National Assembly for Wales
Health and Social Care Committee
The work of the Healthcare Inspectorate Wales
Evidence from the Hywel Dda Health Board – HIW 03

12th September 2013

Health and Social Care Committee
National Assembly for Wales

Email: HSCCommittee@wales.gov.uk

Dear Sir / Madam

Inquiry into the work of Healthcare Inspectorate Wales – Call for Evidence

With reference to the above, as requested please see attached copy of Hywel Dda Health Board's response.

Please do not hesitate to contact me if you have any queries.

Yours faithfully

Chris Wright
Director of Corporate Services

Enc

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Hywel Dda Health Board's response to the National Assembly for Wales Short Inquiry into the work of Healthcare Inspectorate Wales (HIW)

1. The effectiveness of HIW in undertaking its main functions and statutory responsibilities.

1.1 The role of HIW in terms of adult safeguarding in the NHS is less clear than the role of CSSIW and they are certainly much less visible in terms of participating in adult protection referrals about the NHS. HIW also has a specific role around the use of the Mental Health Act.

2. The investigative and inspection functions of HIW, specifically its responsibility for making sure patients have access to safe and effective services, and its responsiveness to incidences of serious concern and systematic failures.

2.1 On behalf of the citizens of Wales, HIW provides independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

2.2 It is questioned how this purpose can be reliably fulfilled when an inspection is as only as good as the time it was conducted. There cannot be an over reliance on self assessment as a process for Health Boards to demonstrate their effectiveness. This must be triangulated with intelligence from other sources/outcome measures in order to provide transparent and rigorous assurance about the safety and effectiveness of NHS services. This is also applicable to nursing agencies and the independent sector.

2.3 However, the observation and engagement with patients during inspections is seen to be effective as evidenced through the reports reviewed. It is very disappointing that in HIW's Dignity and Essential Care themes, Human Rights and Standards for Health Services in Wales they fail to identify the importance of Standard 11 of the SfHSW.

2.4 The Health Board is unable to comment on HIW's responsiveness to incidences of serious concern and systematic failures, but they should be able to demonstrate rigour in their statutory duties to recognize early where there may be signs of systemic failures. There should be a system of regulation and inspection which is proactive and able to identify and respond to early warning signs rather than reactive to a serious issue as seen in Winterbourne View when the response was to prioritise inspection of all Learning Disability Services registered with HIW. The system of inspection should be sufficiently effective as to give confidence that the service is safe. Services which are essentially 'closed' should have more frequent unannounced inspections working collaboratively between the regulator and commissioners of care in those services.

2.5 It has been recognised that a key role for HIW is to 'close the loop' on incidents, however this needs to be further developed and embedded by the inclusion of learning the lessons from events. An example in mental health is when an event occurs this is reported to Welsh Government and HIW are involved, however the Wales wide learning from these events are not shared nationally across Wales in a formal process. Senior Nurses and Managers may share this intelligence with colleagues informally, but there is no formal process for the national learning to take place.

2.6 This is currently being addressed by a Serious & Untoward Incident (SUI) Task & Finish Group, which includes Senior Nurses and Managers across Wales from Health

Boards, Welsh Government, HIW and links with National Patient Safety Agency (NPSA), it is facilitated by Public Health (NLIAH) and chaired by the Vice-Chair of ABMUHB. This work is not yet complete but it is anticipated it will address the way in which we learn the lessons from events across Wales. This principle should be applied to all services and HIW events.

3. The overall development and accountability of HIW, including whether the organisation is fit for purpose.

3.1 Please refer to section 2 if formal and expanded would influence the overall development and accountability of HIW.

4. The effectiveness of working relationships, focusing on collaboration and information sharing between HIW, key stakeholders and other review bodies.

4.1 Please refer to section 2 which describes a very helpful extension of collaboration between HIW and services.

4.2 The effectiveness of working relationships with Local Authorities in adult safeguarding concerns which involve NHS services has not been seen to be clear. HIW should recognize the role that Local Authorities have in adult safeguarding and engage them in providing information relevant to reviews which should enhance the triangulation of intelligence. Further involvement of Local Authorities will enable HIW to understand the challenges in referring NHS concerns to adult protection procedures where Local Authorities maintain the Designated Lead Manager function in the absence of Health Designated Lead Managers.

4.3 HIW and CSSIW appear to have an effective working relationship which has been seen through the recent joint review of DOLs.

5. Consideration of the role of HIW in strengthening the voice of patients and the public in the way health services are reviewed.

5.1 The engagement of patients in providing feedback on their experience of health care services is integral to assessment and development and HIW are seen to engage patients in their visits as evidenced through their inspection reports. This is definitely a concept that would add to HIW processes.

6. Safeguarding arrangements, specifically the handling of whistle blowing and complaints information.

6.1 HIW's independent review of Glan Clwyd Hospital in Betsi Cadwaladr Health Board was broader in terms of safeguarding and protection. This has not been evidenced previously through other inspection reports and it is suggested the former approach is one which should be endorsed for rigour and consistency across the NHS in Wales.

6.2 It is clear through the Serious Care Review at Winterbourne View Hospital and the Francis Report that the requirement for organisations to have a whistle blowing policy is not enough. HIW should ensure that in addition to checking if Health Boards, the independent health care providers and primary care services have in place whistle blowing policies, they should also review evidence of implementation. The availability of a policy is not evidence that it is implemented. The need for this is further evidenced through research into raising concerns and whistle blowing.

6.3 The handling of complaints which may meet the threshold for POVA in NHS

services is evolving and it appears that we cannot be confident in terms of consistency in what is referred to adult protection procedures across the NHS in Wales. The NHS Professional Leads for Safeguarding Adults at Risk are to carry out a scoping exercise to assess the position of each Health Board and work together towards achieving that consistency. HIW's inspection role should enable monitoring of consistency in this area of practice across the NHS in Wales.

6.4 In terms of the future for adult safeguarding and HIW's role, there will be an opportunity to review how Health Boards in Wales are fulfilling their statutory duties in accordance with Section 7 of the Social Care and Well being (Wales) Bill, specifically, the duty to report which has been a concern highlighted through the review of In Safe Hands (2010) and HIW's review of adult protection arrangements in the NHS in Wales. (2010).