Annual Report

2024 - 2025

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Contents

About Us

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

Our purpose

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

Our goal

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

Our values

We place people at the heart of what we do.

We are:

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

Our four strategic priorities set out how we will achieve our goal of being an influential voice that drives improvement in healthcare.

We will:

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

We will:

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

We will:

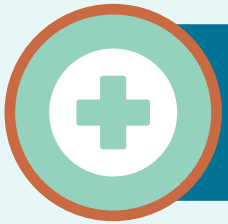
Work collaboratively to drive system and service improvement within healthcare.

We will:

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

What we do

We regulate and inspect independent healthcare services in Wales.



We inspect NHS services in Wales.

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

We monitor concerns and safeguarding referrals.

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

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

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

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

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

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

01.

Foreword

Foreword

Alun Jones
Chief Executive

Welcome to our Annual Report for 2024 - 2025

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

This report is not just a record of what we have done, it is a reference point which allows those involved in delivering services operationally and strategically, and for policy makers, to consider what has gone well and where more attention is required.

Listening to Wales: Concerns and Whistleblowing

This year, we received 743 concerns – a 21% increase from last year and a striking 102% increase since 2019–20.

This rise reflects growing public awareness, increased confidence in HIW's role, and possibly deeper systemic pressures across healthcare services. People are speaking up more often, and with greater urgency, about the care they receive.

We are also seeing greater complexity in the concerns raised. Many involve multiple service areas and higher levels of risk, requiring more intensive follow-up and direct engagement with providers. This has led to a significant increase in the number of cases where we seek assurance, demonstrating the seriousness of the issues being flagged.

Whistleblowing concerns have also increased – up 36% from the previous year. These disclosures often highlight deeper issues such as leadership, governance, and organisational culture.

Staff must feel safe and supported to speak up, and HIW's role as a prescribed body is vital in ensuring their voices are heard and acted upon.

These voices, whether from patients, families, or staff, are central to our work. They shape our priorities, inform our inspections, and help us focus attention where it matters most.

Wales Deserves Safe, Dignified, and Effective Care

This year, we have seen a healthcare system under immense pressure, but pressure cannot be a reason for quality and safety to be compromised or normalised. Our work has uncovered many positive findings, with services that are compassionate, safe, and person-centred. However, we also found environments that are unsafe and systems that are being stretched to their limits.

The NHS: A System at a Crossroads

The NHS in Wales is at a critical juncture. Our inspections of GP practices, emergency departments, maternity units, and mental health services reveal a system stretched to its limits. Staff are doing their best, but they are often under-resourced and working in environments that are not fit for purpose. The challenges are not new.

We have seen emergency departments where patients wait in corridors, maternity units where safety is compromised by staffing gaps, and mental health wards where serious patient safety risks remain unresolved. Welsh Government's Six Goals for Urgent and Emergency Care programme is targeting many of the root causes of these system challenges, increasing access to same-day emergency care, improving discharge processes, and supporting a home-first philosophy. Whilst it is encouraging to see that urgent care delivery is being reshaped, patient demand continues to be high, with this often impacting on patient experience.

What remains a significant concern is the recurrence of issues we have previously identified. There is no doubt at all that healthcare services respond well to the challenge that HIW provides. However, action taken is not always embedded or sustained. Sufficient resources and effective local leadership and governance are the key to sustaining high standards in healthcare.

Yet, we also see resilience. We see staff delivering compassionate, person-centred care in difficult conditions. We see leadership that listens, teams that innovate, and services that improve when challenged. These examples show what is possible when improvement is prioritised and supported.

HIW's role is to hold the system to account and to help it get better. We do this by identifying risks, sharing learning, and supporting improvement. We challenge poor practice, highlight good practice, and use our voice to drive change.

Independent Healthcare: Expanding, But Not Always Ready

The independent sector in Wales is expanding rapidly, particularly in services such as laser treatments, cosmetic procedures, private dentistry, and independent/private general practice (GPs). While this growth brings greater choice and innovation, it also introduces new risks.

This year, HIW issued more urgent enforcement actions within the independent healthcare sector than ever before. Many of these related to

smaller providers, especially laser and cosmetic clinics entering the market without a clear understanding of their legal responsibilities or the standards required to keep people safe.

Providers of independent healthcare services in Wales must be registered with HIW under the Independent Health Care (Wales) Regulations 2011, as set out in the Care Standards Act 2000. Registration is not optional; it is a legal requirement. Providers must demonstrate compliance with national minimum standards for safety, quality, and governance. HIW's registration process includes a formal assessment of submitted documentation, a statement of purpose, and evidence of readiness to deliver safe care.

Unsafe care must not be tolerated, whether delivered by the NHS or an independent provider. Everyone in Wales deserves the same standard of safety, dignity, and respect, regardless of where they receive their care.

Mental Health: A National Priority

Mental Health services continue to face significant and, in many cases, long-standing challenges.

We continue to be concerned about the condition of the estate in many NHS mental health services. This is not a new issue. It has been a recurring theme across our inspections for several years. Some facilities remain so outdated and degraded, that they would not meet the standards required for registration as independent mental health providers. Some of these environments are not conducive to therapeutic care. They fall short of providing the safety, dignity, and therapeutic stability that people need to recover and feel supported. Strategic investment in mental health services is essential, but so too is operational prioritisation. Estates backlogs must be addressed so that patients today, not just those in future years, receive care in environments that are safe, respectful, and fit for purpose. For mental health patients, the physical environment is not a superficial issue; it is central to the delivery of modern, effective mental health care.

We are calling for urgent investment in mental health care across Wales, and a national commitment to improve service access and delivery.

Regulation That Makes a Difference

We exist to make a meaningful difference to the safety, quality, and dignity of care across Wales. This year, our regulatory activity has been both robust and proportionate, focused on protecting patients and supporting improvement. We have:

- Suspended unsafe services where patient safety was at risk
- Designated providers as Services of Concern and initiated formal escalation pathways
- Launched criminal investigations into unregistered providers
- Worked with Welsh Government and national bodies to ensure serious concerns are addressed at the highest levels
- Supported services to improve through targeted monitoring, guidance, and follow-up.

We have also amplified the voices of patients, families, and staff, because real improvement starts with listening. Their experiences shape our judgments and help us focus attention where it matters most.

A Thank You

Finally, I want to thank the people of Wales for continuing to share their experiences with us; your voices shape our work. I also want to thank the dedicated healthcare staff across Wales, our partner organisations who share our commitment to improvement, and most importantly, the incredible team at HIW. Your professionalism, integrity, and determination are what make our impact possible.

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

Alun Jones

Chief Executive
Healthcare Inspectorate Wales

02.

HIW in Numbers

2024-2025 in Numbers

163 onsite inspections

1,657 completed staff surveys

3,407 completed patient, family/carer and public surveys

2024

April

- 14 inspections undertaken.
- Our findings from a joint assurance check of the Community Learning Disability Team in Rhondda Cynon Taf | Healthcare Inspectorate Wales
- Significant improvement made to maternity services at Prince Charles Hospital in Merthyr Tydfil | Healthcare Inspectorate Wales

May

- 6 inspections undertaken.
- Joint Equality, Diversity and Inclusion Strategy 2024-2028 published
- Joint Inspectorate Review of Child Protection Arrangements (JICPA) in Cardiff
- Operational Plan published
- Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for adults in Wales published
- Major improvement required at a mental health facility in Pontypridd | Healthcare Inspectorate Wales

June

- 8 inspections undertaken.
- Insight Bulletin – June 2024 published
- Spotlight Case Study of Good Practice – University Hospital of Wales Emergency Department
- Inspection finds maternity services at Cardiff's largest hospital needs further improvement | Healthcare Inspectorate Wales

July

- 16 inspections undertaken.
- Significant improvement required within a mental health hospital in Mold | Healthcare Inspectorate Wales
- Inspection finds good standard of care at specialist eating disorder hospital in Ebbw Vale | Healthcare Inspectorate Wales
- Maternity services at Singleton Hospital are improving but issues remain | Healthcare Inspectorate Wales

August

- 9 inspections undertaken.
- Emergency Department at Ysbyty Glan Clwyd shows signs of improvement but challenges remain | Healthcare Inspectorate Wales

September

- 16 inspections undertaken.
- Overview Report for Child Protection Arrangements in Wales published

2025

October

- 17 inspections undertaken.
- Annual Report published
- Case Study of Good Practice - Bronglais Hospital Maternity Unit published
- Immediate improvement required at a specialist Mental Health Unit in Cardiff | Healthcare Inspectorate Wales

November

- 14 inspections undertaken.
- Joint Review of how healthcare, education, and children's services are supporting the mental health needs of children and young people in Wales published

December

- 12 inspections undertaken.
- Improvement required at a specialist Mental Health Ward at Prince Philip Hospital in Llanelli | Healthcare Inspectorate Wales
- Cautions issued to providers using unregistered laser services | Healthcare Inspectorate Wales

January

- 18 inspections undertaken.
- Mental Health Monitoring Annual Report 2023-2024
- Heatherwood Court Mental Health Services in Pontypridd De-escalated as a 'Service of Concern' Following Improvements | Healthcare Inspectorate Wales
- Inspection of Emergency Department at The Grange University Hospital Highlights Progress and Continued Challenges | Healthcare Inspectorate Wales

February

- 15 inspections undertaken.
- Annual Report: Deprivation of Liberty Safeguards (DoLS) in Wales 2023-2024

March

- 18 inspections undertaken.
- Insight Bulletin - March 2025 published
- Spotlight Case Study of Good Practice - Heatherwood Court
- Extending Our Strategy: A Year for Continued Progress and Improvement
- Ongoing challenges remain with the Emergency Department at Morriston Hospital in Swansea | Healthcare Inspectorate Wales
- Improvements Noted, Although Challenges Remain for Wrexham Maelor's Emergency Department | Healthcare Inspectorate Wales

03.

Regulating Independent Healthcare

At a Glance: Our Activity This Year

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

A Diverse and Evolving Sector

Many independent services operate alongside NHS care. For example, some independent hospitals provide treatment for NHS-funded patients with complex needs, and many dental practices offer a mix of NHS and private care. We have also seen growth in services offering elective treatments such as laser procedures, weight management, and menopause support.

Balancing Innovation with Safety

From HIW's perspective, this sector brings both opportunities and challenges. Independent providers often bring flexibility and innovation, which can benefit patients, but only when supported by strong governance, clear accountability, and a commitment to continuous quality, safety and improvement.

Our Role as Regulator

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

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

Registration Highlights

This year, we saw a steady increase in registration activity across Wales, reflecting the continued growth and changing landscape of independent healthcare services.

280 pieces of registration work completed

60 new services registered, bringing the total to 750

20 services deregistered during the year

517 private dental services up from 504

110 private-only dental services increased from 73

- The number of independent services and medical agencies grew from 40 to 56 in 2024-25 - a 40% increase over the year and a 70% increase since 2022. Most new registrations were for services led by independent doctors, including private GPs and providers offering wellbeing-focused medical care such as weight management, menopause support, sports medicine, and psychiatry.
- Aesthetic treatment settings (e.g. Laser/ IPL) rose from 110 to 120, marking a 40% growth over 3 years.
- The proportion of drop-in private practices offering NHS services has decreased from 86% to 80%, suggesting a shift towards private-only provision among some providers.
- We received 187 formal enquiries from services asking whether they needed to register with us - a 58% increase compared to last year. These enquiries often come from new providers or services wishing to enter the independent healthcare sector.

Of those:

91

services were required to register, meaning they must meet legal standards before offering care

96

did not require registration, primarily because the proposed service fell outside of current legislation

This rise in non-registration cases highlights a potential gap in the law. Some services, particularly newer or niche treatments – may still pose risks to patient safety even though they aren't legally required to register.

HIW continues to monitor these developments and work with Welsh Government to ensure the system keeps pace with changes in the sector.

Changes in Mental Health Provision

This year saw notable shifts in independent inpatient mental health and learning disability services across Wales. HIW oversaw the deregistration of services at Priory Church Village, St David's Hospital, and New Hall Independent Hospital. These changes were initiated by the providers themselves, and HIW's role was to ensure that the deregistration process was carried out safely and in line with regulatory requirements.

At the same time, several significant new facilities were registered, including Cefn Carnau Hospital in South Wales, new secure wards at Llanarth Court in Monmouthshire, and a brand-new hospital, Seren Gobaith in North Wales.

These services exist to provide complex and specialist care that the NHS may not have the capacity to deliver. Their emergence and closure reflect a shifting landscape in mental health provision, where capacity, quality, and sustainability remain key concerns nationally.

HIW continues to monitor this area closely, recognising the vulnerability of the people these services support and the importance of maintaining safe, high-quality care.

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

Listening and Improving

In response to feedback from providers, HIW is developing a position statement on the use of CCTV in mental health settings, balancing safety with the privacy and dignity of patients. HIW's guiding principle is that CCTV should only be used when it is clearly justified, proportionate, and respectful of patient rights, with a focus on safeguarding and accountability.

Our Registration Team has worked with providers to improve the application process, by publishing revised documents and streamlining the experience for applicants. This work will continue into 2025-26, with feedback welcomed through our "Have Your Say On Our Registration Process".

Independent Hospitals and Clinics

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

We aim to inspect independent hospitals every two years and clinics every three years, though we may visit more frequently if concerns are raised or significant changes occur.

In 2024–25, we completed three inspections of independent hospitals. All three inspections were positive, with very few recommendations for improvement. We found clear and effective governance systems, strong internal controls and clinical audits, good patient information and record-keeping, and safe practices around medicines and infection prevention. Feedback from patients and staff was largely positive, reflecting a strong culture of care and accountability.

We also carried out 13 inspections of independent clinics, covering a wide range of services including weight loss treatments, hair transplants, circumcision and IVF. Most clinics provided clean, well-appointed, and welcoming environments.

While the overall standard was good, we made a small number of recurring recommendations, including:

- Improving the availability of information and services in Welsh
- Providing clearer patient information about treatments
- Offering general health promotion materials
- Addressing minor issues in medicines management.

From HIW's perspective, these findings reflect a sector that is generally performing well, but must continue to focus on consistency, transparency, and patient communication.

Across the UK, the independent healthcare sector is expanding rapidly, particularly in areas such as private GP services and cosmetic treatments. This growth brings greater choice for patients but also increases the complexity of the sector. The sheer volume of treatments now available, many of which are elective, can make it difficult for the public to know whether a service is properly registered or whether the person delivering care is appropriately qualified.

We encourage anyone seeking independent healthcare in Wales to:

- Check that the provider is registered with HIW
- Read our most recent inspection reports
- Confirm that their chosen clinician holds the right qualifications for the treatment they are offering.

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

Dental Practices

Dental services in Wales continue to play a vital role in community healthcare, and our inspections show that while many practices are performing well, there remains room for improvement in key areas. The volume of recommendations and the nature of non-compliance issues highlight the importance of robust governance, consistent training, and proactive risk management.

We remain committed to supporting providers through a balanced approach, combining rigorous oversight with practical guidance. Our inspections are not only about identifying risks, but also about helping practices resolve issues quickly and sustainably. As the landscape of dental care evolves, particularly with increasing demand and complexity, our role in ensuring standards are met and promoting improvement is more important than ever.

Over the course of 2024-25, HIW carried out **50 inspections and 23 pre-registration visits** of dental practices across Wales.

7 **Inspections resulted in Non-Compliance Notices, issued where patient safety was at risk and requiring a response within 7 days.**

50 **Out of the 50 inspections carried out, 2 practices were found to be fully compliant, with no recommendations made, demonstrating a strong understanding of regulatory requirements and a clear focus on quality.**

In total, we made nearly 600 recommendations for improvement.

Around **100** issues were resolved on the day of inspection, reflecting our supportive and collaborative approach. These included:

- Improving access to emergency equipment
- Updating complaints procedures
- Clearer fire exit signage
- Locking clinical waste bins.

Most practices were clean, well-maintained, and provided a positive environment. Patients consistently praised staff professionalism, dignity in care, and adjustments made for disabilities. Health promotion materials were often available in multiple languages and tailored to local communities.
Staff also reported working in supportive teams, contributing to a strong culture of improvement. Many practices offered extended hours or collaborated to provide emergency cover.

Key Areas for Improvement
Analysis of nearly 600 recommendations

Medicines Management

We issued two Non-Compliance Notices for serious risks related to medicine handling:

- Medicines dispensed from split packs without original packaging, risking missing expiry dates and patient safety information
- Oxygen cylinders found below safe levels and not serviced within the required timeframe, posing a risk in emergencies.

Other recurring issues included:

- Expired medicines stored alongside current stock
- Lack of disposal records from pharmacies
- Fridge temperatures not being monitored.

Practices must ensure medicines are stored, dispensed, and disposed of safely and in line with regulations.

Clinical Audit and Quality Improvement

We found inconsistent use of clinical audits across practices.

- One practice received a Non-Compliance Notice for having no audit activity at all.

All practices should maintain a robust programme of clinical and non-clinical audits to support continuous improvement and good governance.

Fire Safety

Fire prevention concerns were identified in **around 50%** of inspections.

- Notices were issued where there was no evidence of fire training, regular drills, alarm testing, or risk assessments.

Basic fire safety systems must be in place to protect patients and staff.

CPR and First Aid Training

One in four inspections highlighted gaps in emergency preparedness.

- In some cases, no staff had up-to-date CPR or first aid training, resulting in enforcement action.

Practices must ensure sufficient staff are trained to respond to medical emergencies.

X-Ray Safety

We found that some practices failed to record the justification for X-ray exposure in patient records.

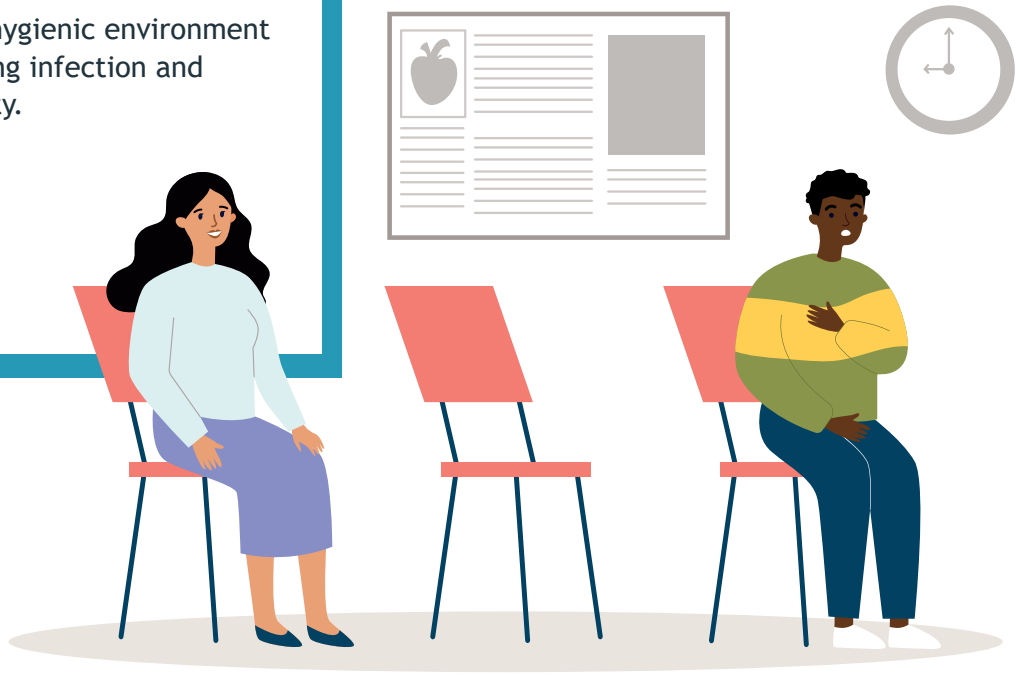
This is a legal requirement under IR(ME)R regulations and essential to ensure that X-rays are clinically necessary and safe.

Infection Prevention and Control

15 inspections noted minor but important hygiene issues, including:

- Cracked tiles, peeling wallpaper, and non-wipeable surfaces
- Incomplete cleaning schedules
- Mops left in buckets and damaged chair upholstery.

Maintaining a clean, hygienic environment is critical to preventing infection and ensuring patient safety.



Independent Hospices

Hospices provide essential care to adults, young people, and children with terminal illnesses or life-limiting conditions. In 2024-25, our teams inspected two independent hospices, one supporting adults, and one supporting children. These services are a vital part of healthcare in Wales, offering not only clinical care but also emotional and practical support to patients and their families during some of the most difficult times in their lives.

Feedback from patients and families was overwhelmingly positive. People spoke of kind, empathetic staff, personalised care, and environments that felt safe and supportive:

Our inspectors observed high standards of person-centred care, with strong multidisciplinary teamwork and holistic approaches to assessment, planning, and delivery. Staff were praised for their ability to communicate clearly and compassionately, ensuring patients and families understood their care options. Teams were described as passionate, well-supported, and deeply committed to their roles.

From HIW's perspective, these inspections reaffirm the exceptional role that hospices play in the healthcare system in Wales. They demonstrate what high-quality, compassionate care looks like when it is tailored to individual needs and delivered by dedicated professionals. However, even in high-performing services, there is always room for improvement.

Our recommendations focused on strengthening governance and clinical systems, including:

- Improving the consistency and quality of patient records
- Ensuring clear protocols for oxygen prescription
- Updating and reviewing key policies regularly.

Our role is not only to assure safety and compliance but also to support continuous improvement. In hospice care, where dignity, empathy, and trust are paramount, our inspections aim to uphold the highest standards while recognising and celebrating the outstanding work already being done.

"The atmosphere, attention to detail and the genuine staff…10 out of 10"

"It feels like they're part of the family"

"An exceptional provision… completely based around our child's needs"

"Excellent care and a quality service" Staff are so kind, caring and empathetic..."

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

Our regulatory responsibilities in the independent healthcare care extend to the registration and inspection of services offering laser and Intense Pulsed Light (IPL) treatments. These therapies are often used for cosmetic or skin-related purposes, such as hair removal or treating conditions like acne or pigmentation.

While it is clear that while many providers are committed to offering a good service, our inspections illustrate that some underestimate the time, knowledge, and systems needed to meet the legal standards required to ensure safety and quality of care.

These services must comply with specific regulations designed to minimise risks, particularly the risk of burns, eye injury, or unsafe treatment environments. As the independent regulator, our priority is to ensure these services are safe, well-run, and respectful of people's dignity.

During our latest inspections, we found that laser and IPL providers had the highest proportion of urgent Non-Compliance Notices across the sector, with 6 out of 21 services receiving a notice. We take immediate action when there is a risk to patient safety and require providers to respond within one week.

Key safety concerns included:

- Outdated or missing local safety rules: Providers are expected to have up-to-date laser safety guidance in place, reviewed annually by a qualified Laser Protection Advisor (LPA)
- Incomplete patient records: Records often lacked important details such as consultation notes, laser settings, or patient and practitioner signatures, which are vital for safe and consistent care
- Weak fire safety arrangements: Several services lacked clear fire risk assessments, alarm tests, and documented emergency procedures.

We also commonly found:

- Missing or non-compliant treatment protocols
- Providers using laser machines that were not listed on their registration
- Electrical appliances not PAT-tested
- Staff without up to date first aid or core knowledge training
- Poorly documented policies and procedures.

These findings show that while treatments may appear low-risk, proper governance, training, and oversight are essential. HIW is committed to holding services to account and helping providers understand their responsibilities, because everyone in Wales deserves safe, high-quality care, whether delivered by the NHS or independent providers.

04.

Taking Action Through Escalation and Enforcement

At a Glance: Our Activity This Year

The Escalation and Enforcement Team leads our response to serious risks across NHS services, independent healthcare, and private dentistry in Wales. HIW can use its civil powers under the Care Standards Act 2000 to enforce actions on registered services when needed. Actions include suspending services, designating providers as Services of Concern (SoC), and starting criminal investigations if warranted.

The SoC process is a formal escalation pathway triggered when a service presents a significant risk to patient safety or fails to meet regulatory standards. It is used for both independent healthcare and NHS services. It involves structured meetings, targeted monitoring, and enables HIW to target actions to drive rapid improvement or, where necessary within independent healthcare, suspend operations to protect the public. For NHS services, the SoC process can result in a designation of Service Requiring Significant Improvement (SRSI) being applied.

While no NHS service was formally escalated to SRSI this year, many NHS services were actively considered and managed through the SoC pathway.

This informed and drove targeted actions and decisions to improve safety and quality.

In 2024-25, the team responded to a range of serious non-compliance issues, particularly in dental and aesthetic laser services, through targeted inspections, urgent enforcement actions, and collaborative interventions. Several criminal cases were escalated to Welsh Government's Legal Services, and HIW maintained oversight of high-risk NHS services, including mental health and emergency departments.

Our approach is grounded in the belief that escalation should be both decisive and proportionate. While we take firm action where care falls short, we also work closely with providers and NHS bodies to support improvement and ensure that services are safe, accountable, and focused on the needs of the people they serve. This balance of escalation and support is central to our role in protecting patients and driving up standards across Wales's healthcare system.

Key Figures and Themes

Escalation Activity — NHS Health Boards

26 SoC Pathway meetings held to inform improvement actions in NHS services

Independent Healthcare — SoC Designations

8 Laser Aesthetics: SoC designations

6 Private Dentistry: SoC designations

3 Mental Health: SoC designations

13 Services de-escalated from SoC

5 Mental health

4 Laser Aesthetics

4 Private Dentistry

SoC Pathway Meetings — Independent Sector

46 Mental Health meetings

39 Private Dentistry meetings

24 Laser Aesthetics meetings

Enforcement Hightlights

3 Criminal Cautions issued:

- **2** in South East Wales (Nov 2024, against four individuals)
- **1** in West Wales (April 2025)

Mid Wales Dental Practice: Suspended for expired training, unsafe equipment and no indemnity cover

North Wales Laser Provider: Suspended for unregistered laser and missing policies

Unregistered Providers & Criminal Investigations

3 active criminal investigations each month into unregistered aesthetic services

Ongoing monitoring of 6-8 unregistered providers monthly

Case Study: Regulatory Oversight in Dental Services

A dental practice in mid-Wales, operated by a sole practitioner, had a long-standing history of regulatory non-compliance, with concerns first identified as far back as 2015. Over the years, HIW provided guidance and opportunities for improvement. However, by early 2025, repeated issues remained unresolved, prompting us to escalate our regulatory response.

Initial Action - March 2025

In March 2025, HIW carried out an inspection of the practice following ongoing concerns. The inspection identified serious risks to patient safety, including:

- Expired emergency medication
- Faulty x-ray equipment
- Un-serviced compressor and autoclave
- Incomplete staff training
- Missing fire safety checks

Due to the severity of these issues, HIW issued a **Notice of Decision** under the **Care Standards Act 2000**, which temporarily suspended the service. A Notice of Decision is a formal legal step taken when a provider fails to meet essential safety and quality standards. We also notified relevant bodies including the local Health Board, the General Dental Council, the Fire and Rescue Service, and the Health and Safety Executive.

Follow-Up - March 2025

A follow-up visit later that month showed limited progress:

- CPR training and emergency equipment remained inadequate
- Staff raised concerns about training and awareness of regulatory responsibilities.

As a result, the suspension was extended to allow further time for improvement.

Improvement & De-escalation - April 2025

By April, the provider submitted evidence of:

- New equipment purchases
- Completion of staff training
- Improved procedures and documentation

While some issues persisted, the overall risk was deemed tolerable. The suspension was lifted, and the case was de-escalated from **Service of Concern (SoC)** status. HIW's inspection team continues to monitor the practice to ensure sustained compliance

Key Learnings

- **Risk-based regulation:** Enforcement was balanced with support to drive meaningful improvement.
- **Collaborative oversight:** Joint working with external bodies ensured a robust and coordinated response.
- **Structured escalation:** The SoC process enabled timely intervention and clear accountability.
- **Evidence-led decisions:** Documentation and transparency were critical to regulatory outcomes.

05.

Assessing the Quality and Safety of NHS Care

At a Glance: Our Activity This Year

The NHS continues to face intense and complex pressures, from rising demand and patient flow delays to workforce shortages and infrastructure challenges. We see the impact of these pressures every day, but we also see the extraordinary commitment of staff, the resilience of teams, and the urgent need for system-wide improvement to ensure safe, effective, and person-centred care.

In 2024–25, our NHS Assurance Team continued to play a vital role in driving improvement through the quality and safety of healthcare services across Wales. Through a combination of inspections, reviews, and follow-up work, we provided independent assurance and identified opportunities for improvement across a wide range of settings.

We carried out 55 inspections across primary care, community, and hospital settings, and concluded three national and joint reviews, with further follow-up work underway.

We also published three major reviews and completed follow-up work on three others:

Published Reviews:

- Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions for Adults in Wales.
- Joint Review: How are healthcare, education, and children's services supporting the mental health needs of children and young people in Wales
- Overview Report on Joint Inspections of Child Protection Arrangements (JICPA) 2019-2024

Follow-up Work:

- Joint Rapid Review of Child Protection Procedures
- National Review of Patient Flow (Stroke Pathway)
- National Review of Mental Health Crisis Prevention in the Community.

Key Themes and Insights from NHS Assurance

General Practice: Compassionate Care, but Gaps in Governance

Our inspections found that patient experience across most GP practices was generally positive, with patients consistently reporting that they were treated with dignity, respect, and compassion. While access to appointments was typically good, recurring concerns were noted around telephone access and the lack of privacy at reception areas. Health promotion efforts varied significantly between practices, with some lacking visible materials or bilingual resources, which could impact patient engagement and understanding.

In terms of safe and effective care, clinical environments were found to be clean and well-maintained across the board. Emergency equipment was usually available; however, the frequency of checks and ease of accessibility differed between practices.

A notable concern was the widespread gaps in infection prevention and safeguarding training, particularly among non-clinical staff. Additionally, documentation issues were prevalent, including missing audit trails, outdated policies, and incomplete risk assessments, all of which could compromise the quality and safety of care.

Leadership and management within practices were often strong, with many demonstrating effective leadership and fostering collaborative team environments. Governance structures were generally in place, but there were frequent issues with policy version control and incomplete staff records. Common recommendations included enhancing business continuity plans and ensuring that policies were appropriately tailored to the specific needs of each practice.

We continue to urge health boards to strengthen their support and assurance mechanisms for GP practices, ensuring that learning is shared, improvements are sustained, and standards are consistently upheld across primary care services.

Emergency Departments: Frontline Care Under Pressure

HIW's emergency department (EDs) inspections are an important part of its overall programme of work, offering independent insight into quality, safety and experience in these fast-moving departments. EDs can often be the place where the symptoms of wider system pressures such as patient flow, discharge processes, and access to community-based care are seen. Welsh Government's Six Goals for Urgent and Emergency Care programme is targeting many of the root causes of these system challenges, increasing access to same-day emergency care, improving discharge processes, and supporting a home-first philosophy. Whilst it is encouraging to see that urgent care delivery is being reshaped, patient demand continues to be high, with this often impacting on patient experience when visiting an ED.

In 2024–2025, HIW inspected four EDs: Ysbyty Glan Clwyd, Wrexham Maelor Hospital, Morriston Hospital, and The Grange University Hospital. These inspections found that overcrowding, extended waiting times, and care delivered in corridors remain common features of emergency care.

Despite these challenges, staff were consistently praised for their professionalism, resilience, and commitment to patient care. However, concerns persist around inconsistent risk assessments, medication management, and the safety of environments for vulnerable patients. While local ED leadership was often effective, staff frequently reported feeling disconnected from senior decision-makers.

Physical environments were frequently unfit for purpose, and although infection control practices were generally in place, they were not always supported by adequate facilities. In some departments, we saw signs of progress, including improved triage and reduced reliance on agency staffing, but these were often isolated improvements rather than system-wide solutions.

Sustained investment, clear accountability, and visible leadership are essential to ease pressure, protect staff wellbeing, and ensure patients receive safe, timely care. HIW will continue to inspect emergency care across Wales, highlighting risks, sharing learning, and supporting improvement where it matters most.

Maternity Services: Compassionate Care, Continued Concerns

Our inspections of maternity services across Wales highlighted both compassionate care and persistent operational challenges.

Staff working in maternity services across Singleton, Neath Port Talbot, and Ysbyty Gwynedd were praised for delivering kind and respectful person-centred care, with many women and families reporting high levels of satisfaction with their experiences. Despite these positive sentiments, staffing pressures and concerns around skill mix were persistent, particularly in high-acuity areas, such as Antenatal Assessment Units and Transitional Care Units. The reliance on agency staff, and gaps in mandatory training compliance, especially among obstetric staff, were also highlighted as ongoing challenges.

Leadership and governance structures showed improvement with new appointments and clearer lines of accountability. However, issues remain around interim leadership roles, limited mechanisms for staff feedback, and inconsistent visibility of leadership across sites. In terms of safety and clinical effectiveness, most units demonstrated robust safeguarding and incident management processes. However, concerns were raised regarding medical handover practices, access to essential equipment, documentation of informed consent, and the oversight and use of obstetric theatres.

Training and development emerged as a key area of risk, with low compliance in mandatory training among medical staff. Some progress has been made in areas such as diversity and equality training, and there are examples of innovative approaches to sharing learning. The clinical environment and facilities were generally described as clean, calm, and welcoming, with efforts made to create a 'home from home' atmosphere. However, improvements are needed in bereavement facilities, bilingual signage, and the availability of translated materials to ensure inclusivity and accessibility for all service users.

While we welcome efforts to share learning and strengthen practice, these steps must lead to consistent, equitable care.

Ensuring Safe Use of Ionising Radiation in Healthcare

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

- Diagnostic imaging – such as X-rays and CT scans to view internal structures
- Radiotherapy – to treat conditions like cancer
- Nuclear medicine – which uses small amounts of radioactive material to diagnose or treat a range of conditions.

Because these procedures involve exposure to radiation, they must be carefully controlled to protect patients and staff. That's where the Ionising Radiation (Medical Exposure) Regulations 2017, known as IR(ME)R, come in. These regulations set out legal requirements for how radiation is used in medical settings, including who can carry out certain tasks, how patients are informed, and how safety is monitored.

HIW is responsible for monitoring compliance with IR(ME)R in Wales. Each year, we inspect around eight NHS and independent healthcare settings that use ionising radiation. These inspections are announced 12 weeks in advance and include a self-assessment by the provider. This allows our inspection teams, supported by technical experts from the UK Health Security Agency's Medical Exposures Group, to focus on the physical environment and real-world practices during the visit.

As part of its programme for assessing compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R), we requested that the Medical Exposures Group within the UK Health Security Agency (UKHSA) undertake a review of IR(ME)R significant accidental or unintended exposures notifications submitted to them. This report covers the period between 1 April 2023 and 31 March 2024.

What We Found in 2024-2025

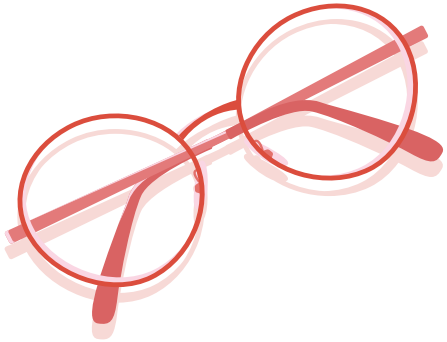
In October 2024, updated IR(ME)R regulations came into effect. These changes reflect advances in technology and place greater emphasis on patient safety, staff training, and the investigation of Significant Accidental or Unintended Exposures (SAUEs).

Our inspections since the changes came into force show that most services are actively working to update their policies and procedures. We met experienced, committed teams who demonstrated strong teamwork and a clear understanding of their responsibilities. Feedback from patients was overwhelmingly positive, they told us they felt respected, well-informed, and safe.

However, we also identified recurring areas for improvement:

- Employer's Procedures (EPs): These documents, which guide staff on how to carry out tasks safely, were sometimes unclear or didn't reflect actual practice. This can create risks, especially for new or temporary staff
- Diagnostic Reference Levels (DRLs): These were not always clearly defined or regularly reviewed, and actions for when doses exceeded thresholds were sometimes missing
- Pregnancy checks: Procedures for checking whether patients might be pregnant didn't always match what staff were actually doing
- Entitlement processes: These define who is allowed to carry out specific tasks under IR(ME)R. In some cases, these roles were not clearly documented or communicated
- Clinical audit: While audit is essential for learning and improvement, we found that some services lacked clear plans for how often audits should happen or how findings would be followed up. Staff also told us that time pressures made it difficult to complete all required audits.

These findings highlight the importance of not just having safe practices in place, but ensuring they are clearly documented, consistently applied, and supported by strong governance. Our role is to provide assurance that services are meeting their legal responsibilities, while also supporting providers to improve and embed best practice.



A Closer Look: A Closer Look: IR(ME)R Case Study

In 2024-25, we inspected a diagnostic screening service site and found that while patients were satisfied with their care, the service was not fully compliant with IR(ME)R regulations. We were not assured the provider had the necessary framework through written procedures, protocols, and quality assurance programmes for staff to carry out their roles safely.

As a result, HIW issued an Improvement Notice under Section 21 of the Health and Safety at Work etc. Act 1974. The Trust responded positively, taking steps to address the issues. We met with the Chief Executive and senior staff to review progress, and the notice was lifted in December 2024.

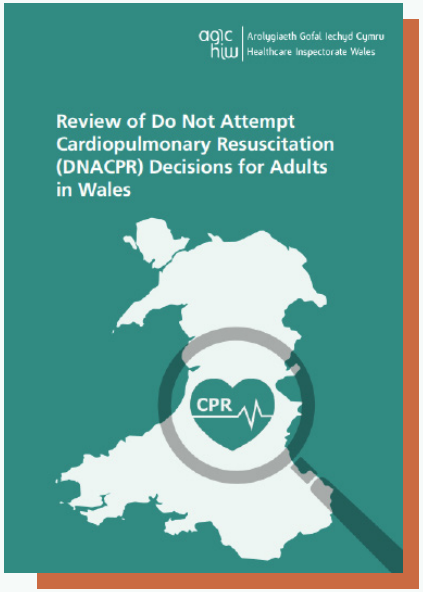
This case illustrates HIW's commitment to using our enforcement powers proportionately and constructively. Where serious concerns arise, we act decisively to protect patients, but we also work closely with providers to support improvement and ensure long-term compliance.

Making an Impact Through Reviews

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

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

In 2024-25, our review programme tackled some of the most sensitive and complex areas of care, with a focus on consistency, collaboration, and compassion.



Review of DNACPR Decisions for Adults in Wales

Our Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions identified several critical areas for improvement and established clear expectations to support more consistent, person-centred practice across healthcare settings in Wales.

We found encouraging examples of good practice, including clear clinical reasoning, compassionate communication, and thoughtful documentation in many cases. Staff demonstrated a strong commitment to supporting patients with dignity and respect, and some services showed how DNACPR discussions can be held well and in a timely manner.

However, our work also highlighted variability in the quality of documentation, with many DNACPR decisions lacking sufficient clinical justification or evidence of meaningful patient engagement. Communication with patients and families was often inconsistent, and healthcare professionals reported limited confidence in conducting these sensitive discussions. Furthermore, equality and diversity considerations such as language needs, cognitive ability, and cultural context were not routinely addressed.

We expect health boards, NHS trusts, and Welsh Government to act on these findings by improving documentation standards, enhancing staff training, and ensuring DNACPR decisions are communicated with clarity, compassion, and respect. Our findings have already helped inform the review of the national DNACPR policy, and we will continue to monitor progress to ensure ethically sound and consistent practice across Wales.

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

As part of our 2024 joint review with Care Inspectorate Wales and Estyn, we found that many children and young people in Wales were not receiving the mental health support they need, when appropriate. Over half of those aged 11-16 said they did not know where to turn for help, and many only received support during a crisis. While early intervention through schools and community services has improved, access remains inconsistent, particularly for children with complex needs, such as those who are neurodiverse or care experienced. Specialist services like CAMHS offered quicker initial assessments, but follow-up care was often lacking, and eligibility criteria vary widely. Welsh-speaking children also faced barriers in accessing services in their preferred language. New crisis services were helping, but demand was high.

We expect services across Wales to work more collaboratively to improve access, consistency, and coordination in supporting children's mental health. We are calling for clearer eligibility criteria, improved communication between agencies, and sustainable investment in early and crisis support. We will use the findings of this review to inform our future monitoring and quality improvement work, and we remain committed to supporting and driving system-wide change that ensures all children and young people receive the support they need.

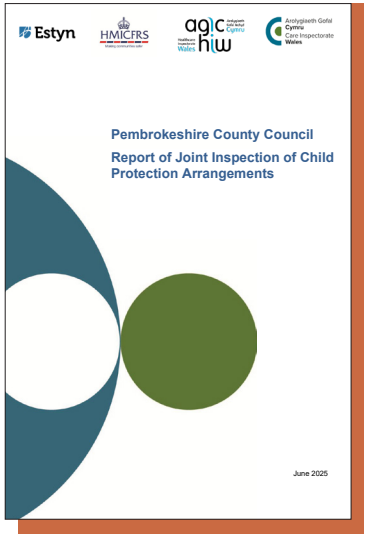
Overview Report: Joint Inspections of Child Protection Arrangements (JICPA) 2019-2024

The five-year programme of JICPA work, undertaken between 2019 and 2024, evaluated the effectiveness of multi-agency arrangements in safeguarding children across Wales.
The inspections found that effective child protection is closely associated with strong multi-agency collaboration, particularly where co-located teams and integrated processes are in place.

While leadership across agencies was generally well-informed and committed, the absence of a clearly defined and consistently applied model of intervention in some areas limited the coherence of safeguarding practice. Workforce instability, including a reliance on temporary staffing, was a persistent challenge, and undermined the continuity of care and the development of trusted relationships with children and families.

Early intervention was most effective where referral pathways were clearly established and thresholds for action were commonly understood. Although awareness of criminal and contextual exploitation has improved, the consistent embedding of specialist expertise remains an area for development. Children and families reported more positive experiences where professionals demonstrated continuity, active listening, and a relationship-based approach. Despite the availability of a broad range of services, variability in access and coordination was evident.

Looking ahead, we and our partner inspectorates expect safeguarding partners to strengthen joint working arrangements. This should include embedding consistent and evidence-informed models of practice, investing in workforce stability and capability, and ensuring that the voices and experiences of children and families are central to all safeguarding activity. HIW remains committed to supporting and challenging services to improve.

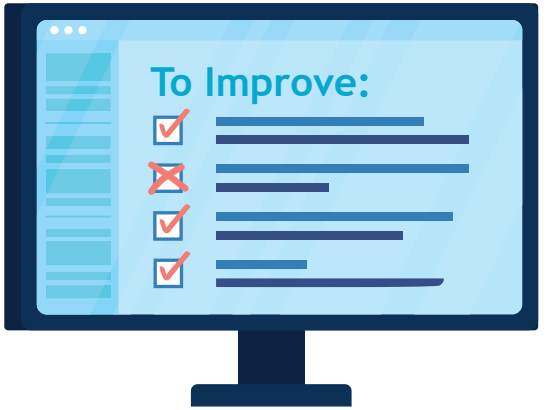


JICPA: Pembrokeshire County Council

Our JICPA inspection in Pembrokeshire revealed a sharp rise in child protection activity, with the number of children on the Child Protection Register doubling between March 2023 and February 2025 and a significant increase in care experienced children.

Despite financial pressures and complex referrals, partner agencies showed strong commitment, with notable improvements in education and policing. However, inconsistent communication, missing critical health records, and health assessment delays were noted. The implementation of the Signs of Safety framework lacked clarity and measurable outcomes. Workforce challenges had also affected morale and service delivery.

As a result of the work, we called for strengthened inter-agency communication, improved child protection planning, and greater attention to workforce wellbeing. Strengthened leadership is also needed to drive continuous improvement with robust governance and performance monitoring. We expect to see tangible improvement and inspectorates will continue to monitor progress closely.



Follow-Up: National Review of Mental Health Crisis Prevention in the Community

Two years on from our national review, we followed up with health boards to assess progress against their improvement plans. We found improvements in primary care access, engagement with third-sector organisations, and the integration of mental health crisis teams into emergency services.

While significant progress has been made, some actions remain incomplete. Key areas needing further attention include implementing physical health assessments, enhancing communication between GPs and health boards, and strengthening service connections for better access to mental health support.

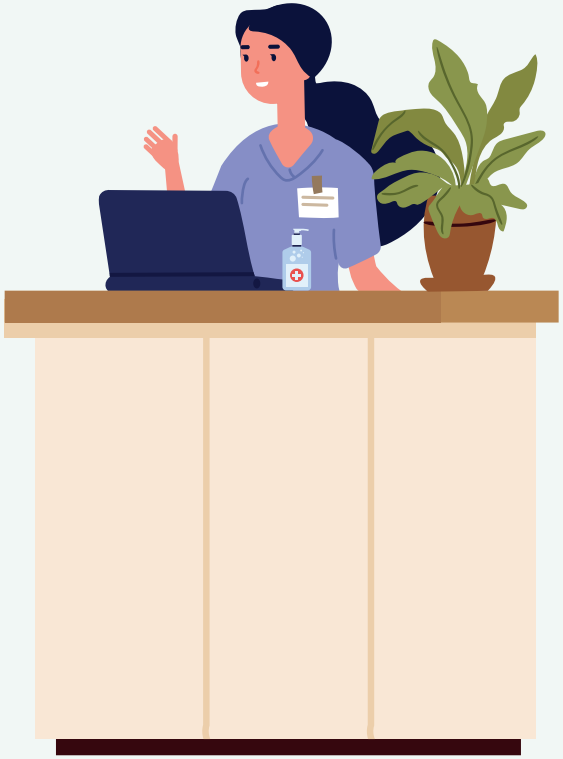
Services must be tailored to individual needs, with improved collaboration across sectors and clearer, more consistent points of access. Public awareness, of available support must be increased, especially for men at high risk of suicide. Continued efforts and engagement are essential for addressing critical gaps and ensuring effective mental health support across Wales. Further engagement will be maintained with health boards through our ongoing assurance work to establish completion of any outstanding actions.

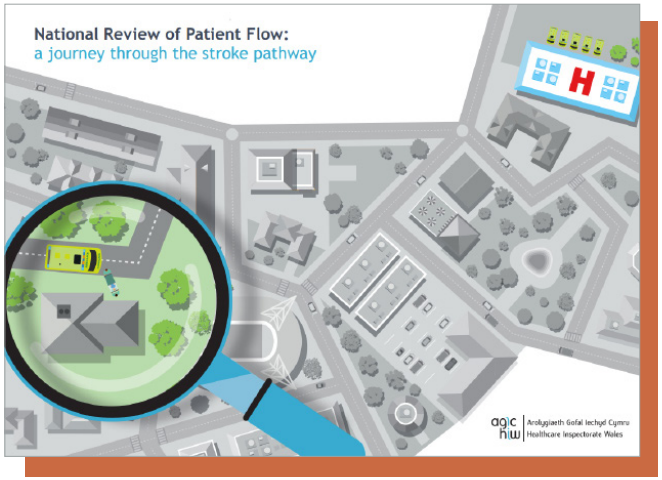
Follow-Up: Joint Rapid Review of Child Protection Procedures

Following the publication of the Joint Rapid Review of Child Protection Procedures across Wales, HIW has continued to work with Care Inspectorate Wales (CIW) and Estyn to monitor progress against the recommendations.
The original review, commissioned by Welsh Government in response to a series of tragic child deaths, assessed whether children's names were being appropriately added to or removed from the Child Protection Register.

Our programme of follow-up work for this review commenced early 2025, however, will continue until autumn 2025. In its early stages the work has focused on how agencies are responding to key issues identified in the review, including inconsistent information sharing, workforce instability, and the lack of a central IT platform to support safeguarding decisions. We have also tracked progress in embedding the child's voice in decision-making and ensuring regular multi-agency training to promote consistency in safeguarding thresholds and procedures.

While many areas of good practice were identified, challenges remain in achieving consistency across Wales. Therefore, the follow-up work to date and in the first half of 2025-26, will focus on a series of discussions with regional safeguarding boards about the improvements made since publication of the report across each area responsible for safeguarding children, and the sustainability of the improvements made.



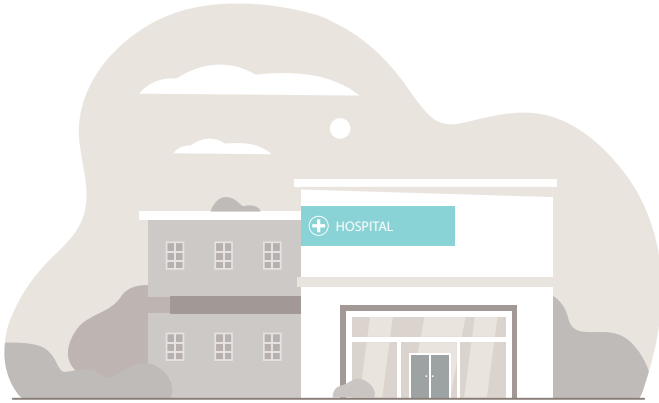


Follow-Up: National Review of Patient Flow - Stroke Pathway

Following our National Review of Patient Flow focussing on a patient's journey through the stroke pathway, HIW has continued to assess how health boards are responding to the risks and challenges identified. The original review explored how delays in assessment, treatment, and discharge impact patient safety and outcomes, and examined the robustness of systems in place to manage flow across each stage of care.

Our follow-up work has focused on improvements in timely access to acute stroke care, coordination between services, and safe discharge planning. We also considered how services are mitigating harm for patients awaiting care and maintaining quality throughout the stroke pathway.

Through our follow up process, it is evident that progress has been made in implementing improvements, although some actions still needed further work for completion. HIW will maintain oversight through its assurance processes and ongoing engagement with health boards to ensure that improvements are embedded and that stroke services across Wales deliver safe, effective, and timely care.



06.

Mental Health in Wales: Our Assurance and Impact

At a Glance: Our Activity This Year

Mental health services across Wales continue to face significant and growing pressures. From HIW's perspective, this is one of the most complex and high-risk areas of healthcare we inspect and regulate, requiring sustained attention, strong leadership, and a system-wide commitment to improvement.

What We Did in 2024-2025

During the year, HIW carried out 25 onsite inspections across inpatient wards and community mental health teams in both NHS and independent hospitals. These covered a broad range of services, including:

- Adult Mental Health
- Older Person's Mental Health
- Child and Adolescent Mental Health Services (CAMHS)
- Learning Disability Services.

Our inspections focused on the quality of patient experience, the delivery of safe and effective care, and the strength of leadership and governance. While we observed many examples of compassionate, person-centred care, **36%** of inspections triggered immediate assurance or non-compliance processes due to concerns that posed a immediate risk to patient safety.

What We're Seeing Across Wales

While many services are striving to deliver high-quality care, recurring challenges remain, many of which have been highlighted in previous years. These include:

- Estate maintenance and environmental risks in inpatient settings
- Workforce shortages and safety concerns
- Gaps in training, supervision, and audit
- Inconsistent documentation and patient information
- Weaknesses in governance and oversight.

At the same time, we continue to see positive practice, including:

- Compassionate and respectful care
- Meaningful patient engagement
- Safe clinical practice
- Strong local leadership.

These findings reflect a system under strain. The rising demand for mental health services, particularly for children and young people is a national concern. Addressing these pressures will require coordinated action across government, NHS Wales, and independent providers, with a focus on workforce planning, investment in safe environments, and stronger accountability.

A Closer Look: NHS Mental Health Units: Dedicated Staff, Systemic Challenges

Across all mental health units, staff were consistently praised for their compassion, respectfulness, and dedication to patient care. Patients frequently reported feeling safe and supported, even in the face of staffing shortages. However, environmental and infrastructure issues were widespread, with many facilities showing signs of physical deterioration such as mould, broken fixtures, and poor ventilation. Ligature risks were a recurring concern, and some units lacked essential safety equipment or had not conducted recent audits. Privacy was sometimes compromised in certain areas due to shared spaces and missing curtains.

Care planning and documentation varied between units, with some maintaining thorough records while others showed gaps in documentation, especially in restraint incident reporting. Mental Health Act documentation was generally compliant, though audit trails were sometimes weak or incomplete. Safety and training were areas of concern, particularly around compliance with Restrictive Physical Intervention and Immediate Life Support.

Infection control issues, unsecured medical equipment and poor medication storage were frequently noted.

Leadership and governance structures were present in most units. Whilst leadership teams were often described as approachable and supportive, staff frequently felt discouraged from voicing concerns and lacked confidence in senior management responsiveness. Governance processes were sometimes undermined by outdated policies and ineffective audit mechanisms. Staffing and resource pressures were evident across units, with high vacancy rates and a heavy reliance on agency staff contributing to low morale. Delays in procuring equipment and allocating resources further impeded the delivery of effective care.

Finally, patient experience and access to therapeutic activities varied widely. While patients appreciated outdoor access and positive staff interactions, many units lacked structured therapeutic programs, access to planned activities, electronic devices, and diverse food options. Therapy spaces were often underutilised or insufficiently equipped, limiting opportunities for meaningful engagement and recovery.

Overall, our findings reflect a mental health system where staff are doing their best under pressure, showing compassion and professionalism that patients appreciate. However, it also highlights serious challenges, particularly with poor infrastructure, inconsistent documentation, gaps in training, and staffing shortages, which collectively impact on the quality of care. Leadership is present but not always effective, and patients often lack access to meaningful therapeutic activities. Overall, it shows a committed workforce constrained by systemic issues which need urgent attention.

Monitoring the Mental Health Act

The Mental Health Act 1983 is the legal framework which allows individuals with serious mental health conditions to be detained and treated in hospital when necessary for their safety or the safety of others. The Code of Practice for Wales (2016) provides guidance on how the Act should be applied in practice, ensuring that patients' rights are protected and that care is delivered lawfully and respectfully.

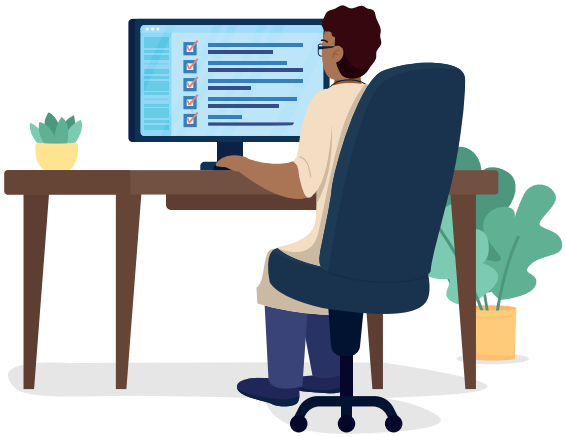
As part of our regulatory role, HIW inspects how services apply the Mental Health Act. In 2024–2025, our inspections confirmed that most patients were detained appropriately and that legal safeguards were generally being followed. We found:

- Well-managed documentation that was accessible and securely stored
- Effective systems overseen by Mental Health Act administrators.
- Advocacy services available and actively promoted to patients.

However, we also identified areas where improvement is needed:

- Inconsistent recording of legal status, patient rights, and key decisions
- Gaps in Section 17 leave procedures, including risk assessments and communication
- Weaknesses in how capacity and consent are assessed and documented
- Delays in reviews and limited administrative support
- Incomplete recording of equality and demographic data.

These findings highlight the importance of robust systems and clear documentation to uphold patient rights and ensure legal compliance. We continue to work with providers to address these issues and support improvements in how the Act is applied.



Second Opinion Appointed Doctor (SOAD) Service

The Second Opinion Appointed Doctor (SOAD) service is a vital safeguard for patients detained under the Mental Health Act who are either unable or unwilling to consent to certain treatments. A SOAD is an independent psychiatrist who reviews whether the proposed treatment is appropriate and lawful. This ensures that patients' rights are protected and that treatment decisions are subject to external scrutiny.

In Wales, the SOAD service is delivered by the Review Service for Mental Health on behalf of Welsh Ministers. In 2024-25, the service managed 782 cases using a hybrid model of remote and onsite assessments. SOADs exercised professional discretion in choosing the most appropriate method for each case, and all decisions were clearly documented.

We work closely with the SOAD service by sharing relevant findings from our inspections and ensuring that any concerns about treatment practices are escalated appropriately. We also support the development of national guidance and tools that help standardise the SOAD process across Wales.

New guidance and toolkits developed in consultation with stakeholders are due to be published in late 2025. These will further strengthen the consistency, transparency, and fairness of the SOAD process, ensuring that patients continue to receive safe and lawful care under the Mental Health Act.

07.

Concerns, Investigations and Notifications

Concerns: Our Activity This Year

We are committed to handling concerns fairly, efficiently, and effectively. Concerns are more than just feedback, they are a vital source of insight that help us identify risks, highlight good practice, and drive improvements across healthcare services in Wales.

Why Concerns Matter

Much of our work in responding to concerns takes place outside the public spotlight. Unlike inspections or published reviews, this activity is not always visible, but it is a vital part of how we hold organisations to account. Through direct engagement with services and providers, we seek assurances, challenge poor practice, and escalate risks where necessary. This work often provides early signals of deeper issues and plays a critical role in safeguarding patients and driving improvement across the system.

While HIW is not a complaints body, the concerns we receive help us build a clearer picture of how services are functioning and where they may be falling short. This intelligence directly informs our inspections, thematic reviews, and wider assurance activity, making it an essential part of our assurance role.

How We Respond

Every concern we receive is triaged and assigned a risk level to determine the appropriate response:

High-risk concerns require immediate action and a response within 2 working days.

Medium-risk concerns are addressed within 5 working days and may involve more direct HIW involvement.

Low-risk concerns are typically signposted to NHS Putting Things Right or the relevant independent provider's complaints process, with a response within 7 working days.

We act swiftly on high-risk concerns, seeking immediate assurances from the healthcare provider involved.

Concerns at a Glance

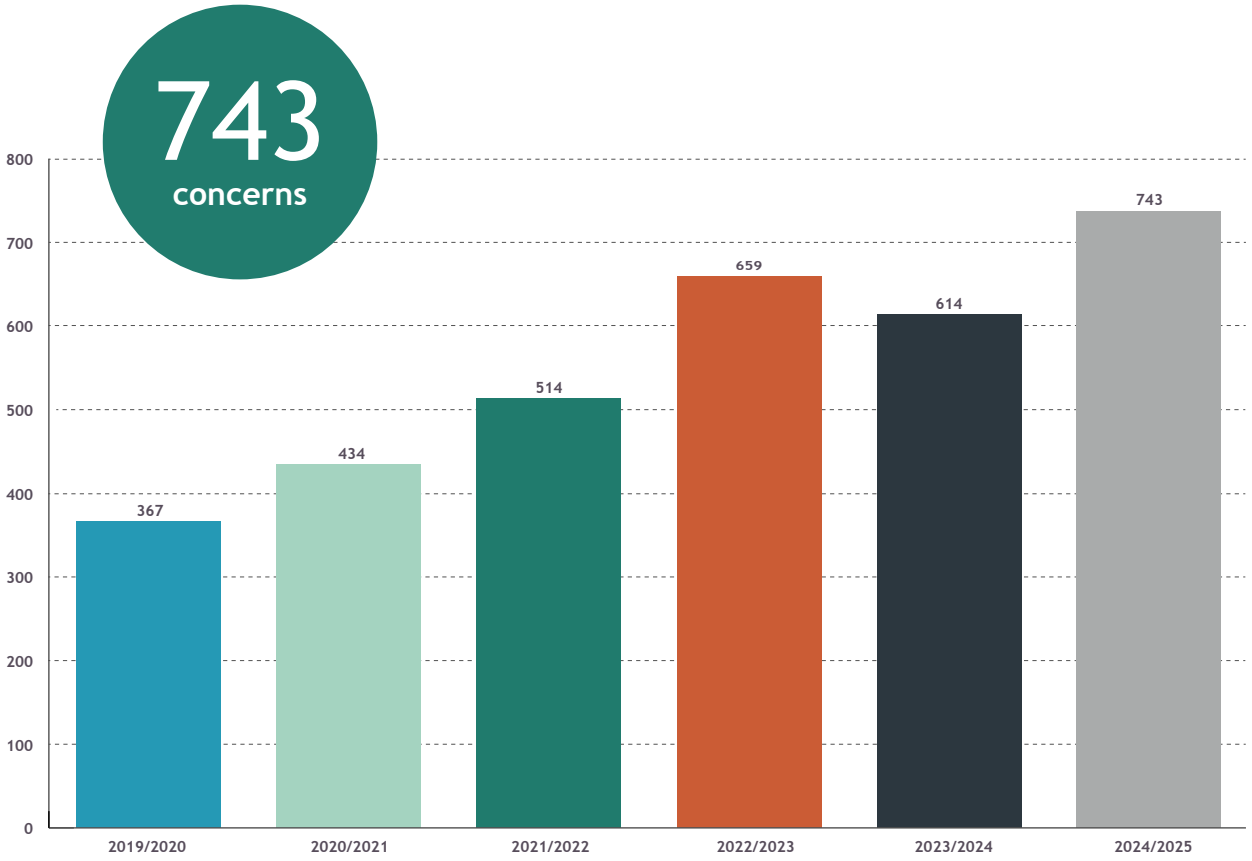
In 2024-25, we received 743 concerns - a 21% increase on the previous year and a striking 102% increase since 2019-20.

This sharp rise reflects growing public awareness, increased confidence in HIW's role, and possibly deeper systemic pressures across healthcare services.

People are speaking up more often, and with greater urgency, about the care they receive. This signals both a demand for accountability and a recognition that HIW is a trusted route for raising serious issues.

We are also seeing a greater degree of complexity in the concerns raised. Many now involve multiple service areas, higher levels of risk, and require more intensive follow-up.

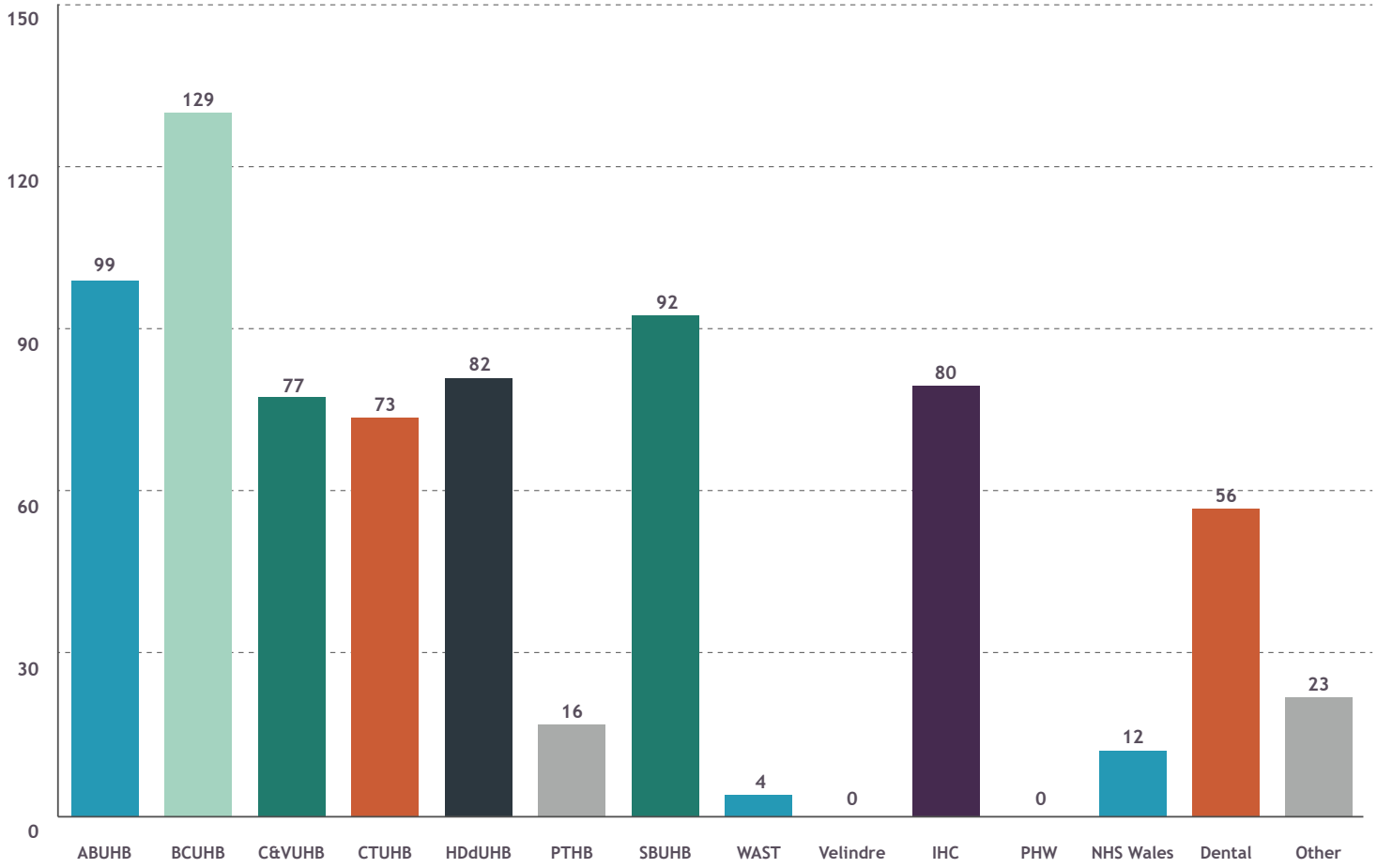
This has led to a significant increase in the number of cases where we seek direct assurances from providers, demonstrating the scale and seriousness of the issues being flagged.



Location of concerns

Abbreviations

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



What People Told Us

The most common themes raised in concerns included:

- Standards of care in inpatient settings (NHS and private)
- Pressures in emergency departments, including long waits and overcrowding
- Access to GP appointments and primary care services
- Access to NHS and private dental care
- Mental health support in both inpatient and community settings
- Delays and poor coordination in hospital discharge processes

Whistleblowing: Speaking Up for Safety

Whistleblowing plays a vital role in protecting patients and improving healthcare services. Staff must feel able to speak out when they witness poor practice, unsafe conditions, or cultural issues that compromise care.

The concerns raised through whistleblowing often go beyond individual incidents. They shine a light on deeper issues such as leadership, governance, and organisational culture.

This is why HIW's role as a prescribed body is so important. Staff come to us not only to report risks to safety and quality, but also to highlight environments where speaking up internally may not feel safe or effective. These disclosures help us identify patterns, escalate serious concerns, and hold organisations to account in ways that might not be possible through other channels.

In 2024-25, we received 120 whistleblowing concerns - a 36% increase from the previous year.

These concerns often related to:

- Standards of care and treatment
- Organisational culture and leadership
- Governance and accountability
- Staffing levels and service capacity.

This reflects both a growing willingness to speak up and a continued need for robust external oversight. We remain committed to listening, protecting those who raise concerns, and ensuring their voices lead to meaningful change.

We take every whistleblowing concern seriously. Depending on the nature of the issue, we may seek further assurances or refer the matter to another regulator.

36%

increase from the previous year

Regulatory Notifications: Keeping Us Informed

Independent healthcare providers are required by law to notify us of specific incidents under the Independent Health Care (Wales) Regulations 2011 and the Private Dentistry (Wales) Regulations 2017. We also monitor compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R).

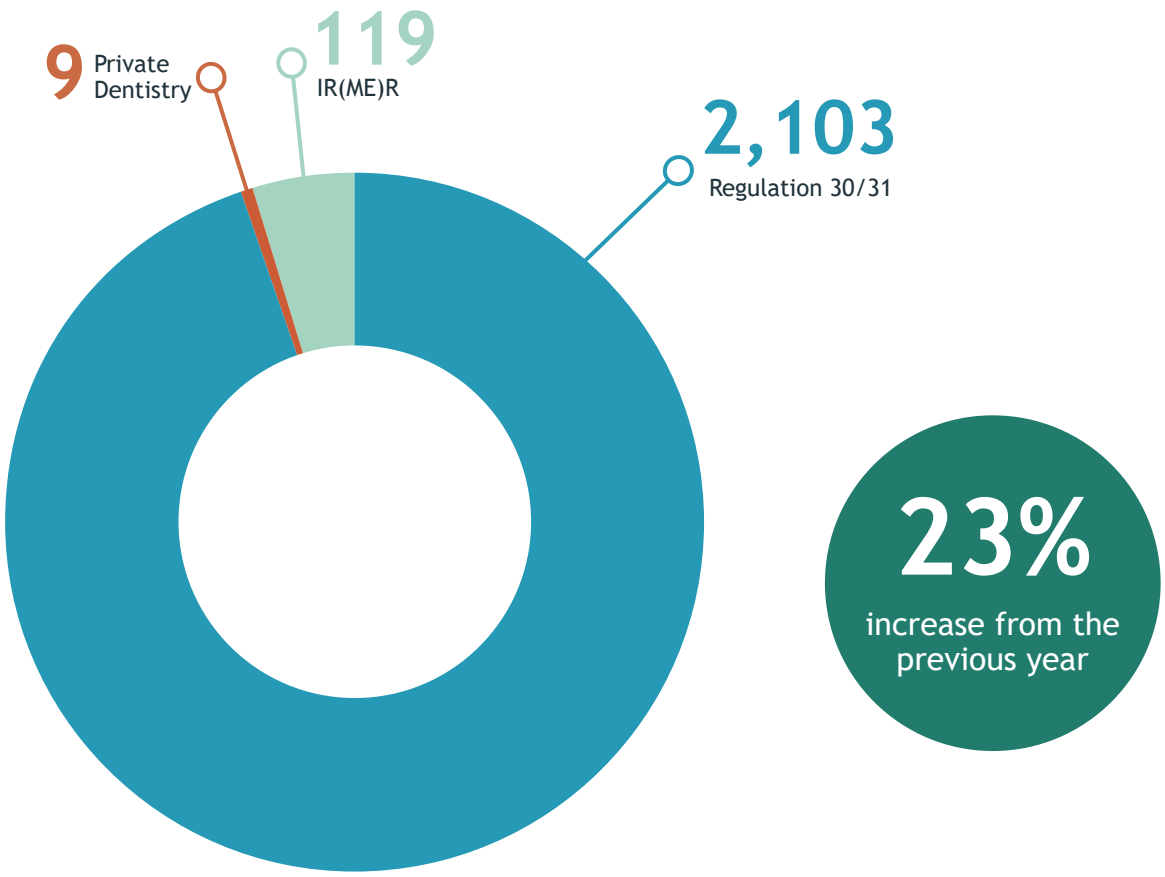
In 2024-25, we received 2,231 statutory notifications - a 23% increase from the previous year.

This rise reflects both increased activity in the independent sector and stronger awareness of reporting obligations.

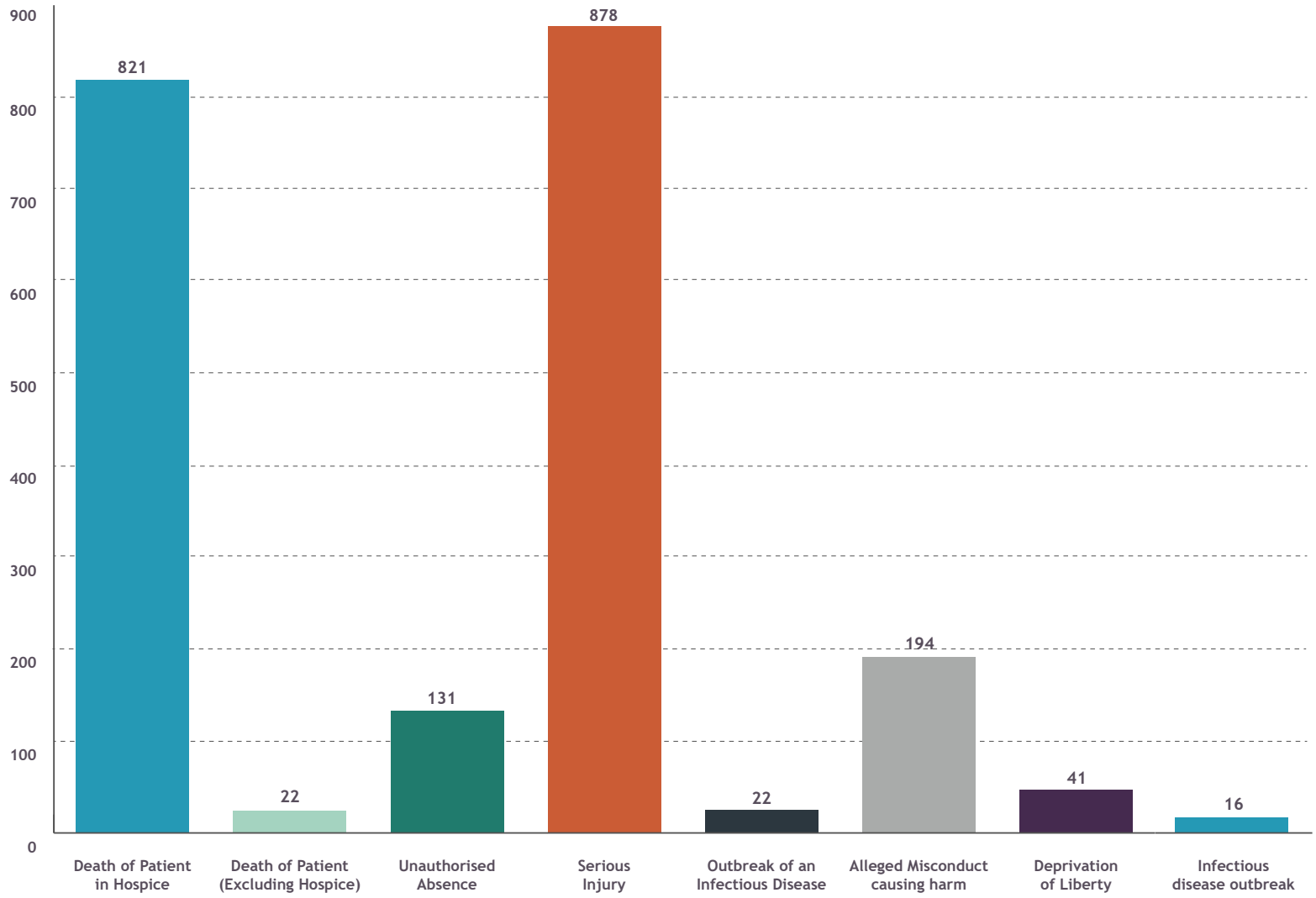
Each notification is reviewed and assessed by our team to determine the level of risk and whether further action is needed. These reports help us identify trends, inform inspections, and guide our regulatory decisions.

We are also seeing more reporting from certain service types, particularly hospices and independent hospitals, which may reflect both increased scrutiny and improved compliance with notification requirements.

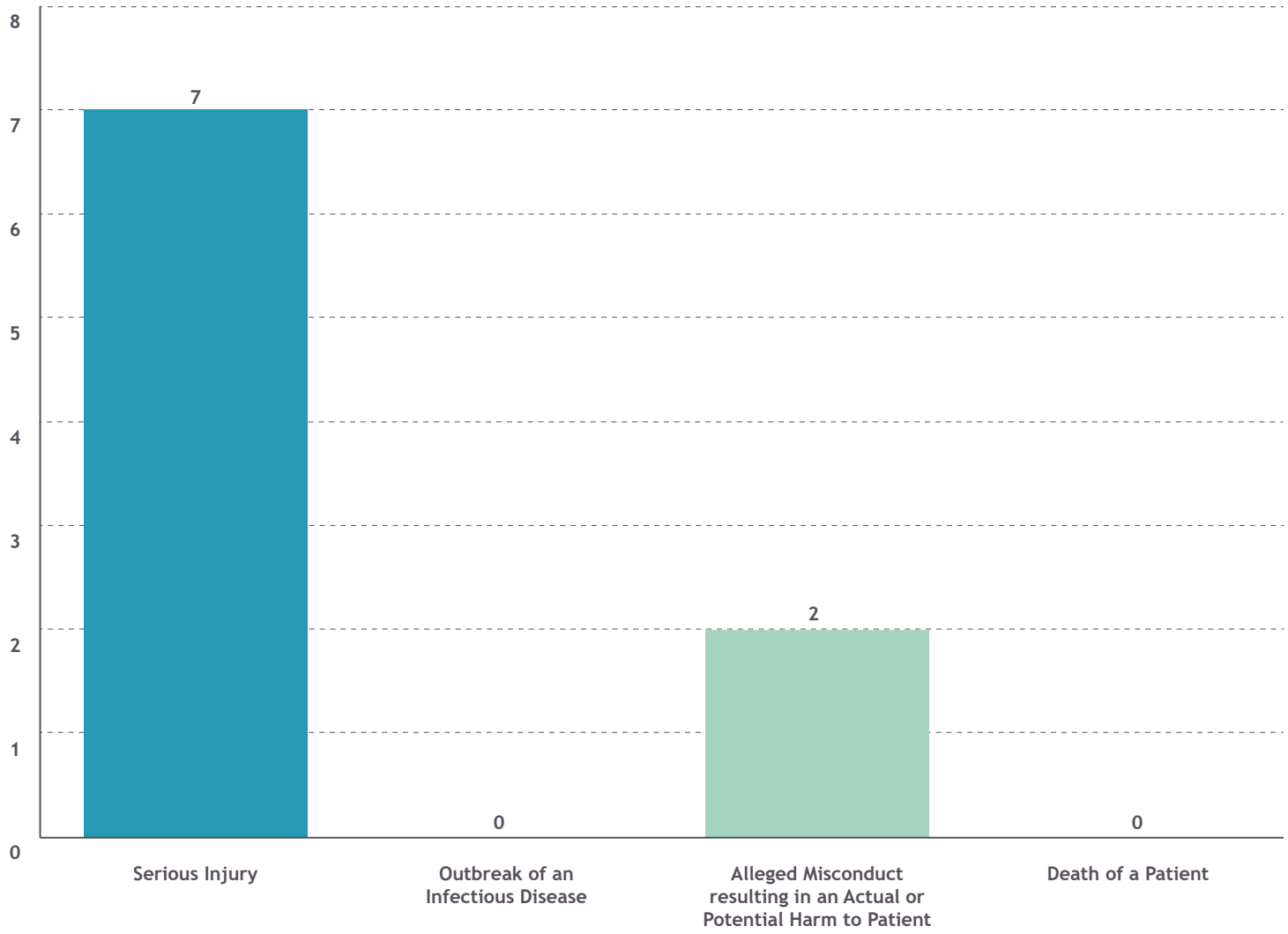
Breakdown of Notifications



Regulatory 30/31 Notifications Reviewed by Subtypes



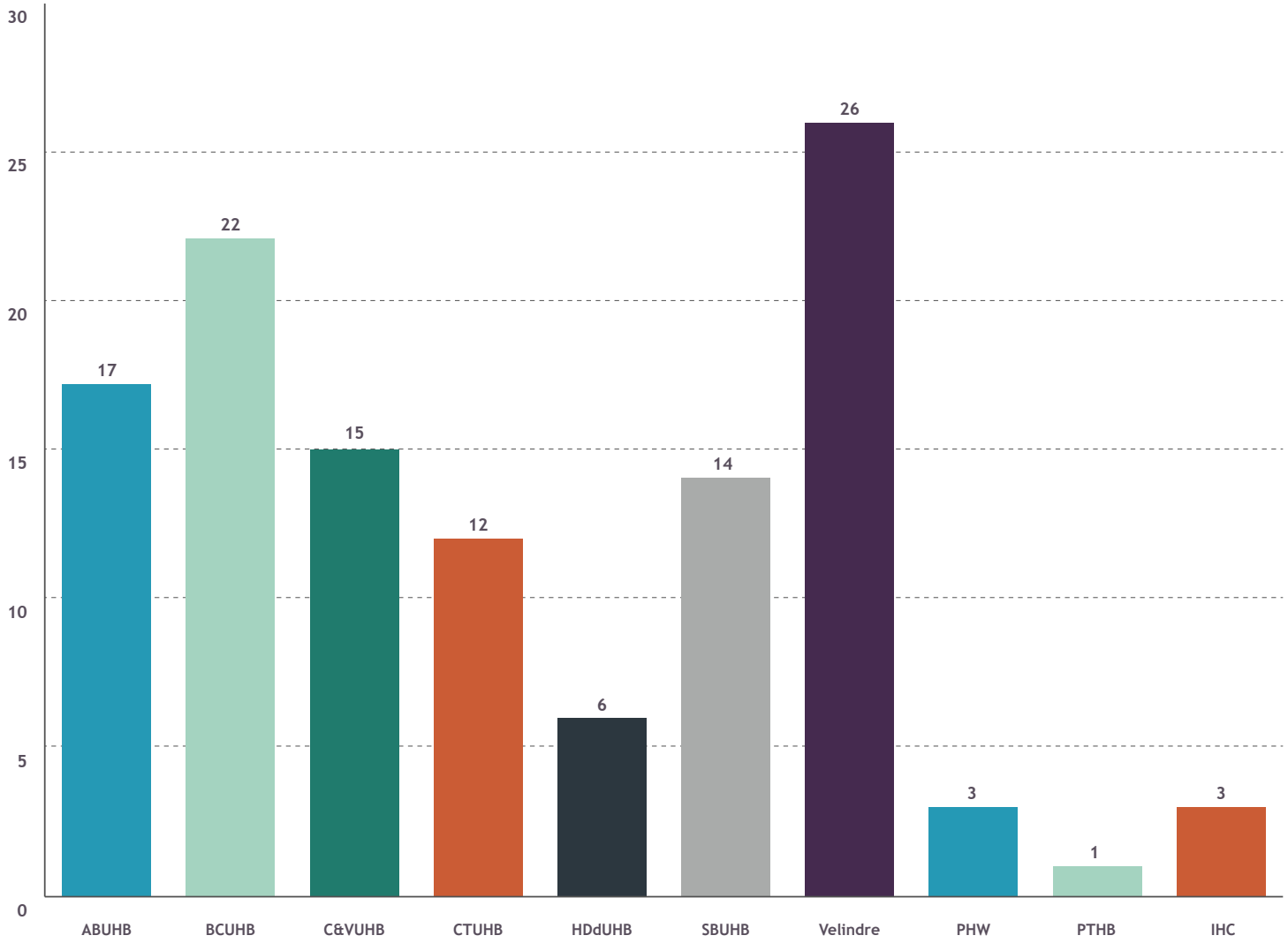
Dental Regulatory Notifications Received



IR(ME)R Notifications by Location

Abbreviations

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



Death in Custody

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

Between 1 April 2024 and 31 March 2025, HIW completed 18 clinical reviews across Welsh prisons:

HMP Parc: Complex Needs and Missed Opportunities

The majority of reviews at HMP Parc highlighted recurring issues in managing chronic illness, mental health, and substance misuse. Six deaths were linked to long-term conditions such as cancer and cardiovascular disease, with several cases showing missed opportunities for early intervention or specialist referral. Mental health concerns including psychosis, depression, and cognitive impairment were present in nearly half of the cases, with inconsistent use of Assessment, Care in Custody and Teamwork (ACCT) procedures and limited trauma-informed care.

Substance misuse, particularly involving Novel Psychoactive Substances (NPS), was a significant concern. Engagement with support services varied, and harm reduction advice was not always documented. Poor integration of external records and delays in information transfer between prisons also contributed to gaps in care.

Key areas for improvement included:

- Timely second-stage health assessments
- Robust referral and follow-up systems
- Consistent healthcare involvement in ACCT reviews
- Compassionate end-of-life care planning
- Stronger harm reduction messaging and documentation.

Other Prisons: Shared Challenges Across the Estate

Reviews from other prisons revealed similar systemic issues. Individuals often presented with multiple vulnerabilities, including mental health needs, substance misuse histories, and suicide risk. Communication and documentation lapses were common, with critical information, such as overdose disclosures or suicide risk indicators, sometimes missing from records or handovers.

Risk assessment tools like the In-Possession Risk Assessment (IPRA) and segregation algorithms were inconsistently applied, occasionally without face-to-face contact or full clinical context. Missed opportunities for early mental health intervention were also noted, and in some cases, ACCT procedures were not followed in line with national guidance.

Additional concerns included:

- Weak clinical governance around preventive care
- Lack of protocols for managing secreted items
- Missed vaccinations and delayed referrals.

These findings reinforce the need for a whole-prison approach to healthcare, where clinical, custodial, and support services work collaboratively to safeguard the wellbeing of individuals in custody. HIW remains committed to supporting continuous improvement through independent scrutiny and evidence-based recommendations.

08.

Engagement and Partnerships

Partnerships

During the year, we strengthened our role as a system connector and enabler of shared learning. Through formal agreements and national collaboration, HIW has helped shape the inspection and regulatory landscape and supported collective efforts to improve healthcare quality and safety across Wales.

Formal Agreements and Shared Accountability

HIW updated and signed six Memoranda of Understanding (MoUs) with key national bodies, including the Public Services Ombudsman for Wales, Human Fertilisation and Embryology Authority, Older People's Commissioner for Wales, General Medical Council, Children's Commissioner for Wales, and the Nursing and Midwifery Council. These agreements reflect HIW's commitment to collaborative regulation, ensuring that concerns are addressed through the right channels and that information is shared effectively to protect patients and improve services.

National Healthcare Summits

HIW hosted two national Healthcare Summits in May and November 2024, bringing together a wide range of partners to share intelligence and reflect on the quality and safety of healthcare services across NHS Wales. These summits are a key part of HIW's role in enabling system-wide insight and improvement. Themes included:

System Pressures

Across both summits, HIW heard consistent concerns about long waiting times for planned care, particularly for patients waiting over 104 weeks. While some Health Boards have made progress, others continue to face challenges. Delays in emergency care and ambulance handovers were also raised, often linked to poor patient flow and delayed discharges. Mental health services, especially for children and young people, remain under pressure, with concerns about access and the NHS's acceptance of private diagnoses.

Service-Specific Risks

Several areas of care were highlighted as national concerns. Ophthalmology (eye care) was identified as a patient safety risk, with variation in performance and gaps in leadership. Maternity and neonatal services were flagged for inconsistent experiences and staffing pressures. Radiology services face high workloads and communication issues between GPs and hospitals, while access to primary care remains fragile, particularly in rural areas.

Workforce and Infrastructure

HIW welcomed signs of progress in NHS workforce planning, including efforts to reduce reliance on agency staff and improve support for overseas recruits. However, significant concerns remain about the condition of NHS estates, with delays in maintenance and governance challenges affecting service delivery.

Innovation and Collaboration

Despite the pressures, summit contributors highlighted examples of innovation, such as Health Boards sharing services, utilising digital tools like the Once for Wales Concerns Management System, and several initiatives and pilot projects taking place across different specialisms. These initiatives demonstrate how collaboration and creativity can drive improvement, even in a financially constrained environment.

This year's partnerships work reflects HIW's evolving role as both regulator and system leader, bringing people together, sharing insight, and helping to shape a safer, more responsive healthcare system for Wales.

Clinical Insight

Over the past year, HIW's Acute Clinical function has played a vital role in embedding clinical expertise at the heart of our inspection and regulatory work. Their contributions have shaped how we plan, inspect, and respond to the quality and safety of care across Wales, ensuring our work remains grounded in real-world clinical understanding.

Use of Peer Reviewers

HIW uses clinical peer reviewers to bring frontline insight and specialist knowledge into our assurance work. These professionals, who continue to practise in their respective fields offer a current, practical perspective on the delivery of care. Their involvement helps ensure that our inspections are not only evidence-based but also clinically credible and relevant to the services we review. Peer reviewers also act as a bridge between HIW and the wider healthcare system, helping us remain connected to the realities of care delivery and fostering a culture of shared learning and improvement. Over the year, we have strengthened our pool of clinical peer reviewers by mapping specialities to ensure we have the right expertise available for each inspection.

Providing Expert Advice

The Acute Clinical team has provided expert advice across a wide range of issues, helping us better understand emerging risks and safety concerns in healthcare settings. Their input has informed both specific inspections and broader system-level reviews, ensuring our findings are robust and clinically informed.

Working with the NHS

The team has actively contributed to national safeguarding groups and consultations, ensuring HIW's voice is heard in shaping health policy and improving care. Their engagement has helped align our work with national priorities and supported the development of safer, more effective healthcare services across Wales.

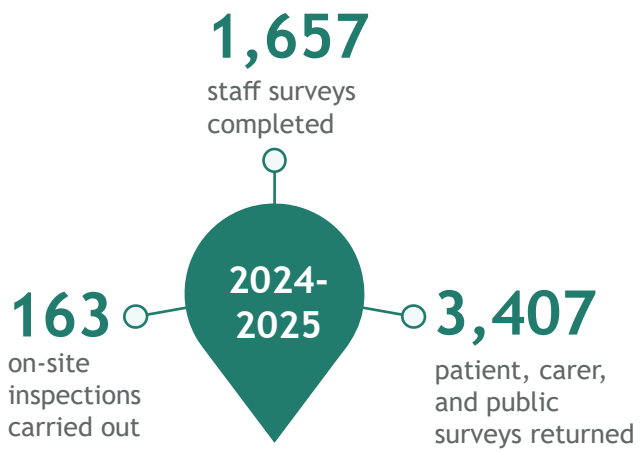
Engagement - Listening and Learning

Listening to the people who use and work in healthcare services is essential to understanding how care is really delivered across Wales. Their experiences give us powerful insight into what matters most and where change is needed.

We build this understanding through every part of our work. During inspections and reviews, we speak directly with staff, patients, and carers, inviting them to share their experiences through conversations and short surveys. Beyond inspections, we use social media, newsletters, posters, and events to reach more people, raise awareness of our work, and gather wider feedback.

This feedback strengthens our findings, challenges assumptions, and drives real improvements in healthcare. People's voices are not just heard; they shape the judgments we make and the changes we push for.

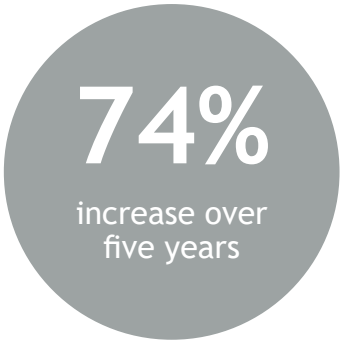
By developing strong relationships and seeking meaningful insight, we gain a deeper understanding of people's experiences of care, helping us influence change where it matters most.



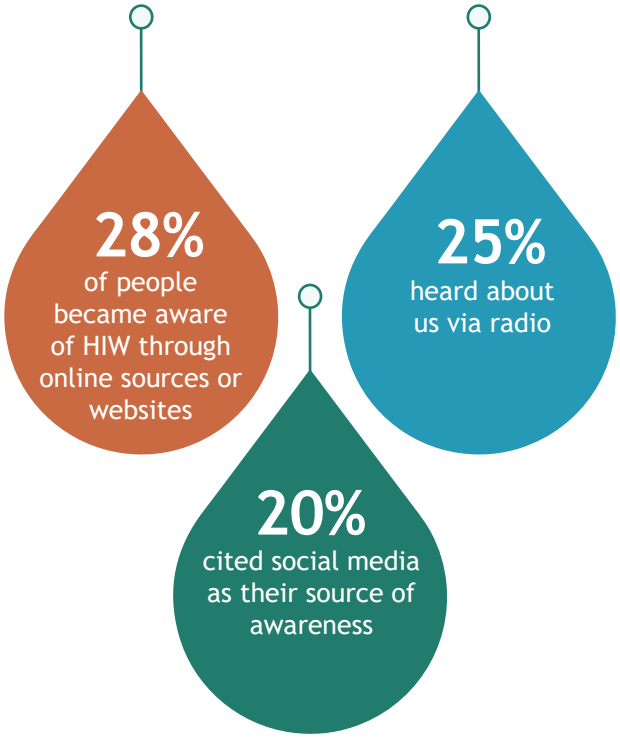
Raising Awareness and Building Public Confidence

During 2024-2025, we issued 140 inspection reports, some of which attracted local and national media attention. This included live and pre-recorded interviews with major broadcasters, helping to raise the profile of our work and reinforce public trust in the independent scrutiny of healthcare services.

Since 2018, public awareness of Healthcare Inspectorate Wales (HIW) has grown significantly from 27% to 47% in 2024, representing a 74% increase over five years. Awareness has nearly doubled, with almost half of respondents now familiar with HIW.



Our latest national omnibus survey shows that:



This growing visibility is vital. It fosters transparency and public confidence, reassures people that care standards are being independently monitored, and encourages healthcare providers to maintain high levels of safety and quality.

Accessible, Inclusive, and Impactful Engagement

We believe that meaningful engagement must be accessible, inclusive, and representative of the communities we serve. This year, we have taken significant steps to strengthen how we communicate, share insight, and build relationships across Wales.

We are committed to removing barriers to understanding and participation.

In 2024-2025, we:

- Produced youth-friendly animations and visual content to accompany our national review of Child and Adolescent Mental Health Services (CAMHS), ensuring young people's voices were not only heard but amplified. These resources were widely shared by partners including Welsh Government Education, Mind Cymru, and Youth Cymru
- Responded to a Government Digital Service audit by addressing all accessibility issues across our digital platforms, improving the user experience for all
- Introduced new internal guidance to support staff in writing clearly and inclusively, and we now aim to publish our work in both PDF and fully accessible web formats.

Learning and Insight That Drives Improvement

We continue to share learning from our assurance work to support improvement across the health and care system:

- Our quarterly Insight bulletins now reach over 7,000 subscribers, providing timely summaries of key findings, emerging risks, and good practice
- We expanded the Learning and Insight section of our website, with case studies and examples of how our work is helping to drive system-wide change.

By making our insights more accessible and actionable, we are helping providers, policymakers, and the public understand how care is improving and where further attention is needed.

Engagement Highlights

Being Visible, Building Trust

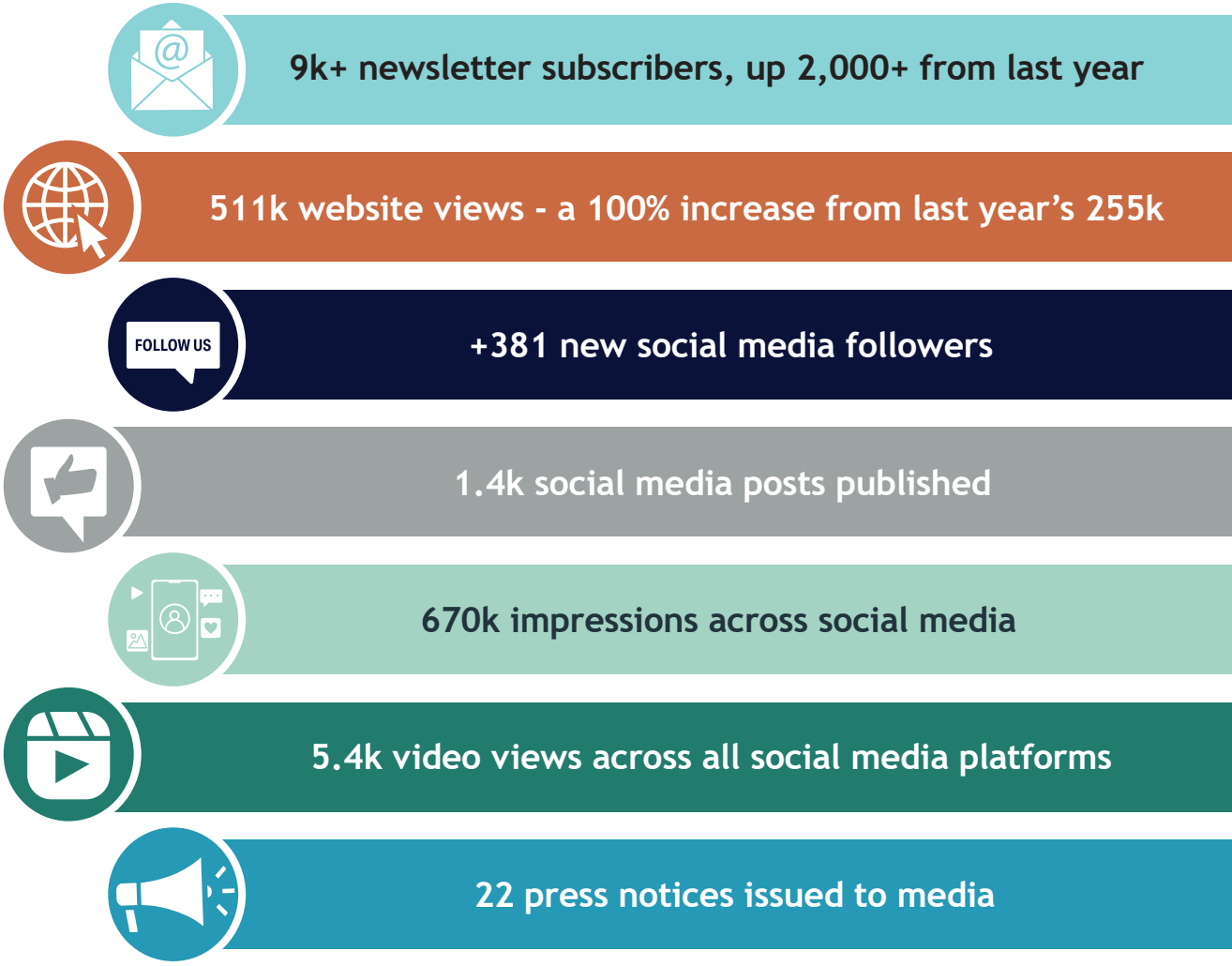
We are more visible than ever before. This year, our teams attended major national events including the Royal College of Midwives Conference and the Mental Health and Wellbeing Show. These opportunities allowed us to:

- Explain our role and how we work
- Gather feedback from professionals and the public
- Promote initiatives such as our peer reviewer recruitment programme.

We also refreshed our exhibition stand and promotional materials to ensure they are engaging, inclusive, and environmentally sustainable reflecting our values in both form and function.

50
Editions of our internal newsletter 'Connect' shared with staff

140
Inspection Reports and 33 News Items published



Championing - Equality, Diversity and Inclusion (EDI)

At HIW we are committed to challenging inequality and ensuring that our work reflects the diversity of the communities we serve. In 2024-2025, we launched our Joint Equality, Diversity and Inclusion Strategy 2024-2028 in partnership with Care Inspectorate Wales (CIW). This strategy aligns with the Welsh Government's Strategic Equality Plan, Anti-Racist Wales Action Plan, and LGBTQ+ Action Plan, and sets out a shared vision for embedding inclusive practice across both inspectorates.

By pooling expertise and aligning strategic priorities, we are better positioned to influence the wider health and care system in Wales.

Why EDI Matters to HIW

We know that people's experiences of healthcare are shaped by their identity, background, and circumstances.
By understanding and addressing these differences, we can help ensure that services are accessible, respectful, and responsive to everyone's needs.

Key Actions in 2024-2025

- **Established an EDI Champions Group:** This internal network plays a pivotal role in embedding inclusive practice across HIW. Champions act as change agents, raising awareness, supporting colleagues, and ensuring EDI is considered in all aspects of our work.
- **Developed an EDI Crib Sheet**: This practical resource equips inspectors with clear, accessible guidance to support inclusive engagement during inspections. It offers prompts and considerations for initiating meaningful conversations with people from underrepresented groups, helping to build trust, uncover lived experiences, and ensure that diverse voices are reflected in our findings.
- **Held an organisation-wide Anchor Day focused on the Social Model of Disability:** the event provided an excellent platform for bringing staff together to hear directly from people with lived experience of disability, the barriers they face and the objectives of the Welsh Governments' Disabled People's Rights Plan. It was a powerful reminder of the importance of listening, learning, and acting to remove systemic obstacles

These initiatives are helping to build a more inclusive culture within HIW and are shaping how we engage with the public, providers, and partners.

Working with Our Stakeholder Advisory Group

Our Stakeholder Advisory Group (SAG) continues to be a vital source of challenge, insight, and direction. This diverse network of organisations, representing people with protected characteristics ensures that our work is informed by those with lived experience and expertise.

In 2024-2025, we welcomed AP Cymru, a neurodiversity charity, to the group. They joined existing members such as Mind Cymru, Age Cymru, Race Council Cymru, Carers Wales, RNIB, Disability Wales, Stonewall Cymru, and Youth Cymru.

The group has directly influenced how we:

- Design and deliver engagement activities
- Gather and interpret feedback
- Ensure our inspections and reviews are inclusive and representative

Their contributions are helping us to better understand the challenges people face when accessing healthcare and to hold services to account for addressing them.

Welsh Language - The Active Offer in Practice

We are proud to promote and support the Welsh language, ensuring people can engage with us confidently and naturally in their language of choice.

- All public-facing communications – from surveys and newsletters to events and digital content – are fully bilingual
- Internally, we now publish our staff bulletin bilingually and run Cornel Cymraeg, a regular feature helping staff strengthen their language skills and cultural awareness
- We continue to work with Welsh Government to uphold the principles of the Active Offer, making the Welsh language a visible, valued, and natural part of our engagement with people and communities across Wales.

In addition, the Welsh Language Active Offer is embedded in our inspection methodology and findings are regularly highlighted in our inspection reports. In 2024- 2025, we identified several positive examples of how the active offer was being taken forward in healthcare services. These include:

- Staff making efforts to deliver the ‘Active Offer’ by greeting patients in Welsh and continuing conversations in Welsh if the patient or visitor was Welsh speaking.
- A paediatric ward with a designated Welsh Language Champion. This role is crucial for promoting the use of the Welsh language and ensuring that Welsh-speaking patients receive appropriate support and services in their language.
- Bilingual information displayed or provided throughout the ward areas. This ensured that Welsh-speaking patients and their families had access to necessary information in their preferred language.

09.

Our Resources

Our Resources

Our people continue to be our most important resource. A programme of learning and development opportunities has once again been designed and delivered in accordance with feedback from staff, along with a series of Lessons Learnt exercises allowing us to reflect and learn from areas of our work.

Our internal People Forum continues to provide a strong and valuable source of feedback to senior HIW managers on staff matters and organisational development. We rely on the clinical expertise of our pool of specialist Peer Reviewers, and we currently have a panel of over 150 with clinical backgrounds.

We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have 44 Patient Experience Reviewers and Experts by Experience who have the critical role of assessing patient experience through talking to patients. Our electronic Customer Relationship Management (CRM) system is now well established and providing valuable data supporting the work of all teams across HIW.

Team	Number of Posts
Senior Executive	3
Inspection	22
Regulation and Escalation	17
Partnerships, Intelligence and Methodology	12
Strategy and Communications	6
Clinical Advice (including SOAD service)	7
Business Management, Digital, and Corporate Services	20
Total	**87**

Finance

For 2024-2025 we had a budget of approximately £5.9m, which includes fee income from our regulatory role in the independent sector. We had the equivalent to 87 full-time staff as well as a panel of over 150 specialist reviewers.

The table below shows how we used the financial resources available to us in the last financial year to deliver our work in 2024-2025.

HIW Budget - £5,345,000

Category	Amount (GBP)
Staff costs	£4,738,368
Travel and Subsistence	£39,534
Learning & Development	£8,643
Non staff costs	£45,411
Translation	£89,807
Reviewer costs	£524,949
ICT costs	£28,308
Total expenditure (a)	**£5,475,021**
Income from Independent Healthcare (b)	£618,065
Total Net Expenditure (a - b)	**£4,856,956**

10.

Contact us

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

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

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