National Assembly for Wales - Health and Social Care Committee

Inquiry into the Work of Healthcare Inspectorate Wales

Supplementary Submission by Healthcare Inspectorate Wales

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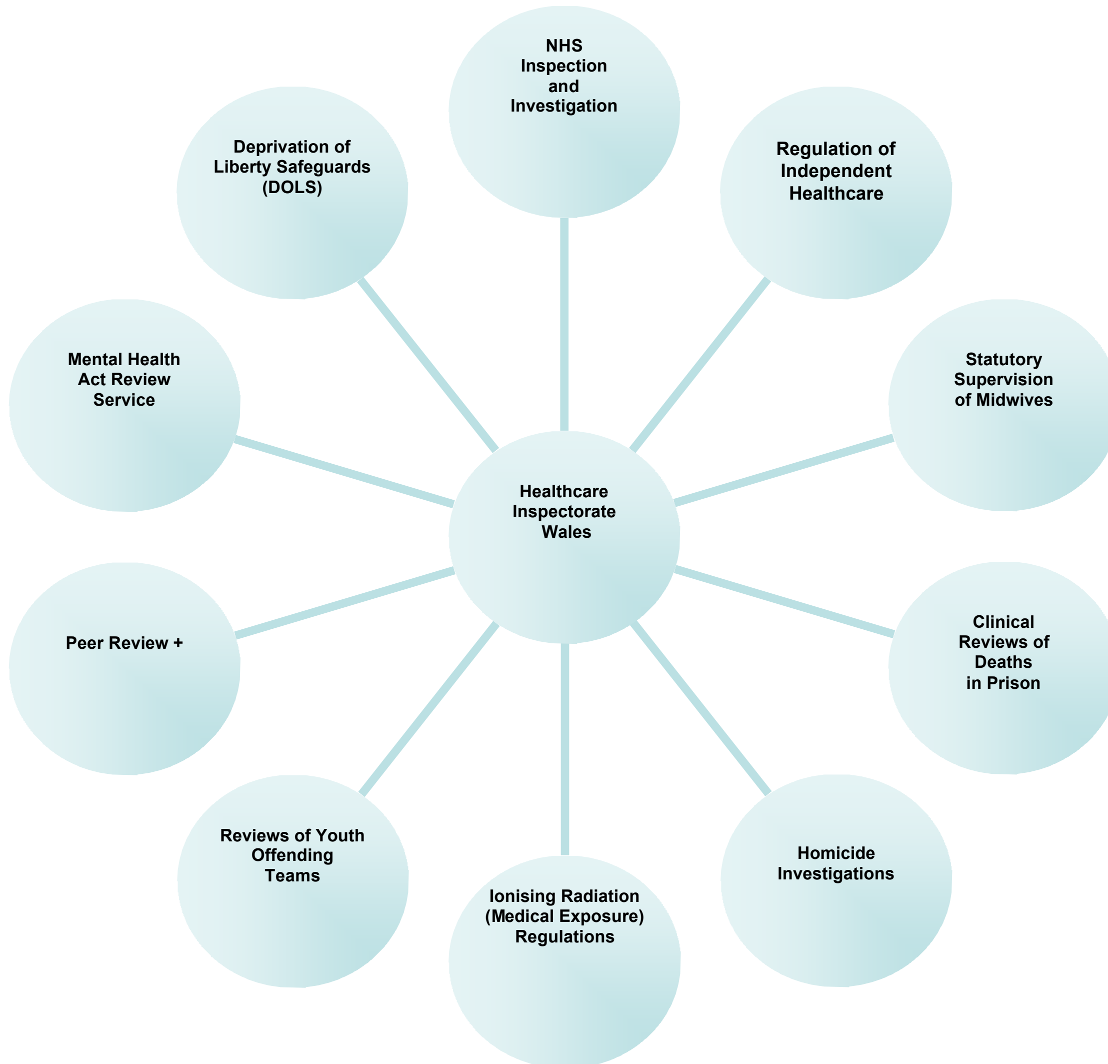
Document 1

Summary of HIW's work and responsibilities, including details of work undertaken over the past 5 years

HIW's work and responsibilities

Our work and responsibilities are wide ranging and as at 1 November 2013 include:



Over the past five years we have gained new responsibilities and lost others; these changes are detailed in the sections that follow.

When undertaking these functions we aim to ensure that

- We inspect against a range of recognised standards, policies, guidance and regulations and recognised best practice
- We focus on how well those who may be in vulnerable situations are safeguarded

- We identify where services are doing well and highlight areas where services need to be improved
- We investigate where there may be systemic failures in delivering healthcare
- We take immediate action if we determine that the safety and quality of healthcare does not meet required standards
- We inform patients, service users and the public about the standards of healthcare in Wales
- We drive improvement through shared learning

Our people

We have a staff complement of 58 most of whom are located in our Inspection, Investigation, Regulation, Local Supervising Authority (LSA), and Knowledge Management Teams.

To support our core workforce, we work with a panel of external reviewers, health and social care professionals and members of the public.

Under these arrangements, people who have specialist experience of providing health services from Wales and beyond and those who have experience of accessing healthcare services, whether as patients, service users or carers take part in our activities.

Our external reviewers may be sourced through:

- Targeted appointment of peer healthcare staff direct from Local Health Boards and Trusts
- Nomination and appointment of suitable specialist expertise via the Academy of Royal Colleges, individual Royal colleges and professional regulatory bodies
- Contracted arrangements for the provision of specialist expertise to advise upon or carry out review work
- Other Welsh and UK Inspection, Audit and Review bodies' arrangements;
- Our own targeted recruitment in certain key specialist areas
- Partnership arrangements with Third Sector and other representative bodies to access people who use services and their carers and families
- Working with the Board of Community Health Councils or individual CHCs

Working With Others

Involving and Engaging Citizens in Wales

We aim to work closely with patients, service users, carers, their families and the public more generally. This helps us to understand people's needs and preferences, to learn from their experiences of health services and to promote openness and transparency about the quality of healthcare.

We do this by:

- Including members of the public as *'lay reviewers'* within our review teams
- Working with patients, services users, carers, their families and representative groups to develop new approaches to our work
- Seeking views and perspectives on specific aspects of healthcare, or within particular communities and areas in Wales
- Consulting on our overall plans and work programmes
- Providing information on the quality and safety of healthcare through the publication of our reports.

We also work with third sector and representative organisations to help ensure that the views of specific service user groups, in particular those who may be seldom reached, inform and influence what we do and how we do it.

Working with policy-makers and service providers

We actively participate in conferences, working groups and development activities in order to create a common understanding of what we can do collectively to improve healthcare in Wales.

We actively encourage secondments and placements of healthcare staff to work as part of our inspection teams in order to support their own professional development and to support sharing of practice across health providers.

Working with other inspectors and regulators, professional bodies and improvement agencies

Across the UK and Beyond

Through our continued commitment and active involvement in the work of the '*UK and Ireland Five Nations Group*[1]' of health and social care regulators, the '*UK Heads of Inspectorates Forum* and the *European Platform for Supervisory Organisations (EPSO)*[2],' we ensure our work is both informed by and influences the development of effective inspection, investigation and regulatory practice in health and social care.

We liaise with health professional bodies and regulators such as the Academy of Medical Royal Colleges in Wales[3], General Medical Council (GMC)[4] and Nursing and Midwifery Council (NMC)[5] both to access professional expertise to help us in the conduct of our work and to influence and be informed by the development of professional standards and clinical practice.

Over the past few years HIW has been working with the GMC and members of the Welsh Revalidation Delivery Board to support and facilitate the development of new arrangements established by the GMC for the revalidation[6] of all doctors in the UK. HIW has also worked with the Deanery to pilot the development and implementation of an assurance framework for appraisal.

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[1] The UK and Ireland *'Five Nations'* group of health and social care regulators comprises representation from the Care Quality Commission (CQC) for England; Healthcare Improvement Scotland (HIS); Healthcare Inspectorate Wales (HIW), the Regulation and Quality Improvement Authority (RQIA) for Northern Ireland and the Health Information and Quality Authority for Ireland.
[2] Established in 1996, EPSO is a European network of officials who have a duty to supervise and monitor the quality of health care in their countries. It aims for a better co-operation on quality of inspection, supervision and monitoring in health services and social care.
[3] Academy of Medical Royal Colleges in Wales - has a leading role in the areas of Doctors' revalidation, training and education and aims to speak with a clear and sure voice on generic health care issues for the benefit of patients and healthcare professionals.
[4] General Medical Council (GMC) – an independent, statutory, UK wide body which registers and regulates doctors practising in the UK.
[5] Nursing and Midwifery Council (NMC) – an independent, statutory body which registers and regulates nursing and midwifery practicing in the UK.
[6] Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC.

In Wales

HIW, Care and Social Services Inspectorate Wales (CSSIW), Estyn (Her Majesty's Inspectorate for Education and Training in Wales) and the Wales Audit Office (WAO) are the four main inspection, audit and review bodies in Wales. Within the framework of a Strategic Agreement[7], we work closely together to ensure that we all play an active role in improving public services in Wales.

We are committed to closer working with the Board of Community Health Councils, as evidenced by the join funding of a post in 2012-2013 to consider ways in which greater collaboration could be achieved between our two organisations. We will be taking further actions during 2013-2015 to implement some opportunities identified.

Wales Concordat Cymru[8]

HIW was instrumental in the establishment and ongoing support of the Wales Concordat between bodies that inspect, regulate, audit and improve health and social care services in Wales. HIW currently holds the Chair. The Concordat is now being updated with leadership from the GMC and this exercise will also inform our current work to clearly describe the external assurance framework for the NHS.

Healthcare summits

Each year HIW facilitates an annual programme of healthcare summits, each one designed to focus on a particular NHS health board or Trust in Wales. The summits involve bodies working across Wales who are responsible for healthcare inspection, audit, regulation and improvement.

These summits provide us a valuable opportunity to share and test the information and intelligence we hold about NHS organisations to establish an overarching, cohesive assessment that drives our respective plans.

Memoranda of Understanding

We work together and share information with many partner organisations in line with the framework established within our Memoranda of Understanding and Information Sharing Protocols.

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[7] The four main inspection, audit and regulation bodies in Wales signed an agreement in 2011 to boost joint working.

[8] The Wales Concordat is a voluntary agreement between inspection, external review and improvement bodies working in health and social care in Wales http://www.walesconcordat.org.uk/

How we target our work

The development of our work programme and our decisions on what we should look at, when and how, takes into account a wide range of considerations:

- The fact that some services, by their very nature, always carry risks, either because of the potential vulnerability of the client group or the complex nature of the service
- Our knowledge of a particular service or organisation indicated areas of concern or worrying trends, perhaps as a result of concerns or complaints received
- The outcomes from our previous work identified areas where further work was needed
- Intelligence we have received from other bodies, or the outcomes from other review work
- The service or issue may have been a recognised national priority for healthcare services
- There may have been new standards or quality requirements against which service provision could be assessed to identify improvements
- There may have been a recognised inequality in the provision of healthcare services, or a high proportion of the population may have been affected
- Performance data may have indicated variations in quality or areas of major risk affecting particular sections of the community or areas of Wales
- There may have been significant or increasing public concern
- The impact of our work may be maximised through joint working with other inspection, audit or review bodies

Over the last five years this has led to

- Routine regulation, inspection and assurance work designed to fulfil our statutory responsibilities and other priorities
- A number of all Wales reviews targeted at areas of special interest
- Follow up work from earlier reviews and inspections
- On-going work with others to inform and influence policy and practice

Our Toolkit of Approaches

We develop and adopt a range of approaches to enable us to effectively assess the quality and safety of healthcare provision. In doing so we seek to take a human rights based approach to all our work and to embed active consideration of equality issues in our inspection and investigation tools and techniques.

Our approaches include:

WORK UNDERTAKEN DURING THE LAST FIVE YEARS

When assessing the quality and safety of healthcare provision over the last five years, we have sought to answer three key questions:

- Are healthcare organisations in Wales fit for purpose?
- Are patients and service users in potentially vulnerable situations safeguarded?
- Are patients and service users being cared for by suitably trained and qualified staff?

These questions run throughout the programme of work described below.

1) Assessment against Doing Well Doing Better: Standards for Health Services in Wales and the earlier Healthcare Standards for Wales

Between 2007 and 2010, NHS organisations were required to carry out annual self-assessments against the standards and to make a public declaration about their performance. HIW's role was to test and validate these assessments.

Performance was tested in three distinct areas that related to domains in the standards:

- the experience of users: *what is this like and is it improving?*
- operational and clinical outcomes: *how is compliance with the standards ensured within services and on hospital wards?*
- corporate issues: *how well do the boards of NHS organisations ensure compliance with the standards?*

Each organisation was judged as reaching one of five levels of maturity:

aware, responding, developing, practising or *leading.*

During 2008-2009, we made unannounced visits to every Welsh NHS Trust, concentrating on Accident and Emergency (A&E) Departments, Minor Injuries Units, Paediatric Wards, Elderly Mental Health Wards, Medical Wards and Medical Assessment units. We also visited a sample of eighty five GP practices across Wales:

Our assessment for 2008-09 focused on:

- **Child protection** - as the Baby Peter case had highlighted significant concerns about services in England;

- **Protection of Vulnerable Adults** - as our previous reviews had highlighted this as an area where more work is needed; and

- **Dignity and respect issues** - as these are fundamental to patients'/service users' experience and matter to us all

by looking in detail at 10 of the 32 Standards, concentrating on the user experience and the environment of care.

Our Assessment Approach for 2009-10

Recognising the introduction of the new health boards in October 2009, and looking ahead to the replacement of the Healthcare Standards in April 2010, we took a different approach to assessment for 2009-10. For the period April to September 2009, we prepared 'Legacy statements' in respect of each of the outgoing organisations and presented these to the leaders of the newly integrated bodies.

From October 2009 to March 2010, rather than conducting a specific 'once a year' exercise, we instead used the results of our overall programme of work carried out during the six months from October 2009 to March 2010 to inform our assessment of how well the new health boards performed against the Standards.

Our Assessment Approach since April 2010

Following a major review by the Welsh Government of the Healthcare Standards for Wales in 2009-10, revised standards - *Doing Well, Doing Better, Standards for Health Services in* Wales - were launched on 1 April 2010.

The approach to assessment of the new standards, developed by HIW together with the NHS seeks to place accountability for driving improvement where it belongs, with the Boards of NHS organisations. At a corporate level, the self assessment requires Boards to collectively consider and assess their organisational fitness for purpose and report on the outcome of their assessment as part of the organisation's Annual Governance Statement.

Our annual inspection programme, special reviews and investigative work are used to inform our assessment of how well organisations are doing against the standards. Discussions at Healthcare Summits test and probe each NHS organisations self assessment identifying areas where the Board's view of their organisational maturity differs from that of the audit, review and regulatory bodies present.

The common themes arising from our annual assessment process were fed back formally to organisations via management letter and in our 2010-2011 Annual Report. The Welsh Government's response to the Francis Inquiry earlier this year set out its intention to refresh the *Doing Well, Doing Better* Standards and discussions are ongoing with policy leads in this regard.

2) Reviews of Organisational Governance Arrangements

Cwm Taf Health Board

In **March 2012**, HIW published a report of its review of the governance and accountability arrangements Cwm Taf Health Board has put in place to ensure the quality and safety of patient care.

Taking account of the governance challenges already identified by NHS Boards in Wales through their *'Doing Well, Doing Better'* self assessments, the review looked at the particular issues facing Cwm Taf Health Board and made a number of recommendations. These mirrored many of the issues facing health boards across Wales, centred on:

- The role and operation of the main Board, its committees and its non-officer members
- Communication of the organisation's vision and objectives, and partnership involvement
- The role played by the Executive Board, supporting organisational structure, clinical teams and leadership, and staff development and appraisal
- Managing risk
- Access to information, and the effectiveness of challenge, scrutiny and monitoring performance
- Handling patient complaints, concerns and claims
- Trend analysis, action planning and sharing learning

Although focused on Cwm Taf Health Board, our scrutiny of this particular organisation raised a number of learning points which were also relevant to NHS and wider public service organisations across Wales. We therefore worked with the Welsh Government, Wales Audit Office and development agencies such as the then National Leadership and Innovation Agency for Healthcare in Wales (NLIAH) to ensure that learning took place at an all Wales level.

Betsi Cadwaladr University Health Board

Work undertaken by the WAO and HIW at the end of 2012 highlighted a number of challenges to Betsi Cadwaladr University Health Board (BCUHB) around governance, accountability and service delivery issues. These were reported to the Board in the WAO's 2012 Structured Assessment findings and Annual Audit Report and in HIW's review of patient care at Glan Clwyd Hospital. They were further reflected in a quality and safety review that HIW has been undertaking during late 2012/ early 2013.

Following consideration of the concerns jointly held by HIW and the WAO, it was decided to commence a single review of BCUHB's Governance Arrangements. This review was to consider:

- The effectiveness of the Board and its sub-committees
- Organisational structure and lines of internal accountability
- Strategic vision and service reconfiguration
- Stakeholder engagement
- Organisational culture
- Performance against key targets and indicators of service quality and efficiency
- Performance management and monitoring
- Financial management and sustainability

3) Regulation of the Independent Healthcare Sector in Wales

Through registration and inspection we regulate the independent healthcare sector in Wales in line with the requirements of the Care Standards Act 2000 and associated Regulations and the National Minimum Standards for Independent Health Care Services in Wales[9].

We inspect independent healthcare settings using a range of our routine inspection programmes. These included; dignity and essential care inspections (DECI) and cleanliness spot checks, as well as a specific programme targeted at independent settings who provide services for people with learning difficulties and mental health services.

As with NHS organisations, we monitor independent healthcare providers, taking into consideration the information and intelligence we received from a variety of sources.

The table below includes follow-up visits where concerns warranted such action. In addition, as part of follow up, action meetings were also held with providers and commissioners as well as a number of national workshops.

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[9] The National Minimum Standards for Independent Health Care Services in Wales - A statement of national minimum standards applicable to independent hospitals, independent clinics and independent medical agencies made by the Minister for Health and Social Services of the Welsh Government under powers conferred by section 23(1) of the Care Standards Act 2000. The National Minimum Standards were revised in April 2011. The current Standards can be accessed at http://www.hiw.org.uk

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
New registrations	1022	219	151	130	98
Changes to registrations	3	15	10	7	6
De-registrations	12	15	117	95	90
Number of inspection visits	54	53	61	19	10 (+26)*

*26 visits to unregistered providers

New regulations came into effect on 1 January 2009 requiring all dentists who provide any level of private dentistry to be registered with HIW. As can be seen from the table above, this impacted greatly on the number of new registrations that occurred in 2009-2010.

One of the key elements of our on-going monitoring activity was our review of notifiable events or serious untoward incidents required to be notified to us throughout the year. Registered persons[10] must by law notify us about specified events or incidents that may directly affect the safety of patients[11]. The number and type of notifiable events received and monitored by HIW **since 1 January 2012** are set out below.

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[10] A person who is the registered provider (a person who runs a service on their own) or the registered manager of an establishment or agency.

[11] Regulation 27 of the Independent Health Care (Wales) Regulations 2002 provided for the notification of events or incidents that may directly affect the safety of patients. The new Independent Health Care (Wales) Regulations 2011 came into force on 5 April 2011. They replaced the 2002 regulations and Regulation 27 notifications are now known as regulation 30/31 notifications. Further information on the requirements on independent healthcare registered providers and managers in this respect may be accessed at www.hiw.org.uk

Type of Event	Total	Average per month	Average per y
Death of a patient in a hospice	1204	*54.73*	*656*
Death of a patient (excluding hospices)	15	*0.68*	*8*
Unauthorised Absence	90	*4.09*	*49*
Serious Injury	86	*3.91*	*46*
Outbreak of an Infectious Disease	6	*0.27*	*3*
Allegation of staff misconduct resulting in actual or potential harm	67	*3.05*	*36*

4) Inspections focussing on matters of Dignity and Essential Care

In **2008-2009** HIW started to take forward a rolling programme of unannounced visits focusing on dignity and respect. Building on this earlier work, and taking account of a number of external reports published by organisations such as The Patients Association, Public Services Ombudsman for Wales, Older People's Commissioner for Wales and Wales Audit Office as well as the views of the public, in **2011** we introduced an updated programme of unannounced spot checks called Dignity and Essential Care Inspections (DECI).

These visits focused on the essential care, safety, dignity and respect that patients received in hospital specifically covering:

- Patient environment
- Staff attitude/behaviour/ability to carryout dignified care
- Care planning and provision
- Pressure Sores
- Fluid and nutrition
- Personal care and hygiene
- Toilet needs
- Buzzers
- Communication
- Medicine management and pain management
- Records management

- Management of patients with confusion
- Activities and stimulation
- Discharge planning

In **2011-2012** we extended our visit programme to include weekends as well as week days, and in **2012-2013** we included evening and night time visits. We continued to focus our attention on older patients, as research showed this group may feel particularly vulnerable during a hospital stay.

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
DECI Inspections	*200	0	5	8	3 (a further 8 planned)

*Between March and April 2009, we made unannounced visits to every Welsh NHS Trust, concentrating on Accident and Emergency (A&E) Departments, Minor Injuries Units, Paediatric Wards, Elderly Mental Health Wards, Medical Wards and Medical Assessment units. We also visited a sample of **eighty five GP practices** across Wales. These visits which were carried out as part of our Healthcare Standards assessment work focused on matters of dignity and respect.

During **2013-2014** this inspection programme is subject to enhancement and further development including:

- Reviewing the DECI ward based tools, including mapping the tools to the Francis Report, making clear links to the specific fundamentals of care areas, and updating DECI documentation in accordance with reviewer feedback

- Developing the DECI processes to make clear the links and reference to patient safety alerts and how patient safety data is used in DECI Engaging with stakeholders such as Diabetes UK to scope areas of improvement, potential additional intelligence sources, and additional modules to cover areas such as diabetic care and therapeutic input on long stay wards

5) Inspections focussing on the environment of care

HIW introduced unannounced infection control inspections to its routine inspection portfolio in **2006-07**. They were introduced in response to growing public concern about MRSA, C. difficile and norovirus. HIW was the first UK inspectorate to introduce this type of unannounced inspection which uses pictorial evidence to support findings.

The tool used for hospital cleanliness spot check s is based on the InfectionControl Nurses Association (ICNA) tool. The approach adopted relies on direct observation, staff questioning and the review of key documents. The review team includes an infection control nurse and lay reviewer.

All visits are unannounced. There is immediate feedback to senior management at the end of the visit and organisations are required to provide us with an action plan detailing how they intend to address any issues and areas of concern identified within two weeks of the publication of our report.

Our review teams visited a variety of wards providing services such as general medical, general surgery, maternity and gynaecology.

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Infection Control Inspections – wards/units visited	182*	22	25	2	0 (16 planned)

*As part of an all Wales review of Diarrhoea and Vomiting we visited 23 hospitals and 170 wards and units across Wales. Management letters were issues to each of the then 9 trusts

During **2013-2014** this inspection programme is subject to enhancement and further development including:

- Development of the infection control tool kit to ensure a greater focus on infection control rather than cleanliness
- Enhancing the inspection process to mirror the process followed for our DECI inspections

- Expanding modules to include a focus on theatres; radiology; C.Difficile and MRSA

6) Learning Difficulty Visits

In May 2011, the BBC broadcast a programme that highlighted abuse and ill-treatment of individuals with learning difficulties, residing at an independent hospital in Bristol. The programme gave rise to great public concern. As a result HIW decided to bring forward our programme of reviews of independent hospitals providing learning difficulty and mental health services.

The focus of the reviews was to ensure that individuals accessing such services were:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plans
- Supported to be as independent as possible
- Allowed and encouraged to make choices
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so

Unannounced visits were undertaken to all registered independent mental health hospitals in Wales. These visits were undertaken at various times of the day, including over the weekend, at night and in the early mornings so that our inspectors' view of the care provided was as objective and holistic as possible.

Our reviews did not highlight the issues of bullying and cruelty identified by the Panorama programme, but a number of areas for improvement were identified and have resulted in a targeted programme of follow up.

Following each visit we met with the Registered Manager and key staff to provide immediate, initial feedback and highlight significant issues requiring action. Where necessary, we followed these meetings with an urgent action letter detailing any regulatory breaches and clearly setting out what action was needed to ensure patient safety and regulatory compliance. We required all organisations we visited to submit an action plan. We also shared our findings with those who commission services from the independent providers we visited.

20 unannounced inspection visits have been carried out since 2011 covering all independent mental health hospitals in Wales. These figures are included in the number of inspection visits given in Section 3).

7) Mental Health Act review service

Since 2009, HIW has been responsible for monitoring the implementation and application of the Mental Health Act 1983 (the Act) on behalf of Welsh Ministers. The role is fundamental to our commitment to protecting those who are most vulnerable.

The main purpose of the Mental Health Act 1983 (the Act) is to allow for compulsory care, treatment and action to be taken, where necessary, to ensure that an individual with a mental disorder gets the care and treatment they need for their own health and safety or for the protection of other people.

Under the Act individuals can be detained in hospital or be required to live in the community, subject to certain conditions as set out in a Community Treatment Order (CTO) or under Guardianship. In some circumstances they can be given treatment to which they have not consented or do not have the capacity to consent. For some people detention under the Act can last for significant periods of time.

The Act has serious consequences for the human rights of individuals who are subject to its powers. It is therefore clear as to the processes that must be followed when consideration is being given to detaining an individual, and when an individual is subject to a detention or restrictions. The Act, together with the accompanying Code of Practice sets out safeguards that are intended to ensure that individuals are not inappropriately detained or treated without their consent.

Our overall aim is to ensure that those detained under the Mental Health Act have a voice and are supported and empowered as far as possible to make decisions over their care and treatment.

HIW have a panel of experienced Mental Health Act reviewers (reviewers) who transferred in from the Mental Health Act Commission. They undertake a rolling programme of both announced and unannounced visits to mental health providers.

The focus of the reviewers is on ensuring that everyone receiving care and treatment in Wales who is subject to the provisions of the Mental Health Act 1983:

- is treated with dignity and respect
- receives ethical and lawful treatment
- receives the care and treatment that is appropriate to his or her needs
- is enabled to lead as fulfilled a life as possible.

Our reviewers visit and talk to individuals who are subject to restrictions made under the powers of the Act. These discussions are held in private and only take place when the individual consents. The Reviewer explores the individual's views on their care and treatment and will ensure that they understand their rights and the reasons for the restrictions placed on them. In addition, Reviewers will check all records and paperwork related to the restrictions placed on the individual and ensure that the requirements set out in the Act and the Code have been met. Any concerns are escalated immediately and are followed up in writing.

Visits are in the main unannounced. There is immediate feedback to senior management at the end of the visit and organisations are required to provide us with an action plan detailing how they intend to address any issues and areas of concern identified.

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Mental Health Act Visits	91	85	52	25	27

8) The Second Opinion Appointed Doctor Service

The Second Opinion Appointed Doctor (SOAD) service appoints independent doctors to give a second opinion as a safeguard for patients who either refuse to give consent for certain treatments or are incapable of giving consent. The role of the SOAD is not to give a second clinical opinion in the conventionally understood medical form of the expression, but to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.

HIW is responsible for managing the SOAD service in Wales. Upon receipt of a SOAD request we aim to ensure that a visit takes place within:

- Two working days for a Electroconvulsive Therapy (ECT)[12] request

[12] A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.

- Five working days for an inpatient medication request and
- 10 working days for a Community Treatment Order (CTO)[13] request

Historically, HIW has experienced some difficulties allocating SOAD requests in accordance with our timescales in West Wales, and so earlier this year we recruited a new Lead SOAD and have set in train plans to recruit further SOADs to cover the west of Wales.

Section 299 of the Health and Social Care Act 2012 came into force on **1 June 2012** in both England and Wales. This means that patients who are subject to a Community Treatment Order (CTO) will no longer require a SOAD to authorise treatment, with the responsibility instead becoming that of the patient's Responsible Clinician[14]. This has reduced some of the pressure on the SOAD service.

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
SOAD requests	811	901	944	758	400

[13] Written authorisation, on a prescribed form, for the discharge of a patient from detention in a hospital onto supervised community treatment.
[14] A Responsible Clinician is the approved clinician with overall responsibility for the patient's case.

9) Deprivation of Liberty Safeguards

In 2009 the Deprivation of Liberty Safeguards[15] legislation introduced a duty for governments to monitor their implementation and operation. In Wales, this duty fell on Welsh Ministers, who delegated the responsibility to CSSIW for social care and HIW for health services. The Safeguards are important because they provide a legal framework around the deprivation of liberty which should prevent breaches of the European Convention on Human Rights (ECHR). Any one of us might temporarily or permanently lose the capacity to make decisions about how we wish to be cared for, whether as a consequence of a sudden injury, a degenerative condition or a life-long impairment. While the number of people to whom the Safeguards have been applied remains small, the potential numbers of people lacking capacity whose well-being and welfare requires robust and well-informed discussion is much larger.

CSSIW and HIW have worked together to collect and analyse relevant data in order to monitor the operation of the safeguards in Wales.

Each year since the introduction of the Safeguards HIW has published a joint report with CSSIW, setting out the results of our monitoring activity across health and social care in Wales

10) Contribution to the National Preventative Mechanism

The National Preventative Mechanism (NPM) was established in 2009 by the UK government to meet its United Nations (UN) treaty obligations regarding the treatment of anyone held in any form of custody. The NPM should have the right to regularly inspect all places of detention for the purpose of monitoring the treatment and conditions of detainees, with the clear purpose of preventing ill treatment of anyone deprived of their liberty.

The NPM is made up of 18 independent bodies, and its work is co-ordinated by HM Inspectorate of Prisons (HMIP). HIW is one of these 18 members.

Each year since 2011 HIW has contributed to an Annual Report published by the NPM. These reports summarised the activities of the 18 members and provided an overview of the state of detention in prisons, police custody, children's secure accommodation, immigration, military and mental health detention.

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[15] Deprivation of Liberty Safeguards apply to people who lack the capacity specifically to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the Mental Health Act 1983 is not appropriate. The aim of the Safeguards is to ensure people are given the care they need in the least restrictive regimes.

11) Special Reviews

We may undertake special reviews of healthcare organisations or services in response to concerns that may arise perhaps from a particular incident or series of incidents. The scale and nature of any special review work depends upon the seriousness or frequency of these.

In the last five years HIW has published the following reviews:

May 2009	Special Review of the outbreak of Clostridium Difficile at the former North Glamorgan NHS Trust between March and April 2008 (now part of Cwm Taf Local Health Board)
Jul 2009	Review of Histopathology Services Provided by North East Wales NHS Trust (now part of Betsi Cadwaladr University Health Board)
Aug 2009	Substance Misuse Services: All Wales Review of Substitute Prescribing Services
Sep 2009	Report on Maternity Services at Gwent Healthcare NHS Trust: Follow up review following Services being placed on 'Special Measures' (now part of Aneurin Bevan Health Board)
Oct 2009	Safeguarding and Protecting Children in Wales: A Review of the Arrangements in Place across the Welsh National Health Service
Oct 2009	Review of the Impact of the National Service Framework (NSF) for Older People in Wales - Phase 1 2008-2009
Jan 2010	Services for Children and Young People with Emotional and Mental Health Needs [A joint review with the Wales Audit Office, Estyn and CSSIW]
Mar 2010	Safeguarding and Protecting Vulnerable Adults in Wales: a Review of the Arrangements in Place across the Welsh National Health Service
Jan 2012	*Growing old my way* A review of the impact of the National Service Framework (NSF) for older people in Wales [Phase II]
Mar 2012	Substance Misuse Services in Wales: *Are they meeting the needs of service users and their families?*
Apr 2012	Review of the Care and Safety of Patients Cared for at Cefn Coed Hospital
May 2012	Healthcare and the Armed Forces Community in Wales
Dec 2012	An Independent Review of Patient Care at Ysbyty Glan Clwyd

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Special Reviews	8	-	1	3	3*

*Currently in progress

12) Homicide Reviews

In circumstances where a patient known to Mental Health Services is involved in a homicide, the Welsh Government may commission an independent external review of the case to ensure that any lessons that might be learned are identified and acted upon. HIW has published the following reviews in the last five years:

29 October 2009	Report of a review in respect of Mr E and the provision of Mental Health Services, following a Homicide committed in August 2007
27 November 2009	Report of a review in respect of Mr D and the provision of Mental Health Services, following the Homicide of Father Paul committed in March 2007 and the Ambulance Response and Care provided to Father Paul's family and Local Community
1 December 2010	Report of a review in respect of Mr F and the provision of Mental Health Services, following a Homicide committed in December 2008
10 January 2011	Report of a review in respect of Mr G and the provision of Mental Health Services, following a Homicide committed in May 2009
30 June 2011	Report of a review in respect of Mr H and the provision of Mental Health Services, following a Homicide committed in March 2009
17 November 2011	Report of a review in respect of Mr I and the provision of Mental Health Services, following a Homicide committed in June 2009
12 September 2013	Report of a review in respect of Mr J and the provision of Mental Health Services, following a Homicide committed in March 2010

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Homicide Reviews	3	1	2	0	4*

* 1 published in June 2013, 3 currently in progress

13) Deaths in Custody while in Welsh Prisons

HIW undertakes clinical reviews of deaths in custody on behalf of the Prisons and Probation Ombudsman (PPO) as part of their investigations into deaths in Welsh prisons. Reports of reviews into deaths in prisons are published by the PPO. Since HIW took on this work in **Apr 2009**, it has completed 47 clinical reviews.

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Deaths in Custody	10	14	3	14	10*

* 6 reports published and 4 reviews currently in progress

14) Joint work undertaken with Criminal Justice Inspectorates

HIW has assisted Her Majesty's Inspectorate of Probation (HMIP) with a programme of joint core case inspections of Youth Offending Services in Wales.

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Core case inspections of Youth Offending Teams	-	18	-	-	-

In addition to this programme, a new approach to the thematic inspection of YOTs was introduced in 2009-10.

Over the last five years HIW has contributed to thematic reviews led by criminal justice inspectorates: Her Majesty's Chief Inspector of Constabulary (HMIC) and HMIP, the most recent of which was 'Examining Multi-Agency Responses to Children and Young People who Sexually Offend', *February 2013*:

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Thematic reviews	-	3	4	1	2

15) Statutory Supervision of Midwives in Wales

On behalf of Welsh Ministers and the Nursing and Midwifery Council (NMC), HIW is responsible, as the Local Supervising Authority (LSA) for Wales, for exercising general supervision over all midwives practicing in Wales. The LSA supports midwives through a model of supervision that aims to protect the public by pro-actively supporting midwives to provide a high standard of midwifery care with an informed choice for women.

The LSA oversees midwives practising across the seven health boards that provide NHS maternity services, as well as a small number of self-employed midwives who provide independent midwifery services in Wales. Health boards are diverse in the type of services they offer, ranging from acute obstetric units to birth centres, but midwife-led care and initiatives to promote birth to be as normal an event as possible, where medical intervention is minimised, remain prominent in each.

Full details of the work of the LSA each year is set out in an Annual Report to the Nursing and Midwifery Council [16]

The LSA is routinely notified of significant untoward clinical incidents in order to consider whether substandard midwifery practice contributed to the incident. Where sub standard midwifery practice may have been a factor, a Supervisory Investigation will be undertaken.

[16]Organisation set up by Parliament to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients.

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Notified incidents	57	71	74	56	17
Supervisory Investigations	28	24	32	37	15

16) Ionising Radiation (Medical Exposures) Regulations

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 (and its subsequent amendments 2006 and 2011). Over the past five years we have achieved this through a programme of assessment and inspection of clinical departments that use ionising radiation. We also reviewed incidents notified to us involving *'exposures much greater than intended'*.

	Financial year				
Type of activity	**2009- 2010**	**2010 –2011**	**2011 –2012**	**2012 –2013**	**2013 –2014 as at 1 Nov**
Notified incidents	-	26	27	29	30
Inspections	5	2	1	4	0*

*4 inspections are planned – these will take place once newly appointed staff receive appropriate training from Public Health England (PHE).

The regulations are intended to:

- Protect patients from unintended excessive or incorrect exposure to radiation and ensure that, in each case, the risk from exposure is assessed against the clinical benefit

- Ensure that patients receive no more exposure than is necessary to achieve the desired benefit within the limits of current technology
- Protect volunteers in medical or biomedical, diagnostic or therapeutic research programmes and those undergoing medico-legal exposure

Given the specialist nature of this area of work, we work with the Health Protection Agency (HPA)[17] to ensure we had access to expert advice to support both the inspection and investigation elements of our work in this area.

17)Controlled Drugs

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 establishes clear requirements for the safe and effective handling of controlled drugs. HIW maintains and publishes a list of accountable officers in Wales.

18) HIW's handling of concerns

It is not HIW's role to routinely investigate concerns about an individual's care and treatment, although we do we consider all information we receive and use it to inform our future work plans – particularly if we identify an emerging pattern of concerns about an individual healthcare setting or service. This information may trigger an unannounced inspection visits or in certain circumstances a Special Review.

We review and consider each concern we receive in order to determine the most appropriate response. We may signpost the individual to other bodies who can help them take forward their concern such as the health board itself; the advocacy service of the local Community Health Council or the Public Services Ombudsman for Wales.

Depending on the matters raised, HIW may also escalate the concern immediately to the Health Board or Trust; offer to meet the complainant or, with the persons consent, offer to write to the Health Board or Trust requesting that the organisation address their concern and keep HIW informed of the outcome.

There may be circumstances when the information provided to us indicates that a patient may be in danger of imminent harm or has been harmed. In this situation we will take immediate action to ensure their safety and also share this information with other agencies such as the Police

[17] The Health Protection Agency's role is to provide an integrated approach to protecting UK public health through the provision of support and advice to the NHS, local authorities, emergency services, other arms length bodies, the Department of Health and the devolved administrations.

On average, HIW responds to around 100 concerns each year from members of the public and current or past health service workers.

Document 2

Approaches taken to the follow-up of inspection work carried out by HIW

We report on our findings in a number of ways

- Immediate verbal feedback on the final day of an inspection
- Management letters requiring urgent action
- General management letters summarising areas for attention
- Traditional reports

We also take various approaches to our follow-up of issues identified depending on the seriousness and urgency of the issue.

Historically, we have worked closely with officials in the Welsh Government's Department for Health and Social Services so that progress with the implementation of our recommendations is monitored and managed through their performance management arrangements for the NHS in Wales.

We may ourselves revisit organisations or services to ensure that suitable progress is being made.

We may also decide to undertake more focused or detailed work in future work programmes. For example, we have further developed our approach to our dignity and essential care inspections to follow up on concerns regarding diabetes care and monitoring identified from both our own inspection activity and the work of the Public Services Ombudsman for Wales. We have also enhanced our review of mental health services to ensure a greater focus on care planning, risk assessment and the provision of meaningful activities.

Further, where it is more appropriate or where others are better placed to take forward follow up work, we share the necessary information with them and provide ongoing support to enable this to happen.

Case Studies 1 – 7 at Document 3 illustrate how these approaches are used in practical situations. The follow-up aspects of these case studies are summarised below.

Case Study 1: Governance Review

This review was itself intended to follow-up on issues that had been highlighted through previous work and sharing intelligence with our partners. It also illustrates our approach to follow-up in matters of significant concern.

Case Study 2: Homicide Investigation

This case study demonstrates follow-up at a number of levels: its findings and recommendations will influence our

routine inspection visits; HIW is working with Public Health Wales to pilot a new approach to ensuring learning; HIW is contributing to a National Task and Finish Group which is following up issues raised from untoward incidents at a national level.

Case Study 3: Infection Control Inspection of Llandough Hospital

This case study provides an example of a more traditional approach to follow-up where concerns are followed through until there is clear evidence that actions have been taken to address the issues.

Case Study 4: Dignity and Essential Care at Brecon War Memorial Hospital

This case study demonstrates extended follow-up undertaken upon receipt of additional intelligence and co-ordinated with other agencies.

Case Study 5: Mental Health Act Visit

This case study demonstrates the undertaking of immediate follow-up (within one week) when the need for urgent action is identified.

Case Study 6: Unannounced visit to a learning disability/ mental health establishment

This case study demonstrates the undertaking of immediate follow-up when the need for urgent action is identified, including agreed restrictions of service until issues are resolved. It also demonstrates actions taken to share intelligence with appropriate stakeholders and to share learning more widely across other providers.

Case Study 7: Unannounced visit to a learning disability/ mental health establishment

This case study demonstrates immediate response to serious concerns emerging from intelligence sharing and subsequent follow-up.

Document 3

Case Studies

Case Study 1

Area: **Special Reviews/Investigations**

Specific Review: **Betsi Cadwaladr University Health Board (BCUHB) joint review with WAO**

Background

Work undertaken by the Wales Audit Office (WAO) and Healthcare Inspectorate Wales (HIW) at the end of 2012 in BCUHB was highlighting on-going and common issues around governance, accountability and service delivery. These had been previously reported to the Board in the WAO's 2012 Structured Assessment findings and Annual Audit Report and in HIW's review of patient care at Glan Clwyd Hospital, but were continuing to emerge in a broader quality and safety review that HIW had been undertaking during late 2012/ early 2013.

Rather than continuing to report separately HIW and the WAO felt that it would be more constructive to undertake a single joint review of BCUHB's Governance Arrangements to draw together the issues. This review was to consider:

- The effectiveness of the Board and its sub-committees
- Organisational structure and lines of internal accountability
- Strategic vision and service reconfiguration
- Stakeholder engagement
- Organisational culture
- Performance against key targets and indicators of service quality and efficiency
- Performance management and monitoring
- Financial management and sustainability

Review Methodology

HIW and WAO convened a joint review team to evaluate existing intelligence. This prompted a period of fieldwork in order to provide a 'current' view of the Health Board. This consisted of a week spent interviewing key members of the Health Board, including the Executive Team, Independent Members of the Board, and also some Chiefs of Staff.

Reporting

Immediately following the fieldwork, HIW and WAO wrote to the BCUHB Chief Executive providing a summary of the review team's initial findings. The full report was published on 27 June 2012.

Follow up

HIW has regular phone calls with the Health Board to monitor progress in respect of the recommendations made within the report. There have also been regular face-to-face meetings which are co-ordinated with work the WAO is undertaking in regard to its annual structured assessment.

HIW/ WAO intend to make a more formal assessment of progress against the recommendations in 2014.

Following publication of the joint report HIW and the WAO gave a commitment to work with the Welsh Government to review and where necessary strengthen the arrangements for identifying and handling risks to service delivery or organisational effectiveness. A Project Board consisting of representatives from Welsh Government, Healthcare Inspectorate Wales and Wales Audit Office has been established to take forward this work.

The Project Board will look to identify a framework in which this information can be exchanged in a timely manner, and to identify triggers and prompts for escalation and intervention, and who should undertake those actions. The Project Board will be consulting with the wider Health Service and interested parties as part of its work.

It is anticipated that the outcome from this Project Board will be communicated in March 2014.

Case Study 2

Area: **Special Reviews/Investigations**

Specific Review: **Mr J Homicide Investigation**

Background

Until 2007 independent external reviews into homicides by those experiencing mental health problems were commissioned by Local Health Boards. The investigations themselves were conducted by review teams brought together from third party health bodies or through commissioning from the independent sector. Since January 2007 all independent external reviews of such cases are undertaken by Healthcare Inspectorate Wales (HIW). Where the services reviewed include social services, then arrangements are made to include social services inspectors from Care and Social Services Inspectorate Wales (CSSIW) in the review team.

Review Methodology

HIW undertakes its homicide reviews under the principles of Root Cause Analysis (RCA). Through its use the root causes for an undesired outcome can be identified and actions designed to prevent or reduce the likelihood of reoccurrence. HIW's investigations are conducted with specialists who are able to provide the review team with expert and objective insight. In this case the review team consisted of a Consultant Psychiatrist, Registered Mental Health Nurse and Lay Reviewer.

HIW undertook an examination of documentation relating to delivery of services by both Health and Probation Services. Interviews were undertaken with key individuals from the stakeholder organisations, including engagement with the families of those affected where they are willing to do so..

Liaison with families is a key aspect of the homicide review process. HIW maintains communication and engagement with the families throughout the course of the review. Family engagement ensures that HIW is able to provide assurance to those affected by events as to the independence of the review process. It also enables families to provide HIW with information that may help inform the review.

Specifics of the Case

Sometime between the 28 February and 2 March 2010, Mr J attacked Mrs A at her home in the Thornhill area of Cardiff. Mrs A sustained severe trauma

injuries to her head and was also found with lacerations to her wrists. Sadly Mrs A died from her injuries. Mrs A was discovered by South Wales Police on 2 March 2010. Mr J had a history of engagement and involvement with Health Services, Police, and the Probation Service. HIW's statutory powers only extend to Health and Social Services; therefore a key aspect of this review was to engage with the Police and Probation services in order to gain their co-operation and enable them to share key information with HIW's review team.

Reporting

Fieldwork was undertaken in late 2012 and after extensive analysis and quality assurance with stakeholders the report was published on 12 September 2013.

HIW held a press event to launch this report in line with previous homicide review publications. This is intended to provide an opportunity for HIW to assist the media in identifying the key messages. It is also important to ensure that mental health is not stigmatised as a consequence of these reviews, and therefore HIW delivers a presentation to the assembled press and media in order to reiterate this key message and to request that they respect the privacy of those affected by the tragic events.

Follow-up

HIW's investigation work is used to influence our general programme of Inspections – for instance the Mr J review contained several findings and recommendations that will directly influence our Mental Health Act visits to Whitchurch Hospital, Cardiff.

Over the last eighteen months HIW has been supporting, along with colleagues from Public Health Wales, a National Task and Finish Group that has been established to consider the findings from untoward incidents, including our homicide reports. The group is taking forward the findings and recommendations from our reports on an all-Wales basis and ensuring that appropriate change and improvement is properly and appropriately embedded in practice. All Health Boards are represented on the group.

Specifically in relation to MR J, HIW is engaged in a pilot initiative being led by Public Health Wales, that will seek to address the recommendations within the report and gain clarity over the actions that have been, or will be undertaken by the stakeholder organisations. This approach is an attempt to reduce the bureaucratic burden on frontline staff by engaging with organisations directly in order to tackle the issues from the 'bottom-up'. This may reduce the traditional over reliance on action plans (a concern that members of the Committee will recognise from the Francis review), and provide a better

opportunity to engage directly with organisations to ensure that there is learning evidenced from these reviews.

Case Study 3

Area: **Inspections**

Specific Review:	**Unannounced Infection Control Inspection to Llandough Hospital – Ward East 8 Care of the Elderly**

Background

HIW introduced unannounced infection control inspections to its routine inspection portfolio in 2006-07. They were introduced in response to growing public concern about MRSA, C. difficile and norovirus. HIW was the first UK inspectorate to introduce this type of unannounced inspection which uses pictorial evidence to support findings.

Information received from patients, public and stakeholders is used to inform this inspection programme.

Review Methodology

The tool used for hospital cleanliness spot check is based on the Infection Control Nurses Association (ICNA) tool and the approach adopted for hospital cleanliness spot checks relies on direct observation, staff questioning and the review of some key documents. The review team includes an infection control nurse and lay reviewer.

All visits are unannounced. There is immediate feedback to senior management at the end of the visit and organisations are required to provide us with an action plan detailing how they intend to address any issues and areas of concern identified within two weeks of the publication of our report.

Specifics of the Case

As part of the fieldwork for our All Wales Review of the Management of Patients with Diarrhoea and Vomiting that was carried out in May 2009 we visited Llandough hospital and as a result concerns were raised in relation to estate issues, cleanliness and infection control on ward East 8. We issued an immediate action notice to the then Cardiff and Vale NHS Trust and we required an action plan to address the issues of concern to be prepared and taken forward. As part of the action plan the then Trust confirmed that refurbishment of the ward would be completed by September 2009.

We re-visited the ward on 24th November 2009. The ward was in a poor state of repair. Cleanliness was poor and a high level of dust and cobwebs were found. There were a number of cleanliness, infection control and estates issues: Handrails were rusty and needed replacing; there was a drainage problem in one of the shower cubicles; windowsills and frames were in a poor state of repair; sinks had unsuitable taps which could not be operated by elbow, knee or sensor; bins were inappropriate for clinical areas; and equipment was dusty.

The ward had been experiencing an increased number of *Clostridium difficile* cases before our inspection and we were concerned that consideration had not been given to the ward environment and how that might be contributing to the increased number of cases.

During the feedback session with staff on the day of our inspection we were advised that the refurbishment had been delayed as the new Health Board was considering the future of the Ward.

Reporting

We immediately wrote to the Chief Executive of the Health Board to request assurances that the issues we highlighted would be addressed as a matter of urgency.

The ward was closed and decanted to enable a comprehensive refurbishment programme to begin.

Follow-up

We revisited Ward East 8 on 19 October 2010 and were pleased to note a good standard of cleanliness. The ward had been redecorated. Flooring had been replaced, bathrooms were clean, new fixtures and fittings were in place; commodes were clean and all linen was stored correctly. We also found some noteworthy practices (which we referenced in our report).

We continue to actively monitor intelligence received and in the event that the assessment of risk / emerging issues increases we will arrange a further inspection.

Case Study 4

Area: **Inspections**

Specific Review: **Unannounced Dignity and Essential Care Inspection – Brecon War Memorial Hospital**

Background

Article three of the European Convention on Human Rights says that no one shall be treated in an inhuman or degrading way. The Human Rights Act 1998 places public authorities in the UK – including all NHS services – under an obligation to treat people with fairness, equality, dignity and respect. Dignity is also one of the five United Nations Principles for Older People and is a key principle underpinning both the Welsh Government's Strategy for Older People and the National Service Framework for Older People in Wales. In 2007, the Welsh Government launched its 'Dignity in Care Programme for Wales.' an initiative aimed at ensuring there is zero tolerance of abuse of and disrespect for older people in the health and social care system.

Against this backdrop of international and UK human rights legislation and Welsh Government policy, in December 2011 Healthcare Inspectorate Wales (HIW) commenced a programme of unannounced 'Dignity and Essential Care Inspections' to review the care of people in hospitals across Wales paying particular attention to older people. This programme follows on from HIW's Dignity and Respect Spot Checks which took place during 2009 and 2010.

Review Methodology

The 'Dignity and Essential Care Inspections review the way a patient's dignity is maintained on a hospital ward and the fundamental, basic nursing care that the patient receives. Information is gathered through speaking to patients, relatives and staff, reviewing patient medical records and carrying out observations.

The inspection methodology focuses on the following areas:

- Patient environment.
- Staff attitude / behaviour/ ability to carryout dignified care.
- Care planning and provision.
- Pressure sores.
- Fluid and nutrition.
- Personal care and hygiene.
- Toilet needs.

- Buzzers.
- Communication.
- Medicine management and pain management.
- Records management.
- Management of patients with confusion.
- Activities and stimulation.
- Discharge planning.

These inspections have been designed to review the care and treatment that all patients receive in hospital, especially older patients which research has proven can be particularly vulnerable during their hospital stay.
The inspections capture a 'snapshot' of the care patients receive on hospital wards, which may point to wider issues about the quality and safety of essential care and dignity. Like our infection control inspections review teams include peer and lay reviewers.

All visits are unannounced. There is immediate feedback to senior management at the end of the visit and organisations are required to provide us with an action plan detailing how they intend to address any issues and areas of concern identified within two weeks of the publication of our report.

Specifics of the Case

HIW visited the Rehabilitation ward at Brecon War Memorial Hospital (then called Y Bannau) on 23 and 24 October 2009.

We identified issues such as poor signage; inconsistent care planning for patients; limited toilet and bathroom facilities; some issues with privacy for patients having treatment; issues with storage and an inconsistent approach to nutritional assessments. In addition, the awareness of staff of procedures relating to vulnerable adults was poor.

Reporting

Feedback was given immediately on the day of our inspection and we wrote to the Chief Executive of the Health Board to request assurances that the issues we highlighted would be addressed as a matter of urgency.

Action plans were produced by the Health Board detailing the arrangements they intended to put in place to resolve the issues we had identified.

Follow-up

Follow-up of the action plan was taken forward by the Mid and West Wales Regional Office of the Department of Health and Social Services.

In January 2011 the Public Services Ombudsman for Wales produced a report following a complaint from the relative of a patient who had received poor care on the rehabilitation ward at Brecon War Memorial Hospital, this highlighted additional issues to those that HIW had raised in 2009.

HIW met with the Health Board regarding this complaint to discuss the issues identified. HIW requested that the Health Board produce updated action plans to detail how they planned to rectify the additional issues identified.

HIW also worked with Brecknock and Radnor Community Health Council who agreed to obtain local intelligence and feed this back to HIW and to the Health Board. The CHC also undertook announced and unannounced visits to the ward in October 2011 and shared their findings with HIW.

HIW conducted an unannounced inspection of the ward in January 2012 to follow up on recommendations from our initial 2009 report, the Ombudsman's report and the findings of the CHC visits.

During our re-visit we were pleased to see that various actions had been completed. The ward environment had improved with better signage around the ward for people with a sensory impairment; privacy for patients had improved with all doors closed when care was taking place; all patients were in receipt of a nutritional assessment; and the rate of Vulnerable Adult training had improved and at the time of our visit was very good.

We identified some issues which still required attention. Staff knowledge about communication aids available to assist patients could be improved, and patients and carers could be better involved in care planning.

The Health Board submitted a further action plan to address these remaining issues in June 2012.

We continue to actively monitor the intelligence received and in the event that the assessment of risk / emerging issues increases we will arrange a further inspection.

Case Study 5

Area: **Mental Health Act Visits**

Specific Review:	**Unannounced Mental Act visit to NHS establishment**

Background

Since 2009, HIW has been responsible for monitoring the implementation and application of the Mental Health Act 1983 (the Act) on behalf of Welsh Ministers. The role is fundamental to our commitment to protecting those who are most vulnerable.

The main purpose of the Mental Health Act 1983 (the Act) is to allow for compulsory care, treatment and action to be taken, where necessary, to ensure that an individual with a mental disorder gets the care and treatment they need for their own health and safety or for the protection of other people.

Under the Act individuals can be detained in hospital or be required to live in the community, subject to certain conditions as set out in a Community Treatment Order (CTO) or under Guardianship. In some circumstances they can be given treatment to which they have not consented or do not have the capacity to consent. For some people detention under the Act can last for significant periods of time.

The Act has serious consequences for the human rights of individuals who are subject to its powers. It is therefore clear as to the processes that must be followed when consideration is being given to detaining an individual, and when an individual is subject to a detention or restrictions. The Act, together with the accompanying Code of Practice sets out safeguards that are intended to ensure that individuals are not inappropriately detained or treated without their consent.

Our overall aim is to ensure that those detained under the Mental Health Act have a voice and are supported and empowered as far as possible to make decisions over their care and treatment.

Review Methodology

HIW have a panel of experienced Mental Health Act reviewers who transferred from the Mental Health Act Commission. They undertake a rolling programme of both announced and unannounced visits to mental health providers.

The focus of the Mental Health Act reviewers is on ensuring that everyone receiving care and treatment in Wales who is subject to the provisions of the Mental Health Act 1983:

- is treated with dignity and respect;
- receives ethical and lawful treatment;
- receives the care and treatment that is appropriate to his or her needs; and
- is enabled to lead as fulfilled a life as possible.

Our Mental Health Act Reviewers (Reviewers) visit and talk to individuals who are subject to restrictions made under the powers of the Act. These discussions are held in private and only take place when the individual consents. The Reviewer explores the individual's views on their care and treatment and will ensure that they understand their rights and the reasons for the restrictions placed on them. In addition, Reviewers will check all records and paperwork related to the restrictions placed on the individual and ensure that the requirements set out in the Act and the Code have been met. Any concerns are escalated immediately and are followed up in writing.

Visits are in the main unannounced. There is immediate feedback to senior management at the end of the visit and organisations are required to provide us with an action plan detailing how they intend to address any issues and areas of concern identified.

The Act also requires the appointment of a registered medical practitioner to authorise the treatment of patients subject to the Act in certain circumstances. These practitioners are known as Second Opinion Appointed Doctors or SOADs and HIW manages this service.

The role of the SOAD is to safeguard the rights of individuals detained under the Mental Health Act who either refuse treatment or who are considered to be incapable of consenting. Despite the name, the role of the SOAD is not to give a second clinical opinion about a patient's condition or diagnosis, but to decide whether the rights and views of the individual have been fully taken account of by clinicians and whether the treatment proposed is in line with guidelines and is appropriate.

Specifics of the Case

Following a SOAD visit to one setting the SOAD notified HIW that they had concerns regarding one patient who had been moved to another area of the unit and was being nursed in isolation in a sparsely furnished room.

Following receipt of this information we brought forward the Mental Health Act monitoring visit as a priority. The unannounced visit was carried out over three days with a HIW member of staff leading one Peer and one Lay Reviewer.

The review team identified a number of issues that were concerning, the key ones being the inappropriate way in which one individual was being cared for .

Reporting

Feedback was given immediately on the day of our inspection. We discussed and agreed the actions that HIW required the organisation to undertake to address the issues identified.

The following day HIW issued an Urgent Action Management Letter to the Chief Executive. These concerns were also escalated internally within HIW to the Head of Inspection and Inspection & Regulation Director.

Follow-up

Following the Urgent Action Management letter the provider submitted an Action Plan to HIW.

Due to the seriousness of the issues HIW met with the service provider the following week to review the provider's progress against their Action Plan. During the meeting the provider confirmed that a more appropriate placement had been found for the patient and that he had been transferred to that setting. Refurbishment of the environment of the ward had also commenced

We continue to actively monitor the intelligence received and in the event that the assessment of risk / emerging issues increases we all arrange a further inspection.

Case Study 6

Area: **Inspection of care provided to individuals with a learning difficulty or mental health issues**

Specific Review: **Unannounced visit to a learning disability/mental health independent hospital**

Background

In May 2011, the BBC broadcast a programme that highlighted abuse and ill-treatment of individuals with a learning difficulty who were residing at an independent hospital in Bristol. The programme gave rise to great public concern. As a result HIW decided to bring forward our annual programme of reviews of independent hospitals providing learning difficulty and mental health services.

The focus for the reviews was to ensure that individuals accessing such services are:

- Safe.
- Cared for in a therapeutic, homely environment.
- In receipt of appropriate care and treatment from staff who are appropriately trained.
- Encouraged to input into their care and treatment plans.
- Supported to be as independent as possible.
- Allowed and encouraged to make choices.
- Given access to a range of activities that encourage them to reach their full potential.
- Able to access independent advocates and are supported to raise concerns and complaints.
- Supported to maintain relationships with family and friends where they wish to do so.

Review Methodology

All visits were unannounced and could take place at anytime of day or night and at weekends.

As part of our inspection process, we routinely hold comprehensive discussions with patients and staff, and we carefully observe the interactions between patients and staff. We may also meet with family members or patient advocates to seek their views on the care provided. In addition to reviewing

the appropriateness of the physical environment we also evaluate the adequacy of a range of documentation including patient care plans, policies and procedures, staff induction and training plans and complaint, restraint and incident records.

HIW uses a range of expert and lay reviewers for the inspection process including a reviewer with extensive experience of monitoring compliance with the Mental Health Act 1983.

There is immediate feedback to senior management at the end of the visit and organisations are required to provide us with an action plan detailing how they intend to address any issues and areas of concern identified.

Specifics of the Case

An unannounced night visit was undertaken to an independent hospital in the Cardiff area in September 2011. Issues in relation to staffing level, the overuse of agency staff, training and the suitability of one particular patient's placement were raised. Patients on some wards also raised with us concerns about the lack of activities, restrictions on drinks and access to outside areas that led us to believe that a blanket approach to risk was being taken.

Reporting

Feedback was given to senior management before we left the establishment. During this we discussed and agreed the actions HIW required the organisation to undertake to address the issues identified.

An Urgent Action Management letter was sent to the provider.

Follow-up

HIW met with the Registered Manager, Responsible Individual and other members of the senior team the following week to discuss the action they were taking to address the issues identified. It was agreed that the establishment would not admit further patients until the staffing issues had been resolved. A further meeting was held with the provider in October 2011 to discuss progress. Further unannounced visits have been undertaken to the establishment and more are planned.

In addition to meeting with the provider HIW met with commissioners to advise them of the action they had taken and to remind them of their responsibilities in relation to ensuring that the patients for whom they commissioned services were safe and appropriately placed.

Two workshops have been held with independent learning disability and mental health service providers to communicate the themes arising from reviews such as this and to ensure learning and improvement.

Case Study 7

Area: **Working with partners to share and respond to intelligence**

Specific Review:	**Unannounced visit to a learning disability/mental ealth independent hospital**

Specifics of the case

HIW liaises on a regular basis with the NHS Wales Mental Health & Learning Disability Collaborative Commissioning Group. Intelligence shared with HIW in July 2013 highlighted concerns in relation to a particular independent provider, particularly around observation and staffing levels.

HIW undertook an urgent unannounced visit to the establishment on the evening of the day that it was advised of the concerns. Staff from the NHS Wales Mental Health & Learning Disability Collaborative Commissioning Group attended with HIW.

Reporting

Feedback was given to senior management before we left the establishment. During this we discussed and agreed the actions that HIW required the organisation to undertake to address the issues identified.

An Urgent Action Management letter was sent to the provider

Follow-up

A more detailed unannounced visit was undertaken over three days (25-26 July 2013). The focus of the visit was on ensuring the safety and quality of patient care.

In addition meetings have been held with commissioners and POVA teams to brief them of HIW's concerns and to ensure that they fulfil their respective roles in ensuring the safety of their patients.

There has been regular dialogue and follow-up with the provider organisation; the last meeting with the Responsible Individual, Responsible Manager and other members of the senior team being held in October 2013.

HIW continues to monitor and work with the provider. Further visits are planned.

Case Study 8

Area: Developing Innovative Approaches that engage Clinicians

Specific Review: Peer Review (plus)

Background

In 2009 Healthcare Inspectorate Wales (HIW) was approached by the Cancer Services Co-ordinating Group who wished to explore opportunities for the introduction of cancer peer review in Wales. As all reviews undertaken by HIW involve a level of peer review[1] and given that cancer services are a key priority area for both organisations it was felt that the knowledge and expertise of both organisations could be brought together to develop an approach to peer review in Wales that was efficient, effective and rigorous.

In 2010 HIW working with lead clinicians from across Wales and the Cancer Services Co-ordinating Group undertook a pilot as part of the development of the peer review process. The experience was positive in many ways and there was buy-in and enthusiasm from clinicians and members of multi-disciplinary teams. However the pilot highlighted flaws in the process for which work has since been taken forward to address. These weaknesses echoed the experiences in England:

- large number of measures to assess against.
- lack of analysis of data and intelligence before the peer review visit to enable clinicians to focus on key areas.
- lack of outcome measures.
- inadequate guidance provided to delivery teams to enable them to properly self-assess and internally validate.

A formal evaluation of the pilots was undertaken and as a result recommendations for a new, more robust process were made and further follow-up work taken forward.

Review Methodology

Over the past two years the Cancer Services Co-ordinating Group and HIW have been working together to research, develop and test peer review

[1] HIW has recruited a panel of peer reviewers who have a wide range of knowledge and expertise in various specialisms. The team for every HIW review involves peers with the relevant professional background and experience.

approaches with a view to introducing a rolling programme of reviews **across** Wales in 2012-13. The model set out in this paper has been developed so that it can be adapted to any service and multi-disciplinary team. It has been designed so that the best use is made of clinicians time and the cost is kept to a minimum as support and the rigour is brought to the process by two bodies that already have a remit to oversee and review cancer services.

Working with cancer and palliative care clinicians an approach to peer review has been developed that incorporates:

- self assessment
- internal validation
- external validation
- peer review visits

In support the peer review process outcome measures have been developed and agreed for each cancer site reviewed to date. This work has been led by the Chairs of the all-Wales Cancer Advisory Groups.

Guidance and training has been developed and rolled out for:

- teams - how to properly self assess
- internal verifiers - how to test and verify self-assessments
- external verifiers - how to test and verify self-assessments
- peer review teams – how to interview and gather evidence

Reporting

To date, in 2012-13 peer reviews of palliative care, lung cancer and Upper GI have been undertaken and reviews of Urology are planned for later this financial year. Reports have been issued to the organisations, and public friendly versions are being finalised.

Follow-up

Concerns were immediately fed back to clinical teams on the day of the visit. Where immediate concerns have been highlighted these have been escalated immediately and urgent action letters sent to the Chief Executive of the provider organisation within three days. Meetings have also been held with senior management where necessary.

Case Study 9

Area: **Benchmarking and learning from other inspectorates**

Specific Review:	**5 Nations Regulators Group and the European Partnership for Supervisory Organisations in Health Services and Social Care (EPSO)**

Background

HIW works closely with other inspectorates from across the UK and Europe. It engages in sharing and learning events and has had a key role in taking forward peer review through EPSO.

HIW was one of the first independent inspectorates to invite peer review of its approaches, inviting colleagues from the then Quality Improvement Scotland to undertake a peer review of the effectiveness of our Healthcare Standards assessment approach. Their report published in May 2008 set out a detailed account of the strengths and weaknesses of the approach providing a sound evidence base to support future improvement and development.

Following our successful involvement in a peer review of the Norwegian Board of health Supervision in 2011-12, HIW is taking part in the peer review of the Danish Board of Health Supervision.

Review Methodology

In developing the scope and approach for the peer reviews consideration has been given to the standards that other organisations have developed for supervisory and audit bodies including those set by the International Society for Quality in Healthcare (ISQua) and ISO/IEC standard 1720:19981

The reviews are aimed at assessing and evaluating the arrangements that organisations have in place to ensure that its statutory basis and functions are clearly set out and that it had satisfactory arrangements in place in relation to:

- statutory basis clear and functions clearly defined;
- independence, impartiality and integrity;
- confidentiality and safeguarding of information;
- organisation and management;
- quality systems;
- personnel;
- facilities and equipment;

- inspection methods and procedures;
- engagement and communication with the organisation or individual subject to review;
- openness and transparency;
- disciplinary sanctions;
- impact assessments; and
- co-operation and engagement with other stakeholders including other supervisory bodies.

Document 4

HIW’s work programme 2013-2014
(Draft)

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Healthcare Inspectorate Wales

Operational Plan

April 2013 to March 2014

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

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

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Foreword

Since 2010, HIW has published annually a programme for the three years ahead, revising and updating it in light of the changes and developments across healthcare services in Wales.

Our last three year programme, for 2012-2015, was published in August 2012 and since then the environment within which HIW operates has undergone significant and rapid change. The NHS in Wales continues to respond to significant pressures brought about by an ageing population, the financial climate and service reconfiguration, all of which increase the level of risk to quality and safety of services. Independent healthcare is also changing with the consideration of additional regulation in the field of cosmetic surgery.

The publication of the Francis Inquiry report in February 2013 and the Keogh review in July 2013 reminded us all that we cannot afford to take for granted the very basic requirements of good quality care. These reports raised some fundamental questions about the way in which all bodies involved in the commissioning, provision, regulation and inspection of healthcare carry out our work, and made clear that the scale of change needed is not just about changing our systems and processes alone – it must also focus on cultural and behavioural change.

There is also considerable review and scrutiny of the role and effectiveness of external assurance bodies such as ourselves and how the landscape of regulation and inspection in Wales may need to evolve to ensure it is proportionate and effective..

Given this rapidly evolving context I have decided not to refresh HIW's three-year programme at this time.

This plan sets out where HIW will focus its activities during 2013-14 to ensure that a fundamental level of assurance is sustained.

Later in the year I expect to publish an operational plan for 2014-15 which makes explicit our delivery proposals for the coming year and invites stakeholders and the wider public to comment on whether our plans are addressing the most important issues, in the right way, to ensure we are having a positive influence on sustainable improvement in the quality and safety of healthcare provision.

This will be the start of a conversation to help me establish a clear, longer term vision for HIW that ensures that what we focus our attention on, and how we carry out our work in the future takes full account of the things that matter most and meets the challenges set for inspection and regulatory bodies.

Kate Chamberlain
Chief Executive
November 2013

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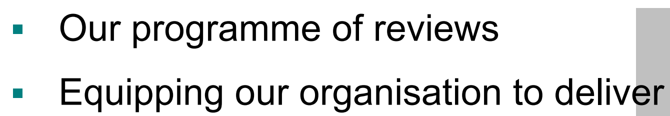
- Our programme of reviews
- Equipping our organisation to deliver



Introduction

This plan sets out HIW's work programme and priorities for the period up to the end of March 2014.

The plan:

- establishes how we will in the short term continue to focus our work on our routine programmes designed to enable us to meet our statutory responsibilities and in so doing drive improvement in the fundamental aspects of good quality healthcare – dignity and essential care, cleanliness and infection control
- recognises the potential vulnerability of anyone accessing healthcare services and focuses on the extent to which health service organisations provide appropriate support to individuals during their involvement with the service. In addition, it enables the ongoing delivery of key programmes of work that focus on ensuring that the well being and human rights of individuals from specific service user groups are safeguarded
- enables us to focus on how we can shift the balance of our work so that we look at front line services delivered within primary and community care settings and not just hospitals – in line with the Welsh Government's own ambition to focus strongly on ill health prevention, health promotion and the provision of primary and community care
- focuses on further strengthening our collaborative approach – in particular sharing intelligence and information on healthcare services with other inspection, audit, regulatory and improvement bodies and those responsible for managing the performance of the NHS in Wales so that any early warning signs are identified and acted upon quickly and effectively to ensure people are properly safeguarded whenever and wherever they access healthcare services in Wales
- ensures we are able to respond to concerns that may arise perhaps from a particular incident or series of incidents
- Strengthens our focus on further developing and improving how we engage, work with and inform patients and the public about our activities, our findings and the impact of our work

And finally, this plan recognises our need to further develop the capacity and capability of our workforce – including our panel of peer and lay reviewers – so that we are able to continue to deliver and develop our organisation to meet increasing expectations in the longer term and in accordance with our overall aims, values and delivery principles.

About HIW

Our Purpose

HIW is the lead independent inspectorate for healthcare in Wales. Its purpose is

> *To provide independent and objective assurance on the quality, safety and effectiveness of healthcare services making recommendations to healthcare organisations to promote improvements*

Our role

- To independently inspect and report on the quality and safety of the provision of healthcare by NHS bodies in Wales
- To inspect and regulate independent healthcare providers in Wales
- To discharge specific statutory responsibilities on behalf of Welsh Ministers
- To provide independent and objective information to patients and the public

The outcomes we seek to influence

- Citizen experience of healthcare is improved
- Citizens are able to access clear, timely, honest information on the quality, safety and effectiveness of healthcare services in Wales
- Citizens are confident that inspection and regulation of the healthcare sector in Wales is sufficient, proportionate, professional, co-ordinated, and adds value

Our values

Central to everything we do, our values establish the fundamental principles that govern the way we carry out our work. They are:

- *Centred on patients, service users and citizens*
- *Openness and honesty*
- *Collaboration, sharing our experiences amongst ourselves and with other review bodies*
- *Efficiency, effectiveness and proportionality in our approach*
- *Supporting and encouraging learning, development and improvement*
- *Professionalism*
- *Driven by intelligence*

Our delivery principles

We have developed a draft set of delivery principles which provide a framework within which we aim to fulfil our overall purpose and influence the right outcomes in a manner that upholds our values and standards of professional practice. These have emerged from discussions with our partners and stakeholders and also take account of the requirements for a robust, proportionate, efficient and effective inspectorate as set out in the *Report of the Mid-Staffordshire Inquiry*[12]. These will continue to evolve as we test what they mean in practice through consultation on our plans and priorities.

Principle 1

We will undertake a balanced annual programme of **NHS** review activity which incorporates elements of

- *Baseline frequency of reviews (announced and unannounced) in specified settings*
- *Additional responsive review in light of issues and concerns*
- *Testing of overarching arrangements for ensuring quality and safety*
- *Testing of organisational responsiveness to complaints and recommendations*

Principle 2

We will undertake a balanced programme of activity for each **independent** healthcare setting which ensures that

- *All settings that are required to be registered with HIW are registered*
- *The registration process ensures that independent healthcare providers meet the relevant regulations and minimum standards*
- *All settings are subject to baseline visits to a minimum frequency*
- *Additional reviews are undertaken in response to issues and concerns*

Principle 3

We will take a professional and measured approach to the delivery of our specific functions

- *The Local Supervisory Authority for statutory supervision of midwives*
- *Regulation and Inspection of Dental Services*
- *Responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005*
- *Second Opinion Appointed Doctor (SOAD) service*
- *Deprivation of Liberty Safeguards*
- *National Preventative Mechanism*

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[2] Robert Francis QC - Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry published on 6 February 2013.

	➢ *Ionising Radiation (Medical Exposure) Regulations* ➢ *Controlled Drugs* ➢ *Nurse Agencies* ➢ *Homicide Investigations* ➢ *Regulation 30/31 Incidents (The Independent Health Care (Wales) Regulations 2011)* ➢ *Protection of Vulnerable Adults (POVA)* ➢ *Joint Reviews with HMI Probation and HMI Prisons* ➢ *Peer Review +* *and will seek to use the information gathered in delivering these functions as far as possible to contribute to fulfilling its responsibilities under Principles 2 and 3.*
Principle 4	We will respond in an appropriate and timely manner to concerns and issues through ➢ *Escalation of concerns and issues in an NHS context through agreed procedures leading, where appropriate, to the introduction of Special Measures* ➢ *Enforcement of registration requirements for independent healthcare providers*
Principle 5	We will report clearly, openly and publicly on the work we undertake in order that citizens are able to access independent and objective information on the quality, safety and effectiveness of healthcare in Wales.
Principle 6	We will keep patients and users at the heart of our work by ➢ *maintaining a panel of lay reviewers to take an active part in the inspection process* ➢ *continuing direct observation and discussions with patients, relatives and staff within our inspections* ➢ *extending our use of unannounced, out-of-hours and weekend inspections* ➢ *developing our overarching framework for public and patient engagement*
Principle 7	We will ensure a professional approach to regulation and inspection by ➢ *maintaining a panel of specialist peer reviewers who can be called upon to provide a professional input to inspection activity;* ➢ *supporting our own staff in their professional and personal development* ➢ *utilising specialist steering groups to advise on effectiveness of, and*

	developments in, inspection methodologies ➢ *establishing a strong Advisory Board to challenge and scrutinise the overall work of the organisation*
Principle 8	We will maintain an overview of the risks, emerging issues and current issues for each inspected body in order to: ➢ *Be able to speak authoritatively in public about emerging concerns and issues; and* ➢ *Use this information to inform our programme of work*
Principle 9	We will take a collaborative approach to our work in which we will seek to ➢ *share intelligence on concerns and issues ;* ➢ *work in partnership with other regulators and inspectors; and* ➢ *place reliance on the work of others in deriving assurance as far as is reasonable and appropriate.*
Principle 10	We will base our review activity on recognised standards as defined by the Welsh Government and in associated guidance, recognised best practice, and requirements defined in legislation and regulation. We will use our experience of the delivery of these standards in order to inform their further development.

Our work in 2013-2014

Our programme of reviews

Principle 1: We will undertake a balanced annual programme of NHS review activity which incorporates elements of

- *Baseline frequency of reviews (announced and unannounced) in specified settings*
- *Additional responsive reviews in light of issues and concerns*
- *Testing of overarching arrangements for ensuring quality and safety*
- *Testing of organisational responsiveness to complaints and recommendations*

What we will focus on	How: we will do it
Focus on the fundamental aspects of health service provision that contribute to the overall experience of patients, their families and others when accessing services	Deliver a programme of targeted, unannounced ***Dignity and Essential Care*** inspections. We will carry out a minimum of 8 inspections before the end of 2013-14 covering each health board in Wales.
	Further develop our approach to the conduct of ***Dignity and Essential Care*** inspections including: ▪ The introduction of revised ward based tools mapped to the issues arising from the Francis Inquiry ▪ The development of additional modules including diabetes and general cleanliness ▪ More explicit referencing within our review approach and reports to the relevant standards and requirements for each aspect of review, e.g., patient safety alerts ▪ Enhancing our risk based selection process.

	Deliver a programme of targeted, unannounced ***Infection Control*** inspections. We will carry out a minimum of 8 inspections before the end of 2013-14 covering each health board in Wales.
	Further develop our approach to the conduct of ***Infection Control*** inspections including: - The introduction of revised ward based tools mapped to the issues arising from the Francis Inquiry - The further development of tools that focus on areas such as MRSA, C. diff and theatres - More explicit referencing within our review approach and reports to the fundamentals of care areas and other standards and requirements including patient safety alerts - Further development of the inspection process to streamline collation of evidence and documentation Enhance our risk based selection process.
Review of the effectiveness of the governance arrangements within GP practices for assuring the quality of care provision and the adequacy of communication between practices and secondary care organisations.	Develop the methodology and plans to deliver a primary care review programme in line with the actions recommended by the Health Minister in the Welsh Government's response to the investigation into the case of Robbie Powell - reviews to be delivered in 2014-2015

Review of the effectiveness of commissioning arrangements for social care (including the interface between health and social care)	Contribute to the design and delivery of a review programme led by the Care and Social Services Inspectorate for Wales (CSSIW)
Follow up review of Child and Adolescent Mental Health Services (CAMHS)	Working jointly with the Wales Audit Office, we will publish the report of our follow up review of CAMHS
Special Reviews into identified issues and concerns	Complete and publish the findings of our review of *endoscopy services* in Aneurin Bevan Health Board
	Publish the findings of our review of infection control arrangements within Abertawe Bro Morgannwg University Health Board following an outbreak of E Coli on the neonatal ward.
	Commission additional investigative work as appropriate in response to identified issues and concerns
Ensuring NHS organisations fitness for purpose through ***Doing well, doing better: Standards for Health Services***	Provide overarching feedback to NHS organisations' on their corporate level assessment of performance against the Standards using the *Governance and Accountability* self assessment module
	Establish the approach to self assessment and reporting against the standards for 2014-2015
	Continue to develop the self assessment modules for key services, including *end of life care* and *cancer services* and support their use in the conduct of the peer review + programme

Principle 2: We will undertake a balanced programme of activity for each independent healthcare setting which ensures that

- *All settings that are required to be registered with HIW are registered*
- *The registration process ensures that independent healthcare providers meet the relevant regulations and minimum standards*
- *All settings are subject to baseline visits to a minimum frequency*
- *Additional reviews are undertaken in response to issues and concerns*

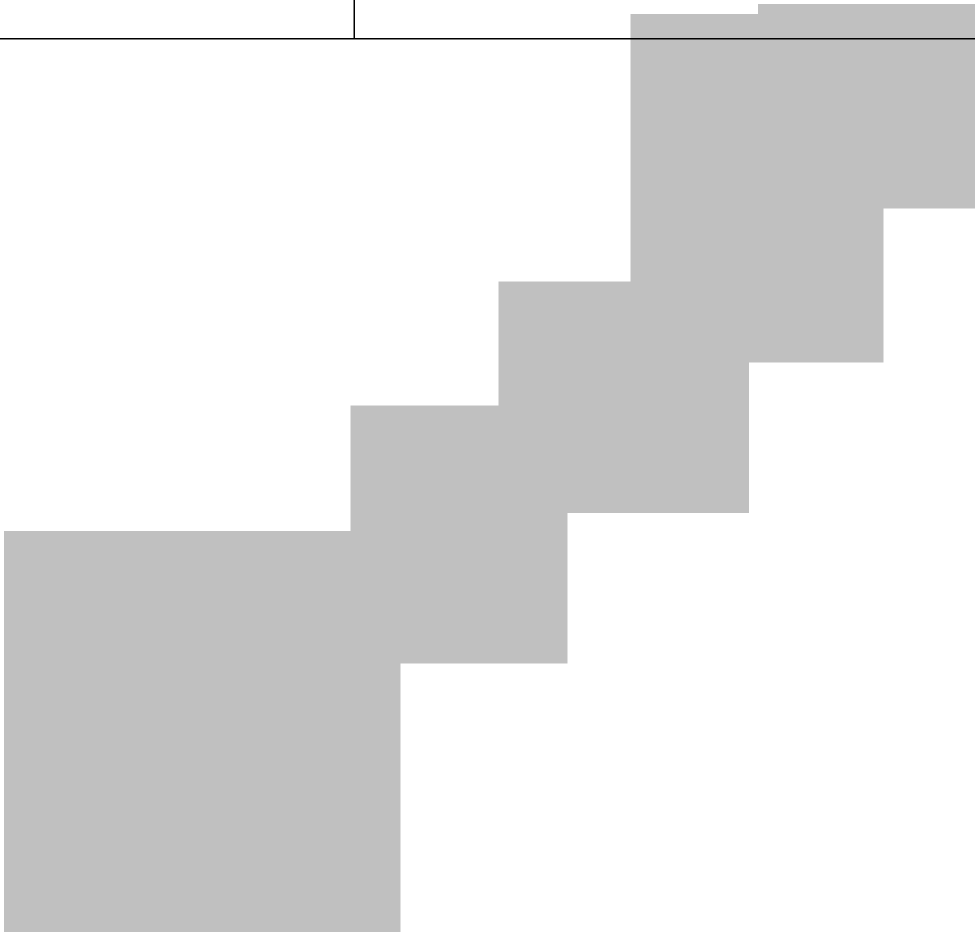
<table>
<tr><th>What we will focus on</th><th>How: we will do it</th></tr>
<tr><td rowspan="4">Register individual healthcare settings providing services for the first time and when services change</td><td>Respond appropriately and in a timely manner where we identify a risk that providers may be operating without an appropriate registration</td></tr>
<tr><td>Register individual healthcare settings</td></tr>
<tr><td>Respond to requests to cancel registration or to vary or change registration conditions</td></tr>
<tr><td>Process annual registration fees</td></tr>
<tr><td>Inspect individual healthcare settings</td><td>Carry out a routine programme of inspections of individual healthcare settings to assess the safety and quality of service provision:

We will continue to focus on services for those who are in vulnerable situations.

▪ We have carried out 15 reviews of providers of mental health and learning difficulty services so far this year, and plan to carry out a further 8 reviews. Follow up visits have been either undertaken or planned for those establishments where concerns were identified

▪ Four visits (both announced and unannounced) have been undertaken to dental hospitals</td></tr>
</table>

	▪ Conduct an annual review of self assessment returns from settings providing IPL and Laser services and carry out a minimum of 6 visits up to the end of the year ▪ A further 20 unannounced visits are planned to other independent healthcare settings
	Undertake additional risk-based reviews in response to specific areas of concern



Principle 3: We will take a professional and measured approach to the delivery of our specific functions

What we will focus on	How: we will do it
The Local Supervising Authority for the statutory supervision of midwives	Ensure that all midwives who practice in Wales have access to, and receive appropriate levels of supervision in accordance with the standards and guidelines set by the Nursing and Midwifery Council (NMC)
	Continue to work with all relevant stakeholders to "future proof" the statutory supervision of midwives in Wales through the development and introduction of a revised model of supervision
Regulation and Inspection of Dental Services	Register individual dentists who wish to provide private dentistry services ensuring they demonstrate they meet the relevant regulations and minimum standards
	Respond to requests to cancel registration or to vary or change registration conditions
	Process annual registration fees
	Devise and deliver a programme of assurance of the quality of private dentistry in Wales
	Develop and put in place new arrangements for practice inspections (private and NHS) from 1 April 2014 onwards

Review Service for Mental Health	Meet our responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005 through an ongoing programme of monitoring visits. So far this year we have undertaken 25 visits and reported on 21 of these. For the reminder of the year we will focus on: ▪ Produce reports on the 4 earlier visits ▪ Carry out 35 visits up to the end of the financial year (resulting in a total of 60 visits in 2013-2014) ▪ Improve the way we report on the findings from each monitoring visit
	Provide a Second Opinion Appointed Doctor Service: ▪ carry out visits in response to requests ▪ determine minimum and maximum visit levels and delivery targets for our SOADs
	Work with the Delivery Unit of the Welsh Government's Department for Health, Social Services and Children (DHSSC) to monitor the implementation of the Mental Health (Wales) Measure 2010 (Parts 2, 3 and 4) through the audit of care and treatment planning. We will visit each Local Health Board in Wales and contribute to the Welsh Government's first post implementation report
Deprivation of Liberty Safeguards	Work with CSSIW to monitor the implementation of the Deprivation of Liberty Safeguards (the Safeguards) during 2012-2013 by NHS and registered independent hospitals when caring for patients who were unable to make decisions about their care The Safeguards are there to protect people whose mental capacity is compromised, who either live in a care home or are patients on a hospital ward. They were developed to ensure that the human rights of such individuals are maintained
	Work with CSSIW to conduct a joint national review of compliance with and awareness of the requirements of the safeguards

National Preventative Mechanism	Continue to be a participant and contributor to the UK's National preventative mechanism. The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) was adopted by the United Nations General Assembly in 2002. Its adoption reflected a consensus among the international community that people deprived of their liberty are particularly vulnerable to ill-treatment and that efforts to combat such ill-treatment should focus on prevention. States which ratify OPCAT are obliged to designate a "national preventive mechanism" (NPM), a body or group of bodies which regularly examine the treatment of people deprived of their liberty, make recommendations and comment on existing or draft legislation, all with the aim of improving the treatment and conditions of detainees. Given its role in relation to the monitoring of the Mental Health Act HIW is one of 18 organisations that form part of the UK NPM.
Ionising Radiation (Medical Exposure) Regulations	Carry out a programme of assessment and inspection of clinical departments that use ionising radiation in their work: ▪ carry out four visits up to the end of the financial year
	Ensure specific incidents involving "exposure much greater than intended" are properly investigated and remedial action is taken as necessary.
Controlled Drugs	Publish a list of "accountable officers" and attendance at Local Intelligence Networks for Controlled Drugs meetings
Homicide Investigations	Undertake investigations into circumstances where a service user known to Mental Health Services is involved in a homicide: ▪ Continue progress in the conduct of two investigations ▪ Report on the findings of one investigation

Regulation 30/31 Incidents **(The Independent Health Care (Wales) Regulations 2011)**	Independent healthcare organisations are required by regulation to advise HIW of any notifiable incidents. HIW will take action to ensure they have been properly dealt with and use the intelligence from these to inform our inspection programme. Where appropriate, HIW will refer any possible adult protection concerns to the relevant local authority and where appropriate engage in Protection of Vulnerable Adult (POVA) meetings
Joint Reviews with HMI Probation and HMI Prisons	Contribute to the conduct of a full joint inspection of Wrexham Youth Offending Team (Powys was visited earlier this year) and thematic inspections of: ▪ Learning Difficulties and Disabilities (Part II) ▪ Girls and Young Women who have offended
	Carry out clinical reviews of deaths in prison custody: ▪ Progress and report (within 50 working days of the request) on 4 ongoing reviews ▪ Commission any further review requests (within 5 working days) ▪ The Prison and Probation Ombudsman (PPO) is required to undertake an investigation of every death that occurs in a prison setting. HIW provides the clinical review element of these reviews on behalf of the PPO for all deaths that occur in a Welsh prison

Peer Review +	Over the past two years the Cancer Services Co-ordinating Group and HIW have been working together to research, develop and test peer review approaches with a view to introducing a rolling programme of reviews across Wales.
	
	During the year we will continue to work in partnership with Cancer Networks and the Palliative Care Implementation Board to:
	
	▪ support the production and publish the reports of a programme of 14 peer reviews focused on the following areas:
	    o Lung Cancer
	    o Palliative Care
	    o Upper Gastrointestinal (GI) Cancer
	▪ Support the planning and delivery of a further programme of reviews focused on urology and palliative care
	
	▪ Plan a programme and timetable of reviews for 2014 to include Lower GI, Head & Neck and Gynaecology

Principle 4: We will respond in an appropriate and timely manner to concerns and issues through

- *Escalation of concerns and issues in an NHS context through agreed procedures leading, where appropriate, to the introduction of Special Measures*
- *Enforcement of registration requirements for independent healthcare providers*

What we will focus on	How we will do it
Ensure appropriate action is taken when NHS services fail to meet the standards and requirements set for them	Work with the Welsh Government and other regulators and inspectors to develop a consistent approach to the identification of and response to emerging issues and concerns through the development and publication of an *Escalation and Intervention* policy and procedures
	Take appropriate, proportionate and timely escalation action to ensure the safety of those accessing services from NHS organisations including, where appropriate seek to place an organisation under special measures
Ensure appropriate action is taken when independent healthcare providers fail to meet what is legally required of them	Develop and publish our enforcement policy and procedures
	Take appropriate, proportionate and timely enforcement action to ensure the safety of those accessing services from independent healthcare providers: ▪ Undertake 26 regulatory/enforcement visits to unregistered providers by the end of the year.

Principle 5: We will report clearly, openly and publicly on the work we undertake in order that citizens are able to access independent and objective information on the quality, safety and effectiveness of healthcare in Wales.

What we will focus on	How we will do it
Increase public awareness and understanding of the work of HIW through stronger communication channels	Develop an overarching Communication strategy, including plans for the use of social and other media
	Progress the development of HIW's new website
	Reintroduce our quarterly newsletter and publish our activity plans
Inform the public and others about the services provided by independent healthcare providers who should be registered in Wales	Maintain a complete and up to date list of registered independent healthcare providers
Publicise our views on the quality and safety of health services in a manner that gives clear account of our activities; drives improvement and informs the development of future health policy	Publish annual reports of: ▪ Our monitoring of the Mental Health Act ▪ Our monitoring of the Deprivation of Liberty Safeguards ▪ Our overall work programme
Improve the accessibility, availability and impact of our publications	Introduce and explicitly set out performance measures relating to timeliness and quality of reporting

Principle 6: We will keep patients and users at the heart of our work by

- *maintaining a panel of lay reviewers to take an active part in the inspection process*
- *continuing direct observation and discussions with patients, relatives and staff within our inspections*
- *extending our use of unannounced, out-of-hours and weekend inspections*
- *developing our overarching framework for public and patient engagement*

What we will focus on	How: we will do it
Further strengthen the voice of patients and the public in setting our direction and ways of working	Consult on our overall plan and work programme for 2014-2015
	Publish our Stakeholder Engagement Strategy, incorporating our plans for engaging on our longer term vision and direction
Involve patients and the public in all our review activity	Continue to progress our recruitment process for new lay reviewers Strengthen arrangements for matching; appointing and equipping individual reviewers to participate in specific work programmes
	Further develop our links with third sector and other service user and patient representatives to ensure the widest range of participation in our work: ▪ engaging on our overall plans and work programmes ▪ seeking views and perspectives on specific aspects of healthcare, or within particular communities and areas in Wales ▪ working with patients, service users, carers and their families to develop new approaches to our

	work
	Further strengthen our formal links and relationship with Community Health Councils through the agreement and introduction of a new Operating Protocol
Improve our responsiveness and increase the transparency of our activities	Raise awareness of HIW's distinct role in and arrangements for responding to: ▪ feedback and concerns about healthcare services from members of the public and from healthcare workers ▪ feedback and concerns about HIW itself
	Consider and respond appropriately to queries and concerns raised with us about the quality and safety of healthcare services in Wales

Equipping our organisation to deliver

Principle 7: We will ensure a professional approach to regulation and inspection by

- *supporting our own staff in their professional and personal development*
- *maintaining a panel of specialist peer reviewers who can be called upon to provide a professional input to inspection activity;*
- *utilising specialist steering groups to advise on effectiveness of, and developments in, inspection methodologies*
- *establishing a strong Advisory Board to challenge and scrutinise the overall work of the organisation*

What we will focus on	How we will do it
Develop the capacity and capability of our core workforce	Continue with our comprehensive programme of recruitment
	Develop our overarching Learning and Development strategy and plans to support our workforce (including our external reviewers) when they: ▪ join our organisation ▪ move into new roles; undertake new areas of work; take on new responsibilities or introduce new ways of working ▪ leave our organisation through effective induction; development of core skills; specialist knowledge, skills and expertise; continuing personal and professional development.

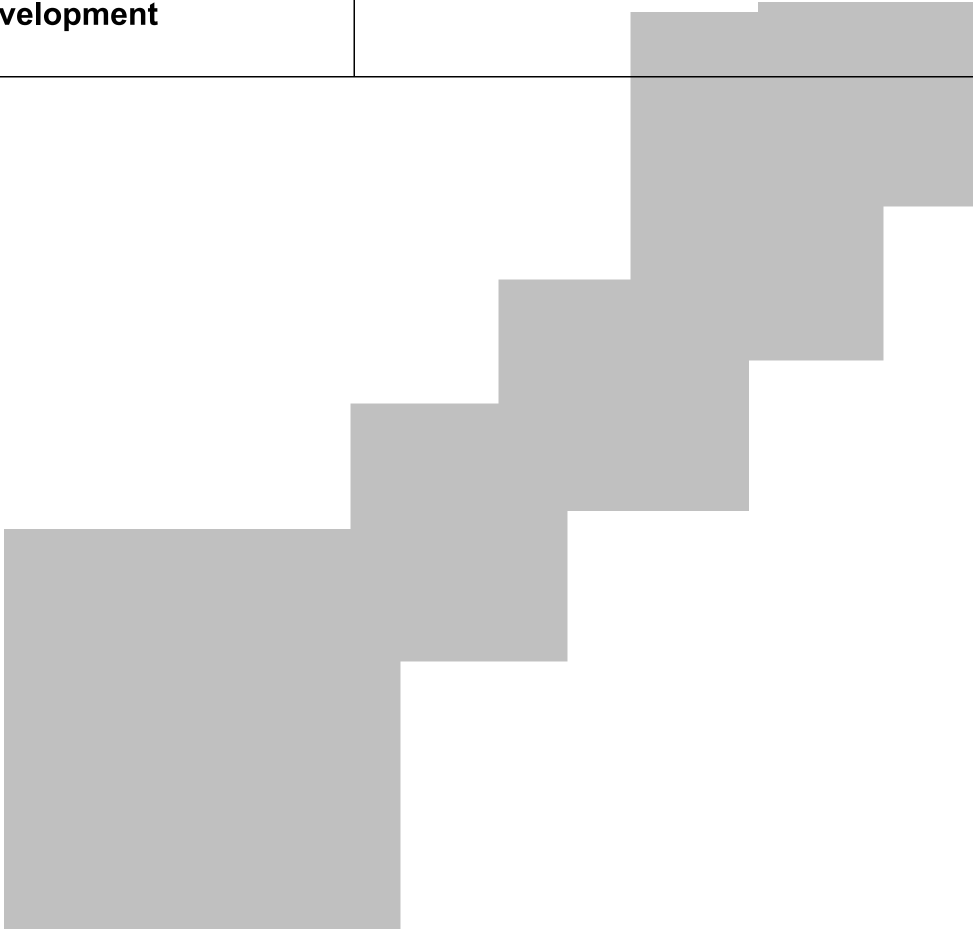
Engage and empower our workforce	Further develop our approach to communicating with our workforce through: ▪ Regular staff events and conferences ▪ Internal e-communications
	Review the findings of our staff survey and ensure areas for further development/improvement are taken forward within our programme for organisational development
Ensure we have access to the specialist expertise we need to enable us to effectively deliver our work programme	Continue to develop our "mixed model" approach to sourcing specialist expertise from a variety of sources including: ▪ Targeted appointment of "peer" healthcare staff direct from Local Health Boards and Trusts across Wales ▪ Nomination and appointment of suitable specialist expertise via the Academy of Royal Colleges in Wales, individual Royal Colleges and professional regulatory bodies ▪ Contracted arrangements for the provision of specialist expertise to advise upon or carry out review work, e.g., inspection of private dentist, IR(ME)R work ▪ Other Welsh and UK inspection, Audit and Review bodies' arrangements (and in turn providing other IAR bodies with access to our own external expertise) ▪ Our own targeted recruitment in certain key specialist areas, e.g., SOADs, MHA Reviewers, LSA Lay Reviewers, etc

Access specialist advice to inform the development of our work programmes and inspection / investigation approaches	Establish steering groups to advise us on specific aspects of our work

Develop the professional practice of Healthcare Inspection and Investigation	Agree a plan to support the development of the Healthcare Inspectors Profession through:
	▪ the design and introduction of revised Standards for Professional Practice that establishes a common baseline within which all our review work is carried out, supported by:
	  ○ Professional Practice Guides
	  ○ A robust quality assurance framework; and
	  ○ Benchmarking activity
	▪ the development of a new Professional Skills Framework for Inspectorate staff

Strengthen our overarching governance arrangements	Learning from our own and others experiences, establish an Advisory Board to oversee, challenge, champion and scrutinise HIW's operations
Provide efficient and effective corporate support	Manage our resources effectively through strong budgetary control linked to the achievement of our plans and priorities
	Ensure awareness, understanding and compliance with our *Corporate Policies and Procedures*
	Continue to develop our *Records Management*, *Information Security and Handling* and *Information assurance* arrangements

	Review and where appropriate strengthen our *Business Continuity* arrangements
	Further develop our organisational *Performance Monitoring and Reporting* system
Design and implement a comprehensive programme of Organisational Development	Design and implement an Organisational Development programme to prioritise and co-ordinate our development activities alongside the ongoing delivery of our functions



Principle 8: We will maintain an overview of the risks, emerging issues and current issues for each inspected body in order to:

- *Be able to speak authoritatively in public about emerging concerns and issues; and*
- *Use this information to inform our programme of work*

What we will focus on	How we will do it
Further improve our intelligence base through the development of our knowledge management function	Undertake a systematic mapping of relevant sources of intelligence (both hard data and soft intelligence) and establish routine information flows with key partners
	Review, develop and support our regular programme of *Internal Analysis* meetings to consider the risks, current and emerging issues for each NHS body
	Review and revise our *Organisational Profile* for each healthcare provider to facilitate analysis and the identification of issues
	Review and further develop the role of our *Relationship Managers*
	Produce commissioned and regular *briefing* and *research/analysis* reports to inform HIW's overall plans or to support the delivery of HIW's specific work programmes or projects
Share the information and intelligence we hold about NHS organisations and services to establish an overarching, cohesive risk profile that can support the development of an integrated plan of assurance for NHS Wales	Review and extend the scope of our information sharing agreements with our partners ensuring clarity on our respective roles
	Facilitate, support and further develop our programme of *Healthcare Summits,* (each one designed to focus on a particular NHS health board or Trust in Wales) to include bi-annual meetings

Principle 9: We will take a collaborative approach to our work in which we will seek to

- *share intelligence on concerns and issues ;*
- *work in partnership with other regulators and inspectors; and*
- *place reliance on the work of others in deriving assurance as far as is reasonable and appropriate.*

What we will focus on	How we will do it
A stronger framework for External Assurance	In partnership with the Concordat Forum[3] and the Head of Inspectorate Group[4] establish an explicit external assurance framework for NHS Wales which sets out the respective roles and responsibilities of the different bodies involved in the provision of public assurance.
	Work closely with others through a range of Wales and UK wide fora so that we better align our requirements and develop our approaches; make the best use of our combined capacity and place reliance on others work where appropriate in fulfilling our own responsibilities
	Review, revise and where appropriate introduce new agreements with other partners to support our working relationships

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Principle 10: We will base our review activity on recognised standards as defined by the Welsh Government and in associated guidance, recognised best practice, and requirements defined in legislation and regulation. We will use our experience of the delivery of these standards in order to inform their future development.

What we will focus on	How we will do it
Clearly establish the defined standards and legislative requirements that apply in all our review work	When developing our review methodologies or when revising existing approaches explicitly reference the relevant standards and legislative requirements
	When reviewing the format and content of our Reports more clearly reference the relevant standards and legislative requirements that apply to our findings
Influence the setting of standards and introduction of legislation designed to achieve specific/ improved outcomes	Inform the Welsh Government's reviews of: ▪ Doing Well, Doing Better: Standards for Health Services in Wales ▪ The regulation of private dentistry
Support the revalidation of Doctors	Continue to work with the Deanery and ABMU Health Board to pilot an assurance process for appraisal