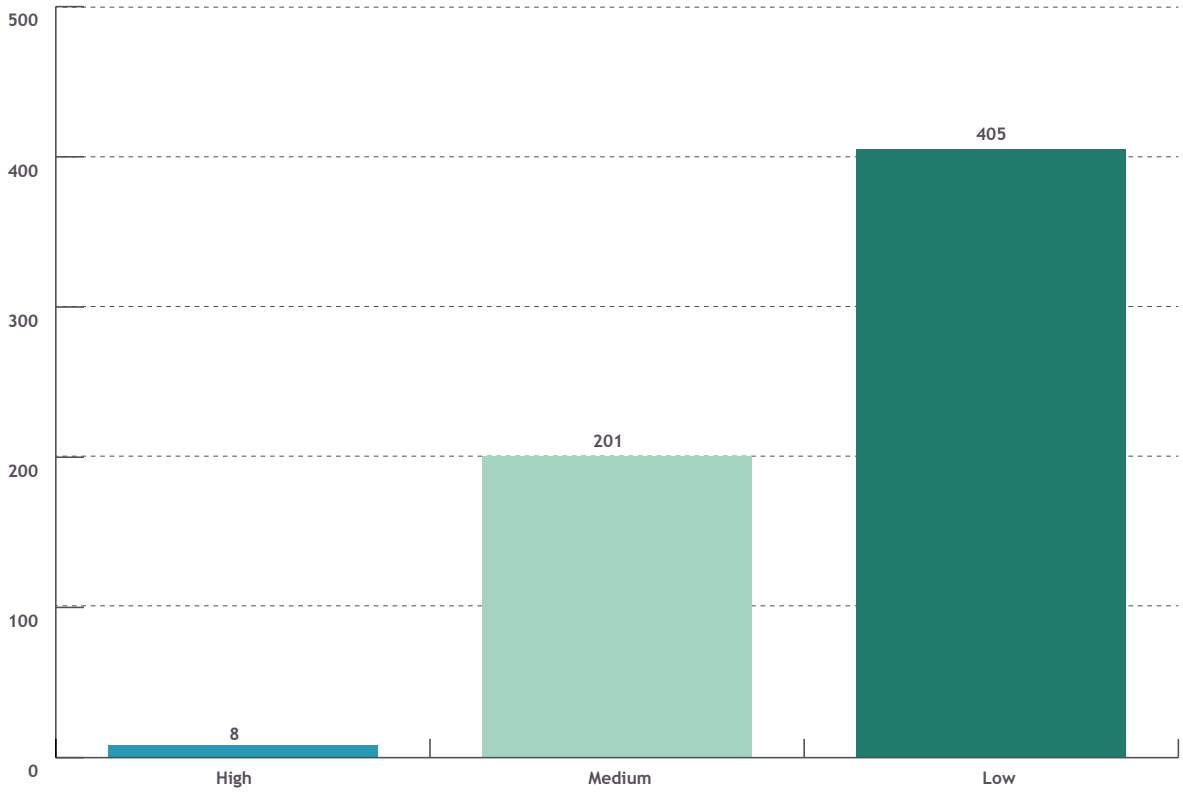
In total we received 614 concerns from 1st of April 2022 to 31st of March 2023. This represents a slight decrease of 45 concerns compared to the previous year.



HIW responds immediately to all high-risk concerns. This can be in the form of immediate escalation to the healthcare organisation for assurance, and/or immediate intervention via safeguarding structures or the police. In 2023-24, we requested further assurances from the relevant healthcare organisation in a quarter of the concerns we received.

The number of high risks concerns received has decreased this year, with an 87% decrease on the previous year. The drop is mainly due to changes in the way in which we triage concerns based on the level of the response required.

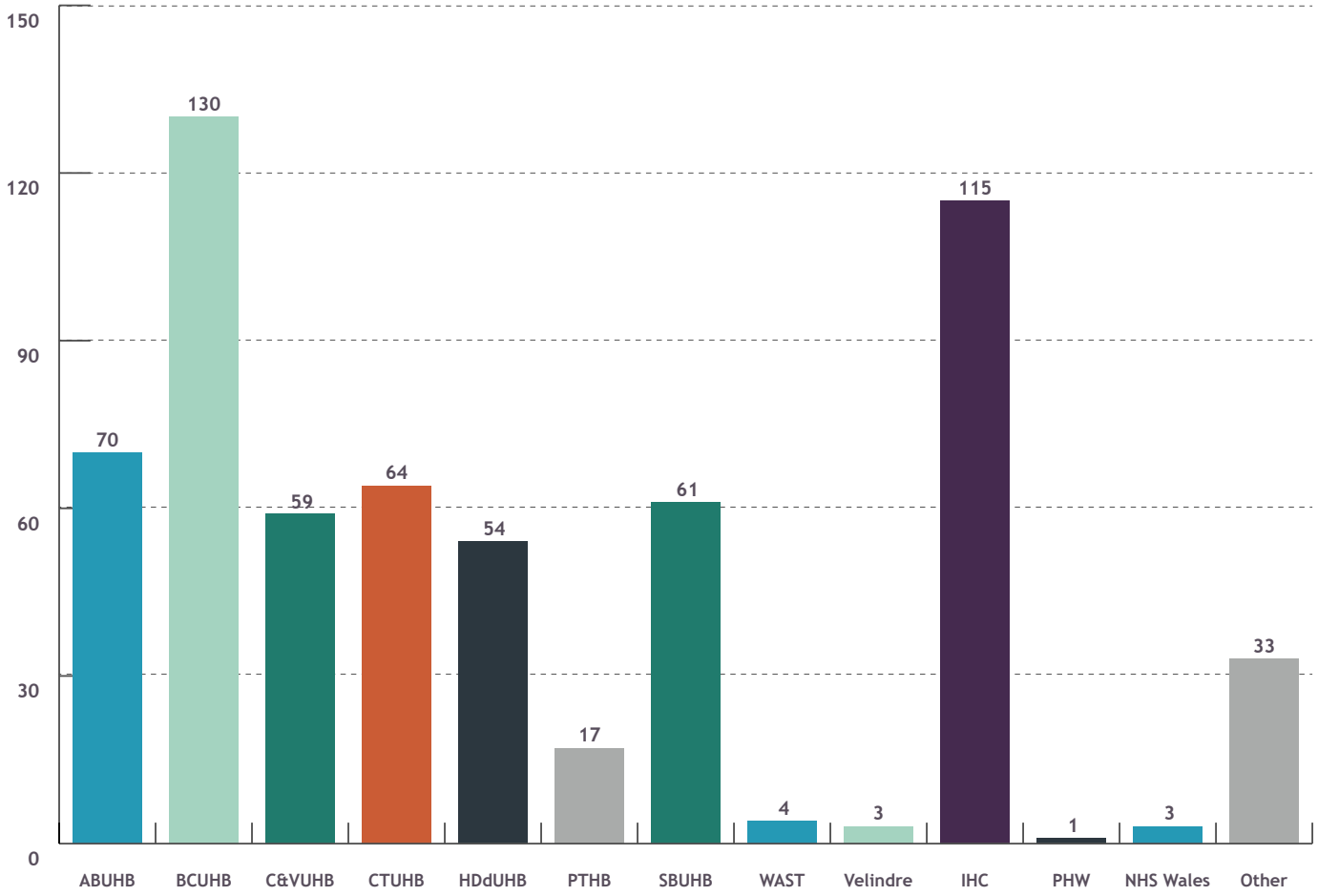
- High-risk concerns require immediate action and response within 2 working days, either by HIW or another agency.
- Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days.
- Low-risk concerns are those concerns that are generally dealt with by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



Location of concerns

Abbreviations

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



Whistleblowing Concerns

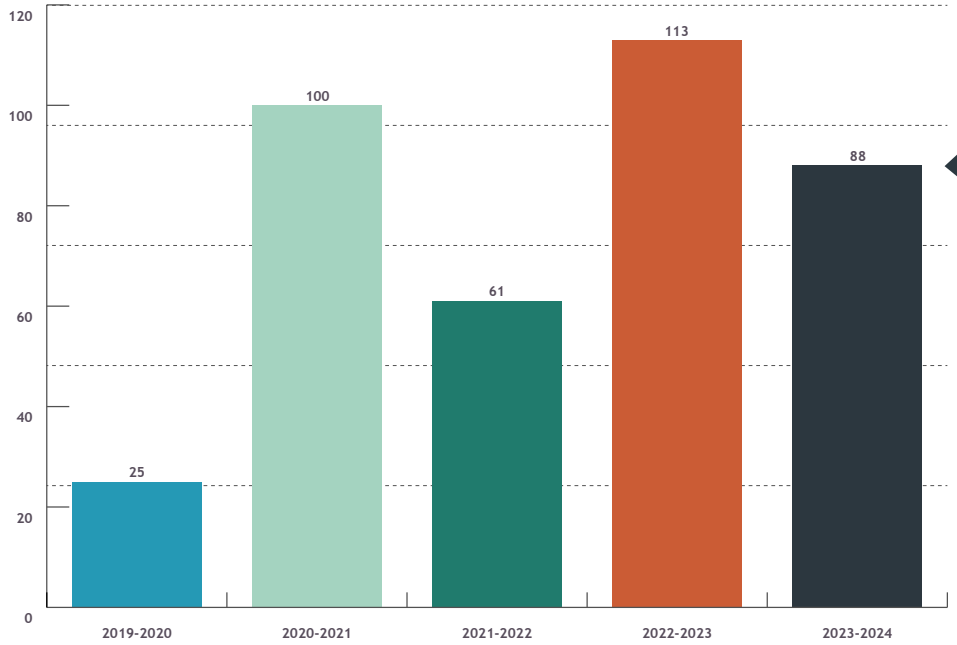
Whistleblowing is the term used when someone who works in or for an organisation wishes to raise concerns about malpractice, wrongdoing, illegality, or risk in the organisation. These concerns can affect patients, the public, other staff, or the organisation itself.

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 legislation 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.

Key themes for whistleblowing concerns received during this period have included issues relating to a service's culture and management, inadequate internal governance process, low levels of resourcing, and concerns regarding the standard of care and treatment provided to patients.



22%
reduction on the previous year

Death in Custody

Every death that occurs in a prison or other authorised location in Wales is subject to an investigation by the Prisons and Probation Ombudsman (PPO). HIW contributes to the PPO's investigation by conducting a clinical review of each death that occurs in a Welsh prison or other authorised location.

The aim of our clinical reviews is to assess and evaluate the level of care and medical treatment given to inmates while they are 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.

The past year's death in custody reviews have highlighted recurring trends and themes related to the treatment and care of individuals in custody.

These have included:

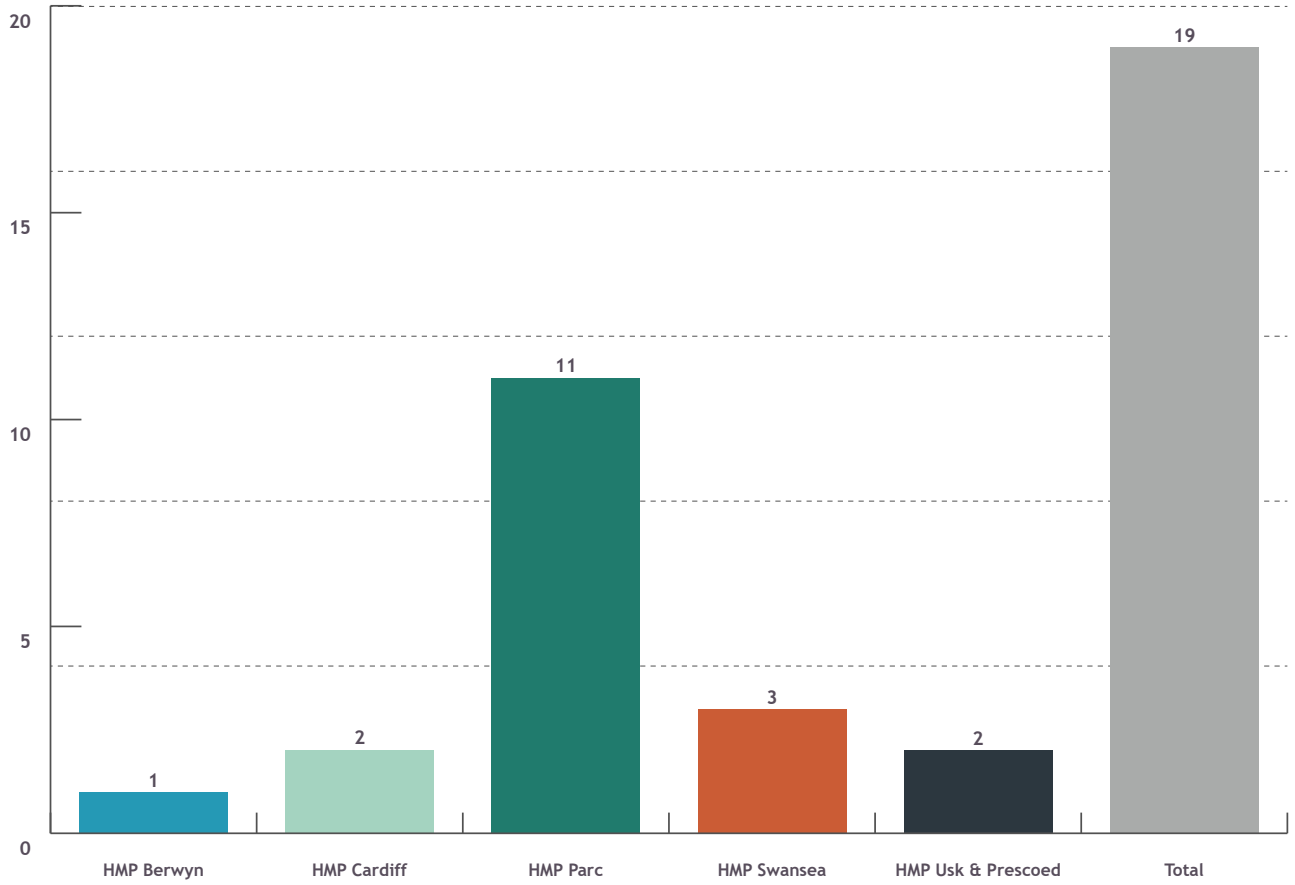
- The need for staff to prioritise comprehensive and timely documentation
- All staff need to be familiar with appropriate escalation procedures, to ensure concerns are identified and addressed promptly
- The need for timely healthcare requests, including blood tests, and the follow-up of any abnormal results
- Prison healthcare services must ensure the availability of essential medical equipment, in a timely manner to avoid compromising patient care.

Number of Death in Custody Clinical Reviews

19
Total

12
Natural Causes

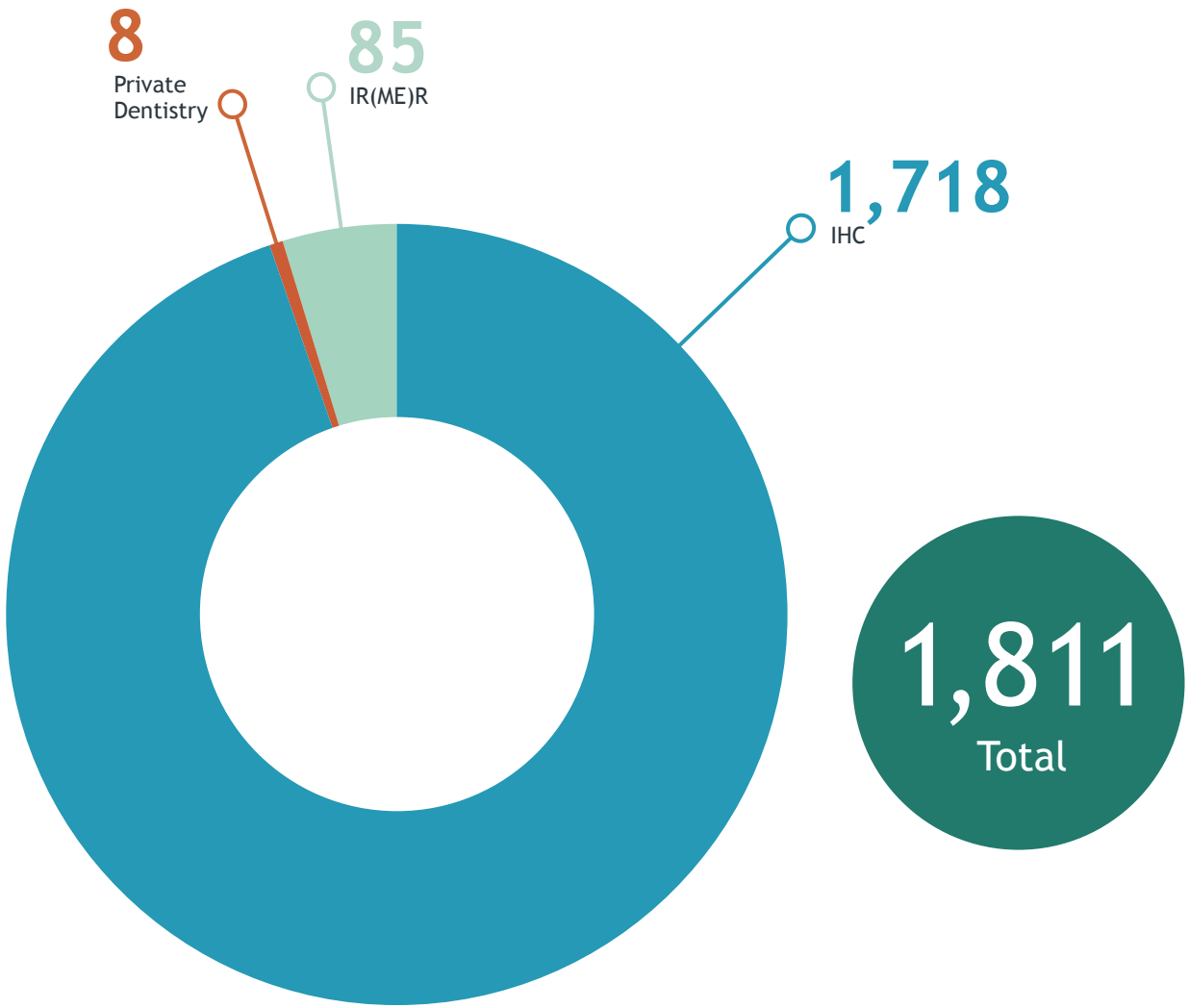
7
Other than natural Causes



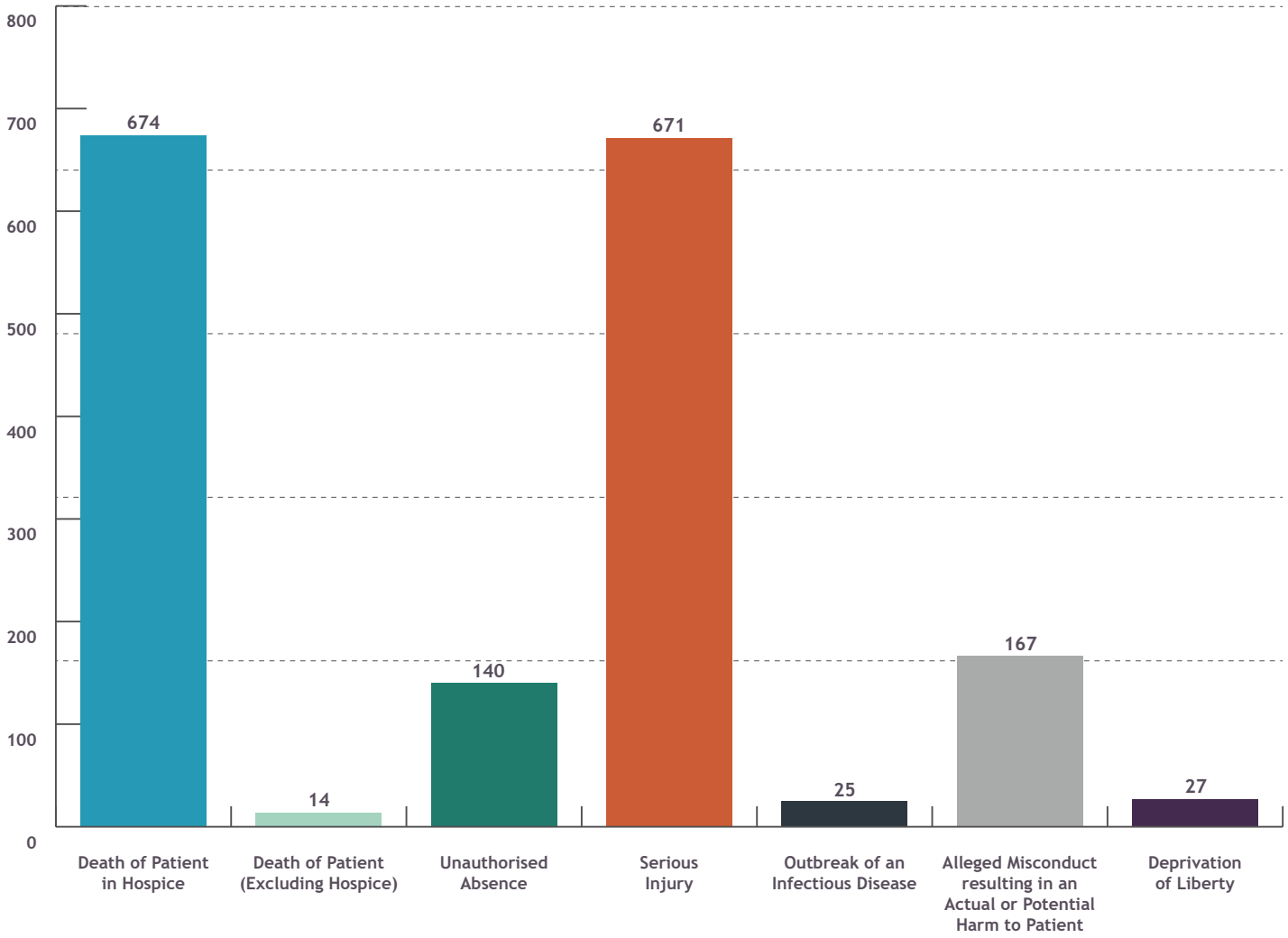
Notifications

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.

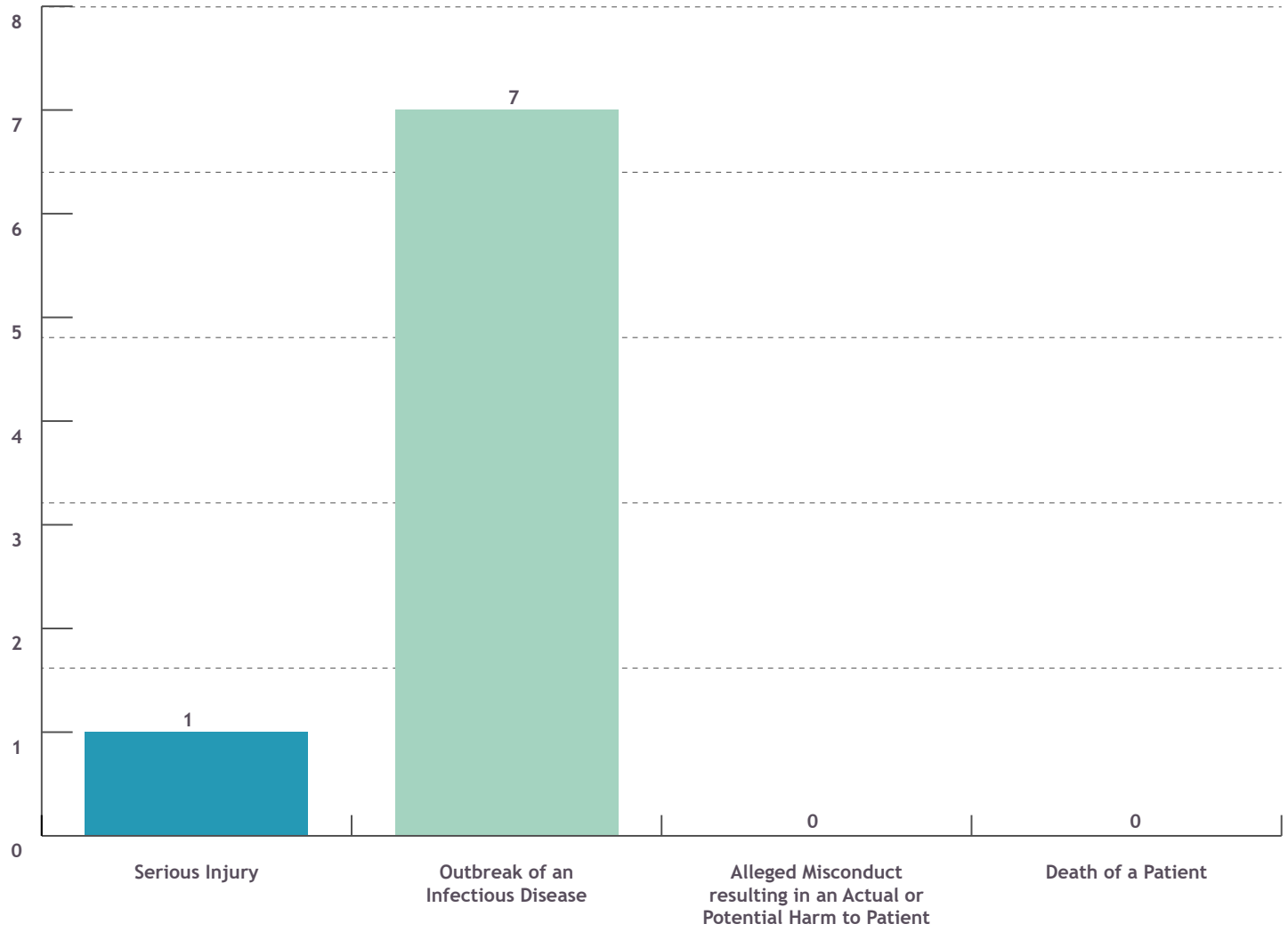
The total number of regulatory notifications received in this reporting period was **1,811**. This figure includes notifications against the following set of regulations:



IHC regulatory notifications by subtype

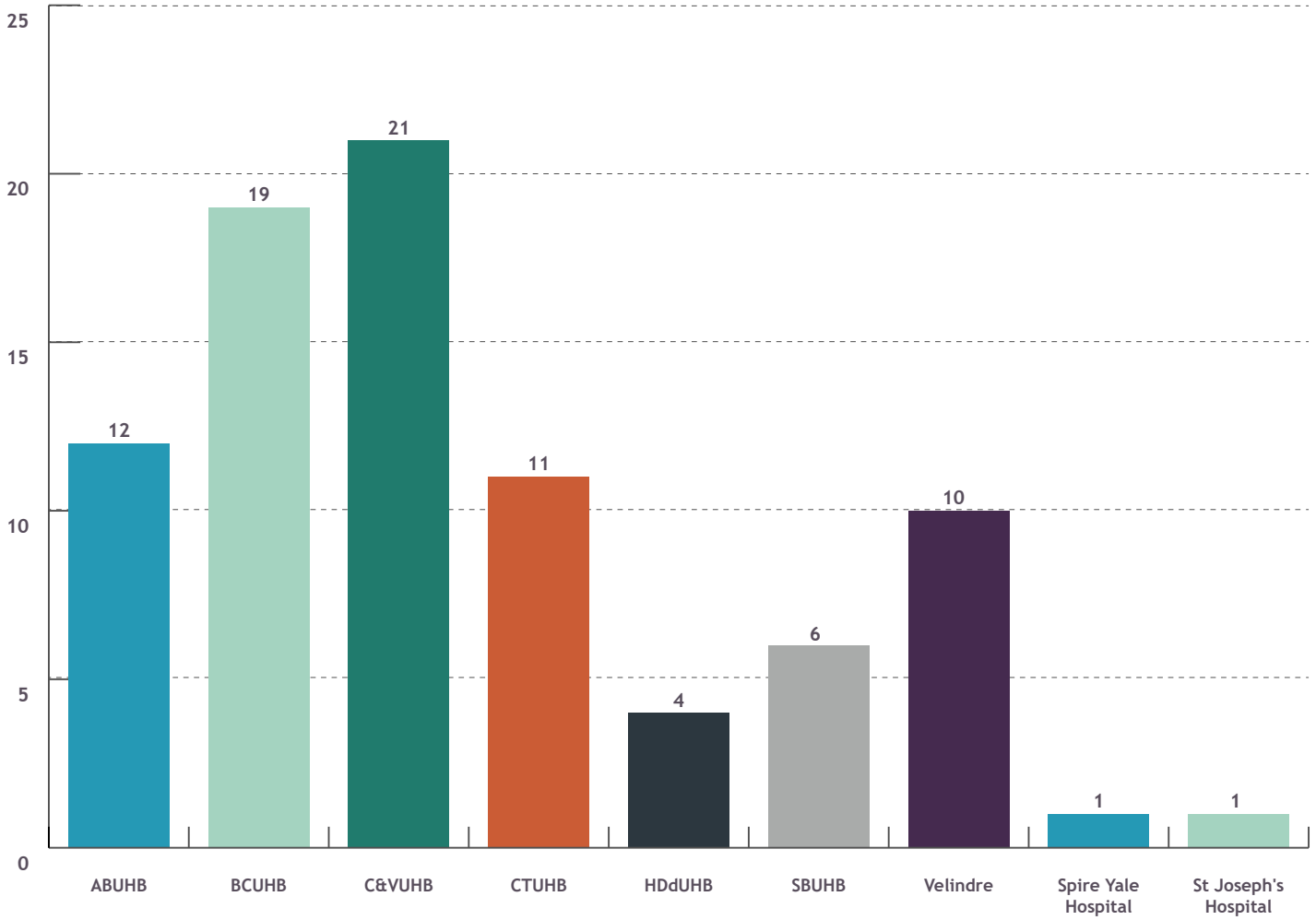


Dental regulatory notifications by subtype

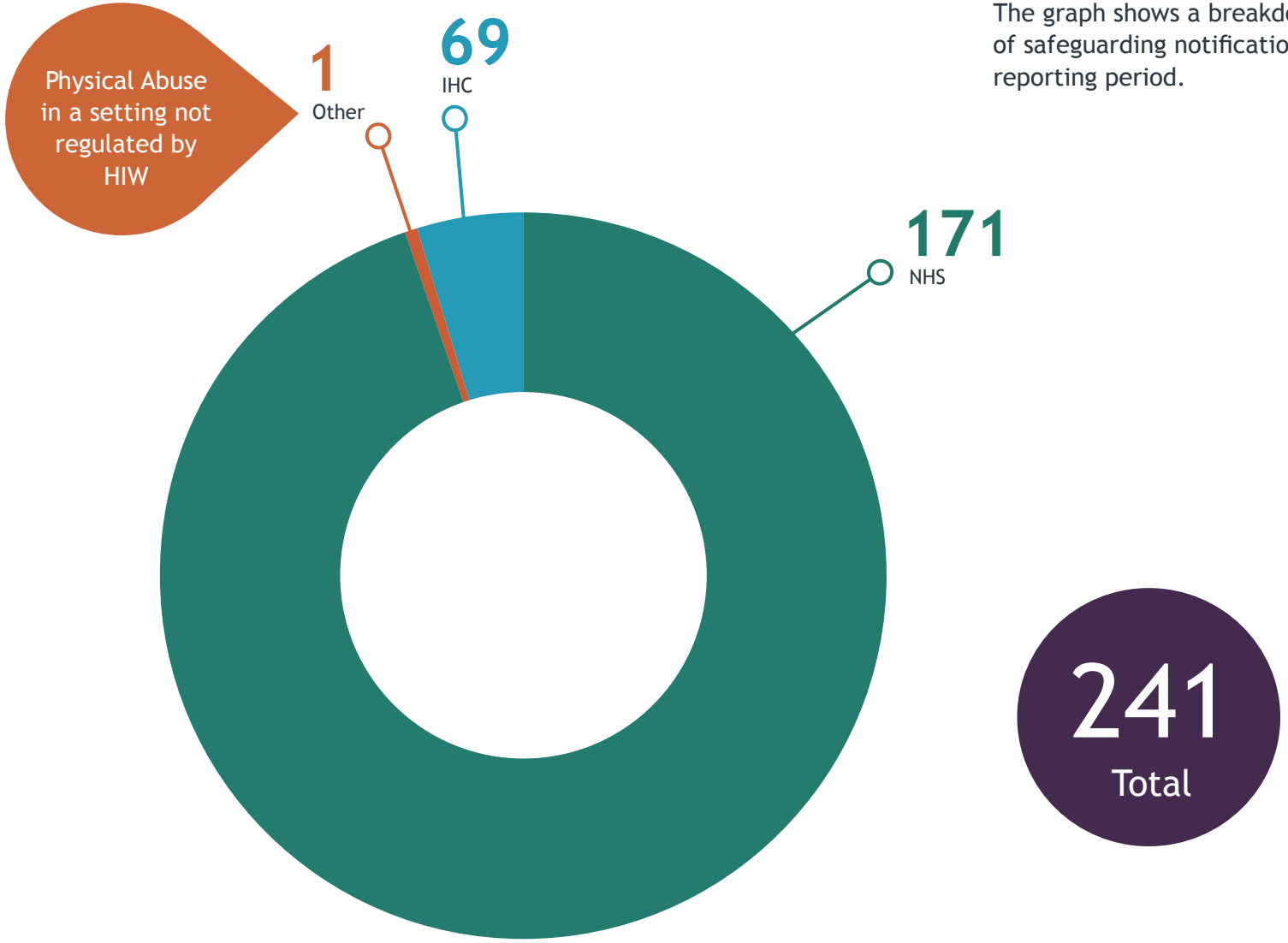


IRMER notifications received

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



Safeguarding



The graph shows a breakdown of the number of safeguarding notifications received for this reporting period.

08.

Our Resources

Our Resources

Our people 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. Our internal People Forum continues to provide a strong and valuable source of feedback to senior HIW managers on staff matters and organisational development.

We rely on the clinical expertise of our pool of specialist Peer Reviewers, and we currently have a panel of over 200 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 who have the critical role of assessing patient experience through talking to patients. Our electronic Customer Relationship Management (CRM) system is now well established and providing valuable data supporting the work of all teams across HIW.

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

Finance

For 2023-2024 we had a budget of approximately £5m.

We had the equivalent to 87 full-time staff as well as a panel of over 200 specialist reviewers.

In line with other public sector organisations, we continue and expect to experience sustained budgetary pressures. To respond to a very challenging budget situation, we spent part of 2023-24 working together as an organisation to prioritise and, where possible, make efficiencies to the way that we work.

The table below shows how we used the financial resources available to us in the last financial year to deliver our work in 2023-2024.

HIW Budget	£4,970,000
Expenditure	
Staff costs	£4,819,171
Travel and Subsistence	£33,178
Learning & Development	£30,768
Non staff costs	£72,421
Translation	£125,220
Reviewer costs	£615,419
ICT Non CRM costs	£95,391
CRM	£51,424
Total expenditure (a)	£5,842,992
Income	
Total income from Independent Healthcare (b)	£524,262
Total Net Expenditure (a-b)	£5,318,730

09.

Contact

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh