Recommendation 19 – We recommend that Healthcare Inspectorate Wales and Community Health Councils jointly develop and implement plans to ensure better working relationships; the 2015 Operating Protocol should be reviewed, to identify how it is working in practice, to address areas for improvement and ensure effective and timely sharing of information.

Accepted
This was a commitment within the existing protocol and work is underway by officials in both organisations to conduct this review.

Recommendation 20 – We recommend that HIW agree with health boards' processes for securing Healthcare Inspectorate Wales timely and regular access to summarised complaints data from health board, to inform their work.

Partially Accepted
The Public Accounts Committee recognises the significant programme of work led by Welsh Government on managing complaints, including the Keith Evans review of complaints data. HIW would prefer to minimise burden on health boards and will work with Welsh Government to mandate health boards to share their complaints data with both HIW and Welsh Government, rather than providing bespoke analyses to HIW.

Recommendation 21 – We recommend that an electronic solution is put in place to enable Assembly Members to contact the Chief Executive of Healthcare Inspectorate Wales directly.

Accepted
Assembly Members can currently contact the Chief Executive of HIW directly by - e-mail: hiw@wales.gsi.gov.uk; Kathryn.chamberlain@wales.gsi.gov.uk - telephone: 0300 062 8163 - fax: 0300 062 8387 - letter: Dr K Chamberlain Healthcare Inspectorate Wales Welsh Government Rhydycar Business Park Merthyr Tydfil CF48 1UZ On occasion the Chief Executive has visited Assembly Members at their offices to discuss concerns raised by constituents.

Recommendation 22 – We recommend that Healthcare Inspectorate Wales puts in place focused, robust and effective arrangements with partner agencies to improve joint working and learning, better developing shared intelligence resources to support the inspection work of HIW and others.

		vulnerability of the individuals receiving care and have specific responsibilities in this regard relating to mental health. We are also members of the National Preventative Mechanism which is made up of 20 bodies who monitor places of detention across Scotland, England, Wales and Northern Ireland. This includes police custody, prisons, court custody, immigration and military detention, secure children's homes, and places where people are detained under mental health legislation. The HIW Director of Strategy and Development also sits on the Advisory Board for the NHS CEHR.
4	HIW can make a major contribution to the safety and care of patients by holding boards to account for the clinical performance of doctors through the medical revalidation process. Therefore it should give high priority to working with the General Medical Council to ensure that Health Board leadership and governance of Responsible Officer Regulations is effective.	HIW works closely with the General Medical Council through the Concordat Forum, the GMC Advisory Forum for Wales, and regular bilaterals. HIW also works with the Revalidation Support Unit of the Wales Deanery in their oversight of the development of the revalidation process. The extent to which revalidation is being properly implemented is an important consideration in our assessment of an organisations governance and assurance processes.
5	HIW and the Welsh Government should explore the usefulness of audit tools developed by the Royal College of Physicians and consider whether they should be built into the new Health Standards which are being developed; and whether they could contribute to HIW's inspection programmes.	When developing the methodology for inspections HIW draws on the established professional best practice from a variety of sources and this would include those tools and checklists developed by the Royal Colleges. Representatives of the Royal Colleges are invited to sit on our Stakeholder Reference Groups when new methodologies are being developed and the Academy of Medical Royal Colleges is represented on our Advisory Board.

6	HIW should develop a proportionate risk-based inspection programme informed by its collation and analysis of intelligence. The inspection programme should include: • closer working with CHC's will be essential to ensure the best use of information and intelligence at individual ward level or other settings. • learning lessons of good practice from the Welsh Government's use of spot-check visits to a substantial number of hospital wards which assessed the safety and quality of care and use these to inform their development of short-form DECI inspections. This would allow a greater number of inspections to be carried out. • continuing with its new approach to cleanliness and infection control to prevent hospital acquired infections. It should remain a top priority and capacity issues should never compromise its ability to deliver this aspect of its work. • finding resources to increase the number of inspections it undertakes of GP practices.	(I) HIW has an agreed Operating Protocol with the CHCs, this was formally exchanged in March 2015. A review of this is now underway. (II) HIW has liaised closely with the original spot check programme and a number of the reviewers have now joined our external reviewer panel. HIW has reviewed the application of short form visits to consider how we can build on these in order to introduce the rigour of evidence capture and reporting necessary that underpins a formal inspection programme. (III) A specialist task and finish group has been working with HIW to develop a three year approach to supporting the introduction of the new Infection Prevention and Control guidelines and providing assurance on their implementation. (IV) HIW has a responsibility to operate within the budget allocated to it by the Welsh Government. The volume of GP inspections undertaken needs to be considered by HIW when it prioritises the way in which this budget is used. A change in the proportion of GP inspections impacts the inspection activity elsewhere.
7	HIW should formalise its agreements with the following bodies: • The General Pharmaceutical Council, which is the principal regulator of the pharmacy profession in Wales; and report on the effectiveness of pharmacy regulation across Wales in its Annual Report. • The General Optical Council, which is the principal regulator of the optical profession in Wales; and report on the effectiveness of optical regulation across Wales in its Annual Report.	HIW has agreed a Memoranda of Understanding with the General Pharmaceutical Council. HIW is undertaking a thematic review of Ophthalmology. The General Optical Council is on the stakeholder group for this review and this will provide an opportunity to test the need for a formal MOU.

8	HIW should expand peer, thematic and special reviews as they can improve the quality of care for patients and service users across Wales. Thematic and special reviews in particular should be further developed as they can identify solutions to problems in one service or locality that can be taken up by the whole of the sector. At the same time the regulation and inspection of healthcare services should not be compromised.	The Welsh Government has now established an All Wales Peer Review Steering Group to manage an annual programme of peer reviews across all services provided by the NHS in Wales. The steering group will report to the National Quality and Safety Forum. The steering group membership includes a representative of HIW and this continued association, along with the existing escalation process, will help give weight to the peer reviews. Since 2015-16 HIW has introduced the use of thematic reviews. We continue to undertake special investigations where there are matters of concern.
10	In relation to work in Mental Health and Learning Disability settings HIW should: • increase the volume of inspections of NHS inpatient facilities to better protect the interests of patients who have a mental health problem or learning disability. • focus its inspection model more on evaluating patient outcomes and less on scrutinising whether appropriate processes have been followed.	We continue to ensure that we undertake inspections of NHS inpatient facilities. In addition to our core programme we have been doing a thematic review with CSSIW on Learning Disabilities. Where appropriate we use our stand-alone Mental Health Act visits to provide diagnostic information so that we can target our full inspections more effectively. Our inspection, visit and review approach is already focussed on examining the quality of the patient experience. Although HIW also looks at specific process issues (particularly with regard to whether legal requirements have been met) this is done within the context of the care received.

12	HIW should refresh its Statement of Purpose to make it patient and citizen focused. The public should clearly understand that its role is to ensure they receive the best quality treatment and care, as well as protect them from being harmed. Also, the Statement of Purpose may want to give greater emphasis to HIW's role of promoting Wales–wide improvements and innovation in healthcare, that it could be much more than an inspector of individual services.	HIW has a clear statement of purpose, values and outcomes it seeks to achieve which is now included in all its published plans. This will also be made more clear with the launch of the new website.
14	HIW should further develop and publish a Communications Strategy, which will allow it to communicate more effectively with the public. It will be able to provide evidence that it is delivering a highly valuable service on their behalf. Increased interaction with patients and service users through multi–media formats will provide valuable information to support target led inspections of services where concerns are raised.	HIW has refreshed is communications strategy resulting in greater and more interactive use of social media. A new website has been commissioned and is currently in development, with a launch date planned for June 2016.
15	HIW should include more information in its Annual Report on the outputs and efficiency of work processes which serve patients, service users and other stakeholders. The number of customer care measures should be minimised, to allow scarce resources to be used to evaluate significant outcomes.	HIW's annual reports are now focusing on themes and findings from our work. We do not only produce an Annual Report we also publicise thematic analysis of specific work programmes on a period basis. We report openly on our performance targets, including volume and timeliness.
16	HIW to evaluate the effectiveness of their inspection and review models, to not only gain a better understanding of the performance of healthcare providers, but also as a means to help them improve the quality of inspection activities. Providers should have the opportunity to give feedback on whether HIW's scrutiny of their service is useful, and to what extent it helps them identify those aspects	We undertake evaluations of our activities where appropriate: - We evaluated the new model of midwife supervision - We evaluated and published learning and themes from our homicide reviews - We have reviewed and refreshed our approaches to dignity and essential care inspections and to our mental health reviews.

	which need to be improved.	- We have piloted and evaluated an approach to GP inspections - We use stakeholder reference groups to advise and challenge for new and/or significant areas of work e.g. Dental Inspections, GP Inspections, Mental Health activities - We undertook a baseline stakeholder survey early in 2014/15.
17	HIW to measure the outcomes of its most important areas of inspection: showing how its inspections have had a significant impact on the safety and quality of healthcare services by helping providers improve their performance.	Attribution of cause and effect is difficult to achieve and has also been the subject of international review without much success as reported through the European Partnership of Supervisory Organisations. However, we continue to use the learning from evaluations such as those identified above to develop the way in which our work can help to support improvement.
19	HIW, after consulting with stakeholders, should publish a Statement of Risk outlining its approach to regulation and inspection. It should explain the minimum frequency of inspections and reviews it will carry out of both NHS and independent sector bodies and put this within the context of its capacity to meet these targets.	We are transparent on how we prioritise our work in our published plans.
21	HIW should review the implementation and effectiveness of LHBs and Trusts service user strategies, in line with the Welsh Government's guidance A Framework to Assure Service User Experience, to determine whether they are genuinely involving patients and carers as a means of improving the safety and quality of services.	This could be considered as a potential thematic review, but would need to be prioritised alongside other proposals. Our reviews consider patients experience and the extent of patient involvement in their own care as a matter of course.
25	HIW should always carry out follow-up actions when inspection results indicate this is necessary and in the most serious instances of service failure, should be more robust in the use of its enforcement powers, and publish data on how it has used these powers in its Annual Report.	HIW has a strategic approach to follow up, including conducting follow up visits. This will be published during the Summer 2016. A new process for managing services of concern has been implemented. Tripartite escalation and intervention arrangements are in place for the NHS.

27	HIW should consider the value of developing a framework for assessing the quality and safety of all healthcare services. The framework could reflect significant patient outcomes, and be aligned with new refreshed Health Standards, the self-assurance systems that health bodies use to measure their own performance and clinical indicators used by professional regulators and Royal Colleges. The framework should be common to the work of both HIW and CSSIW as patients and service users are increasingly receiving integrated health and social care services. Clear information would be provided to members of the public and inspection reports and results would encourage improvement and innovation by providers.	This is a significant piece of work and further consideration needs to be given to this in light of changing service provision and direction such as the development of integrated services. We continue to learn how other bodies are developing their judgment frameworks
28	HIW should scrutinise whether: • Health bodies are providing the most effective clinical treatments to patients. Patients not only want to benefit from being looked after in line with essential life maintaining care such as being fed, hydrated and being assisted with going to the toilet as necessary, but they also want to receive the best available clinical treatments. • Lessons promoted by the 1000 Lives Improvement programme are being delivered during the course of individual inspections or reviews; or they could be the subject of national thematic reviews.	HIW tests whether care and treatment is provided against the published standards. It is not our role to test the effectiveness of clinical treatments. That is a matter for other bodies, such as NICE. When conducting thematic reviews we would draw on best practice from a number of sources including 1000+ Lives
33	HIW should increase collaboration with third sector organisations which offer advice and advocacy to patients and carers to gather more information about any concerns they	HIW continues to liaise and network with the third sector to keep up to date with the unique information of special associations and interest groups such as RNIB and AHL. Where

	may have about the quality of healthcare services e.g. Carers Wales, MIND Cymru and Citizens Advice Cymru.	HIW conducts thematic and/or specialist reviews HIW includes the third sector within its review advisory/steering groups. There are three third sector organisations who are members of the stakeholder group for our ophthalmology thematic review. Our Strategic Plan has been out for public consultation.
34	HIW and CHCs to hold listening events in local communities as well as involve experts by experience in their inspection teams when an in–depth review of a particular hospital or LHB is taking place.	HIW has a closer working relationship with the CHC since signing the Operating Protocol. This includes HIW placing reliance on the CHCs' intelligence gathering from different sources. Lay reviewers are used in HIW's inspections to ensure the patient perspective is captured. We would still hope to be able to utilize the CHCs' public engagement role in order to hold listening events and we will discuss this further with CHCs when they have been able to progress further in the development of their corporate strategy, planning and standards.
36	HIW should carry out more national thematic reviews of healthcare services. All providers across Wales should be following international benchmark standards of good care and HIW's role would be to scrutinise whether each health body is implementing them; and if they are continuously self-assessing their performance in order to drive up standards of care. It would be testing whether the self-assessments of performance are valid or not and by working with Public Health Wales and other expert bodies, identify lessons from highly successful providers which could benefit all patients and service users if implemented across the whole of Wales.	We have implemented a programme of national thematic reviews. These have been set out in our Strategic and Operational Plans.

38	Where appropriate HIW should give priority to carrying out joint reviews with the WAO of the governance, leadership and performance of LHBs and Trusts; and consider asking the PSOW to offer his expertise.	We work closely with the WAO to co-ordinate their corporate assessment work with our reviews of corporate governance. WAO performance leads meet regularly with HIW relationship managers. Where significant concerns arise we undertaken joint review work.
40	HIW should validate whether Health Boards and Trusts are following benchmarks of best practice and performance managing healthcare services to the highest possible standards.	HIW reviews draw on established published standards and best practice in developing methodologies for standard inspections and for thematic reviews.
41	HIW and CSSIW should work together to develop an integrated inspection framework to scrutinise the performance of health and social care organisations. The aim would be to assess the quality of integrated care, whether people are receiving seamless services when they move between primary care, hospitals and social care in registered settings.	HIW and CSSIW work together on a theme by theme basis developing approaches appropriate to the subject. We undertake joint work in (Deprivation of Liberty Safeguards) DOLS and publish a joint report. We are working together on a joint review of Learning Disability Services. We involve CSSIW where appropriate in our Homicide Reviews. The Green Paper explored the possibility of further integration.

Annex B

PAC Recommendations – BCUHB

Recommendation 12 – We recommend that Betsi Cadwaladr UHB provide an update to our successor Committee in the fifth Assembly on progress towards improving mental health services by June of 2016.

Accepted

Progress towards improving mental health services is monitored by the Health Board bi-monthly as part of the Special Measures Improvement Framework. Robust arrangements will be put in place internally by the Director of Mental Health Services, to collate all information that will be required for reporting on mental health services to the 5th Assembly by 1.6.16.
Key performance indicators for mental health services are to be developed by the Director of Mental Health Services and monitored locally, by Autumn 2016.

Recommendation 13 – The Committee does not believe that GP Out of Hours coverage is acceptable in Betsi Cadwaladr UHB and we recommend the Health Board urgently address this.

Accepted

The BCUHB GP OOH service has focused improvement on three key areas, namely: governance and accountability; quality and access; and workforce.

Key improvements delivered over the last seven months have included:

- New performance and accountability structures supported by clear lines of reporting linked with site based management teams and an agreed Scheme of Delegation.
- GP OOH risk register has been developed and maintained reflecting local and pan BCU risks.
- Implementation of an 'Escalation Policy' based on good practice from Cardiff & Vale Health Board.
- Active involvement with the FISH Primary Care/OOH capacity/demand modelling work supported by WG
- Rollout of Treatment Escalation Plans (TEPS) working with designated Care Homes with Nursing, and specified GP practices.
- Successful recruitment of Nurse Practitioners and GPs together with enhanced use of paramedic practitioners.
- Completion of a pan BCU baseline assessment in preparation for 111*. Installed and operationalised the new software to capture calls waiting (prior to being answered) which offers the opportunity to better understand the patient experience and clinical risk.

An Internal Audit Review of GP OOH standards has been approved by the Audit Committee, to be carried out by 1.7.16.