Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Cyfrifon Cyhoeddus

The Public Accounts Committee

10/11/2015

Trawsgrifiadau'r Pwyllgor
Committee Transcripts

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cynnwys
Contents

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are recorded in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
Jocelyn Davies	Plaid Cymru The Party of Wales
Mike Hedges	Llafur Labour
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Kate Chamberlain	Prif Weithredwr, Arolygiaeth Iechyd Cymru Chief Executive, Healthcare Inspectorate Wales
Alun Jones	Cyfarwyddwr Arolygu, Rheoleiddio ac Archwilio, Arolygaeth Iechyd Cymru Director of Inspection, Regulation and Investigation, Healthcare Inspectorate Wales
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Bethan Davies	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk

Joanest Varney-Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Dr Paul Worthington	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:01.
The meeting began at 09:01.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody. Welcome to today's meeting of the Public Accounts Committee. If I could just make the usual housekeeping notices and remind everybody that the National Assembly for Wales is a bilingual institution and that Members and witnesses should feel free to contribute to today's proceedings through either English or Welsh as they see fit. If you've got a mobile phone, if you could switch that onto silent or off, as these can interfere with the broadcasting equipment. I just remind everybody that, in the event of a fire alarm, we should follow the instructions of the ushers. Members have obviously received the guidance on oral declarations of interest, so we'll take any declarations as they arise on the agenda.

Papurau i'w Nodi
Papers to Note

[2] **Darren Millar:** Item 2 today is papers to note. We've got a number of papers. First of all, there are our minutes from the meeting held on 3 November. I'll take it that those are noted. We have a letter from the Welsh Government in relation to orthopaedic services. This responds to the recommendations in the Auditor General for Wales's reports. All of the recommendations have been accepted, and, of course, we've got Andrew Goodall coming before the committee on 24 November, so we'll have an opportunity to raise any questions that Members want to raise at that point. I'll take it that that letter is noted.

[3] We've had a letter also from the Welsh Government in response to the further queries we raised on welfare reform. They have given some comprehensive answers, to be fair, but we may want to recommend in the legacy work for the next Assembly just to revisit some of the consultation recommendations and communication recommendations that we made. Are

Members happy to note that letter too? Excellent.

09:02

Llywodraethu Byrddau Iechyd GIG Cymru
NHS Wales Health Board Governance

[4] **Darren Millar:** We'll move on then to item 3, continuing with our inquiry into NHS and health board governance. Members will know that this has been a long ongoing inquiry and that there have been a number of interesting developments, shall we say, during the course of it. We chose to defer any further evidence sessions as a result of the announcement that special measures had been put upon the Betsi Cadwaladr University Local Health Board back in June, and decided to take further evidence after the 100-day mark. So, we've got three further evidence sessions in this inquiry, the first one of which is this morning, with Healthcare Inspectorate Wales.

[5] I'm very pleased to be able to welcome Dr Kate Chamberlain, chief exec of HIW, and Alun Jones, director of inspection, regulation and investigation at the healthcare inspectorate, to the table today. Can I thank you for the paper that you presented for Members, which we've obviously all had an opportunity to look at? Obviously, many Members have questions arising from that paper and as a result of some of the other evidence we've received from elsewhere. Can you just give us a flavour, Dr Chamberlain—a very brief overview—of how you contribute to effective governance in the Welsh NHS as an inspectorate?

[6] **Dr Chamberlain:** Yes—happy to. In a way, all of the work that we do is contributing to us forming a view on how effectively the health boards and the trusts within the NHS are themselves looking after the quality of services that they're responsible for. So, we try and make sure that, whether it is our front-line inspection programme that we're undertaking or whether it is a specific review of governance, we draw out from all of that work the themes and issues that will contribute towards a view on how effective the governance is. What we've then been trying to do, certainly more over the space of the last 18 months, I would say, is to think about how we play those issues and those themes back into the health boards themselves, so that they can take action on those issues that are raised. So, last year, for example, we produced annual reports for each health board. We took each of those annual reports back to discussions at individual board meetings—in some cases, those were at board development sessions; in some cases, those

were at full board—to enable the board to consider how they can use what is coming out of our work, and out of wider concerns, incidents and issues, as part of their governance system to improve services across the board.

[7] **Darren Millar:** There's been an interesting development, hasn't there, with the publication of the Marks review into the regulatory framework and the inspection regime. How have you responded? Have you made any changes as a result of the Marks review? We're obviously aware that the Welsh Government has responded with the publication of a White Paper, but where do you sit in terms of your response to date, as an inspectorate?

[8] **Dr Chamberlain:** I can probably give you quite a long answer on this, so if it's too long, please do feel free to interrupt me. I'd probably characterise the recommendations that Ruth Marks made as, sort of, four different groupings. There were recommendations that she made about what we do, there were recommendations she made about how we do it, there were recommendations she made about who we do it with, and there were recommendations that she made about how we operate as an organisation. I think it comes through quite clearly in the report that, actually, a lot of the things that she was talking about we already had in train at that point, but she's quite clear that the intention of her report was to try and just, sort of, help us along the way, if you like.

[9] So, in terms of the 'what we do', she talked about the importance of continuing to focus on some of the core areas like infection prevention and control. We've had a task and finish group operating for some time looking at how we interface in that area, on top of which, this is one of the themes that plays through into our regular inspections routinely. She talked about the need for general practitioner inspections. Again, we've recently set up an advisory board, it's now met for a full year's cycle, and part of the feedback that we had from our advisory board in terms of framing our plan was the importance of focusing not just on low-volume, high-risk services, but also those high-volume services where so many of the public interface with the health service for the first time. So, albeit modest, we do have GP inspections as part of our programme. We're already considering the introduction of thematics into our programme. Again, we have two that were in the plan for this year and we've also been out and consulted within our strategic plan as to what our thematic programme should be looking at three years ahead.

[10] One area where possibly we wouldn't take the same direction that Ruth suggested is in peer review, because our view is very much that we've

been facilitating a programme of peer review in cancer services, but ultimately the value of peer review is that it is peer-to-peer review; it is not inspection. So, we've been working with the Welsh Government, and the Welsh Government is now taking forward the oversight and co-ordination of that programme. We're simply there to make sure it's sufficiently robust and independent in the way that it operates. So, we are taking that forward, but maybe not in the way that Ruth would have envisaged.

[11] NHS mental health services, we continue to do our inspections in NHS mental health and we use those as a way of covering a number of different mental health issues. So, as well as the general issues surrounding mental health inspection, we also look at aspects of the Mental Health (Wales) Measure 2010; we look at Mental Health Act 1983 monitoring visits, where that's appropriate to detain patients in those settings; and, this year, we're piloting work on community treatment orders as part of those inspections as well. So, it's about getting more impact from the inspections that we do. She also talked about the importance of follow-up, and I'm sure we'll come back to follow-up at parts of this session this morning, so I won't go into that in any detail. So, a lot of the things that she suggested should be part of our programme, I think you can see, are part of our programme and are being taken forward.

[12] In terms of how we do it, she made recommendations about making sure that we use best practice coming out of professional bodies, royal colleges et cetera. The starting point for any inspection is to identify what best practice is out there, and therefore, 'What are the standards we should be inspecting against?' So, that is something that, again, we already do and we continue to do. For our new inspections, we bring together stakeholder reference groups. So, we have a stakeholder reference group involving those relevant professional bodies for GPs, for dentists, for mental health. So, we are making sure that we draw on that recognised best practice, drawing on peer expertise.

[13] She talked a lot about risk-based work. We do base our work on an assessment of risk and on the intelligence that we can gather. It's not entirely risk-based driven, but we have a number of sources, again, that I'm sure we'll come back to—so I won't go into that in any detail here—that we use to inform where we go.

[14] She talked about the importance of involving the public. We have public representation on our advisory board, and we also use lay reviewers as

part of our inspections. In fact, we've recently gone out and recruited more of those, and there was a training day on for a new tranche of lay reviewers yesterday within our offices.

[15] She also talked about the need to evaluate and to move forward with what we do. We are currently in the process of going through an evaluation of our homicide reviews. I think, again, if we're going to talk about, during the course of the session this morning, the different types of inspections that we do, you'll be able to see how those have evolved through us assessing what is coming out from the inspection processes that we've done and how we can best get at the issues that are of most importance.

[16] She talked about a number of things that we should stop doing. She sort of acknowledged that that wouldn't have a great impact really in terms of our capacity to do other things, but, for example, the local supervising authority for midwives—we were in the process of trying to agree an alternative hosting organisation for that. That's now been rather overtaken because the function itself—the Nursing and Midwifery Council is looking at how that can be taken out in its current form.

[17] Deaths in custody are actually quite a useful way—although she's suggested we shouldn't do them—for us to look at the services that health boards are providing within the secure estate and, of course, the Social Services and Well-being (Wales) Act 2014 talks about social care in the secure estate, and it's important that we think about health and social care in tandem when we think about where we're going with that. And on homicide investigations, as I say, what happens with those I think needs to be informed by the evaluation that's currently taking place.

[18] Where else can I—? She talked about joint working. We have a number of mechanisms for joint working. So, we have the inspection Wales programme, in which we work together with the other three key regulators, inspectors and auditors within Wales. We have a concordat forum, which brings together a much broader range of inspectors and regulators to talk about current issues. It includes the Health and Safety Executive, the General Pharmaceutical Council, and the General Medical Council, so we can talk about common issues. We have the summit process that brings together regulators across the board to talk about each of the health boards to share intelligence, both soft and hard, and to think about to what extent the type of things that we are finding support each other. Then, we've got the escalation framework—the tripartite arrangements—where we work together

in that way as well.

[19] Again, on our advisory board, we have representation from a number of those key agencies to make sure that we are joined up. So, on our advisory board, we have the Royal College of Nursing, we have the community health councils—the chief executive sits on that—the Academy of Medical Royal Colleges, as well as representatives of the public.

[20] Governance-wise, I've mentioned the advisory board. She's suggested revising our purpose statement—we have a purpose statement, and I'll come back slightly to that—communications and the web. I feel like I've been promising this forever, but we are actually doing some work at the moment on changing our web hosting so that we can make our web easier to access and reports easier to find. She talked about the nature of enforcement and the measures. We have reviewed our enforcement policy; we have a new enforcement policy in place. The escalation framework you'll already be familiar with. Then, she talked about a number of broader issues that are about the landscape in which we operate. So, our relationship with the CHCs, our relationship with the Care and Social Services Inspectorate Wales and those sort of areas, and, of course, those have been picked up by the Welsh Government and are out for consultation in the Green Paper at the moment.

[21] So, there were 42 recommendations, and I sort of skirted over a lot of them, but I'm sure we will get into—

[22] **Darren Millar**: You have, and I've given you time because it paints a very useful background, I think, for some of the areas that Members want to question you on. I'm going to bring in Jocelyn Davies and then go over to Mike.

[23] **Jocelyn Davies**: It was about the working together that I wanted to ask you about because I've got the Marks review here, and you know that there were concerns there about collaboration and so on. In fact, it says that information is weak—certainly when this was written, anyway, but things may have changed since, and perhaps you'll be able to tell us about that—and that the voluntary collaboration had had a minimal impact. I noticed that you mentioned the concordat, but you'll know that the Health and Social Care Committee here heard from the board of CHCs that the concordat has failed because there is no uniform communication between the various CHCs and yourself. So, it seemed to me that, if we're going to move to this sort of early warning system and have an effective inspection system, sharing intelligence

and knowing what other people know are important, but it seems to me that those are sadly lacking. So, since the production of the Marks report, what changes have you made so that that is more effective?

09:15

[24] **Dr Chamberlain:** One of the key areas of the way in which we get together I referred to are the summits. We've actually changed from—. The summits used to take place over five days, and used to be quite intensive conversations, but with a lot of change of personnel around the table. We've now distilled those down; they happen twice a year, but they happen quite intensively, on a single day. What that means, for example, is that, for some of those bodies that do have different individuals who look after different health bodies, they are pulling that information together, and we can have one discussion in one place.

[25] If I can use the community health councils as an example, really, because you referred explicitly to those, we have the operating protocol in place that says how we're going to work together, but, actually, there's always a risk that things like that become documents—they don't become a part of working practice. Now, within HIW, we've introduced a system of what we call relationship managers. So, there is a senior manager who is responsible for each of the NHS health bodies and maintains their ongoing intelligence about what's happening in that area. That's been very effective in terms of developing local working relationships with the chief officers of the community health councils. I wouldn't say it's perfect yet, and I'm sure community health councils wouldn't, but we are beginning to see a much stronger flow of intelligence between the two bodies. Also, the regulations of the community health councils have changed, which enables more consistency of standards and operation to be brought in, and we are talking to Tony Rucinski about how we can co-ordinate that. Sorry, Jocelyn—you wanted to come in.

[26] **Jocelyn Davies:** So, you know that this idea of the early warning system, or sharing that intelligence—the Health and Social Care Committee thought that it should be a kind of top priority. But, in order to do that, what the Marks report says is that you can't carry out intelligence-led inspections based on this idea of risk, unless you've got really strong data. So, since the production of this report, what changed—I understand you have summits and perhaps communicating better together—in relation to you having strong data in order that that is there to enable you to have that early

warning system?

[27] **Dr Chamberlain:** I'm just trying to think what's—

[28] **Jocelyn Davies:** A strong and stable database of performance data.

[29] **Dr Chamberlain:** We do meet regularly with the Welsh Government, so we are aware of the type of performance information that they're tracking. But what we're not trying to do is to replicate the Welsh Government's role in performance management of the NHS. So, those are our sort of indicators and signposts, if you like. For us, some of the key sources are: we have concerns that are coming into us, which we will also track; we will talk, on a regular basis, to the chief officers to find out what concerns are coming in to them through the community health councils, so the flow of data; and, before we go out on inspection, we will also be talking to the community health councils, and finding out what sort of information they already have, both through focusing those inspections, and to talk about what type of issues we should be doing.

[30] If I can hand over to Alun. Alun's got what might make it a bit real for you, Jocelyn—there are examples of cross-referral, if you like. Early warning systems—I probably shouldn't be saying this, given that I was a statistician—but early warning systems, I think, are less likely to be effective if they are wholly reliant on data and numbers than if they are, particularly in an environment like Wales, dependent upon relationships and people talking to each other, and being able and willing to share things that they're concerned about, before it gets to the point of being reflected in the numbers.

[31] **Jocelyn Davies:** Yes, I can see that, but one thing that comes out clearly—and before we bring Alun in—from the Marks report is that that sharing and talking to each other wasn't effective, and, in fact, it says

[32] 'that voluntary collaboration between organisations has often had minimal impact'.

[33] It seems to be that this was a weakness that was being identified. I can see what you're saying about, you know, you can't totally rely on data, but having strong data certainly does help.

[34] **Mr Jones:** Yes, I can give you a couple of examples. Is this working?

[35] **Jocelyn Davies**: You don't need to—your light's on.

[36] **Mr Jones**: I think the first example to give you is where we received a concern from a member of the public—and it appeared very credible—about the treatment of a patient on a ward. There was a lot of detail, and it felt real, and, obviously, there's an onus on us to establish whether these facts are true, and to do something about it if we can. In this example, we wrote to the health board to say, 'Okay, this is the information we've received', to give them an opportunity to respond to that, to say that they were aware of it, and a complaint had been made to them, or something along those lines. Although we were satisfied with the response—we were satisfied that the health board had investigated fully that matter—we couldn't be sure that that behaviour, the behaviour of the staff in question, wouldn't be something that was repeated. Now, as an organisation, we can't be there all of the time, and it is difficult to catch poor behaviour sometimes because people don't behave in a certain way when you're there. We had a conversation with the CHC and alerted them to the fact that this was an issue, and we felt that it was better for them and that it was more within their remit for them to go in and have a conversation with some of those patients, because that's a less stressful way for the patients to disclose information than to tell the health board. You know, sometimes patients don't want to complain to the direct staff who are giving them care.

[37] So, what happened in that case was that the CHC was able to go in and talk to a range of patients to establish whether they were comfortable, happy, whether they'd had similar experiences, and they hadn't, but we felt at that point that we had done due diligence between us in establishing whether there was something to be more worried about. Now, obviously, we've also logged that information in our own database, and we reserve the right to match that with anything else we hear and say, 'Okay, we are going to go in and have another look or we are going to do something', so we would always retain that knowledge of what happened.

[38] If I could give you another case as well, it's a sort of reciprocal thing where the community health council for one of the health boards contacted me recently to say that a complaint had been made about a health board. It was a quite alarming, distressing situation around a patient who had been not treated well at all and it had been detrimental to their health. They escalated it, if you like. They referred that one on to us because it was about patient safety and it was about the standard of clinical care. In that case, again, we always give the health board an opportunity to respond to that, but

we look at what data we hold. The health board has done a full investigation and it is dealing with that complaint. I think an independent team is looking into that case, which is reassuring to us, but we still reserve the right to go in and inspect if there's a point at which we don't trust the health board in terms of its response or we don't feel that it's sufficient. So, there are two examples there where we've shared information each way—

[39] **Jocelyn Davies**: So, do you periodically look at the ombudsman casebook to see what complaints they've been dealing with? And do you use that as part of your database?

[40] **Mr Jones**: Yes, it's one of the sources of information that we consider—

[41] **Jocelyn Davies**: So, the level of complaints is something that would be recorded on your database? I mean, it doesn't seem like there's a radical change from when the Marks report was produced in terms of this idea of collaborating together, sharing each other's information and moving to this sort of early warning system based on risk.

[42] **Dr Chamberlain**: I think I probably disagree with you on that. I don't think we're there in terms of having a full, integrated complaints database that includes all of the complaints—

[43] **Jocelyn Davies**: Well, here's your opportunity, Kate, to tell us what's changed since the report was published. You've given me two examples—okay—

[44] **Mr Jones**: I can give you more examples, if you want—

[45] **Jocelyn Davies**: Yes, well, okay, but what's changed since this report? You weren't doing that before then, were you?

[46] **Dr Chamberlain**: I would say the relationships between—. The cross-referrals between us and the community health councils were not nearly that well developed before because the personal relationships between the chief officers and our relationship managers were not in place. The communication is now much more structured, much more regular, and we do have a better common understanding of the respective roles of our organisations. However, what you are asking me about there is whether we have a big comprehensive database of complaints that we can then data-mine—

[47] **Jocelyn Davies:** Well what I'm asking you is: what's changed in terms of collecting information and sharing information since this report was published?

[48] **Dr Chamberlain:** We now have much more significant flows. We have flows of information in terms of performance from the Welsh Government; we have flows of information in terms of serious incidents that are coming in both from the independent sector and from the Welsh Government, which are reviewed in a different way in order to inform our inspection; we have a significantly enhanced sense of the range of concerns and complaints that are being provided to us and to the community health councils that we have access to, both in terms of framing our plan and deciding where to go but also in terms of framing the plan for the inspection once we have decided where to go so we know exactly what it is that we're looking for.

[49] As well as those issues, we also now have a much stronger bank of intelligence from our own work, which has gone on over the last 18 months, which can tell us what type of things are being learned from, are being responded to, within the health boards. When we come on to the follow-up, one of the things that we will be talking about, for example, is that the hospital inspections that we've done this year are not being focused necessarily directly on the wards that we visited the previous year, but we are looking at that flow of intelligence and that flow of information through so that we can test in our new inspections whether those inspections show that the learning has taken place because, in terms of health board governance, it's not about how an organisation responds to a recommendation in a place; it's about how it ensures that those issues are not replicated across the board. So, it's my view that our work is much more intelligence-driven, but I'm not going to sit in front of you and say there isn't more that we can do, because I certainly think there is.

[50] **Mr Jones:** Can we look at practical examples?

[51] **Daren Millar:** If you can be very brief—. In fact, if you can respond when I bring these other two Members in—it's on joint working, isn't it, Aled? I'll bring you in first and then Jenny. Aled.

[52] **Aled Roberts:** Rydw i eisiau eich herio chi ynglŷn â'r ffordd rŷch chi'n cydweithio efo'r cynghorau

Aled Roberts: I want to challenge you on the way in which you collaborate with the CHCs, because—

iechyd cymunedol, achos—

[53] **Jocelyn Davies:** Hang on, there's no translation. Is it on no. 1? Do you see the little button there?

[54] **Aled Roberts:** Iawn, rydw i eisiau eich herio chi ynglŷn â'r ffordd rŷch chi'n cydweithio efo'r cynghorau iechyd cymunedol achos, rydych chi'n ymwybodol, mae'n debyg, o'r adroddiad o ran yr ymweliadau dirybudd o fewn wardiau iechyd meddwl yr henoed yn y gogledd, yn mynd yn ôl i fis Rhagfyr 2014. Roedd yn rhaid i'r iechyd cymunedol sgwennu at brif weithredwr Betsi Cadwaladr ym mis Mehefin 2015, ac fe gafodd pob Aelod Cynulliad yn y gogledd gopi o'r llythyr yna sy'n sôn am 39 ymweliad gan y cyngor iechyd cymunedol yn ystod y flwyddyn flaenorol. Mae'n sôn nid am brosesau, ond yn sôn am—rwyf eisiau dyfynnu un peth ar ward Gwanwyn:

Aled Roberts: I want to challenge you on the way that you collaborate with the CHCs, because you are aware of the report on unannounced visits on mental health wards for older people, going back to December 2014. The CHC had to write to the chief executive of Betsi Cadwaladr in June 2015, and every Assembly Member in north Wales had a copy of that letter, which mentions 39 visits by the CHC during the previous year. It talks not about the processes, but about—I want to quote one thing in relation to the Gwanwyn ward:

[55] 'The ward was observed to be chaotic and disorganised. The ward environment, whilst clean was generally unkempt. Rising damp was seen as was peeling paint and plaster…Most of the walls were bare…The bedrooms were sparse without any personal touches and in places there were unpleasant odours'.

[56] In fact, in one of the wards, the ward had to be deep cleaned. So, did you get copies of those 39 reports?

[57] **Dr Chamberlain:** We have not been receiving reports consistently from every CHC across Wales, and there have been some issues, certainly—more than one issue—where there have been long-standing concerns within a particular CHC that have not previously been drawn to our attention. On the back of that—because I have said this is a work in progress and relationships are improving; I don't think they're there yet—but on the back of that, I've

been in contact with the chief officer of the CHCs and I've asked him to go out to each of his chief officers to confirm that there are no long-standing issues of concern that have not been previously drawn to our attention. Now, at the moment, the confirmation that I've had is that we are now aware of those issues that the CHCs have been raising on a regular basis with the health boards.

[58] The other thing I would say is that, in terms of our communication with the CHCs, we do routinely share all of our reports with the community health council also under embargo. So, they receive copies of all of our reports. Again, the operating protocol says that they will share their reports with us; this does not yet routinely happen everywhere.

[59] **Aled Roberts**: Felly, a oedd hynny'n digwydd yn y gogledd? Faint o'r 39 o adroddiadau gawsoch chi yn ystod y flwyddyn 2014?

Aled Roberts: Therefore, was this happening in north Wales? How many of the 39 reports did you receive during 2014?

[60] **Dr Chamberlain**: I'm not aware that we received any.

[61] **Mr Jones**: I don't remember.

[62] **Aled Roberts**: So, you didn't receive any?

[63] **Dr Chamberlain**: I'm not aware that we received any. I'm prepared to be corrected when I go back to the office.

[64] **Jocelyn Davies**: You can send us a note if it's different.

[65] **Aled Roberts**: Achos tystiolaeth y CHC ydy,

Aled Roberts: Because, according to the CHC's evidence,

[66] Unfortunately, it has been difficult in many cases to get a prompt response, or in some cases, any response at all to adverse CHC reports.

[67] **Aled Roberts**: A wnaeth y bwrdd iechyd, felly, ddweud unrhyw beth wrthych chi ynglŷn ag adroddiadau, hyd yn oed os nad oeddech chi'n eu derbyn nhw'n uniongyrchol oddi wrth y cyngor

Aled Roberts: Did the health board, therefore, say anything to you about the reports, even if you weren't receiving them directly from the CHC? Was there any discussion between you and the health board

iechyd cymunedol? A oedd yna unrhyw drafodaeth rhyngoch chi a'r bwrdd iechyd a oedd yn dweud bod yna nifer o bryderon ynglŷn â'r wardiau iechyd meddwl i'r henoed yn y gogledd cyn i chi fynd atyn nhw ym mis Rhagfyr 2014?

about the number of concerns about the elderly mental health wards in north Wales before you went to them in December 2014?

[68] **Mr Jones:** I'm not aware of discussion from their side, but I think it's clear from our programme of work during 2014-15 that there was a strong emphasis on Betsi Cadwaladr. During that year—so, this would have started in April 2014—we conducted six large mental health unit inspections across Wales. Three of those were in Betsi Cadwaladr, so you can see that Betsi Cadwaladr is drawing our attention and that we're doing some very thorough work there. In fact, ultimately, as to the escalation of the health board towards special measures, which occurred in a number of stages, the thing that we were bringing to the party, to the tripartite conversation, was that the health board was not responding to our reports, or it wasn't taking the necessary action on the back of our reports, and that we were having to say the same thing time and time again. So, I'm confident that what we did in Betsi Cadwaladr during that period was robust. I can't tell you—. Well, I don't think the health board told us about the CHC reports.

09:30

[69] **Aled Roberts:** Pa wybodaeth rydych chi'n ei derbyn gan y byrddau iechyd ynglŷn â chwynion?

Aled Roberts: What information do you receive from health boards in terms of complaints?

[70] **Dr Chamberlain:** We don't receive much information on a routine basis from the complaints systems that are held by the health boards.

[71] **Aled Roberts:** Why's that?

[72] **Darren Millar:** It's a goldmine, isn't it, of information complaints as part of your triangulation of information, surely?

[73] **Dr Chamberlain:** It is a goldmine. I think it's important to retain a sense of scale for the inspectorate itself, and a sense of its capacity to handle large volumes of data. It might be worth just giving the sense of—. Our research and intelligence team is three and a half people, and they prepare

the inspection packs for every single one of our inspections. They are processing all of the data that is coming into them. I think that what you are flagging up is a really important and really valuable piece of work, but for information to be valuable, it has to be presented in a way that it can be absorbed. That means, in order to address that work, we have got to be able to work with the health boards and, as part of a single project, to think about how that vast array of complaints and information can be analysed, captured and presented on a consistent basis that will enable us to identify the themes, trends and the location of the type of issues. I would absolutely love to do that piece of work. I think you're right; it would be an absolute goldmine, but I think that, at the moment, it would be a significant capacity challenge, and it would need to be taken forward across the whole of the Welsh NHS. Probably, it flows from the Keith Evans report in terms of making best use of that information on complaints. There is a lot of information and data out there that we can use.

[74] **Aled Roberts**: Rwy'n derbyn nad yw hi'n bosib i chi edrych i mewn i bob cwyn, ond yr oedd adroddiad Tawel Fan yn dweud bod nifer o'r teuluoedd yn y ward honno wedi bod yn cwyno i'r bwrdd iechyd am flynyddoedd ac wedi bod yn cyfarfod ag uwch-reolwyr yn y bwrdd iechyd a dim byd yn digwydd. Yr hyn y byddwn i yn ei ddisgwyl yw, os oedd yna unrhyw fath o gwynion, neu batrwm o gwynion, eich bod chi'n ymweld â'r safle. Mae'n rhaid imi ddweud, wrth imi ddarllen adroddiad Tawel Fan, ei bod hi'n anodd deall sut oedd unrhyw arolygwr yn mynd i mewn i'r ward honno heb sylwi bod yna broblemau sylfaenol o ran y gofal a oedd yn cael ei roi i'r henoed yn y ward honno. Y cwbl yr wyf yn ei ddweud yw nad wyf yn disgwyl ichi edrych i mewn i gwynion, ond os oes gennych batrwm o gwynion am nifer o flynyddoedd, nid wyf yn deall sut nad ydych chi, ar yr adeg honno, yn

Aled Roberts: I accept that it is not possible for you to examine every complaint, but the Tawel Fan report said that a number of the families in that ward had been complaining to the health board for years and had been meeting with senior managers within the health board and nothing was happening. What I would expect is, if there was any kind of complaint, or a pattern of complaints, you would visit the site. I have to say, in reading the Tawel Fan report it's difficult to understand how any inspector was going into that ward and not noticing that there were fundamental problems in terms of the care being given to the elderly people on that ward. All that I'm saying is that I'm not expecting you to look at every complaint, but if you have a pattern of complaints for a number of years, I don't understand how you, at that time, don't go in to see exactly what the situation is.

mynd i mewn ac yn gweld yn union beth yw'r sefyllfa.

[75] Yn yr un modd, yr ydych chi wedi sôn am fesur perfformiad o ran y Llywodraeth. Mae yna adroddiad Betsi Cadwaladr arall, a gyhoeddwyd ym mis Mawrth eleni, am adrannau brys. Roedd adran achosion brys Wrecsam wedi methu pob mesur perfformiad yn y flwyddyn flaenorol. Mae hynny'n wybodaeth sy'n cael ei rhoi i Lywodraeth Cymru yn wythnosol. Nid wyf yn deall sut, os oes yna fethiant o ran perfformiad—mae'n sôn am *performance dashboard*, ac mae hyn ar gyfer y bwrdd iechyd cyfan—ei fod wedi methu ar bob mesur.

In the same way, you have mentioned the performance measures in terms of the Government. Now, there's another Betsi Cadwaladr report, published in March this year, on emergency departments. The Wrexham accident and emergency department had failed every performance measure in the previous year. That information is given to the Welsh Government on a weekly basis. I don't understand how, if there is a failure in terms of performance—it talks about the performance dashboard for the entire health board—it has failed on every measure.

[76] **Mr Jones:** I can certainly talk about Wrexham.

[77] **Dr Chamberlain:** I was going to say, 'Do you want to do Wrexham A&E?'

[78] **Mr Jones:** I can't remember the exact date, but towards the end of 2014, certainly—it would have been autumn 2014—we inspected Wrexham A&E. We wrote an immediate assurance letter to the health board because we were concerned about whether the levels of activity could be sustained. We felt that staff were under pressure and we felt that patients would potentially come to harm if the conditions there persisted. So, we wrote to the health board. This is part of our standard processes: to feed back at the end of the inspection our concerns, but also to write to them to formalise that within two days so that it's on the record that we are concerned. Obviously, the health board was under different leadership then, but we weren't satisfied with the response that we were given. We didn't feel that it was adequate, and we wrote to the health board, in total, three times in order to secure the assurance that we needed. Their answer wasn't robust enough. They were not giving enough evidence to us of, for example, working with the Welsh Ambulance Services NHS Trust to reduce the flow of patients into the

department. If that was becoming a problem, we felt that, clearly, you can't just keep receiving patients if you run out of resources and the department is full.

[79] So, I think we did a very thorough piece of work there in terms of bringing that to their attention, bringing it to the public's attention and being dogged and determined to get the right response from the health board, and to make them understand that we couldn't be fobbed off with a simple, 'Yes, we accept your recommendations and we've done something about it now'.

[80] **Darren Millar:** Okay. Jenny.

[81] **Jenny Rathbone:** I have real concerns about the agility of your organisation, starting with your website, which still hasn't been revised one year after the Marks report, which is a pretty straightforward thing to do—you just bring in somebody who knows about websites. But, I think, listening to the conversations you've just had with colleagues the other side of the table, I'm concerned that (a) you're not getting the data you should be getting, and if you're not getting it, why aren't you going out there to demand it? But, (b) it isn't about duplicating the work that's been done either by CHCs or by health boards; it's about using that data to analyse. The most important question is: are organisations learning from when things go wrong? Because if they are, then they're organisations that are keen to improve, but if you aren't even asking that question, because that is the key question, it seems to me, for your organisation—. You can't stop things going wrong occasionally, but does the organisation learn from it? Is it a learning organisation? That is the key data that was missing from the list you gave, Kate, and which I didn't hear. That's one question.

[82] The second question is really about your strategic role to ensure that clinicians are operating according to the National Institute for Health and Care Excellence guidelines, because it isn't your role to examine complaints; your role is to ensure that the health service is fit for purpose. So, on those two points, I wondered if you could just give us some idea of what you are doing.

[83] **Dr Chamberlain:** Can I go in first and you can come in after? In terms of the learning, I think it might be worth starting from looking at how our inspection regime has changed from last year to this year. So, last year, if you look at just our hospital inspections, we did 50 single ward visits. On the

back of those 50 single ward visits, if I was going to come out with one key conclusion, it would be that services are very inconsistent. For me, it's the inconsistency of services that is a key challenge for health boards.

[84] We've published quite a lot of thematic analysis of the work that we did; we published a summary of the work on GPs, a summary of the work on dentists and a summary of the work on dignity and essential care. We published annual reports for each health board and, coming through all of that, one of the key themes is this one about inconsistency.

[85] So, this year, rather than going back and doing these 50 site visits—dip in, dip out, let's give us the coverage to see what's happening—we're going in and we're doing hospital inspections. We're calling them hospital inspections, but actually they're more like mini-thematics. So, we will, for example, go in and look at women and children's health within a health board, and we will visit a number of different sites and a number of different settings. During the course of those inspections, we will look at the type of issues that we raised previously to find out whether we are still finding those issues within other services, because that, for me, is a key test of the extent to which an organisation is learning, improving and making sure that issues that are identified aren't replicated elsewhere. So, that, for me, is the key one. Alun, did you want to add anything to that?

[86] **Mr Jones**: It was just to say that, in our inspections this year—the hospital inspections that Kate has just been talking about—what we do is we look through our reports from last year. Let's say, for example, we're going to the Royal Gwent Hospital. We will look through our inspections for Aneurin Bevan last year to see what we recommended, and when we're at the Royal Gwent this year we will look to see whether those recommendations have been implemented in different settings, so you wouldn't go back to the same ward necessarily—you might go back to the same ward, but if we're looking at other wards we would seek to confirm whether or not the health board has learnt from our inspection last year and dealt with that issue across the whole health board and not just in the single ward that we visited last year.

[87] **Jenny Rathbone**: So, you are inspecting whether or not the learning has been embedded.

[88] **Mr Jones**: Absolutely. Yes. The other important thing to add—Kate mentioned that we have a relationship manager for each health board. Relationship managers aim to attend quality and safety committees at health

boards and that does give us an insight into what the health board itself is talking about and we would expect there to be reference there to complaints, concerns and what they're learning. I guess, in the case of Tawel Fan, if there is a lack of transparency around the fact that lots of patients and relatives are complaining—if that doesn't come through the internal systems and it doesn't get discussed at a quality and safety meeting or in other fora, which we can take papers from and so on, then it is difficult for us to know if, you know, something is being—. I'm not saying it is being supressed, but you could understand that a health board may choose not to talk publicly about the issues that it's dealing with.

[89] **Jenny Rathbone:** Well, I still have considerable concerns. It shouldn't take 50 ward reports to know that there are inconsistencies of services; we could've told you that, because ever since I came here in 2011, there's been a huge amount of evidence on this. I still don't understand, when you do a service inspection, how are you knowing that people are operating according to NICE guidelines?

[90] **Dr Chamberlain:** Can I answer that? Before we go out and do an inspection, we make sure we know what we are looking for and we make sure that we know what represents best practice in the areas that we are inspecting. The other way that we do this within the context of our inspections is we have a panel of specialist peer reviewers who come in who are experienced in that particular area. So, we expect them not just to be looking specifically at the questions they've been asked to look at within the inspection, but they also have a wider professional antennae.

[91] So, stakeholder reference groups that we have will make sure that best practice and recognised best practice is embedded in the inspection methodology that we have, and the professionals that we bring in will make sure that there is the right degree of professional challenge in terms of what's acceptable and what's not, so that they can flag up things that they are relating to.

[92] **Jenny Rathbone:** Local specialists will be briefing the team on 'These are the things that don't appear to be compliant'.

[93] **Dr Chamberlain:** Yes. They are an integral part of the inspection team; they are there on site, they are looking at practice and they are briefing the inspection manager in terms of what should and shouldn't be highlighted in the feedback at the end of the inspection for which, if there is something of

significant concern, we would issue an immediate assurance letter, or whether there are other things that should be raised with the health board in terms of the practice that we see. We also have other referral mechanisms. So, if we saw practice that we thought was unacceptable or practice that we thought needed to be moved on, or we spot issues that we think are NHS-wide issues in terms of awareness or practice, we can raise those with the Welsh Government. Of course, then the chief medical officer or the chief nursing officer can make sure that they are going out to their peers and taking that forward.

[94] We are also at the national quality and safety forum, where, again, there are representatives from each of the health boards, and a number of medical directors attend. We have opportunities to raise issues at the national quality and safety forum. In fact, I gave a presentation to them last month in terms of generic themes coming out of the issues in the inspections that we've undertaken.

[95] **Jenny Rathbone:** Okay. So, these specialists on your teams ought to be able to ensure that you don't miss key issues, but how come that didn't work in the case of Betsi Cadwaladr, then—with Tawel Fan's 39 reports et cetera? Clearly, best practice was not being operated.

[96] **Darren Millar:** Perhaps in responding to that as well—you did mention the fact that there are inconsistencies from one ward to the next earlier on, and yet you're going back to inspect different wards rather than the ones you found the problems on. I think that was what you said. We do know, particularly in north Wales, that we had some very good practice and some very bad practice literally next door. So, how do you overcome that to make sure that you are actually revisiting the places where there was bad practice, where there are pockets of really poor culture that aren't being dealt with and addressed?

[97] **Sandy Mewies:** Can I add to that?

[98] **Darren Millar:** Of course.

09:45

[99] **Sandy Mewies:** One of the things that's puzzling me slightly is that you're saying—and we've identified ourselves here—that there are inconsistencies in health services throughout Wales—all sorts of them. But

what you seem to be doing—and I might have this wrong—is you have an issue in one area and you then talk to people about what you should be looking at, but there is some basic benchmarking that you must do, surely. I mean, if you go into a dental practice, I would have thought you'd be looking at the hygiene, for example, or the basic cost of an inspection, but I'm not clear how you're doing that because in every inspection, whichever organisation you are, you do need to have some sort of benchmarking that you know that you have that expertise within your own organisation. Now, you say you've got clinicians and so on doing this. It's the backstop—. I just can't get what the backstop is here. So, you go to all these people—or different people, stakeholders—and say, 'Well, what should we be looking at?' Presumably you're responding—. I'm not even clear what you're responding to. Do you tend to respond only to complaints or are you doing regular inspections to see that things are working as they should be?

[100] **Darren Millar**: Okay, we've slipped slightly away from where we were, but we'll come back to that in a second, Sandy, because I think it's an important point. But this issue of inconsistency and revisiting and wanting to make sure people have learnt from problems you've identified—. If you're going back to a different place, how do you know?

[101] **Mr Jones**: It's not our intention to go back to a different place, if I could just clarify that. So, if we did an inspection and there were significant concerns, there is a process we follow to track whether the health board is taking action, and some of that has to be them telling us what they've done and whether we feel assured by that, but we also retain the right to do a direct follow-up and to go back. And we have done that and we do do that. There are examples where we've gone back to the same ward. There were probably about four or five non-mental-health follow-ups last year in the NHS. I think, in the case of Betsi Cadwaladr, we are going back to the same units repeatedly. I can't think of the name of the unit, but, as I said, last year, we did three inspections. I think the year before we did a couple. So, they are very much on our radar, Betsi Cadwaladr, the three main mental-health units—

[102] **Darren Millar**: What you're saying is that it's not routine to revisit the same place. You're saying this is an occasional thing, really, aren't you? It's more routine to actually go back to a different place but it's part of the same service—

[103] **Mr Jones**: I'm saying we would take the opportunity—. If we're going

back to anywhere in the health board, we would take the opportunity because it makes sense to look at what we've said before anywhere else in the health board and just see whether that's a problem there as well. If we felt that there was a risk there and the health board hadn't taken action and there were patient safety issues, then we would go back to the same location again. I think the other thing I would say is that, in 2013-14, we did 127 inspections as a total as an organisation and since the Ruth Marks review and the changes we've made, we've done 351. So, we've doubled that and we're going to exceed that again. I think if you're doing 351 inspections a year, you can't follow each of them up every year because—is there an exponential growth in what you've done before, and can you test and check it again? So, we have to do that in a sort of measured way and we have to consider where we think there might be a failure or a continued problem.

[104] **Dr Chamberlain:** Can I step back a bit? We seem to be getting a lot into the very specifics of HIW, and I think it might be helpful to set us within the landscape a little bit. What's quite helpful about Ruth Marks's report is the way she articulates the various layers that need to be there as part of the assurance system. So, she talks about the first-tier being very clearly the professionals. The professionals themselves have to be responsible for their own practice, they have to be responsible for others' practice, and they should be flagging up issues and concerns where these arise, and they need to be surfaced properly. So, the best way of being everywhere all the time is through the eyes and ears of those professionals who work within the services. The next level clearly has to be the role of the health board in providing assurance. So, we go in at the first level and we look. We sort of almost dip into particular services to find out whether what we are seeing on the ground reflects, based on our knowledge of that organisation, what we would expect to see in terms of the standards that they are expecting.

[105] We also then, at a health board level—we expect the health board to have proper governance and assurance systems in place for them to be sure that they are providing a consistently good quality of service, that they are responding to concerns and issues and learning from them. And we use a whole variety of mechanisms through our work to test the extent to which that is actually happening. There is then a tier, which is that the Welsh Government performance manages the NHS. It has a vast array of performance information available to it. We would not try and replicate that performance management role of the Welsh Government; it's important that they are using it and are intervening. They have a delivery unit, which is there to support, assure and intervene where there is a case of failing services.

Again, it is really important that we do not try and duplicate and redo the role of the Welsh Assembly Government, but it is also really important that we do talk to the Welsh Government. We know what they're doing, we know what they're finding, we know who has sight of which issues and what they are doing on them. If we find issues and are sort of dealing with something sort of quite contained—if you look at the work that we did in GP practices, we found there was a significant ongoing issue with the quality of discharge information that we felt was replicated across Wales. It wasn't specific to a particular organisation or a particular body, and it was really important that that was addressed. That was an issue where we then referred that on to the Welsh Government as part of their role in terms of the NHS. So, there is a cross-referral of work there.

[106] There are then the community health councils, and there clearly is the patient voice and the patient representative. They have a view through their advocacy work. We are on a journey with the community health councils, but those relationships are developing and we are finding that we are able to share a lot more information with them. I wouldn't say that we're there yet. I'm not going to say that we've got it all perfect yet. But they look at things very much from the patient view, and they are using lay members to go out and do lay inspections. We then come through and we use integrated inspection teams, which include a lay component. They include our specialist professional peer reviewers to look at specific issues where we feel there is a need to focus on them.

[107] Part of that risk is that we cannot always focus the capacity that we've got on those areas where we know there are problems, because the NHS in Wales is very broad. There are a number of organisations. We cannot be there all the time. If we know those issues have been highlighted and there are others who are dealing with them, we expect them to get on with dealing with them. We cannot have other areas that are never inspected, which is why, to an extent, looking at risk and the way in which we focus our resources is as much an art as it is a science.

[108] In terms of that specialist input, and to sort of pick up on some of what you were saying, Sandy, we have specific inspection tools that we use to inform our inspections. When we are putting those tools and that guidance for inspectors together we will bring together a group of relevant professionals from the royal colleges and from practising professionals to make sure that we are drawing on best practice and that we're not out of date and that we are looking for the right things. Once those tools are there,

we will bring together these integrated teams so that it isn't a tick-box exercise against those prompts, and it enables relevant professional clinical judgment to be applied to say, 'Well, it may look like it's all right, but actually there are these nuances and those things'.

[109] So, we are part of that assurance system, and we will feed into every layer of that assurance system. But we are not everywhere. We cannot be everywhere, and we cannot follow up on every individual recommendation or every individual inspection that we do because we simply don't have the capacity. That's why we are trying to do so much more in terms of drawing out the themes and issues from what we do and referring on to other bodies, cross-referring with other bodies, so that we can make the best use possible of the capacity that exists in that landscape. I'm not sure how much that helps, Darren.

[110] **Darren Millar:** It does help. It puts a bit more meat on the bone, but can I just ask two very specific questions arising from that? Obviously, if we take the example—. Betsi has been a little bit of a case study as part of this governance inquiry, as you might imagine. Assembly Members were raising concerns about Tawel Fan on behalf of their constituents—many of us around the table here—for a long time before that particular unit was closed, and before it became a focus of attention, if you like, from other organisations, yet your systems don't appear to try to attempt to capture the views of Assembly Members on issues that are emerging in their own casework, for example, which may help to point and form part of a useful intelligence-gathering exercise for your inspectors. Is that something you think might be helpful in the future?

[111] **Dr Chamberlain:** I would like to encourage Assembly Members to bring matters to our attention. I would find that really, really helpful, but I'd also like to encourage members of the public to bring matters to our attention. We have a slightly confused message to the public, and I think that's something that Tony Rucinski and I are keen to address, which is that it's very difficult to encourage members of the public to raise their concerns with us and then go back and tell them, 'But we don't investigate individual complaints.' That's a really challenging one. But, actually, by managing a joint message between our two organisations, I think we've got something quite compelling there that we are talking about.

[112] **Darren Millar:** But, of course, you're also not entirely independent from the Welsh Government, and Assembly Members were writing to the

Welsh Government with their concerns, because they were not satisfied that the response from the health board in the Tawel Fan case was entirely satisfactory. Was that intelligence not shared, the ministerial correspondence, with you, from Assembly Members, in order to draw attention to a very real issue that was unfolding on the ground in north Wales?

[113] **Dr Chamberlain**: I'm not able to comment on what was happening at that time, because I wasn't—

[114] **Darren Millar**: Can you find out?

[115] **Dr Chamberlain**: I can certainly find out what had been shared. I know now we do get copies of ministerial correspondence; we do get issues that are referred to us by the Welsh Government, saying, 'We have received this correspondence. Please can you tell us what is being done about this, or what is not being done about this?' But that doesn't prevent you as AMs writing to us directly.

[116] **Darren Millar**: So, just to get this clear: the Welsh Government can, but are not required to, share copies of ministerial correspondence where concerns are being raised by Assembly Members with you.

[117] **Dr Chamberlain**: I couldn't tell you whether they are required to—

[118] **Darren Millar**: I mean, as I say, you're a slightly different inspectorate to other inspectorates, in that you are part of the Welsh Government. You're not entirely independent in the same way that Estyn and others are.

[119] The second question, if I may, is about your resources. You've made a number of references to the capacity of your organisation to do the follow-up work and to undertake further work on inspections. Are you adequately resourced?

[120] **Dr Chamberlain**: I've also tried to set out the landscape that we operate in, and there was quite an intensive conversation about this, I think, previously when I came before the Health and Social Care Committee. It would be very difficult for me to sit here and say I would not like to do more, but, by the same token, I am not the only part of the assurance landscape, and I think what's really positive is that the Green Paper provides an opportunity to have a proper consultation and a proper consideration of what

that landscape should look like. For example, I've referred to the fact we do quite a small GP inspection programme—I think 28 GPs this year; there are 400-odd GP practices out there. It's going to take us a long time to get through them all. But there's also a question mark about what value it would add. We are doing quite a large dental inspection programme, because we've agreed it specifically with dental policy within the Welsh Government, and we've been picking up the inspection regime from another service. So, it was important to get a good baseline in terms of what's going on in practices out there.

[121] But there is more that I'd like to do, in order to be able to—. One of the benefits of moving to hospital inspections is they're also more efficient and more cost-effective, and, actually, picking up on some of the conversations that we've had around the room about really focusing, maybe we don't need to do routine programmes, and we should focus almost entirely on a thematic basis to give us good coverage of settings and particular themes. But that's a conversation that I'm quite happy to have. I think, yes, I could do more.

[122] **Darren Millar**: You could do more, but are you adequately resourced to do what you're doing at the moment?

[123] **Dr Chamberlain**: I think the big challenge that we have at the moment is resilience. Because we are a small organisation, because—

[124] **Darren Millar**: Just a 'yes' or 'no' will do. Are you sufficiently resourced to do what you're required to do at the moment, and to do it well?

[125] **Dr Chamberlain**: There isn't a 'yes' or 'no' answer to that, because—

[126] **Darren Millar**: I don't like to make you uncomfortable, but I'm just asking whether you might be able to give us a 'yes' or 'no' answer. It would be helpful to the committee.

[127] **Dr Chamberlain**: Am I adequately resourced? I think the answer to that would have to be 'no'. I would like to do more.

[128] **Darren Millar**: Okay, thank you. Julie wanted to come in, and I'm going to come to Oscar then.

[129] **Julie Morgan**: It was about when we were discussing inspections. When

would you do an unannounced inspection? What are the criteria for doing an unannounced inspection?

[130] **Mr Jones:** The first principle in terms of answering that is that we would always want to do an unannounced inspection. So our starting point is 'We're going to do an inspection, why wouldn't we?' But why would we announce it? There seems no reason to announce it. So, all of our hospital inspections are unannounced. The kinds of inspections we do announce are GP inspections and dental inspections, and some of the independent sector that we inspect, including organisations that use lasers. Our criteria, really, are around the size of that organisation. If it is going to be disruptive to do an inspection, if that's going to impact on the customers or the patients, then we wouldn't—we would announce, sorry, just to be clear.

10:00

[131] So, you can have some very small organisations with just one or two people working there, and if you turn up unannounced, you would stop people being treated or receiving the service that they're there for. But in the scale of things, the hospital inspections that we do are about 95 per cent, 99 per cent unannounced.

[132] **Julie Morgan:** So, your aim is to always be unannounced and there's a specific reason for announcing.

[133] **Mr Jones:** Exactly.

[134] **Julie Morgan:** That's the way you actually work. So, that depends on what we've been discussing today, about picking up where to go, really, in many ways. I'm particularly interested in the primary care inspections. Is that a new move, to do the primary care inspections?

[135] **Mr Jones:** I think it was about 18 months to two years ago that HIW committed to following up on the Robbie Powell case, which I'm sure you're all familiar with. I think initially that piece of work was a desktop exercise, finding out information from different sources to establish whether or not there had been learning from the Robbie Powell case, which dates back some years. After that, we felt that there was a real need to actually go and have a look at some of these services, and since then, our advisory board, the board that we take advice from strategically for HIW, has also endorsed the need to look at primary care services, because for many people it's their first

experience of healthcare, and it's the first rung on the ladder of the care they're going to get. If you don't get that right, then the consequences can be significant. So, it followed on from the Robbie Powell case and the need to assess whether or not practices had learned. But this year we've adapted our approach slightly, so having established that, we've adapted our approach to be more comprehensive—in fact to look at more aspects of the way that kind of care is delivered.

[136] **Julie Morgan:** I think you said, Kate, that you'd learned from the primary care inspections of GPs that there were issues to do with discharge.

[137] **Dr Chamberlain:** Yes.

[138] **Julie Morgan:** I don't know whether you could expand on that. Also, you've obviously been visiting dental practitioners as well. Could you tell us what you've learned from the dental practitioners and inspections?

[139] **Dr Chamberlain:** Do you want to take that?

[140] **Mr Jones:** Sorry, what was the first question—about primary care and discharge?

[141] **Julie Morgan:** Yes, and what you have learned.

[142] **Mr Jones:** Okay. So, both through our inspections, but also through concerns information that comes into us from professionals and from patients, we have heard that there are examples where, on being discharged from a hospital, the information that flows back to the practices is inadequate in a number of ways. So, that could be as extreme as the patient's name being missing from that documentation, or not adequately describing the care they've received in the hospital, and what needed to be followed up now that they're back at home or somewhere in the community. So, we had a number of examples where that communication was just inadequate, and that's something that we summarise at the end of our inspection programme into a report covering a number of issues. We took that to our—we have a stakeholder group, which includes the BMA and other interested parties, and they said to us, 'Look, the quality of discharge information is something that's been going on for 20 or 30 years. Professionals in the service know about it. Everyone knows about it. What are you going to do, HIW?' It was a fair point, and we felt that we needed to ask that question of Welsh Government, so we wrote to Andrew Goodall and we

set out the evidence from our inspections, and also the strong views of the steering group.

[143] **Julie Morgan:** And has there been a result?

[144] **Mr Jones:** Well, what you have to say, I think, is that it's a problem that's prevailed for 30 years. It isn't going to be fixed overnight, so you have to be realistic about that, but the response we had was to acknowledge the issue, which I think is the first step to solving it, and Welsh Government, I understand, have been looking at how they can move to a quicker roll-out of an electronic patient record system. I think it's piggybacking on a pharmacy system that they have that can ensure that that communication does happen, and there's an audit trail for it. Also, they gave us a response that sought to get the buy-in of the medical directors for each of the health boards, and we were told that those medical directors have committed to looking locally at what can be done to train doctors and improve. There's the electronic side of things, which is about whether it happens in the trail, but there's also the quality of the information, which could be an issue, regardless of whether it's electronic, or not. So, it was a good answer; it was an answer that didn't suggest that things could be fixed soon, but I feel that, having raised it, it has increased the pace at which Welsh Government is working towards a solution.

[145] **Julie Morgan:** In terms of actually seeing whether progress is being made on the solution, will you be then looking at what evidence you're receiving to show that?

[146] **Mr Jones:** Absolutely. We continue to have a programme of GP inspections this year, so we will be looking at that and we will pick up on whether or not discharge information has improved in any way. Because we have a broad array of work, we can also look at that from the delivery end as well. So, when we're in the hospitals, we have the ability to look at the mechanisms there for producing that kind of information. So, we have the ability to do that in the future.

[147] **Julie Morgan:** If I could just, Chair, ask about dental practices. What have you learned from the inspections of dental practices?

[148] **Mr Jones:** We produced an annual thematic report on this a few months ago. What we've learned is that the majority of dentists are operating in a safe, effective way, but there are some who are not as aware of the

regulations as they should be. We found a small number of examples where decontamination issues have existed, and cleanliness issues, which clearly is worrying. There has been a case in the news recently, which I'm sure you're aware of. In those examples, if it's a private-only dentist, we have the facility to take enforcement action or to remove their registration so that they can't practice. But, I think what's encouraging is that, in the examples where we have found problems with cleanliness, I can think of two examples where dentists have voluntarily closed whilst they resolve those issues. So, it could be an issue of flooring in the practice that may promote the growth of bacteria, or something like that—old infrastructure and estate. I can think of one dentist in particular who completely refurbished their practice, or the clinical end of the practice, in order to meet the regulations and in order to reopen. So, I think our presence has acted as a catalyst for those kinds of conversations about whether you should be operating at all.

[149] **Julie Morgan:** So, if a practice is mixed NHS and private, you have a different role then, do you?

[150] **Mr Jones:** Well, yes, it's a difficult one, because we could stop them operating privately, and—

[151] **Julie Morgan:** Has that ever happened?

[152] **Mr Jones:** It hasn't had to happen yet, because they've voluntarily closed for whatever period it takes them to bring themselves back to a standard. But, we have very close contact with each health board and the primary care leads within the health boards, and we will always flag up an issue to them. Whether it's private or mixed, or if it was solely NHS, we would always let the key people in the health board know, because more often than not, it is the health board's money that is paying for the care in that practice, regardless of whether it's private, in terms of the way it's commissioned.

[153] **Darren Millar:** Mohammad Asghar.

[154] **Mohammad Asghar:** Thank you very much, Chair. Thank you very much, both of you, Alun and Kate. The thing is, in my own constituency office, every next complaint is about the NHS and the service people get, where the standard they receive is so diabolical—that's the word I'd use—it's seriously concerning and really alarming. The thing is, you are saying you have got to maintain standards in the NHS delivering services to the patients, but the fact is that what we get is that you're playing judge and jury,

employing people to judge their own standards—the dentists, doctors and clinicians themselves. I think that is not right. You should be having some sort of independence to check the standard of NHS services. That's one. You are paying serious money. I appreciate the number has increased from 33 to 202 lay inspectors, paying them £250 a day. That's serious money. That should be paid to some people who are really—. That's one.

[155] Secondly, if you travel by train and plane, the quality, if they want to improve in certain public services—they normally give you cards and, at the end of the journey, you have to write your comments; why can't you observe that? It's much cheaper. You get from patients their views on how they have received their treatment in the hospitals and save a lot of money. So, those sorts of areas. I haven't had time to look through it yet, but I personally think our constituency offices are inundated with complaints, whether it's dentists—they're decaying—hospitals; they are really in a different shape. You name it: any area, it's not delivering.

[156] **Darren Millar:** Two issues there: in terms of capturing patient experience, and also this risk that professionals will look after each other, really, as part of that framework. Can you just respond to those issues?

[157] **Mr Jones:** So, in terms of the—. The patient experience always forms a key part of our reports, and, consequently, our inspection work. We will always speak to patients; you will see that feature in our inspection reports. One good example, I think, I've got is that, a couple of months ago, we did an inspection in the ABMU health board. Approximately a month before that inspection, we sat down with the community health council and we asked them if we could go through their database of information on what patients had told them. So, we had that initial conversation in order to focus our inspection. So, we could determine within that—health boards are big organisations—which hospitals we should go to, and which wards we should look at. So, we had that conversation, and, having taken that into account, and lots of other factors about where we might go, about a week before the inspection, we again contacted the CHC and said, 'Okay, we've considered all these things; this is where we're going to go. Is there any specific information that you hold about those wards that we need to be aware of when we go in?', in order to follow up the concerns that the CHC might have. So, I think that's an example of how you can track that through, and then, when you get there, we would always speak to patients. I hope that helps to answer.

[158] **Dr Chamberlain:** The issue about clinicians always looking after each other I don't think is right. And also to remove that, in terms of the clinical input that we have to our inspections, the clinicians that are on ours are removed from any conflict of interest, so they won't be in their local areas working with their local peers. So, there is an independence in terms of the scrutiny of what's going on with the service, but it's also important to recognise that, yes, the complaints and concerns are an important focusing tool to identify where things might not going be right, but they're also a very small subset of the entire number of people who are having interactions with the NHS every day. So, yes, we have to use them to focus, but they're not an entire picture in terms of the quality of services that's being provided.

[159] If I can draw, for a moment, on a personal anecdote, I'm thinking of an encounter that I'd had with the service in England recently, where I'd provided some direct verbal feedback to the management of that particular area, because the service that we'd had was very good in part and very bad in part. And, actually, it's important that feedback is balanced, because focusing on the negative can demoralise and can demotivate, and can cause as many problems as it helps to solve. So, you need to get that balance in terms of the perspective of the services that are out there. There is a lot of good work; there are a lot of staff that are working very hard and providing very high standards of care, and, actually, they are, very often, as disturbed and upset and demotivated by the poor things that can happen as the patients themselves. If you can deal with that feedback in a balanced way, it is a way of helping to improve services.

[160] **Darren Millar:** Okay. Thank you. Mike Hedges.

[161] **Mike Hedges:** Can I carry on with primary care, and then I want to go on secondary care after? On primary care, I don't get many complaints, but almost all of them are about booking appointments, especially from people with hearing loss. Telling somebody with hearing loss—either complete, or a small amount of hearing loss—that they have to phone up at eight o'clock in the morning acts as a severe barrier. Last week, when I was at the launch of a deaf organisation's manifesto, a lady there made the point that she cannot phone the doctor at eight o'clock in the morning because she can't hear what they're saying the other side. Have you come across that and have you made any recommendations?

[162] **Mr Jones:** Specifically in relation to hearing?

[163] **Mike Hedges:** Yes, specifically hearing.

[164] **Mr Jones:** No, I don't think I have come across that. I think we've probably got examples where there's been an absence of induction loops to aid people when they're in the practice, but not through phone calls, I don't think. Certainly, in dentists, one of the things we look for—if we're talking about that kind of primary care, we would look for the ways in which the practice communicates with the public, including websites, the size of the signs outside saying who the dentists are and things like that.

[165] **Mike Hedges:** I will write to you specifically, but the booking of appointments is probably over two thirds of the complaints I get. The other thing is, you're looking at primary care, are you looking at polypharmacy in primary care? Everybody has their own little bugbears, and polypharmacy is mine. Are you looking at polypharmacy and the effect of it? We know all drugs are tested, but they're not tested in conjunction with 97 other drugs—quite literally, nine or 10 other drugs—when they're tested, and that can have a health effect. Do you look at that?

10:15

[166] **Mr Jones:** I don't think we have looked at that, but I'd be happy to consider it.

[167] **Dr Chamberlain:** No, I don't think we have looked at it. I'm just trying to think—we've had 36 responses to our strategic plan on issues that we should look at in the future. And, by all means, write to us, because it then becomes part of the long list of issues that we can consider.

[168] **Mike Hedges:** But it's not abnormal for somebody to take 10 or 12 different tablets, and I have concerns about that, which leads me on to my final question. You've got four domains, and one says 'effective service'. As you know, Dr Keogh said that, in England, about 10 per cent of interventions did no good, and I know that some doctors are investigating. The Welsh health service has said between 10 and 15 per cent either do no good or actually do harm. Are you looking at interventions that don't do any good? There'd be a huge saving to the national health service in Wales if interventions that did no good were actually stopped—never mind those that do harm. Are you looking into those areas, because that, to me, is one of my major areas of concern?

[169] **Dr Chamberlain:** Again, it's not something that figures on our list of forward issues that could potentially be looked at. By all means, write to us—it's something we can certainly consider. I'm just thinking, if there's a value-for-money dimension to it as well, certainly we work closely with Wales Audit Office colleagues, so there may well be something that would be considered as part of their review programme.

[170] **Mike Hedges:** The Wales Audit Office have actually produced a report—I don't know whether it's in the public domain or not—about interventions that were not—

[171] **Darren Millar:** It is in the public domain.

[172] **Mike Hedges:** It is. About interventions, where they, again, talk about fairly substantial sums of money. Are you aware of that report, or are you going to become aware of it?

[173] **Dr Chamberlain:** Personally, I'm not aware at this moment, obviously.

[174] **Darren Millar:** Okay, thank you. Sandy.

[175] **Sandy Mewies:** Thank you, Chair. I want to talk about targets, but I still want to refer back to some of the things that have been discussed. First of all, how do you prioritise your work? Because the health service is huge—and I do appreciate that the areas are vast. I mean, the difference between primary health care and secondary health care, dentists, doctors, pharma, et cetera, et cetera. But, of course, one of your purposes is to provide the public with independent and objective assurance of the quality, safety, and effectiveness of healthcare services, and make recommendations, and that's Wales wide.

[176] The Chair asked you did you feel you were sufficiently resourced, and I understand, Dr Chamberlain, you don't want to say—. Everybody would like extra staff, if you were asked, of course. If somebody said to me, would I like extra staff, I'd probably say 'yes'. So, how do you prioritise work, because your remit seems very wide and varied? So, on top of that, do you think it's time now to look at your remit, and exactly what you should be focusing on? Because 351 inspections in a year, it's nearly one a day, almost, isn't it? You must have Christmas and New Year's Eve off, or something like that. That's an awful lot of inspections. How many people do you have on your inspection teams, and how long do they spend during an inspection?

[177] **Dr Chamberlain:** On—

[178] **Sandy Mewies:** Can I just—? Because I think this is all part of the same package. I'd like you to go back to your own—. Your key areas are looking at healthcare organisations in Wales, looking at standards, policies, guidance and regulations. So those are your benchmarking issues, presumably, then; that is your bog-standard benchmarking, before anything else comes in—if you can confirm, or not, that. I think Mohammad Asghar mentioned lay reviewers. You've decided not to pay lay reviewers. Is that a cost issue? And you said, Mr Jones, that you're recruiting reviewers now, and they will be volunteers from now on. [*Interruption*.] Yes. How well is that recruitment going and, given that you seem to be strapped for people, do you think that you're going to get sufficient voluntary reviewers to replace the lay reviewers who are being paid now?

[179] Going on to targets, your verbal feedback—you know, probably two hours of inspection—

[180] **Darren Millar:** I'm just thinking, Sandy, perhaps if we give them the opportunity to respond briefly and then we'll come to the targets.

[181] **Sandy Mewies:** Okay. I think the problem is that it's all linked in.

[182] **Dr Chamberlain:** Okay. I'll do something on resources, expectations and the scale of our inspection team. I'll ask Alun to talk a bit about the prioritisation process and how we go about putting our plan together. Then I'm happy to come back on the lay reviewers bit and part of the rationale for why we've made the move on the lay reviewers and then you can come back with anything that you think we haven't covered within that.

[183] The reason I had so much difficulty answering Darren's question about, 'Do you have adequate resources?' is because I don't think it's a complete question. I think the question is, 'Do you have adequate resources to meet people's expectations of you?, and I think, in that context—

[184] **Darren Millar:** No, no. I'm sorry, my question was: do you feel that you have adequate resources to do the job that you are required to do? That is the question I asked you. So, you have a task to perform, which you are commissioned to do by the Welsh Government: do they give you enough money to do that work?

[185] **Dr Chamberlain:** Okay, so—

[186] **Darren Millar:** And you responded—you did respond—and said, 'no'. Now, if you want to—

[187] **Dr Chamberlain:** Let me expand a bit on that then.

[188] **Darren Millar:** Please, but not for too long; I don't want to labour this point.

[189] **Dr Chamberlain:** Doing what's required of me, I think, is about doing what is expected of us, and I think you've quite rightly flagged up that the NHS is a very wide body. So, if the expectation is that we will be in all of these places regularly and following up on every inspection, then, no, we certainly don't have the resources to do that. However, we need to have that conversation, quite rightly, as you say, about what specifically is our remit and what is our role.

[190] Ruth Marks's review was partly predicated on the need to review our role, and what she concluded was, actually, that our role is quite coherent. The various functions that we have—whether they are the responsibilities for general assurance of the NHS, for regulation and inspection of the independent sector, or our specific responsibilities under the Mental Health Act 1983—do form part of a coherent whole. So, our remit, as articulated, in effect, is coherent and it is the right sort of remit.

[191] Obviously, there are—. The landscape—. I make no apologies that I keep coming back to the landscape, because the landscape is quite complicated. The Public Health (Wales) Bill, for example, is talking about, potentially, the registration with local authorities of a number of other services. But, potentially, the registration of tattoo parlours will then overlap with the work that we may do with those tattoo parlours that have lasers in the back office—

[192] **Sandy Mewies:** I think we're talking about the here and now.

[193] **Dr Chamberlain:** Yes, but it's important to think about how all of these bits fit together in terms of the expectations of us. I'm not uncomfortable with the remit that we currently have.

[194] **Darren Millar:** Are you uncomfortable with the resources that you currently have?

[195] **Dr Chamberlain:** I think, in order to do that, I could definitely make a case for being able to do more within that remit. So, it's probably worth—you asked about inspectors as well and how many people we actually have—giving you a sense of our size. There are 60 posts within the organisation in total. So, of those, if you think about how they break down, four of those are with the local supervising authority for midwives, which is a specific self-contained ring-fenced function. We have two individuals who provide clinical leadership to the team, because not all of my inspectors are clinicians. So, I have a clinical director and I have an individual there who has a specific clinical lead on mental health. We have six people in our investigations and concerns team, who are managing incoming concerns, but are also doing work such as the homicide investigations and special reviews. We have six people in our regulation team, who manage the registration, the variation and the deregistration of registered providers. We have 15 people plus two vacancies in our inspection team—so that is lead inspectors, assistant lead inspectors, and a couple of administrative support staff within there. We've got three and a half in our intelligence team, which I referred to earlier; seven and a half in our team that are involved with—and I'll come back to our specialist reviewers—recruiting, training and managing the relationships with resourcing our inspection team with our specialist peer reviewers. And we have a panel of over 200 specialist peer reviewers, so we will send dentists on dental inspections, and GPs or practice managers on GP inspections. We have one communications officer, supported by somebody who helps us get our publications out, but also a first point of contact, and probably four corporate services. I hope that that adds up to—

[196] **Sandy Mewies:** I'm sure it will.

[197] **Dr Chamberlain:** Plus the chief executive's office, which is a small number. That should add up to about 60. So, in terms of quantum, which is why we supplement with our panel of specialist reviewers—over 200—we couldn't possibly employ the full range of specialist expertise, because they wouldn't be fully utilised. It's much more cost-effective to bring them in.

[198] In terms of the move to lay reviewers, there's a number of reasons for moving to voluntary lay reviewers. I'm not saying that the financial benefits of that aren't something that were taken into account, but I think there are also benefits in terms of making sure that we have a wide panel of volunteers

who we can use quite broadly and we're aligning ourselves with other organisations, third sector, thinking about how we can bring these people in on a slightly less formal and contracted basis. There's also always a risk with lay reviewers that the longer an individual is a lay reviewer the less lay they become because they become part of the inspection process. So, it gives us more flexibility in terms of how we manage that really valuable input to our inspections as a resource. Off the top of my head, I'm afraid I don't know how many we've managed to recruit in the last recruitment exercise, but I can certainly find out for you.

[199] **Darren Millar**: Sandy, do you want to touch on your targets?

[200] **Sandy Mewies**: I'd like a note on that anyway, if you don't mind. If you've been recruiting, you must know how many people you've recruited.

[201] **Dr Chamberlain**: We will do, but as I say, we had a training course yesterday and I don't have that to hand.

[202] **Darren Millar**: Just before you move on, Sandy: Jocelyn, on the lay reviewers.

[203] **Jocelyn Davies**: So, if you send a dentist to conduct the inspection, do you pay the dentist?

[204] **Dr Chamberlain**: Yes.

[205] **Jocelyn Davies**: But you don't want to pay the lay people. And, how are you going to get a broad range of people when you can only have people if they're volunteers who can afford to do it for nothing? It seems to me that if you're prepared to pay the dentist, why aren't you prepared to pay the lay person?

[206] **Mr Jones**: One of the reasons why we pay—. It would be great if dentists wanted to volunteer to do work with us, that would be fantastic in an ideal world, but when dentists come and work for us, they have to backfill the commitments that they're not making back at their practice.

[207] **Jocelyn Davies**: I can see your reasons for paying the dentist; what I can't see are your reasons for not paying the lay person who's giving up their time and effort, and it seems to me that you don't quite value it as highly as the professional, clinical input. As you can see, I don't like that. If we have

lay inspectors of schools, we pay them. And, you say that lay inspectors are supposed to focus on the patient experience, which is one of your top priorities, but you're not prepared to pay for it.

[208] **Darren Millar**: You'll send us a note on the numbers that you've recruited, and you'll send us a note on the rationale behind your decision not to compensate lay inspectors for their time in the support that they give to your processes. I'm going to come to you in a second, Aled, but I know that Sandy just wants to test this area on targets.

[209] **Sandy Mewies**: Perhaps I should say—it's not an interest, but I was a lay inspector at one time and—. Anyway, I would be interested in the facts and I would like to know what your projections are from, not just what the result of your review is, but what your projections were and how is that going to impact on your organisation. Because I think one of the things I am not clear about is this: you do a lot of work, but I am not clear at all about how your outcomes are monitored. I have no idea, even after what you said—you've explained the landscape again and again; I think I understand the landscape—I do not understand how the outcomes of the work you've done are monitored and evaluated, and, to go back here, I'm sure that's something that I'll be thinking about anyway.

[210] Your targets: you've got your two hours. Well, 100 per cent, that's a pretty easy target after—. You'd have a team meeting, and you'd just talk about it, your feedback. Your management letter, which is, again, two days—68 per cent. I'm surprised it's not more than that because, immediate actions, I would say, shall we substitute urgent for immediate, and in health urgent is slightly different to inspection in other areas, isn't it? What are you doing to improve that?

[211] You provide a draft report just for accuracy checking within a maximum of three weeks of inspection. You're only hitting 61 per cent there. Is that because they're not sending back to you? You may be sending them the draft report, and I accept that, but you're not getting it back quickly enough. Then, I would be saying, 'Well, has HIW got the teeth it needs to demand things?' Because, some of the things you've said, I'm not quite clear—. You know, people aren't coming back to you; why aren't they coming back to you?

10:30

[212] And then, publishing the agreed report and action plan on your website within a maximum of three months—only 67 per cent. What are the difficulties? How are you going to improve that? Because that's the public assurance that is part of your mission statement, isn't it? That's the public assurance.

[213] But, in all that, how do you monitor and evaluate the results of that inspection? You're now going back to hospitals. It's a pretty good idea to go back to the same hospital to see if what you found was broadly disseminated. Are you finding that that's the case? In some areas, how do you decide, 'We need specifically to go back there to see that particular action'?

[214] **Dr Chamberlain:** Do you want to talk through this, Alun?

[215] **Mr Jones:** Yes, okay. So, we mentioned earlier on that we have a relationship manager for each health board. The relationship manager internally acts as the focal point for the decision making about the programme of work for the year. They would have a relationship with colleagues at the Wales Audit Office and with the community health council. They would also ask internally what information we hold and what our reports have said in the past. All of this really is to form a view on whether this is something we're worried about—

[216] **Sandy Mewies:** And that's a very central person.

[217] **Mr Jones:** Yes, and a senior person as well. So, I guess there are two questions we ask ourselves: is there something we're worried about that warrants an inspection; and, is there something we don't know about? That's an equally important question. So, if there are services that we haven't been to for a while—. We've acknowledged that we can't be everywhere and that it's a broad NHS out there. We do go and look at services, if we haven't been to them before. So, women's and children's services have been a feature of some of our inspections this year. That's because we just don't know or there is not enough intelligence there. So, sometimes, arming ourselves with that information, going out there and having a look, is really, really important.

[218] It's really difficult to tell you how we juggle those things, but there is a robust conversation about what we should do. We also take a view from our advisory board on areas. So, our advisory board has told us that primary care

is important, that mental health is—. There are lots of vulnerable people in mental health and, if the services aren't up to standard, then that can impact on them disproportionately.

[219] **Sandy Mewies**: Could you send us a note on the expertise of that advisory board?

[220] **Dr Chamberlain**: Yes.

[221] **Mr Jones**: Yes.

[222] **Sandy Mewies**: Thank you.

[223] **Mr Jones**: So, that's how we develop our plan for the year for each health board. Then what we do is we test ourselves continually on whether that's the right plan, based on what we are finding out during the course of the year. So, we have a thing internally called the risk and escalation committee. It's an opportunity for all key people within HIW to come together once a month and say, 'Okay, what concerns have we received? What's come out of a summit meeting, which can involve up to 10 other agencies? What do we feed into that? And here's our plan that we started with for the year, does it still hold true? Is it the right plan?'

[224] This is something that we've put into place since the Marks review. It's something that has evolved, but as we've gone on, we are now changing our plans. As a result of that, we'll go to a different hospital or a different ward or we'll create an inspection that was never in the plan and think about what we drop. I can think of an example recently where we gave up a dental inspection in order to go and have a look at a ward where we had some concerning information that had come in. Where we know about something, we will always take action. We've talked today about whether we have all the data we need, but where we know about something, where it's come to us, we will always take action of some sort.

[225] **Darren Millar**: And your targets?

[226] **Sandy Mewies**: Your targets. How are you improving—

[227] **Darren Millar**: Why aren't you hitting your targets?

[228] **Mr Jones**: In terms of the publication?

[229] **Sandy Mewies:** Well, what are you doing to improve it? You've got targets. Sixty-one per cent isn't great, is it? Do you need more power to say to people—? Is it the other side that's not coming back to you, or do you need to improve those targets yourselves, and how are you going to do it?

[230] **Mr Jones:** I would acknowledge that the figures could be better, but there are some subtleties within those figures that I think it's worth talking about. So, I acknowledge what you're saying about the two days. Our target, really, is to communicate with the health board as soon as possible. It might be less than two days. Sometimes, it can take three or four days because there are technicalities around what we found and we need to get together and make sure we write the right letter in as robust way as possible. We may need to draw on the whole inspection team and what they found. So, I think if you looked at the profile of how long it takes us to communicate, the two days—. We're at—. Where are the figures this year—?

[231] **Sandy Mewies:** It's at 68 per cent.

[232] **Mr Jones:** It's 68 per cent. I think if you looked at two to five days, you'd probably get up to about 90 per cent, and then there are some beyond that that clearly are not acceptable. They probably come down to staff illness or some kind of operational difficulty.

[233] **Sandy Mewies:** And then your 61 per cent for providing the draft report—

[234] **Mr Jones:** Yes. I think what we have found through experience this year is that we have doubled our delivery levels in the last year. What we've found is that our inspectors, when they've got maybe 10 reports on the go—there are 10 pieces of work over a two or three-month period—they actually sometimes have to reprioritise something. So, they will have to sit down and say, 'Right, I've got to do that two-day letter now, and that's much more important than getting a draft report out to the organisation'. So, we have struggled a little bit with that particular target, but what we are focused on is the three-month target because getting it into the public domain is more important than how quickly the health board—

[235] **Sandy Mewies:** And that's 67 per cent.

[236] **Mr Jones:** Yes, it's rising, actually. It's 72 per cent for the year so far. I

think, in the main, the gap there between where we'd want to be and where we are is down to two things, really. One is that, sometimes, we have to give health boards longer to respond, and until they've responded we can't finalise the report. There may be reasons for that. It might be sickness absence at the health board. It may be that they want to put it through their governance processes, so they might want to take it to the quality and safety committee. But then we have had a small number of inspection reports where we had illness in our team. Kate talked earlier on about the resilience. We have 15 inspectors; if you lose one or two of them to illness, that's a large percentage and it can impact on timeliness of reports.

[237] **Sandy Mewies:** Do you get your reports challenged? Is there a mechanism for challenging your report?

[238] **Mr Jones:** By the health board or by someone else?

[239] **Sandy Mewies:** By anybody you're inspecting.

[240] **Darren Millar:** Factual accuracy.

[241] **Mr Jones:** Yes, factual accuracy checks by the health board. They will challenge back if we've just got it wrong. There is a feedback session at the end of our inspection where we have senior people from the health board who will come and we will tell them what we've found. They'll quite often robustly challenge us, and that's right, you know; we don't want to get it wrong. So, yes, we have a number of layers of question-and-answer built into the process internally; again, with people like the relationship manager checking that report and trying to triangulate that evidence with other things they know about the health board.

[242] **Sandy Mewies:** Okay. Thank you.

[243] **Darren Millar:** Can you just tell us how long the longest wait is at the moment for the publication of a report, just as a matter of interest?

[244] **Sandy Mewies:** And the duration.

[245] **Darren Millar:** Yes. Well, just in terms—. You know, you've got your three-month target, and you say that you're up to 72 per cent; how many people are waiting four months, five months, six months or seven months for the publication of a report?

[246] **Dr Chamberlain**: We'll give you figures on that. We don't have them with us.

[247] **Mr Jones**: We do have figures for that, but not—[*Inaudible.*]

[248] **Dr Chamberlain**: We do monitor it on a monthly basis. So, we can send those through to you after the committee. That's not a problem.

[249] **Darren Millar**: Okay. That would be useful. Thank you. All the way though, by month.

[250] **Jocelyn Davies**: Can I just ask a supplementary question?

[251] **Darren Millar**: Yes.

[252] **Jocelyn Davies**: Do you think that it is a valid reason for not responding to you if somebody in the health board's on the sick? Do you seriously think that that's okay, that they say to you, 'Sorry, we can't meet our three-month deadline because Mr X has got the flu' or something?

[253] **Mr Jones**: I think it's right that the right person responds to the report. If someone is known to be off sick and it's not going to be for long, it is worth waiting for them to come back if it's a few days. Sometimes that can knock out other processes, such as translation for us. So, it might be that that delays it. They would absolutely need to find somebody else to respond, and they would need to tell us how long it's going to be. We wouldn't just give them an open-ended, 'Well, take as long as you want, then'. We would say, 'Well, when are they going to be back?', and if they said, 'It's going to be three weeks', maybe that's just about acceptable because you want to get the right answer. If it was more than that, we'd be saying, 'Well, hang on a second, is there no-one else who knows how to respond to this, or no-one else with the expertise within the health board?' So, if we've given the impression that that's a big issue, then I would correct that and say that—

[254] **Darren Millar**: But you also seem to be pointing to capacity issues yourself as an organisation to turn some of these things around. Sandy made an important point about the average duration of an inspection.

[255] **Mr Jones**: It depends what kind of inspection it is. If it was a dental practice, it's around a day and a GP is around a day. The bigger hospital

inspections are typically two days or two and a half days, but we are sending much bigger teams now. We are sending up to seven people; so, the man days within there are quite a lot. Our mental health unit inspections take three or four days. It does depend on the size of the establishment.

[256] **Darren Millar**: Okay, thanks. Aled.

[257] **Aled Roberts**: Rwy'n derbyn bod yna lawer iawn o waith da yn cael ei wneud o fewn y gwasanaeth iechyd, ond rwy'n meddwl, erbyn hyn, fod yna achos inni adfer hyder y cyhoedd o ran diogelwch. Nid wyf yn dallt, er enghraifft, o ran yr adroddiad ar adrannau brys yn y gogledd—mi roedd y cynllun gweithredu wedi cael ei gytuno efo'r bwrdd iechyd ar 2 Rhagfyr 2014, fe wnaethoch chi gyhoeddi'ch adroddiad ar 23 Ionawr, ac eto nid oedd y cynllun gweithredu ar eich gwefan chi tan 28 Mai. Os ydw i'n Aelod Cynulliad yn y gogledd neu os ydw i'n aelod o'r cyhoedd, sut yn union ydw i'n mynd i weld sut mae'r bwrdd iechyd yn y gogledd yn ymateb i'ch adroddiad chi?

Aled Roberts: I accept that a lot of good work is being done within the health service, but I think that, by now, there is a case for us to recover the public's confidence in terms of safety. I don't understand, for example, in terms of the report on emergency departments in north Wales—an action plan had been agreed upon with the health board on 2 December 2014, you published your report on 23 January, and yet the action plan wasn't on your website until 28 May. If I am an Assembly Member for north Wales or if I am a member of the public, how exactly am I going to see how the health board in north Wales is responding to your report?

[258] A gaf i hefyd ddweud bod y sesiwn dystiolaeth yma'n rhan o'r gwaith rydym ni'n ei wneud o ran y ffordd y mae'r byrddau iechyd yn cael eu llywodraethu? Mae'n rhaid imi ddweud, yn yr holl amser rwyf i wedi bod o fewn llywodraeth leol, nid wyf erioed wedi gweld cyfarfodydd mor ddiwerth â'r rhai rwyf wedi gweld cofnodion ohonyn nhw. Rwy'n teimlo mai beth rydym ni'n ei gael yma ydy rhyw ddarlun o gyfundrefn sydd yn cynnal llawer iawn o gyfarfodydd, yn

May I also say that this evidence session is part of the work that we're undertaking in terms of the way that health boards are governed? I have to say that in all the time that I have been in local government, I've never seen meetings so valueless as the ones that I've seen the minutes of. I feel that what we have here is some sort of picture of a system that holds a lot of meetings, it holds a number of activities, including summits, concordats and protocols, and so

cynnal gweithgareddau, gan gynnwys uwch-gynadleddau, concordatiau a phrotocolau a phob peth felly, ond dim llawer iawn o hyder ynglŷn ag unrhyw beth yn newid.

forth, but not much confidence in terms of anything changing.

[259] Mi oedd adroddiad Parnters4health yn y gogledd yn rhestru nifer o gyfarfodydd, yn cynnwys un rhwng doctoriaid ac uwch-reolwyr, un ar 26 Chwefror 2014, sydd yn rhoi 13 o argymhellion ymlaen. Yr unig ymateb i'r rheini yw:

The Partners4health report in north Wales listed a number of meetings, including one between doctors and senior managers, one on 26 February 2014, which put forward 13 recommendations. The only response to those is:

[260] Was this done? No evidence. Still outstanding. No action identified. No evidence. No evidence. No evidence. Was this done? Was action taken? What was the outcome? What was the outcome?'

[261] Roedd cyfarfod yn cymryd lle, ond dim byd yn newid. Hefyd, os ydych chi'n edrych ar yr adroddiad o ran—. Rydych chi'n dweud bod yna waith rŵan yn mynd ymlaen o ran yr adrannau brys yn y gogledd. Mae'ch cynllun gweithredu chi ers mis Ionawr wedi dweud:

A meeting was taking place, but nothing was changing. Also, if you look at the report—. You say that work is being done now regarding the emergency departments in north Wales. Your action plan since January has said:

[262] 'health board is advised to improve the staffing levels'

[263] at A&E departments. A review was undertaken in November 2014, which identified the current emergency department nurse staffing was understaffed at Wrexham by 15.81 whole-time equivalents, representing an increased budget demand of £664,696.

[264] I've looked through all the board documents at Betsi Cadwaladr. It's the usual response—ongoing.

[265] During and after the review:

[266] 'the Maelor Site continues not to meet WG Emergency Targets with high level of both 4 hour and 12 hour breaches'.

[267] Betsi board minutes—ongoing.

[268] So, what has your relationship manager done regarding those ongoing matters from the emergency department review at Betsi Cadwaladr? This was our finding: that there were matters being reported to the board, month on month, and nothing happening.

[269] **Darren Millar**: There are lots of elements to the question there, so, please, take some time.

[270] **Dr Chamberlain**: I will let Alun come back in on this in a moment, but the thing that I would come back to, certainly with Betsi Cadwaladr, is that we had concerns about the responsiveness of the health board to the issues that were being raised with them, the changes they were making, and that is part of the journey that we have been on in terms of the governance reviews, in terms of the escalation of the status of the health board and in terms of the placing of the health board in special measures. It's really important now that the health board gets itself organised, so that it can respond to the issues that are being flagged up, and that it can move services forward. One of the issues—

[271] **Aled Roberts**: It was really important in December 2014, and I was in that emergency department last Monday. What those staff—who are recognised as being staff who were highly efficient, working under a great deal of pressure—need to know is what that health board is doing regarding the 15.81 whole-time equivalents, as far as nursing staff are concerned, and the fact that they've been operating for many months with six consultants, rather than the eight consultants who are identified as being required, even under the previous level of patient referrals in that department.

10:45

[272] **Darren Millar**: Okay, Aled. Let Dr Chamberlain respond.

[273] **Dr Chamberlain**: That question you need to ask of the health board. What we are continuing to flag up as part of the work that we're doing with the health board is they cannot allow the focus on getting the governance right to take their eye off the ball in terms of services. So, it is a consistent message back that you can't be so focused on making sure that you have continuity and good-quality governance whilst taking your eye off services.

There has to be a focus on improving mental health, improving emergency services, getting the right staff in the right places. It is a message that we have heard back consistently as part of our work. Alun, do you want to come in in terms of anything else?

[274] **Mr Jones**: Only that I mentioned transparency earlier on and whether health boards are transparent about concerns that are coming in, and that helps us to know—. I think, in the example you've given, this is one where the health board is being transparent about the shortfall in the department, and the strength, or the benefits, of going in and inspecting a department that the health board is already saying is short on staff are limited, because I think there is an internal conversation about what we are going to do about this, how we are going to deal with it and, as Kate said, the issues around governance.

[275] **Aled Roberts**: If there is transparency, how do I as an Assembly Member, and how do I as a member of the public in north Wales, understand what that health board is doing, if the only response in their board minutes is 'Ongoing'?

[276] **Darren Millar**: Perhaps you can tell us in terms of the GP out-of-hours stuff, because this has been pertinent to the decision that was made—it was a significant factor in the decision that was made to put the health board there into special measures. Did you have any intelligence at all about problems in the GP out-of-hours services before the report was leaked to the media, as a result of it being given to Assembly Members?

[277] **Dr Chamberlain**: I did not.

[278] **Darren Millar**: You didn't. So, all of these systems that you have are clearly not working. What was your relationship manager doing, in order to sort things out? Given that the health board itself commissioned this report, where was your relationship manager? Why wasn't that reported to your relationship manager, as part of your intelligence community that are out there, feeding you back information?

[279] **Dr Chamberlain**: I think what was clear about the GP out-of-hours one is that was one of those examples that I've pointed to where it was something that was clearly known to, and within the sight of, the CHCs. That is something that had not come through and had not been raised with us as part of the CHC conversation.

[280] **Darren Millar:** You can't blame the CHCs.

[281] **Dr Chamberlain:** I'm not blaming the CHCs.

[282] **Darren Millar:** You've got relationship managers, who you say sit on quality and safety committees, who regularly meet with senior managers at these boards, and yet that board managed to commission a report into serious concerns that it had about the capacity and the quality of services that were being provided by its GP out-of-hours service, and your relationship managers, your intelligence systems, didn't know. You can't just blame other people. Why didn't they know? Why aren't your systems better acquainted with being able to pick up this information? Should there be requirements, when health boards commission work because of concerns, that they share the reports with you as soon as they're available, even if they're in draft form? There are no such requirements at the moment, are there?

[283] **Dr Chamberlain:** There are no such requirements, and I'd find that extremely helpful, because some of the relationships we have with health boards are, I would say, more open and more timely than those that we have with other health boards. I think it's also important to realise that, for the relationship managers, this is part of their job, it's not their entire job, and they do not sit on quality and safety committees; they will attend, on occasion, quality and safety committees, but they will not be constantly present. So, yes, I absolutely agree with you, I think there is something there that can be exploited far more effectively in terms of the conversation with health boards, but again, this is a matter of balance.

[284] **Darren Millar:** Obviously, you are part of the Welsh Government, the Welsh Government knew about this ongoing work—or certain individuals in the Welsh Government certainly did—on GP out-of-hours, why didn't they feel it necessary to share it with you? Have you explored that?

[285] **Dr Chamberlain:** I haven't explored it with them directly, no.

[286] **Darren Millar:** Okay. Just one final question, before we close this session, if I may. Four out of seven health boards are currently in some sort of enhanced monitoring arrangements, or are on the road with the escalation process. Can you just tell us—? I appreciate that there's a tripartite arrangement to put a board into special measures, but further down the

pecking order, for the enhanced monitoring arrangements et cetera, is it the same tripartite arrangement that makes the recommendation to Ministers?

[287] **Dr Chamberlain:** Yes.

[288] **Darren Millar:** It is. Obviously, Ministers can use their discretion to choose to accept the advice or not. Have there been any occasions where Ministers have not accepted your advice to escalate?

[289] **Mr Jones:** No.

[290] **Darren Millar:** There haven't.

[291] **Mr Jones:** Not since the implementation of this particular system.

[292] **Darren Millar:** Yes, okay, but prior to the new arrangements, were there any occasions where Ministers chose not to take your advice to escalate situations in boards?

[293] **Dr Chamberlain:** No.

[294] **Mr Jones:** No.

[295] **Darren Millar:** There weren't. You seemed a bit more hesitant, Mr Jones.

[296] **Mr Jones:** I've only been in the organisation for 18 months, so I can speak to the period that I've been here. I'm not aware of anything beyond that, and I don't think Kate is either.

[297] **Dr Chamberlain:** Not since I've been in post.

[298] **Darren Millar:** Okay, thank you. That brings us to the end of this evidence session. Alun Jones, Dr Kate Chamberlain, thank you very much indeed for your attendance. You'll receive a copy of the transcript for any factual inaccuracies to be pointed out to us, and we look forward to receiving the additional information which you said that you will relay to the committee to inform its work. Thank you very much indeed.

10:51

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cynnig:	*Motion:*
bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).	*that the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).*

Cynigiwyd y cynnig.
Motion moved.

[299] **Darren Millar:** I now move the motion under Standing Order 17.42 to resolve to exclude the public from the remainder of our meeting. Does any Member object? There are no objections, so we'll go into private session. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:51.
The public part of the meeting ended at 10:51.