Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee

Dydd Iau, 7 Tachwedd 2013
Thursday, 7 November 2013

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Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod hwn ac Eitemau 1 a 2 ar Agenda'r Cyfarfod ar 13 Tachwedd
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting and for Agenda Items 1 and 2 of the Meeting on 13 November

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 reported 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

Leighton Andrews	Llafur Labour
Mohammad Asghar	Ceidwadwyr Cymreig (yn dirprwyo ar ran William Graham) Welsh Conservatives (substitute for William Graham)
Rebecca Evans	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Simon Brindle	Dirprwy Gyfarwyddwr, Gwasanaethau Cymdeithasol, Is-adran Deddfwriaeth a Pholisi, Llywodraeth Cymru Deputy Director, Social Services, Legislation and Policy Division, Welsh Government
Kate Chamberlain	Prif Weithredwr, Arolygiaeth Gofal Iechyd Cymru Chief Executive, Healthcare Inspectorate Wales
Emma Coles	Pennaeth Rheoleiddio ac Arolygu Gwasanaethau Cymdeithasol, Llywodraeth Cymru Head of Social Services Regulation and Inspection, Welsh Government
Mandy Collins	Dirprwy Brif Weithredwr, Arolygiaeth Gofal Iechyd Cymru Deputy Chief Executive, Healthcare Inspectorate Wales
Janet Davies	Cynghorydd Arbenigol, Ansawdd a Diogelwch Cleifion, Llywodraeth Cymru Specialist Advisor, Quality and Patient Safety, Welsh Government

Mark Drakeford	Aelod Cynulliad, Llafur (Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Health and Social Services)
Grant Duncan	Dirprwy Gyfarwyddwr, y Gyfarwyddiaeth dros Iechyd Cyhoeddus, Llywodraeth Cymru Deputy Director, Directorate for Public Health, Welsh Government
Anna Hind	Cyfreithiwr, Tîm Gofal Cymdeithasol, Llywodraeth Cymru Lawyer, Social Care Team, Welsh Government
David Pritchard	Pennaeth Rheoleiddio a Datblygu'r Gweithlu, Llywodraeth Cymru Head of Regulation and Workforce Development, Welsh Government
Alyson Thomas	Diprwy Gyfarwyddwr Adolygu Gwasanaethau a Datblygu Sefydliadol, Arolygiaeth Gofal Iechyd Cymru Deputy Director of Service Reviews and Organisational Development, Healthcare Inspectorate Wales

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

Sarah Hatherley	Y Gwasanaeth Ymchwil Research Service
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser
Richard Johnson	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk

Dechreuodd y cyfarfod am 09:31.
The meeting began at 09:31.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning; I welcome members of the committee to this morning's meeting of the Health and Social Care Committee. The meeting is bilingual and headphones can be used for simultaneous translation from Welsh to English on channel 1 or for amplification on channel 0. I remind everyone to please turn off their mobile phones and any other electronic equipment that may interfere with the broadcasting equipment. There are no scheduled events this morning, so in case there is a fire alarm, please follow the directions of the ushers. We have received apologies from William Graham this morning. I welcome Mohammad Asghar as a substitute in his absence. We have received notification that Lynne Neagle will be late this morning.

09:31

Ymchwiliad i Waith Arolygiaeth Gofal Iechyd Cymru: Tystiolaeth gan Arolygiaeth Gofal Iechyd Cymru
Inquiry into the Work of Healthcare Inspectorate Wales: Evidence from Healthcare Inspectorate Wales

[2] **David Rees:** We have received evidence from Healthcare Inspectorate Wales. I welcome Kate Chamberlain, the chief executive of Healthcare Inspectorate Wales. I think that you have been in post since January of this year.

[3] **Ms Chamberlain:** That is right.

[4] **David Rees:** I also welcome Mandy Collins and Alyson Thomas, both from Healthcare Inspectorate Wales. Thank you for your written evidence. I appreciate that there was a lot of it, but we did specifically ask the healthcare inspectorate to provide more detail. That was very helpful, so thank you very much for that. We will move into questions straight away, if that is okay. I will start the questions.

[5] We have received from many witnesses in previous sessions an indication that they are concerned about the capacity of the healthcare inspectorate to be able to deliver on its functions. It was established in 2004, and in 2006 additional responsibilities were provided, and in 2009 more responsibilities were provided. Are you in a position today to be able to deliver on all those responsibilities? Kate, will you start?

[6] **Ms Chamberlain:** I certainly will. Probably the first thing to think about is whether the range of responsibilities that we have is logically consistent and right. We have given you quite a lot of information on the type of work that we do. For me, looking at the range of stuff and how it fits together, there is a logical strand that brings that together, with us as the lead inspectorate for healthcare in Wales. In terms of the range, I think that it is appropriate that they should be with HIW. There are maybe one or two of them that might have a more appropriate home, but there are also maybe one or two things that are done elsewhere that it might be appropriate to locate with HIW. However, broadly, I think that our role is about right.

[7] We do have issues though, possibly, in terms of the capacity that we have to deliver on responsibilities. What you will have heard from quite a number of the evidence submissions that you have had and the oral evidence that you have heard is that we have struggled to deliver, particularly in terms of the timeliness of some of the reporting. I do not want to step too far back, but since 2010, when the organisation last went through an organisational redevelopment, we have had some problems in recruiting staff and in being able to retain staff within the organisation. That is something that has impacted on our ability to deliver across the full range of functions.

[8] **David Rees:** Have you been able to identify the reasons as to why you have had difficulty in recruiting staff?

[9] **Ms Chamberlain:** Oh, yes. There have been a number of those. Partly, I think we have been in a position where we have been intending to change the location of the office, and that certainly has not helped. It can be difficult to recruit staff, certainly on a substantive basis, when they know that their place of work is going to be changing. That is something that we have resolved very recently. We have now moved the headquarters for the organisation to Merthyr Tydfil. Being located in Merthyr Tydfil, we have been very successful recently in recruiting to a key number of posts. We are in a much better position now in terms of moving forward.

[10] **Gwyn R. Price:** I want to move on to capacity. As you say, a number of witnesses have said that the constraints mean that you have focused a lot of work on regulation rather than inspection. Would you say that that is a fair assessment?

[11] **Ms Chamberlain:** In terms of the focus on regulation, it is probably difficult to be specific about exactly what the balance is between regulation of independent healthcare and of the NHS. I think it is true to say that, in the wake of Winterbourne View, there was a programme of work that we did undertake, which was to look at mental health and learning disability institutions. Certainly, that will have involved taking some of our capacity away from our core work programme within NHS hospitals in order to deliver that. Would you like to say a bit more about that, Mandy?

[12] **Ms Collins:** Yes, if you do not mind. What we did was look at where our highest risk was. If we were totally honest, post-Winterbourne, we could not assure ourselves or be assured that we did not have a Winterbourne in Wales. Therefore, we rolled out this programme. However, it was not about a difference between inspection and regulation. It was about a focus on where we felt our risk areas were. We have totally reviewed our approach in terms of spending more time in organisations, talking to patients, relatives, carers and staff, and doing unannounced night and day visits. That has resulted in an awful lot of follow-up work: not just follow-up visits, but working with commissioners as well as providers, and holding workshops to get under the skin of some of the real issues we were looking at. We did not find the same problems as Winterbourne, but we certainly found issues in relation to staffing levels and overuse of agency staff, which was really impacting on the therapeutic input being afforded to individuals within those institutions. So, it did result in an awful lot of work, but it was to make people safer and to ensure, where we feel our focus needs to be, the provision of more quality care within those institutions.

[13] **Gwyn R. Price:** So, do you think that you are back on line now after getting over that initial hump?

[14] **Ms Collins:** We are certainly back on line. What I will say is that we have further work to do and we are on a little bit more of a journey. As raised by Kate, we have had issues with staffing, not just in relation to numbers, but in terms of capability and competency. Some of that is due to the restrictions we have had in the past, which I think we have now overcome, in terms of having to follow Welsh Government recruitment processes, which has meant that we have been recruiting from a pool within Welsh Government, rather than bringing in what we know we need, which is professional experience within the service so that people have the confidence to go into hospitals.

[15] **Gwyn R. Price:** Has that restraint been taken off you now so that you can go further?

[16] **Ms Collins:** Absolutely. Since Kate came into post in January, there has been an awful lot of work to overcome some of the restrictions we had previously.

[17] **Leighton Andrews:** I would like to understand a bit more about the constitutional relationship of Healthcare Inspectorate Wales to the Welsh Government. Do you get an annual remit letter?

[18] **Ms Chamberlain:** No. I am a Government department.

[19] **Leighton Andrews:** You are in a Government department, but you do not get an annual remit letter. Okay. How often do you meet the Minister, and which Minister do you meet?

[20] **Ms Chamberlain:** I am within the Local Government and Communities Directorate,

but I am independent within that, so I have access to the Minister for health to talk about the things that I am finding.

[21] **Leighton Andrews:** How often do you meet the Minister for health?

[22] **Ms Chamberlain:** Since I started at the beginning of January, I have probably met him about five or six times.

[23] **Leighton Andrews:** There is no scheduled quarterly meeting, however, as there might be with, say, the Estyn inspectorate for the Minister for education.

[24] **Ms Chamberlain:** No, it is as required.

[25] **Ms Collins:** Would you mind if I add to that?

[26] **Ms Chamberlain:** No, please do.

[27] **Ms Collins:** I think the issue for us is that we are independent of the Minister for health. So, the Minister for health does not set our remit. One of the issues that we had long discussions around prior to coming here, Mr Andrews, is that, previously, when we first came into being, we came regularly in front of the Health and Social Services Committee to talk about our remit and report back on our annual findings. We found that very useful in terms of holding us to account and making sure that we are publicly accountable. That seems to have fallen off the agenda along our journey over the last couple of years.

[28] **Leighton Andrews:** I would like to ask another question. Given your point about your independence from the Minster for health, have you looked at the relationship of other inspectorates to other Ministers and the nature of accountability and reporting?

[29] **Ms Collins:** This is something that we have raised within HIW, because we currently sit within the local government directorate, so our Minister is the Minister for local government and not the Minister for health. It is certainly something that we have discussed over the last couple of weeks, because coming to committee brings a real focus to some of these key issues as to how we enter into debate, not just with this committee, about where we should sit constitutionally.

[30] **Leighton Andrews:** For the record, Chair, I would just say that, in respect of Estyn, it is independent of the Minister for education, but the Minister for education gives it an annual remit letter.

[31] **David Rees:** That is noted. Kirsty is next.

[32] **Kirsty Williams:** Going back to the issue of 'we could not satisfy ourselves that we did not have a Winterbourne on our hands in Wales', I think the motivation behind the committee's undertaking this review is in light of scandals in the NHS in England and wanting to satisfy ourselves that our inspection regimes are fit for purpose. If you did not know whether you had a Winterbourne on your hands, are you confident that you would know whether you had a Mid Staffs on your hands?

[33] **Ms Chamberlain:** If I can come in on that, what I would like to do is to step back to think about what the role of the inspectorate is in terms of the way the health service works in Wales. I think it is important to recognise that the responsibility for day-to-day management of safety and quality rests with the local health boards and that the inspectorate cannot possibly be everywhere, in terms of trying to look at things on an ongoing basis. Therefore, part of our role is to make sure that we are testing, probing and looking at the intelligence to

see whether there any warning signs that there may be some significant systemic issue that we need to go in and look at further.

[34] I think there is room for a legitimate conversation about what sufficient testing actually is, within the context of the way these things work in Wales. For example, one of the things that I have been doing since I came in is to start thinking about how we would plan a sufficiently robust testing of practice within different NHS and independent care settings. My view is that, in order to do something that is sufficiently robust, you would probably want to have a minimum level of visiting, or a minimum frequency of visiting, for particular settings. There is certainly room for discussion about how frequent that should be, but you can start asking whether we should, for example, go into every acute hospital once or twice a year and into every community hospital once a year, or once every three years. I think there is room for a discussion on that. We also need to have quite an open discussion about what you would do while you were there. So, if you are going to go in, for how long do you go in? There are different models and approaches that are being taken to this in the various UK administrations, certainly in the wake of Francis. So, what do you need to do in order to satisfy yourself that you have tested and probed sufficiently in terms of making sure that what the organisation says is happening, and thinks is happening, is being reflected in practice?

[35] What you could then argue is that, because we are a reasonably small country in Wales, and we have a system where we have organisations, such as the CHCs, some of that intelligence and testing could be done in order to focus our activity most appropriately on the areas where there are the highest risks. There is scope for greater joint working there. However, we then have to have the discussion about the fact that, if we are an independent inspectorate, forming our own views, we cannot place an over-reliance simply on what others are coming up with. I am sorry that this is a bit of a long answer, but I will get to the short answer to your question. I do not think that we have had that discussion appropriately, and my concern at the moment, in terms of being able to give you the assurance that you want, is that I am not convinced that we have sufficient coverage, in terms of testing, for me to be able to give you that strong assurance. Part of the reason we have not had that discussion in the past is that, given that we have not been able to fill all the posts that we wanted to fill, it has been a conversation around whether, if we were fully staffed, we would be able to do a sufficient amount of testing. Certainly, on the back of some of the preliminary analysis that I have done, I have some concerns about whether, even with a full complement, we would be able to do enough for me to be able to satisfy myself to that extent. However, that is a conversation that I think we need to have. What I have suggested, and what you have seen in some of my papers, is that I am intending to put out a plan for the delivery plan for 2014-15, and I would like to be able to say, ‘Within our existing capacity, fully staffed, this is what we believe our work programme should be, based on our knowledge of existing priorities for the year ahead.’ I think that is the point at which we can have a conversation about what is the right, proportionate and appropriate level of inspection by us in the context of Wales.

09:45

[36] **Kirsty Williams:** Throughout that answer you have said that there is room for a discussion, and that there need to be a discussion. A discussion between whom?

[37] **Ms Chamberlain:** I think a very public discussion, which makes very clear what our role is in the process. Within the context of Wales and the other players in the system, there is a piece of work to look at how the external assurance framework should fit together and what the roles of the various players are in it, because it is quite a complex field. That is something that we are working with the concordat forum on. We do have to be, I think, far more explicit about what we can and cannot do in terms of that testing and probing, and we also have to be quite explicit about the fact that responsibility for managing patient safety and quality on an ongoing basis rests with the healthcare providers, and this is the approach that we are taking

to testing that. Does that help?

[38] **Kirsty Williams:** It helps. It is not wildly reassuring, I must say, sitting here listening to you say those things. Are you saying that the testing that is currently happening is not robust enough, and, even if you reformed the way that you do your testing, you are not confident that you would have the capacity to deliver against that?

[39] **Ms Chamberlain:** I think I am saying that I am satisfied that the way in which we are currently using our capacity is responding to the issues and concerns that we are finding. Probably a very good example of that is the fact that we did go up to Betsi Cadwaladr and do the review in response to the things that we found. I think, though, that, in order to do that, what you are finding is a knock-on effect on some of our other parts of work. I am certainly aware that a team went to Betsi and did the work in Betsi, and in order to do that I have had to delay reporting on a number of other pieces of work that that team was involved in. This plays back, then, into some of the other evidence that you have had from others. It is also true, I think, to say that, in terms of the way that we have been focusing and prioritising the work on the concerns and issues that have been drawn to our attention, possibly some of this baseline frequency stuff—which is, are we doing sufficient testing of the areas where there really is not a lot of noise at the moment, just to make sure that we can have confidence?—perhaps that is not being done to the extent that I would be happy with.

[40] **Kirsty Williams:** Obviously, it is difficult for you because you are relatively new in post, and you are having to get to grips with what you have found within the organisation. In response to Francis, the CQC is utilising a host of data as a smoke alarm for whether something is going on. It is using those data to identify risk in every single trust. Are you undertaking a similar review process for the data that you are monitoring?

[41] **Ms Chamberlain:** I would probably say, at risk of being contradicted, that ours are possibly a little bit stronger than that. We do review the intelligence and information that comes into us, but I think that part of the strength that we have, because of the way that we work together in partnership within Wales, is that we also have a process of what are called healthcare summits, whereby the various regulators and inspectors get together to discuss all the intelligence they have at their disposal and to test and challenge each other on whether the perceptions that we have of a particular body are borne out by our collective intelligence and evidence. I think it is the closeness of that working that is really the strength of the way that things are set up in Wales.

[42] **Kirsty Williams:** We have evidence from the CHCs, however, that says that the concordat that you have enjoyed with the CHCs, which are the people on the ground in the hospitals, has failed, and that there is no uniform communication between the various CHCs in Wales and yourselves. It is not your fault that the CHCs do not send you the intelligence, but I am bit concerned if that is the strength of the system, because we have had evidence to the contrary to say that, actually, that communication does not happen and those concordats have failed.

[43] **Ms Chamberlain:** I will ask Alyson and Mandy to come in a moment, but I think there are a number of different ways of looking at what the CHCs actually said to you, because I do not think it was the whole picture. One of the challenges with the CHCs is that, previously, they worked very independently in each of the areas, and now, certainly post review, there was a look to get far more consistency in the way that they work with us, which I think that will strengthen things in terms of forwarding on, on an ongoing basis, the intelligence that was referred to in the evidence that you received. It is also true to say, however, that CHC members do consistently turn up at the summits, so, even if they are not sending on reports on a routine basis, they are part of that process and they are sat around the table.

[44] **David Rees:** Lindsay Whittle wants to come in on this.

[45] **Lindsay Whittle:** Good morning. We have had evidence that your range of functions and statutory responsibilities has grown significantly since 2004. It is quite an extensive list that has been provided. Do you think that some of your responsibilities could be undertaken by other external bodies, or within the Welsh Government itself? You mentioned that you have a difficulty recruiting. How many staff do you employ, and how many vacancies to have? Do you know?

[46] **Ms Chamberlain:** Yes, I do know.

[47] **Lindsay Whittle:** Sorry for that. When people are asked for statistics, they do not always have them readily available.

[48] **Ms Chamberlain:** I do have some information in front of me that I could certainly pull out, but I can give you a broad sense of it now. Our complement is approximately 58 staff. The exact number of vacancies that we have at the moment I could not tell you with any great degree of certainty, partly because we are in the middle of an ongoing and significant recruitment process. So, I know that, for example, we recently filled our communications post, because we recognise the need to do a lot about the way in which we communicate what we do and what we find to the public. We recently filled a head of inspection post, but in that case, it was filled internally, so it has not helped with reducing the vacancy count. We recently filled our head of corporate support post, but that was from outside, so it will have reduced the number of vacancies. We have a number of vacancies at lead reviewer level, but we also have a number of staff who are acting in those posts on development opportunities. Now, it is difficult to know how many vacancies we have until that recruitment has run through, because we do not know how many of those posts will be filled on a substantive basis from inside the organisation or from outside. I think that we probably have somewhere between five and 10 at the moment that we are seeking to fill.

[49] **Lindsay Whittle:** Forgive me, but the posts that you have mentioned do not sound like coalface posts. I would be looking to employ more inspectors, really—you know, more Indians as opposed to chiefs, perhaps.

[50] **Ms Chamberlain:** They certainly are. The head of inspection is a coalface post. That person is not a manager; they go out on site. The reviewer posts that I referred to are coalface posts; they are specifically out on site and are within inspections and investigations. I would argue that the communications post should be regarded as a coalface post, because, if we do not communicate effectively what we are doing, what we find and the results of our work, I do not think that we would be fulfilling a core part of our purpose as an organisation.

[51] **Lindsay Whittle:** Thank you for enlightening me on that. Finally, I have just a quick question. How do you work with whistleblowers? What is your policy to assist whistleblowers in coming to you?

[52] **Ms Chamberlain:** We are a designated body for receiving whistleblowers. Perhaps I could ask Mandy to provide some detail on that.

[53] **Ms Collins:** We take all whistleblowing contact extremely seriously, and we do what we can to safeguard their identity. Over the last 12 months, we have had five contacts with whistleblowers, and they have led to us taking immediate action in following up on their concerns, and not just with the organisations that the whistleblowers come from, but with other agencies that we feel are able to assist in moving the agenda forward.

[54] **David Rees:** Rebecca Evans has a supplementary question on this topic—[*Inaudible.*]

[55] **Rebecca Evans:** It is just to go back to the first part of Lindsay's question, which is—[*Inaudible.*]—effectively done by other bodies, to free up the capacity to undertake the kind of work that Kirsty was talking about earlier. I particularly want your view on your role in monitoring the Mental Health Act 2007, for example; could that be done by Welsh Government, or by another body?

[56] **Ms Chamberlain:** I will go back to the more general question first, on the stuff that we do that could not possibly be done elsewhere. I think that there is one possible function that I would flag up in that area that does not, for me, feel as if it has a clear fit with the role of the organisation, and that would be the role of the local supervising authority for midwives. That feels far more as if it is a regulation-of-professionals role rather than an oversight-of-the-service-type role. That is something that we have started to look at; not in a great deal of detail, but it has certainly been flagged up as an area that we might want to consider further.

[57] As to whether others might be able to pick up on some of our other functions, I will start off by saying that I think that there is quite a logical fit. Certainly, part of the value of having the mental health work located is that it gives us another stream of evidence and footfall on the ground in the bodies that we inspect, so that we can use that as part of the testing process to get a clear view of what patient experience and patient care are like in these bodies. That is what we need in order to test and probe appropriately. So, there are a number of issues that mean that not doing that would weaken us in terms of the intelligence base that we have, but I would also question the practicality of it, because unless we are arguing that whoever would be picking up on this function is currently sitting there with capacity to do so, which I doubt is the case, then either they may ask for a transfer of capacity from us in order to enable them to pick it up, or we would be saying that there is additional capacity somewhere in the system to support it and, in which case, I would question the logic of moving it out when it could be bolstered and supported in situ, because structural change and movement like that is a disruption in and of itself.

[58] **Ms Collins:** To me, all of these pieces of work are a bit like a patchwork quilt. They built up a picture of an organisation. As Kate said, on mental health wards, you are building up a picture of how that organisation is governed because of the way in which it is managing the fitness for purpose of its mental health services. Similarly, some of the work that we do on deaths in prison build up a picture about the interface of the healthcare services in secondary care with other organisations, such as prisons. It all helps to add to the richness of what we know about an organisation. So, you could say that you could start to unpack and unwrap this, but if you did that, would you still get that richness in understanding about how healthcare, in the round, is working in Wales?

[59] **David Rees:** Elin, do you want to come back on that point?

[60] **Elin Jones:** I would like to go back to the discussion on intelligence and the intelligence gathering that you did. I would like to understand better what kind of intelligence you collate. What do you mean when you talk about 'intelligence'? You touched on the whistleblowing aspect of that, but what else comes into that pot? To take it from there, when you assess risk, based on that intelligence, what other factors or criteria of risk would then lead to the triggering of an inspection?

[61] **Ms Thomas:** There is quite a wide range of information that we take into account, which we refer to as 'intelligence'. That might be information that we receive from other bodies that have carried out work in that organisation, information on complaints made about health services—

[62] **Elin Jones:** Are they complaints to the ombudsman or community health council complaints?

[63] **Ms Thomas:** Yes, or complaints from members of the public who come to us directly. We also take into account information from the health boards in terms of the complaints that they have received and their handling of complaints. We pull all of that together and we sit down regularly as a team to consider what all of that information is telling us and what we might therefore need to do in response to that information. When determining the level and nature of the response to that information, we will also take into account the work that others might be doing and we will consider whether or not we might be best placed to respond or whether another organisation might be best placed to respond. So, we make a judgment based on that collective information, which will include hard data but also a lot of soft information that we have about that organisation.

[64] **Elin Jones:** So, in terms of the LHB information that you use, do the health boards formally report to you quarterly on the complaints that their chief executive has received or the complaints received through their complaints procedure? Do they present their risk registers to you in relation to staffing ratios and what is flagged up in their risk registers on staffing ratios and other risk factors within their establishments?

[65] **Ms Thomas:** No, they do not formally report to us, but we have access to that information as it is publicly available. So, we pull out that information and look at it ourselves. They do not formally report that information to us. What they do provide to us on an annual basis are the results of their corporate level self-assessment against the standards for health services. That provides a great deal of information as to where that organisation is against a range of governance questions.

[66] **Elin Jones:** However, on the complaints to LHBs and the complaints process, you said that that information is publicly available. I do not know whether it is, but I guess that it would only be publicly available right at the very end of a process. Complaints processes can take a very long time and you could lose something by just waiting until they end. So, I wonder how you have better access to that information than somebody like me would have.

10:00

[67] **Ms Thomas:** That is where there is a greater opportunity, as Kate referred to earlier, for us to work more strongly with community health councils, for example. So, there is an awful lot of information that they have available through their advocacy service. We are not yet routinely receiving that kind of information so that we can respond more quickly to some of that information, so that there is scope for us to pull together information earlier than is currently the case.

[68] **David Rees:** Are you saying that the complaints data that you are looking at from health boards are currently available as completed complaints processes, and not necessarily ones that are being dealt with at any point in time?

[69] **Ms Thomas:** Indeed.

[70] **Kirsty Williams:** May I just clarify something? You are using data that are in the public domain. It is only recently that risk adjusted mortality index data have been put in to the public domain. Risk registers had to be accessed through freedom of information requests, because they were not in the public domain. Serious errors have to go through FOI because they are not in the public domain. I am trying to get a sense of this. If you are relying on information that is publicly available and not on reporting from the LHB, and all of these things are only available under FOI, are you making such requests of LHBs? Otherwise, do

you have a secret website that we do not know about, because we have to FOI them?

[71] **Ms Chamberlain:** We have other sources of information as well. We see copies of incident reports and we have regular bilaterals with the Welsh Government to find out what sort of intelligence is coming up as part of its performance monitoring, so that we get access to the information that it is using as well. So, there are other sources of information as well as those. I am sure that Mandy would like to add to that as well.

[72] **Ms Collins:** We are not going to pretend that it is perfect, because it is not. Part of why we are so pleased to be here today is that we can discuss some of the issues that we have had with resources and also be totally open and honest about where we have done well, but also where we know that there is room for improvement. To be perfectly honest, in terms of some knowledge management, that is work in progress. What I will say is that we can have access and we can request access—you have mentioned FOI—but we can also fine people if they do not share information that we need, through the Act that came into being back in 2004. We have never used that, but we can do it. We have always wanted to be very clear about not wanting to overburden by making more information requests, but where we are now, in terms of relooking at our needs on knowledge management, is that we are very clear about what we need and when we need it. Let us be totally honest, some of the information is coming to us too late in the process.

[73] **Ms Chamberlain:** It is possibly something that you would expect me to say, because of where I come from: I previously worked in statistics and knowledge management, and there is scope for us to improve the way that we work in this area quite significantly. I think that there is a risk almost of asking for too much, too often, so that we begin to lose sight of the really key issues. I am keen that we develop the way in which we are asking for real-time information from both those that we are responsible for reviewing and from those who are also in the business of reviewing, overseeing and performance managing those. We need to get the right things in a timely way so that we can respond to them, rather than getting lots of stuff that we then simply invest an awful lot of time in trying to drill through to try to find out what is most likely to direct us in the right way.

[74] **David Rees:** Kirsty, have you finished?

[75] **Kirsty Williams:** That is fine, but if I could come back to follow up on that later, I would be grateful.

[76] **Leighton Andrews:** Do you have what might be recognised as an inspection cycle for health organisations?

[77] **Ms Chamberlain:** Mandy may be able to illuminate you on whether we have had one in the past, but this brings me back to what I was saying about the need to be clear about, for example, what the minimum frequency of inspections might be and to be quite explicit about that so that we can have a discussion more widely about whether that is sufficient. However, it has to be rooted in our capacity to deliver. What I do not want is to be saying that we should be doing certain things every year if we are reasonably clear that we are only going to have the capacity to do it once every two years. That is where I would like us to be, and that is what I will be setting out in the plan.

[78] **Leighton Andrews:** Yes, but there has to be an ideal position, does there not? Or maybe not an ideal position, but an optimal position.

[79] **Ms Chamberlain:** There has to be a recognised position. I would start from the fact that I think that we should be in every acute hospital at least once a year and the more complex ones probably twice a year, but even that, I think, is a bit of a blunt instrument,

because you then have to start thinking what being in that setting means. Does it mean that we go in and we review a range of specialties? Does it mean that we look at two wards? Does it mean that we look at a patient pathway through from—[*Inaudible.*]—to accident and emergency? I think that it is about what is reasonable, proportionate and sufficient in order to provide the reassurance that we need.

[80] **Leighton Andrews:** Who is the accounting officer for Healthcare Inspectorate Wales?

[81] **Ms Chamberlain:** Ultimately, the accounting officer will be the director general of local government and communities.

[82] **David Rees:** We will now move on to the next set of questions, which are from Oscar.

[83] **Mohammad Asghar:** My question will relate to inspection methods and self-assessments. Reading some of the written evidence from Betsi Cadwaladr University Local Health Board was very alarming. It stated that

[84] 'since the process of monitoring the standards is now on a self-assessment basis, we have lost the added benefit of having the opportunity to benchmark with other LHBs'.

[85] Hywel Dda Local Health Board states in its written evidence that

[86] 'there cannot be an over reliance on self assessment as a process for Health Boards to demonstrate their effectiveness'.

[87] Finally, the independent healthcare standards are out of date, and it is difficult for members of the public to see exactly what work is being done in this area. Could you clarify to the committee the role of Healthcare Inspectorate Wales in reviewing compliance with the standards for health services in Wales and aspirations for the future?

[88] **Ms Chamberlain:** I will ask either Mandy or Alyson to lead on that, because you will see from the evidence that we have submitted that it is an approach that has changed over time. Actually, I think that it is an approach where we need to be stepping back slightly to where we were, rather than continuing with where we are.

[89] **Ms Collins:** I will start from the point of view that we use self-assessment as part of the process. It is not a process in itself, because it is then followed up with visits. When we started with the first set of healthcare standards, we had a self-assessment tool that went out to the services and required them to assess themselves against all 32 standards. We did some benchmarking and we undertook visits. We had asked them to assess themselves on a maturity matrix and then, through our visits, we would say, 'Actually, you've said, for example, that you are really good at infection control, but our visits have shown that you're not'. So, there would be a challenge and a report that went into the public domain. There was an element of benchmarking across the service.

[90] There were real concerns around that process because it was considered by organisations to be very time-consuming for them, and they questioned some of the benefits of it. The new standards are not our standards—they are Government standards. We have no role in setting the standards. We just use them to assess. So, if they are out of date, that is for the Welsh Government to take forward, not us. We decided that we wanted to be very clear that, in terms of inspection, we need to take cuts of an organisation; we need to understand how it is governing, but we also need to test how it is governing through looking at things at board level. So, we address the ward-to-board gap, and we discuss how the PAC around Betsi

Cadwaladr University Local Health Board was happening. It is also about how we test that that is not happening. We then move on to have a look at the governance and accountability arrangements in an organisation, and we test, through our inspections and our footfall, whether that board really knows its organisation. So, it is never meant to be a stand-alone process. We are always meant to be visible.

[91] We have talked about some of our capacity issues, and there have been real capacity issues. If you were to ask whether I am disappointed that we have not done more in terms of inspection, I would say that I am, because I am in HIW and I have worked there because I want to make a difference to patients. You do not make a difference by sitting, looking at a self-assessment on top of a desk. You make a difference by being out there and testing the experiences of Mrs Jones on any day, on any night, on any weekend. I think that we have really focused on that by bringing unannounced inspections and inspections at night and on the weekend. Do we do enough of them? Absolutely not, because of the capacity problems. Actually, is the principle and the philosophy behind what we do, in terms of getting an organisation through self-assessment to recognise its responsibilities for ensuring that the organisation is fit for purpose and testing their response on whether they truly know their organisation? My personal opinion is that that is the right approach, but we need to be out there doing more inspections.

[92] **Mohammad Asghar:** Thank you for that passionate answer—

[93] **Ms Thomas:** One of the key things that we had in mind when working with the health service to develop the approach to self-assessment was that it needed to be a process that was owned by the health service itself, so that it was not just a process that Healthcare Inspectorate Wales developed and imposed on health organisations. We very much wanted it to be part of those health organisations' own internal arrangements. It was very much designed so that boards themselves used the self-assessment process in order to satisfy themselves that they knew where their organisation's strengths and weaknesses were, in order that they could give assurance to their local communities. Our role was very much to test that. The introduction of the self-assessment was much more than just being about information for HIW to target its work. It was very much designed for the organisations themselves to use that as a tool to get its own assurance.

[94] **Mohammad Asghar:** Thank you for that answer. What are the benefits and challenges of self-assessment in terms of driving up standards, which you are not setting, but which the Government is setting?

[95] **Ms Collins:** If we look at where we were with the first round of self-assessment, we will see that the reason why we changed our approach is that they were treating it like an exam; they were sitting in rooms thinking about what the right answer was. That is not self-assessment. True self-assessment is about an organisation really and truly reflecting on its own performance, and that needs a level of maturity. To be honest, it was quite clear from the first round of assessments that some organisations had that level of maturity and wanted to truly reflect, and that others wanted to get the right answer, to get a good scoring on the maturity matrix. That is why we have really changed to look at the governance rather than to look at the other 32 standards holistically. We are looking at the governance and accountability and then testing the rest of the standards through our inspection visits. We are also testing the boards' awareness through that. You have to be really careful with self-assessment, because it can leave itself open to game-playing and people giving you the answer they think you want, rather than the real answer about where that organisation is.

[96] **Mohammad Asghar:** Finally, what is the timescale for the implementation of service-specific modules?

[97] **Ms Collins:** We have already started. It is, again, about engaging with the service. So far, we have developed modules for cancer and palliative care and those have led into us taking forward some work with the service around peer review. That is the peer review plus, which has a backbone of rigour, where we as the inspectorate ensure that we are satisfied that it is done with a level of rigour. So, it is not a peer review based on gentlemanly discussions and agreements. There are outcomes, action plans and changes being made as a result of peer review. We have also been doing some work with mental health services across Wales in terms of looking at the self-assessment model for that, as well looking at maternity services.

[98] It is really important that we work with services so that they translate the healthcare standards into a language that the service understands. If you can bear with me, I will give you an example. When we were looking totally at the 32 standards and looking, for example, at child protection, those working with the adult mental health service were saying to us, 'Child protection? We don't provide services to children so it doesn't apply to us'. We would say, 'Well, actually it does, because you're dealing with parents of young children who are quite poorly on occasion. You are also dealing with children visiting wards. So, absolutely, child protection does apply to you.' We have been spending an awful lot of time with services to ensure that they totally understand how those standards relate to them.

[99] The other thing that we have been trying to do—around the myriad standards that are out there, as well as the guidelines, NICE guidelines and patient safety alerts—is to try to work with services to make sense of all that, because they become a bit overwhelmed by the amount of guidance that is out there. So, through the individual models, we are spending time. They get a pocket book and if they are managing mental health services, for example, it will tell them what they need to be doing to make sure that they are providing safe services, first and foremost, as well as driving the quality of their services.

10:15

[100] **David Rees:** Could I ask about self-assessment? I have come from an organisation that was involved in self-assessment and had to do some evaluation before its inspections. What percentage of those bodies that are doing self-assessment are, as you pointed out, taking the serious aspect of this on board, realising the benefits it can give and not just doing the tick-box exercises?

[101] **Ms Collins:** At the moment, I would say that you are looking at about 50% of organisations.

[102] **David Rees:** So, it is only about half that are really embracing what it can provide.

[103] **Ms Collins:** Absolutely, and you are leading me on to discuss some of the hidden benefits of Healthcare Inspectorate Wales, because our reports go into the domain, and a lot of work goes on in the background, in terms of discussions and supporting organisation to become mature. We can only ever give a snapshot of an organisation. Those organisations have got to own for themselves the quality and safety of their services and they have to have their own internal governance arrangements. As was said earlier by Kate and Alyson, we come in and we poke and we prod. We do not, and we cannot, live in these organisations. Can we do better, in terms of poking and prodding? Yes, absolutely, but, fundamentally, ownership for safety and quality has to sit with the organisations, and we do a lot of work behind the scenes to get them to understand their roles and responsibilities in that.

[104] **Leighton Andrews:** I think poking and prodding is a kind of shorthand for inspection. I just want to understand a few more points. Do you meet regularly with the equivalent bodies in the other home nations?

[105] **Ms Chamberlain:** Yes, we do.

[106] **Leighton Andrews:** Do you have any observations on the constitutions of those organisations, compared with yours?

[107] **Ms Chamberlain:** By 'constitutions', do you mean their organisational structures?

[108] **Leighton Andrews:** I mean their structures, accountability, the nature of board appointments and those kinds of matters.

[109] **Ms Chamberlain:** One of the things that has become clear is that they have very different remits, particularly if you look at Healthcare Improvement Scotland, which is involved in healthcare improvement and in setting some of the standards, as well as going out there to make sure that the evidence base is clear, in much the same way that NICE does, and then going out to scrutinise and assure to make sure that those standards are being adhered to. In Northern Ireland, there is very much an improvement focus in terms of RQIA. I cannot remember what RQIA stands for.

[110] **Leighton Andrews:** It stands for the Regulation and Quality Improvement Authority.

[111] **Ms Chamberlain:** Thank you for that. They will probably be quite offended now, because I was with them last Friday.

[112] **Leighton Andrews:** I was just Googling while I was listening.

[113] **Ms Chamberlain:** We were having quite a broad discussion last Friday about the extent to which our role is about holding to account and providing assurance, as distinct from getting within an organisation and supporting improvement. That then also begins to impact upon the way in which you pick up your programme and the way you prioritise and set your programme. The Care Quality Commission is obviously in a completely different place, in terms of its accountability, where it sits and the range of its remit. I also think that there is possibly a bit of a challenge in terms of the way that the CQC is undertaking its role, in that it feels as if it is almost becoming the organisation that is responsible for the quality of services that are being provided, and I think that that is probably a risk, if you begin to take the really intensive type of review approach that it has been taking. One of the things we have been looking at, for example, is how it is assuring itself, in terms of the performance of acute hospitals. Certainly, if you look across the different administrations, you will see that there are very different approaches, in terms of the input that is being given. The CQC is going around and reviewing everywhere over 15 months, with teams of anywhere between 20 and 80 inspectors going in for a week. In Northern Ireland, they are planning to review all of their acute hospitals over the next six months, sending in teams of 10 inspectors over a period of a week. So, we do have those sorts of discussion about how they focus their work and how they are accountable for their work in that way.

[114] **Leighton Andrews:** Do you have the capacity for unannounced inspections?

[115] **Ms Chamberlain:** We have the capacity for unannounced inspections and we do them. I am not convinced that I have capacity for sufficient unannounced inspections.

[116] **David Rees:** We have questions now from Rebecca, Darren and Kirsty. We will start with Rebecca.

[117] **Rebecca Evans:** I wanted to ask you about special measures. The board of CHCs told us when it came to committee that it had no understanding of the escalation process within HIW and the Welsh Government. It did not understand what constituted special measures or

what happened when special measures were enacted. So, could you talk us through the process?

[118] **Ms Chamberlain:** Healthcare Inspectorate Wales has the power to recommend special measures. One of the things that I have been trying to get my head around is that there is no single, clear definition of what constitutes special measures. Depending on the nature of the issue, there could be a range of possible responses to that. It is also possible to say that, on occasion, action is taken that might constitute special measures by any reasonable definition, but it is not called that. Certainly, on the back of the work that was done in Betsi Cadwaladr health board, one thing that has been triggered as a result of that is a joint piece of work between us, the Wales Audit Office and the Welsh Government to almost step back from the term 'special measures' and think more widely about what the escalation process is when concerns arrive, what the triggers are for taking those concerns to the next level and, quite explicitly, who has the responsibility to act when concerns are triggered and escalated in that way. That is the piece of work that I think will come out with more clarity about the process and more clarity about the application of the term. Having said that, I know that HIW has taken special measures in the past. Mandy, would you like to say anything about that?

[119] **Ms Collins:** One that you may remember was under Gwent Healthcare NHS trust, as it was then. We went in to look at maternity services and, in particular, at circumstances surrounding a series of maternal deaths. When we looked at it, it was quite clear that there was a gap between the board and understanding what was going on in maternity services. We took the step of making recommendations for special measures and, for that organisation, the special measures were immediate action plans, weekly visits, follow-up reports and a huge amount of scrutiny on that organisation from us, as the inspectorate, until we felt satisfied that the issues and concerns that we had about that organisation had been rectified in a way that was sustainable in the long term.

[120] **Rebecca Evans:** You both referred to the fact that you can only recommend that special measures are put in place. The Wales Audit Office expressed to us some concern that ministerial agreement, which is necessary, could potentially fetter your ability to act autonomously, independently and swiftly. Is that a concern that you share?

[121] **Ms Chamberlain:** It is probably not a concern that I share. I have not been here long enough to say that I have never been stopped or had a recommendation refused, but certainly my perception, in terms of the independence that we have to respond to the issues that we find, is that I have never had any indication that I would be prevented from doing so. I think that part of the insurance that sits around that is that, because of the independent nature of my role, there is nothing to prevent me from publically stating that I have made a recommendation to the Minister that such and such an organisation should be put in special measures. So, because I have that freedom, I would have no problem in doing that. That is the sort of information that should be placed in the public domain alongside the response of the Minister with either a 'yes' or a 'no' and, 'This is what we are doing about it'.

[122] **Darren Millar:** As a follow-up to that, I appreciate that you might—[*Inaudible*.]—since your appointment, Kate, but, in terms of HIW as an organisation, in its lifetime, how many times have special measures been recommended?

[123] **Ms Collins:** In its lifetime, we have recommended special measures three times, the latest being in relation to a former special measure around Betsi Cadwaladr health board in terms of our follow-up. The others would have been in relation to Gwent healthcare trust, and the work that we did in Cwm Taf around the governance arrangements, when we went in and did a special review that included three follow-up visits before we came to the final report on its governance arrangements.

[124] **Darren Millar:** So, those recommendations were made and, in each case, accepted, I assume, by the Ministers. You seem to use them very sparingly compared with, say, Estyn, as an inspectorate, which might go into a school, find significant problems and then be able to instigate special measures immediately in order to rectify a situation. Is that because there is no clear definition of what a special measure is or is not? In addition to making the health board aware that you are seeking to intervene in some way, and the Minister giving you permission to then do so, who else do you have to notify when special measures are enacted? Do you have to let patients or community health councils know? As I understand it, you do not.

[125] **Ms Chamberlain:** As I understand it, we do not. What is interesting about the conversation that we have just had is that we have referred in that context to the Betsi Cadwaladr work being special measures. Certainly, in that context, admittedly it was in the first month or two of me being in post. I did not recommend that we put it in special measures; I simply said, 'This is what we are going to do about it', and we sat down with the Wales Audit Office and said, 'This needs a single integrated review to pull together all of the issues that we think are affecting this body'. This is why I think that the project that is currently going on—and that is why it flowed out of that—was about us needing a formality of process, but it is a matter of whether the formality of that process is clearly enough understood. It is important that the process must not get in the way of the action. For me, it is the action that is taken in response to the escalation of those concerns that is most important.

[126] **Darren Millar:** I think that the difficult issue for me to grasp is, as you have articulated very well, the separation of the responsibility for delivering the high-quality care from your role as an inspectorate in ensuring that your recommendations, if you like, are fulfilled and carried out. So, you do not have a direct responsibility for managing the implementation of your recommendations in that case, do you, even under special measures?

[127] **Ms Chamberlain:** Not for managing the implementation, but I would say that, under special measures, we have a specific responsibility for monitoring the implementation and for requiring people to report to us on progress and how much progress they are making.

[128] **Darren Millar:** That sort of brings me on to the next issue that I wanted to discuss, which was the follow-up work that you do as an organisation.

[129] **David Rees:** Kirsty has a question on this.

[130] **Kirsty Williams:** It was on follow-up.

[131] **Darren Millar:** Pardon me if Kirsty had already indicated that she wanted to go on to that, but I am interested in knowing your capacity for follow-up work and making sure that your recommendations are implemented, because it has been an issue that witnesses have referred to, and which has been, perhaps, absent or often too absent in the past.

[132] **Ms Chamberlain:** I think that I would refer you back to the case studies that we have given you in the evidence. I think that it is possibly too much to say that it has been absent. My own view is that we need to be closing the loop slightly more. I think that there is a piece of development that we need to do. Typically, we have reported on the pieces of work—the inspections—that we have done at bodies. We have reported on each one of those. I would like to be able to get us to a point where, as part of our reporting, certainly at board and organisational level, we are drawing together all of the findings from that as part of a formal report that says, 'These are the thematic issues that are arriving at your particular body'. As part of preparing for that thematic analysis, because I do not think that it would be good use of our capacity, however big it is, I do not think that we should be going out there to each of the bodies that we review, asking, 'Have you completed action 46 on action plan 19?',

because that gets us into a very mechanistic process, which does not necessarily demonstrate change. Actually, I would like to see us doing, at least annually, a more holistic piece of work with an organisation that says, 'We would like to examine how you are responding to the concerns, issues and recommendations that have been made to you', whether they are the recommendations that we have made, the learning that is coming out of your complaints process, or the issues that are coming out through ombudsmen's reports to form a far more holistic view of how that organisation is handling the change. That is where I would like to get us to in terms of follow-up. I hope that we have demonstrated through the case studies that, actually, where there are significant issues, we do not let go of them. However, it is probably fair to say that we do not monitor every recommendation from every action plan that we issue.

[133] **Darren Millar:** I have one final question. That will have an impact on your resource needs, will it not?

[134] **Ms Chamberlain:** It will.

[135] **Darren Millar:** You have said that you are preparing your plan for the next two years.

[136] **Ms Chamberlain:** Yes.

[137] **Darren Millar:** Will that plan have a resource request attached to it, and do you have a ballpark figure, even this morning, in terms of the sorts of additional resources that you might be seeking from the Welsh Government? We are in the middle of the budget round, as you know.

[138] **Ms Chamberlain:** The delivery plan that I am going to produce—and part of the reason I have not produced it yet is because I am waiting for formal notification of the capacity that I will have in terms of going forward—will set out how I would prioritise the use of the capacity. Then we need to have a quite realistic discussion about whether that is sufficient and whether that prioritisation is correct.

10:30

[139] My personal view is that, once I have done that, it will not be sufficient. Next year, even if I were to be given enough to do what I think I need to be doing, I would not have time between now and April to get the resources in place to be trained and fully experienced to be out on site. So, we have time to have that discussion on the basis that we can then nest it, if you like, within the other review that is going on of audit and inspection bodies, and nest it within the review of the external assurance framework so that we can make sure that whatever we are saying should be done is proportionate and is making best use of the combined resources in Wales. We cannot lose sight of the fact that for every £1 spent on inspection, that is £1 not spent on service delivery. We need to make sure that whatever we are doing is focused in the right areas and is really adding value.

[140] **Darren Millar:** If that pound is saving lives—

[141] **Ms Chamberlain:** Exactly, that is why I am saying it has got to be adding value. We have to be doing the right thing.

[142] **Kirsty Williams:** May I come to the issue of follow-up? You referred to your case studies. I will take as an example case study 4; it is an area I know particularly well. You carried out an unannounced inspection in October 2009 and found the service wanting. It says in your note that you reported immediately on the day with feedback and then wrote to the

organisation. In this case study, you are not able to evidence any further contact with that organisation until the outcome of a critical ombudsman's report in 2011. That is when you went back to the health board. You did not carry out your follow-up until, as it says here, you conducted a visit in January 2012 to follow-up on the recommendations of your initial visit in 2009. Am I being unrealistic in thinking that a follow-up that far after the initial visit is the optimum that we can expect from your organisation?

[143] **Ms Collins:** This is a case study that, at the time, I lived and breathed. What we do not reflect is the number of conversations that went on with senior management at that organisation, particularly the nurse exec, in taking matters forward.

[144] **Kirsty Williams:** If all that went on, why did you not put it in your case study?

[145] **Ms Collins:** It should have been there, Kirsty. It should have been.

[146] **Kirsty Williams:** We can only judge you on the evidence the organisation puts forward.

[147] **Ms Collins:** You are absolutely right. It should have been in there. There is a lot of work, as I said earlier, going on in the background. The last thing we want to do, particularly if there are issues of patient safety, is to leave it until two years later. Sometimes, it is not about an inspection, because we know what the issue is, but it is about working with that organisation and understanding what it is doing about it. We went back as a result of the ombudsman, which threw up different issues to what we had covered. Would I like to be sitting here saying that we went back in 2010 or even nine months after the first visit? Absolutely. I would be doing you a disservice if I was to say otherwise.

[148] **Kirsty Williams:** Okay. May I also look at how you provide feedback? Your website has a list of unannounced hospital cleanliness spot checks. It says when they were carried out, but only five out of the 19 visits show the LHBs' action plans, and there is no indication of what HIW has done as a result of those action plans. The website has not been updated for over a year. Any inspections that you might have carried out within the last 12 months are not even publicly available. Why is that?

[149] **Ms Chamberlain:** Do you want to say anything on the action plans?

[150] **Ms Collins:** Do you want to talk about the website first, and then I will talk about the action plans?

[151] **Ms Chamberlain:** Okay. We acknowledge that our website is simply not up to the job. It is something that—and Alyson may wish to add to this—appears to have been under redevelopment for some time now. It simply has not been progressed as far as I would want. I do not think that it communicates particularly well. I do not think that it is easy to search. I think that it is very difficult to find reports on an area where you want to find out exactly what has been done. I am not going to sit here and defend our website, because I do not think that it is good enough. It is one of the first things that will be tackled by the communications manager. Having said that, if we are going to make a virtue out of what I do not think is particularly virtuous, there is a lot of information on there, but that is part of the problem. Part of the problem is that you cannot find it and you cannot work out effectively what it is really telling you about the quality of services in Wales, and that is something that I think we need to do an awful lot on in the near future. That is part of the reason that I refer to the communications post that we have coming in as being part of front-line delivery rather than being a back-office job.

[152] **Kirsty Williams:** In answer to Darren Millar's question, you said that you would like

to get to a situation where you would complete this circle of inspection. When are you hoping to get there?

[153] **Ms Chamberlain:** Part of what I want to include in the business plan for next year is something about how we rebalance in terms of not—. I do not think that we are going to have a great deal of capacity to do a great deal of additional inspection, so I think we have to be making far more—I do not want to say 'capital', but to get far more value out of the ones that we do in terms of how we are pulling out the issues that really need to be addressed and making sure that people are addressing them.

[154] **Kirsty Williams:** In answer to Leighton Andrews, you acknowledged that you do unannounced inspections, but that you do not do enough of them. Could you give us a sense of what the gap is between what you are currently able to carry out and what you would regard as an adequate number of unannounced inspections? What is the gap?

[155] **Ms Chamberlain:** This, again, brings us back to what we think is the minimum baseline frequency versus the amount that we need to do to respond. Again, going back to some of the figures, I would like to think that we would be able to say that we had been into every community hospital at least a minimum of once every three years, and additionally. I do not think that we do that at the moment; I think we are probably on about one in five. I would like to be able to say that we are going into every acute hospital every year and more than that for the bigger ones; I do not think we do that at the moment. Mandy, I would probably say that it is about one in three, is it?

[156] **Ms Collins:** One in three.

[157] **Ms Chamberlain:** One in three. We are quite a way off.

[158] **Kirsty Williams:** So, it is a big gap.

[159] **Ms Chamberlain:** Yes.

[160] **David Rees:** Before I move on, Mandy, do you want to answer the question on the action plans?

[161] **Ms Collins:** I will assure you that there is an action plan. An action plan starts on the day of the visit. No team leaves a hospital without giving formal feedback to the senior team and focusing on key findings. If there are real concerns around patient safety, we will not leave until they are sorted and addressed and we are happy that the way they are being addressed will lead to immediate change in terms of key safety issues. In terms of follow-up of those concerns that need to be dealt with within weeks, not months, of our visit, there is a management letter that goes to that organisation straight away, we will escalate internally, and there will be meetings with the senior management team if needs be. However, I totally take on board Kirsty's comments. That needs to be more visible. Our role is around public assurance, and, therefore, every step of the process in terms of what we do to assure ourselves around the safety and quality of services needs to be in the public domain. We are very open and transparent in terms of final reports; the background work needs to be more visible.

[162] **David Rees:** Kate, do you want to add to that?

[163] **Ms Chamberlain:** The only thing I think I would add to that is, again, to take us back to where we have been over the last 18 months to two years, as a result of the vacancies that we have been holding and the constraints that we have been under, we have tended to prioritise getting out on site over providing public information and that sort of accountability role. I would prefer to be far more open and do less but actually close that loop and do the

reporting.

[164] **David Rees:** Rebecca has a follow-up question on this and then we will move on to Elin.

[165] **Rebecca Evans:** A written submission that we received from an organisation called Dignity in Care said that unannounced inspections were sometimes not unannounced and that front-line staff knew that they were going to be taking place. I should say that there was no evidence attached to that to support it, but I did want to give you the opportunity to respond.

[166] **Ms Chamberlain:** We also do not have any evidence to suggest where that may have been the case. I think we have set out in our submission the arrangements that we go through, or, if we have not, we would certainly consider doing so, in that, if we are going to do an unannounced inspection, typically on an NHS site, we would notify the local manager, maybe half an hour before we arrive, which hospital we are going to be in, but not specifically which ward, simply so that the site manager knows that we are going to be there and that we are going to be on site. So, to that extent, you could argue that it is not unannounced because you know half an hour before, but it is, I would say, to all intents and purposes unannounced, certainly in that context.

[167] **Ms Collins:** May I just add to that? For our regulated providers, we do not even make a phone call half an hour before, because they are smaller, and we know there is going to be an on-site manager. The reason why we do ring through to the chief executive of the health board is because they are large organisations and they need to make sure that somebody senior is there for the feedback meeting at the end of the day. So, that is the only reason. I have to admit I was a bit flummoxed, and could not understand how this statement was made, because, certainly within our organisation, we do not even tell the review team the exact wards that we are going to prior to our visit. It would just be the full-time member of HIW staff who would know.

[168] **Elin Jones:** Healthcare Inspectorate Wales has a chief executive. The other inspectorates, or some of them, have chief inspectors. I wanted to ask what the difference in role is for your organisation to have a chief executive rather than a chief inspector, then I want to go on to the single integrated review model, and the Betsi Cadwaladr experience with the auditor general. We discussed that with him when he gave evidence. The review of 'board to ward', I think he described it as. Do you think there is scope to work more collaboratively and to undertake similar reviews in other areas in Wales? He outlined to us that that discussion and decision would happen on a risk basis in discussion with yourselves, and I wanted you perhaps to explain to us how you would go through that process of analysing the risk and the need for a single integrated review in any other place, or again in Betsi Cadwaladr.

[169] **Ms Chamberlain:** If I miss one of those questions please tell me, and I will answer them. To be honest with you, I do not know why HIW has a job title of chief executive rather than chief inspector, and I am not aware that it has a significant difference in terms of job content. It may just be an issue of how it is written, but I do not actually know that. It may be something that is worth going back and having a look at.

[170] In terms of joint working, I think there are probably three key interfaces that we need to manage effectively in Wales if we are to make best use of our combined skills. There is the interface between ourselves and the Wales Audit Office, which you have referred to. I think part of the reason that we decided to work together in the way that we did at Betsi Cadwaladr University Local Health Board is because we had both, separately and independently, been raising very similar issues over a period of time from our respective work programmes, and we felt that it would possibly even be more helpful to the organisation if, rather than being

constantly battered from different sides, with people saying the same thing, we brought together in a more collegiate way the things that we thought it really needed to be tackling as an organisation. I think that worked well, because we were able to draw on specialist peer reviewers to come in as part of our team to provide credibility for the work that we were doing. We were able to link the 'so what?' questions, if you like, in terms of patient safety, and some of the feedback on the issues to the financial management issues, so that it was all part of one and the same thing, and to draw on the financial skills of the auditors. I think the messages that come out of the joint working, both for ourselves and the auditor general's office, is that the use of those complementary skills in that co-ordinated way was actually very effective and very powerful in that particular setting.

[171] Would we want to do it everywhere? I think it is probably true to say that we do work in a collegiate way in terms of informing each other's work, because we do the review of the governance and assurance statements ourselves, and the Wales Audit Office does the structured assessments. We do meet and talk on a regular basis about the type of issues that are coming out and feed back to each other. So, this plays back into the fact that we are a small country in Wales and we do work very collectively and collegiately together. If we were to do another review of that type it would be to try to capture, I would have thought, similar types of issues to those at Betsi—the fact that there are a number of things that have been ongoing for some time that we are identifying, where we feel there would be value in presenting those as a single whole back to the body itself.

[172] So, that is one of the key interfaces. I said there were three. We have referred already today on a number of occasions to the need to think about how we work effectively with the community health councils. They have a wealth of intelligence through their advocacy service, and they also go out on site, possibly far more often than we can. If we can develop them as a source of intelligence and leverage then I think we can move quite a long way, which is why I have been working with Cathy to develop the memorandum of understanding and what we need to do to implement it properly. The other key interface is the one with CSSIW, and, as we move to models of integrated care, we are going to need to make sure that we work on a far more collegiate basis with CSSIW. I think we are helped in that way, because we sit within the same part of the Welsh Government, and we now sit in the same building. There are opportunities for us to think about how we manage that interface between us effectively, in terms of doing joint work, and we already do that in areas such as deprivation of liberty safeguards. Has that captured all the elements, or have I missed something?

10:45

[173] **Elin Jones:** It was very comprehensive. Just to go back to the single integrated review model, I just want to be clearer on the criteria for the decision making that you and the auditor general would undertake in order to decide whether you believe that that model of an integrated review would serve a purpose in another health board in Wales. I am not clear what the criteria are for deciding on that model, other than that you are getting lots of issues in both organisations and getting a lot of intelligence about issues that are of concern.

[174] **Ms Chamberlain:** I think that that was a question that we asked ourselves, after Betsi, and it was in asking ourselves that we decided that we needed to do this joint piece of work on what is the escalation and action framework for concerns in NHS bodies. I do not particularly want to pre-empt that exercise, because it is that exercise that will set out quite clearly what the process is and what the triggers are, and who is required to act in what particular circumstances. I would expect that also to cover at what point we would act together.

[175] **Elin Jones:** Okay. That is fine.

[176] **David Rees:** Lindsay is next.

[177] **Lindsay Whittle:** Thank you, Chairman. I notice that you investigate deaths in prisons, and that is a role that you undertake on behalf of the Prisons and Probation Ombudsman, as well as investigating death in custody. You also review armed forces healthcare in Wales. These are not devolved matters; they are the responsibility of the Home Office and the Ministry of Defence. Do they pay you for this? I am interested in armed forces healthcare in Wales, because the Royal Welsh, for example, is based in Wiltshire. Do you review their healthcare in Wiltshire? How do we do this?

[178] **Ms Chamberlain:** The armed forces report—

[179] **Lindsay Whittle:** Sorry, I am not suggesting that we should not look after prisoners' health and inspect their care, and the same goes, obviously, for the armed forces.

[180] **Ms Chamberlain:** I will let Mandy tell you a little bit more about the armed forces report, because that was before my time, and she will probably understand the genesis of it more. However, it was a specific piece of work.

[181] In terms of deaths in custody, we provide the clinical input to the reviews that take place. I do not think that we are paid for it. As far as I know, we are not paid for it, and I am not even convinced that I would necessarily ask to be, because the area that we are looking at is the interface with the healthcare providers in Wales. We talked earlier about the patchwork of sources of information that we get to inform our judgments about whether there are issues and concerns in an area. The types of issues that come out from those sorts of reviews in terms of communication between the secondary care providers, the prison, discharge summaries, general communication in those sorts of areas, turnaround times, and all those sorts of things, are important parts of the evidence that we would want to be able to draw on in terms of the performance of the provider. So, we are not specifically reviewing the prison; we are reviewing the care that has been provided to the prisoner. Mandy, would you like to expand on that?

[182] **Ms Collins:** We are not paid for that work. We make sure that we bring together a team of peer and lay reviewers to undertake those visits. So, there is a cost to HIW—one that was probably not factored into our budgets at the start. However, as Kate said, it is really part of this rich tapestry of us understanding what is going on in healthcare in Wales. Some of the findings are quite significant and would be indicators of the relationship, not just with prisoners, but probably with primary care as well. So, that is why it is really important work.

[183] In relation to the armed forces review, it was a one-off exercise. HIW was involved in a working group that was set up by Ministers. As a result of that, what we undertook was more of an inquiry into experiences rather than a full-blown inspection of services. From that, though, there were some important messages for HIW, certainly in relation to when, in the future, we look into primary care and into secondary care mental health services in terms of flagging issues up for servicemen who might have post-traumatic stress but have not been recognised yet, and how we make sure that primary and secondary care are aware of the background and history of some of these servicemen, not least those who might be in the territorial army services and would not therefore get support back at the base like those who are in full-time service.

[184] **Lindsay Whittle:** I have a quick follow-up question.

[185] **David Rees:** Kate would like to come back on that point.

[186] **Lindsay Whittle:** I beg your pardon.

[187] **Ms Chamberlain:** I would like to add one thing to give you a bit of context with regard to the death in custody reviews. We said in the briefing that we are doing about 10 of them in 2013-14, and, typically, each one takes about 10 days' worth of HIW's time and 10 days' worth of an external reviewer's time. So, we are talking about 100 days' worth. It is not a significant part of our work, but it is an important part of our intelligence base.

[188] **Lindsay Whittle:** Yes, of course. We are due to open a new prison in Wrexham, are we not, which might be a very large prison? Not all of them will be Welsh prisoners, as there will be people from across the border as well. Their healthcare is important. Once again, this will be extra work for you, but there will be no extra allocation. The reason I ask about payment, given that these are not devolved issues, is that in these austere times, if we are having all of these new facilities, they should come with a cheque book.

[189] **David Rees:** To be fair, as Kate has explained, it is the healthcare aspects that she will be looking at more than anything else.

[190] I would like to ask one question. Mandy, you have mentioned lay reviewers very often. Some of the witnesses that we have heard from previously have identified a concern over the extent of the use of external reviewers within the process. Is that of any concern to you? How long does it take to train a lay reviewer, and are you in a position to use those people more frequently, because, obviously, they have their own work?

[191] **Ms Collins:** We have a panel of lay reviewers—and I am sure that Alyson will tell you a little bit about how we are moving forward—and they are an important part of our teams. I will give you an example. In relation to peer reviewers, if you look at the changes in infection control over time, you would see that if we did not use the expertise of specific peer reviewers, we would not get that in a general nurse. In the homicide reviews that we undertake, we need specialised input from psychiatrists and psychologists. Therefore, we really have to maintain that panel. I know that there are concerns in some of the evidence that they do not understand the context of Wales, but that is where we as an organisation really are very clear about the training that we provide to give that context. The team always contains a full-time member of HIW staff who will steer it and make sure that the context of the work is given to the team and that it is supported.

[192] With regard to our lay reviewers, they are trained and supported, but we do not want to overtrain them, because we want them to ask the 'why?' questions. We find that peer reviewers are sometimes afraid to ask or they assume knowledge. Our lay reviewers are a really important part of our team. They are not a token gesture; they are fundamentally important. Perhaps I could give you an example. A couple of years ago, we did some work on learning disability services and the way in which services are provided in accident and emergency departments to those who have a learning disability. We worked with Mencap Cymru to do that piece of work and we used some of its members to come out on the inspection visits as service users and lay reviewers. We went into A&E and asked how they would address communication with an individual with a learning disability. They talked at great length at how good they were at it and what tools they would use. The question had been asked by a young lady who had Down's syndrome, who was very capable of asking those questions, but the answer was given to the full-time member of HIW staff, who was stood behind the lady. That really tested, to my mind, not just the approaches they had, but the culture and attitude of that service.

[193] So, in my view, we always need a team and we always need a team of peer reviewers who have up-to-date knowledge, not knowledge that they had 20 years ago, and specialised knowledge at that. Doctors and nurses cannot be specialists in everything, and we certainly

need the lay reviewers who will constantly ask the ‘why?’ questions. As to whether it challenges services, yes, it does, absolutely. The regulated sector certainly found it very difficult when we introduced it there over the last 12 months, because it was being asked questions that it had never been asked before, and it was difficult for the sector. Do I think that it was the right thing to do? Yes, absolutely. Will it impact on improvements to the quality of patient care? Yes, absolutely, because it was focusing on the quality of day-to-day life within a secure unit, which was based around meaningful activity, being afforded section 17 leave, and, most importantly, about feeling safe and valued.

[194] **David Rees:** Thank you. We have five minutes left, and I have three people with questions. I ask for short questions and answers.

[195] **Darren Millar:** I asked if I could come in as well, Chair.

[196] **David Rees:** All right. We have four now.

[197] **Mohammad Asghar:** My question is regarding dentistry. In my surgery, I get regular complaints about dental practices. I understand that they are run by their own rules rather than by NHS rules. People pay their national insurance contribution all their life. If you are a pensioner and you miss two appointments, they remove you from the register. Are they run by their own rules or by rules set up by you? These people—the dentists—are guaranteeing patients that if they are off the NHS system, they guarantee the work on your gums. If not, there is no guarantee. My constituents are telling me so. I would like to know whether they are run by your rules, or their own rules? You pay them, so do something about it, because teeth are decaying.

[198] **Darren Millar:** Chair, my question also relates to primary care and the role of the inspectorate in monitoring policy within primary care—GPs, et cetera.

[199] **Leighton Andrews:** That was mine. [*Laughter.*]

[200] **Mohammad Asghar:** Three in one.

[201] **Lindsay Whittle:** A triple crown question.

[202] **Ms Chamberlain:** I will say something on primary care in terms of GPs, and I will let Mandy come through on dentists. I would probably say that we have not done a great deal on GPs recently, but we have a role in looking at primary care in terms of GPs. We are in the process of developing an approach and a methodology to roll out a programme of reviews during 2014-15. That will also be reflected in the business plan. That will also mean that the capacity that we devote to that will not be devoted to other stuff we may have been doing this year, and that will be part of the trade-off that we will need to be open about.

[203] **David Rees:** You have talked an awful lot about the work plan for 2014-15. Would it be possible for you to send a copy of that to this committee once you have confirmed it?

[204] **Ms Chamberlain:** I would not only like to send a copy of it to this committee, but, if you could find time, I would welcome the chance to come and discuss it with you.

[205] **Mohammad Asghar:** Wonderful.

[206] **David Rees:** On the question of dentistry, Mandy, did you want to respond?

[207] **Ms Collins:** We currently regulate private dentists. So, any dentist in Wales who provides any level of private service is required to be registered with HIW. They are required

to work within the rules of the General Dental Council, and they are also required to work within the regulations set by Welsh Government and any related minimum standards. So, they are required to comply with a series of requirements. We are currently working with the chief dental officer and his team on bringing forward a rolling programme of inspections for the independent and private sector that has some level of synergy with the requirements of the NHS so that we can look holistically at dental services and practices in Wales. At the moment, the issue is that each dentist has to be registered with HIW, not each dental practice. That gives us some problems in terms of the scale of the issue, which is something that we are looking at with the chief dental officer. There are requirements placed on those providing private dentistry in Wales.

[208] **Elin Jones:** My question is on legislation, which we are about to discuss under the next item of our agenda, which is the White Paper on the future of regulation and inspection of care and support in Wales. Do you think that there is an opportunity to change the legislative basis of your work in the legislation that is coming up, especially in the light of the fact that you mentioned the integrated care policy move, with hospital care possibly moving out to virtual wards and happening in homes, and your role with CSSIW in that? Sorry, it is 11 a.m., and it is a big question to end on. I just wanted to know quickly whether you think there is an opportunity for you to undertake some legislative change to your set up, if needs be, in that legislation.

11:00

[209] **Ms Chamberlain:** We are working closely with the team that is developing legislation to see if there are any particular areas we would want to address as part of this. I do not think that there is anything significant at the moment, but possibly the one area that we are giving consideration to—and some of you may remember this—is the issue of the MMR clinic in Swansea. There was some concern about whether we had any powers to say or do anything about it and about whether there was a loop hole. One of the things we have been talking to the legislation team about is whether there is scope, because of the immediacy of that issue, to use this legislation to close that hole. I am not entirely sure where that discussion has got to.

[210] **David Rees:** Just to clarify, it was not the MMR clinic; it was a single-vaccine clinic.

[211] **Ms Chamberlain:** Yes; sorry.

[212] **Kirsty Williams:** Did you sign off the paperwork that your organisation sent to the committee?

[213] **Ms Chamberlain:** Yes.

[214] **Kirsty Williams:** You did. Thank you.

[215] **David Rees:** I will finish with the last question, although it might not be a question, but a comment. We have heard various concerns from various witnesses about the time it takes for reports to be produced. They were not questioning the feedback straight away after an inspection, but they were questioning the written reports for them to formally act upon and to be able to ensure that their action plans met what was in the reports. Will you be able to assure those people that you will be getting those reports done quickly so that the time lag between an inspection and the publication of a report is not what they are now experiencing, which, in some cases, is many months, and in double figures?

[216] **Ms Chamberlain:** That is my intention, yes.

[217] **David Rees:** Thank you very much for attending today, and thank you for providing answers to the various questions. You will receive a copy of the transcript to check for any factual inaccuracies. I thank Kate Chamberlain, Mandy Collins and Alyson Thomas for coming in today and for giving their time.

Gohiriwyd y cyfarfod rhwng 11:02 ac 11:16
The meeting adjourned between 11:02. and 11.16

Papur i Gyflwyno'r Ffeithiau ar y Papur Gwyn ar Ddyfodol Rheoleiddio ac Arolygu Gofal a Chymorth yng Nghymru
Factual Briefing on the Future of Regulation and Inspection of Care and Support in Wales White Paper

[218] **David Rees:** Welcome back to this morning's session of the Health and Social Care Committee. I welcome David Pritchard, head of regulation and workforce development; Simon Brindle, deputy director of social services in the legislation and policy division; Emma Coles, head of social services regulation and inspection; and Anna Hind, lawyer for the social care team. Good morning and welcome. The purpose of this session is to explore why the White Paper has been developed, what the Government aims to achieve in this policy area and how it intends to proceed over the coming months. I will invite Simon to take us through that in the first instance. Then we will move to questions from Members.

[219] **Mr Brindle:** The White Paper, which was published several weeks ago, was announced by the Deputy Minister in June 2012. Following the feedback on the White Paper on the social services Bill, which is now the Social Services and Well-being (Wales) Bill, it became clear that there was an appetite and a need to have a broader approach, to look at the legislation and regulation issues following that, to take full account of that feedback that was coming in to that consultation and to develop the approach that was taken with stakeholders over the previous year, which resulted in the proposals set out for consultation in the White Paper.

[220] The key needs for change are due to the fact that social services have moved on since the legislative basis around regulation and inspection was put into statute. There are implications resulting from what is in the social services and well-being Bill, but also other changes such as new emerging service models, the role of integration, which you discussed in the previous item, and the need to make sure that our regulation and inspection regime in Wales is keeping people safe, but also promoting a high standard of care.

[221] There are five broad areas that the White Paper sets out and that the Government is seeking to legislate on. The first is to strengthen and enhance the role of the citizen in the regulation and inspection of social services and care. So, that is the transparency agenda and making sure that we have annual reports setting things out clearly, so that members of the public can understand the strengthened areas for development within services. It is also about embedding citizen engagement within the inspection and regulation process, with the use of citizen panels and so on.

[222] The second area is a proposal to move to a service regulation model, rather than an agency or a setting model. That has implications to it in terms of where a provider is operating on multiple sites; it would give the inspectorates an opportunity to consider the performance of that provider in the round, rather than in its individual settings. It would bring in a widened, broadened scope to consider the financial robustness of a provider, not just the actual nature of the care going on. One issue that has emerged in recent years, and one of the failures of care that you will be very aware of, is that a lot of the problems stem from the provider being in financial distress. Therefore, it reduces its staffing levels and the quality of

care goes down—perhaps not to the level of falling to absolute failure, but when that happens multiple times in multiple settings it becomes a strong story. To be able to consider the performance and role of a provider in the round, and to consider it as a service, gives us an opportunity to intervene on an organisational level. One issue that is not a change in policy but a continuation of what is currently on statute but not enforced is the issue of whether registration should be chargeable. That is currently a power that Welsh Ministers have but have not exercised. The White Paper proposes a continuation of that.

[223] The third key area that the White Paper sets out is around workforce regulation. There are no major fundamental changes set out in the White Paper, but, throughout any changes in legislation, we need to consider the cost and benefits, both in terms of enhancing the quality of care and the assurance it gives, and also the delivery impact and the cost of applying that. Some of the consultation feedback is showing differences of view about the broadness of the scope of who should be in the regulatory workforce.

[224] A fourth key pillar within the White Paper concerns the proposals for a national institute, which would have an enhanced role to professionalise the workforce and provide a strategic hub for improvement in workforce development in particular.

[225] The last area set out within the Bill is ensuring that the regulation and inspection systems work well together. For example, you were just hearing evidence from HIW. Particularly with the integration of health and social care, it is very important that the inspection system fits well together and we do not have gaps and overlaps.

[226] To give an overview of the process, the consultation for the White Paper is now live. It closes on 6 January. There have been specific engagement events with relevant key stakeholders. The third of those is to be in Llandudno next week or the week after. We are receiving feedback on the principal White Paper as well as the easy-read version, the Welsh version, and the young person's version, which are out there. When the White Paper closes, we will be analysing the responses. We will produce a regulatory impact assessment on the back of that and, subject to the various approvals and clearances, the Minister's intention is to proceed to develop a Bill that will be brought before the Assembly through the second half of the Assembly term, seeking to get Royal Assent before the end of this Assembly term.

[227] **David Rees:** Thank you very much for that introduction. Lindsay, you have a question.

[228] **Lindsay Whittle:** On page 38, paragraph 121, there is passing reference to the potential role of various regulatory bodies. In the next paragraph, there is a statement about them working together and sharing information. That is absolutely crucial in light of the fact that we have had inquiry after inquiry pointing to a lack of shared information leading to the deaths of children in particular. What systems do you think should be in place to make the sharing of information mandatory? There is a good deal of care and support provided by third sector organisations. How can the Welsh Government ensure that they are rigorously regulated and inspected? I have two supplementary questions after that, if I could, but shall we take those first?

[229] **Mr Pritchard:** Clearly, the Deputy Minister has prioritised the issue of sharing information, reflecting the general concern. One thing that I would say about the White Paper and the development of legislation in this area is that we recognise the number of key dependencies that will impact on the subsequent shape of legislation. One of those is a Welsh Government review of audit inspection and regulation that is currently under way. There is also the Paul Williams commission into public services et cetera. I think that both of those will significantly inform how this particular area is taken forward. Our key aim is to ensure that the regulators are provided with the powers to share information, and that it should be

incumbent on them to do so when they have that information. That will be the process that we are intending, at this stage, to set out in legislation.

[230] **Lindsay Whittle:** Incumbent does not sound mandatory to me. Forgive me, I am a valley boy. It should be mandatory, surely.

[231] **Mr Pritchard:** That will certainly be one of the options that we present to the Deputy Minister for her consideration. There is potential for us to make it incumbent—a duty of candour, if you like, if you wish to call it that—upon regulators to share information. That will be a decision that we will include in the options that will be made available to the Deputy Minister in due course.

[232] **Lindsay Whittle:** Thank you for that. It is not—

[233] **David Rees:** [*Inaudible.*]

[234] **Lindsay Whittle:** Yes, I appreciate that. It is not strong enough for me. That is all that I want to say. There was also the question on the issue of regulation and inspection of the third sector organisations.

[235] **Mr Pritchard:** Where third sector organisations are delivering care and support under the definitions of care and support of the social services and well-being Bill, they will be regulated in the same way as the independent sector or the public sector. We have had representations from stakeholders regarding some anomalies in this area, where money is provided through the public purse in a variety of ways, and we have mentioned in the White Paper that we are seeking to close any potential loopholes in that particular area.

[236] **Lindsay Whittle:** Thank you. Again, through you, Chair, is it possible that we could have a mention of the Equality and Human Rights Commission, which could play an important role in inspecting care and support providers in the public and private sectors? Should there be a statement in the White Paper about whistleblowers?

[237] **David Rees:** I suppose that what he is asking is whether you can consider those in the next stage of your public consultation, effectively.

[238] **Mr Pritchard:** Yes. As Members will be aware, we are required to produce an equality impact assessment as part of our work. That is in development now; so, we will take on board those comments.

[239] **Lindsay Whittle:** Thank you very much.

[240] **Elin Jones:** Where in the consultation do you foresee that comments will be raised on the registration and regulation of integrated care because of the development of Government policies to look to integrate care between social care and healthcare? Do you have any views at this point as to how this legislation could be an opportunity to put that new model of care on a legislative basis, to make sure that it does not fall through a gap, almost, between social care regulation and healthcare regulation and inspection? My other point is—

[241] **David Rees:** We will take the first question first, and then I will come back to you.

[242] **Mr Brindle:** I will start on that, and colleagues may wish to add their comments. Having just returned from a secondment in Bridgend, where I was corporate director for wellbeing and overseeing an integrated team where district nurses, occupational therapists and social workers were all working under joint management, and increasingly provided blended care, I think that it is quite important that the legislative framework around regulation

adapts and is futureproofed in the sense of being able to effectively provide an overview and the assurances that inspections and regulations are supposed to bring in those settings. In practice, on the ground, the relationships between the organisations mean that they co-ordinate and work together. I think that we can empower and require that kind of joined-upness so that we do not have multiple inspections of providers where that is unnecessary because it can be done once, and even more importantly, that we avoid any gaps. So we are very conscious of the changing nature of the model, and what might have been provided in silos previously may well look very different going forward.

11:30

[243] **Elin Jones:** Also, provided in settings, of course—either a care home or a hospital setting—whereas the new model may well have a lot of health and social care care that is provided in homes, and it will not be as easy for inspection and regulation regimes to find what is happening.

[244] **Mr Brindle:** That is one of the advantages of moving towards a service model rather than a setting model, because we are actually focusing on the citizen-outcome and the nature of the care delivered rather than the place it happens.

[245] **Elin Jones:** That relates to my second issue, then, which has been one that I have raised over a few years now in this committee, on residential care work that we did—that is, the issue of registration, and how it sometimes cannot allow for settings in care homes to provide care for an individual as their care develops and their assessment changes. From my perspective, in my constituency, what it can mean quite often is that you change from a dementia residential assessment to a dementia nursing assessment, and that can mean that someone is relocated 50 miles away. I understood that this legislation would address some of those issues, but I am struggling to find which bit in the White Paper that is.

[246] **Mr Pritchard:** You are absolutely right—it is part of the intention to prevent people having to leave an establishment because the nature of the care they receive changes, unless it is clearly of a level of specialism that requires that. The example that you give is one that we would want to prevent. The intention is that the service model is a more flexible model. It allows providers to broaden the range of services that they can provide more quickly and appropriately, but the truth is that the way we can achieve that policy aim is how we set out the regulations that will follow the primary legislation. At this stage, it is a policy aim to achieve that, but what I cannot give you today is the detail, line by line, of how we will achieve that. That is certainly something that we will want to achieve.

[247] **Rebecca Evans:** I was pleased to hear that you hold stakeholder events, and that you produce easy read and young persons' versions of the White Paper. I was wondering if you could give us an overview of the stakeholder events, particularly how you are seeking to engage both practitioners and service users. I am keen to hear how you engage with disabled people, particularly people with learning disabilities as well as young people and older people.

[248] **Mr Pritchard:** If you will forgive me, I will start by giving a little bit of the background of how we got to the White Paper, because I think that that helps us to understand it. We have undertaken significant consultation to get to this point, including using the Deputy Minister's citizen panels, which are groups of citizens that have been established in order for us to be able to talk to users, families et cetera, about key developments at a strategic and operational level. We have involved users at that stage.

[249] In terms of the consultation events that we are currently running, we are holding three across Wales, and what we have sought to do in those is to invite not only those who are

directly involved in the delivery of regulation—that is the regulators, local authorities et cetera—but also the third sector groups that are representative, and bring together those particular groups. We have a long list of the organisations that have been invited and represented at those events, and it is through that arrangement that we hope to hear those voices, as it were.

[250] The Deputy Minister has established a second phase, if you like, of citizen engagement following the citizen panels, and we will continue to use those opportunities as we go on beyond the consultation, when we shall be developing more detailed legislative policy.

[251] **Rebecca Evans:** So, the citizen panels would include people who have these disabilities, rather than their representatives.

[252] **Mr Pritchard:** They did, yes.

[253] **Mr Brindle:** They are our service users.

[254] **Darren Millar:** My question is in relation to the points that Rebecca has made. Older people, in particular, are clearly heavy users of social services. I was just wondering what specific action you are taking to try to engage with older service users and what engagement you have with the Older People's Commissioner for Wales in the development of the legislation.

[255] **Mr Pritchard:** The Deputy Minister and I have met the older persons' commissioner and the office of the older persons' commissioner on a number of occasions as we have developed the White Paper. While I would not wish to speak for her, I think that she would recognise that a number of the points that she has made are regarding, for example, the fact that she is very keen that we recognise and understand that residential accommodation is people's homes. That is one of them. So, we have worked with her, and we continue to have that dialogue, and it is a very positive dialogue.

[256] You will be aware that she is using her powers to undertake a review of provision for older persons at this moment in time, and we are very keen to see what emerges from that and whether there are any messages that we can include in this work. You may also be well aware that, through the social services directorate—where we as officials sit—we have cross-governmental responsibility for the older persons' strategy, which involves significant direct engagement with older persons. So, we have that feeding into our processes, too.

[257] **Darren Millar:** The other issue that needs to be addressed is that there are many people who are not users of social services but may become users of social services in the future. What are you doing to cast the net a little bit more widely, to try to draw those people into the debate about the future of the regulation and inspection of social services?

[258] **Mr Prichard:** Citizen panels do have both service users and non-service users. Clearly, we have a hope that, through the internet and so on, we will attract some interest, and we will seek to publicise the consultation et cetera. However, the organisations that we have been working with are not necessarily those that are represented. For example, Children in Wales would sit on the Deputy Minister's partnership forum—her leadership group. It is not just about those children who receive services directly, but also about the wider group. So, we hope, through those organisations with which we are working quite closely, to get those messages to them.

[259] **David Rees:** I am going to bring Rebecca in, just on this topic.

[260] **Rebecca Evans:** I wanted to ask whether you engaged with carers' groups as well, because carers are obviously key partners in the giving of care to people.

[261] **Mr Pritchard:** Yes. Forgive me if I repeat myself. We have invited carers groups to our consultation events, and one of the key responsibilities of the social services directorate is to oversee the carers strategy for the Welsh Government as a whole. So, again, we are in the fortunate position, as a social services team, of being engaged in that dialogue, and we will continue to use those opportunities as time goes on.

[262] **Darren Millar:** I was going to ask specifically about carers as well, but there is another issue and I want to see if you can address it. In response to me, you mentioned that this is publicised on the internet, and people respond over the internet, which is great for people who have access to the internet and are competent and able to use it. How do you intend to try to reach out more broadly to those individuals who might be a little bit more difficult to reach?

[263] **Mr Prichard:** I suppose that our approach has generally been on the cascade principle, in that we are working with stakeholders, representative groups and others to raise awareness through their networks of the consultation and the key issues that they have. Whether we feed that back through those groups or they feed it back themselves, we are clearly limited as officials in terms of what we can do about going around Wales. That has been our approach. Of course, we are very keen to see as much response as possible to the consultation. The more we get, the more powerful those messages will be, and we will be able, I think, on 6 January, to make a judgment about how successful we have been. However, one of the key messages that we have as officials is that that does not end the consultation and discussion process; that must continue as we go forward in developing the more detailed legislation.

[264] **Mohammad Asghar:** I am very keen to see this White Paper. The most important part of it, but there are only 12 or 13 lines in it, is on the new models for service funding and delivery. You are getting new models; where are they coming from and what impact will they have on existing models. Will there be improvement? You talk about more funding—grants and more private sector involvement. It is a very long subject, but you have only included a very concise few lines. We need more elaboration. You are not giving us the right picture here; it needs a big picture and then signs should be put on it.

[265] **Mr Brindle:** You are absolutely right that it is a huge issue. The scope of the White Paper is how the regulation and inspection system can cope and adapt to those things going forward. The purpose of this is that we recognise that there are developments and changes. We need to have the flexibility within law to cope and adapt to those emerging models and, if necessary, the flexibility to change as they emerge. This is to give us a list of underpinning, so that as those detailed models emerge in other places, the inspection and regulation system is fit for purpose and future-proofed to cope with those. The detail of those changes is something that we need to make sure that our inspectorates can inspect effectively, under those new models.

[266] **Mohammad Asghar:** Are there totally new models, or are they coming from the other side of the channel?

[267] **Mr Pritchard:** The Care Standards Act 2000 was an interesting example. It is only 13 years since the Care Standards Act 2000 was laid, and many of the models of care that exist today did not exist when that was written. Direct payments have changed many ways of delivery, as has the increasing use of day care, for example, and different models of day care. What we have seen in the relatively short period of the Care Standards Act 2000 is that the reality of the market and the delivery of social care has gone beyond the legislation that was

set. We do not know what those models of care will be and we cannot predict what they might be and how they might emerge, but it is our hope and desire that we have a regulatory system that is robust enough to respond to those changes when they occur and that we do not get caught out, if you like, by the speed of the market and the speed of delivery in being able to make legislative recompense.

[268] **Gwyn R. Price:** In light of the collapse of Southern Cross, I see that you are going to suggest amendments to the Social Services Well-being (Wales) Bill, but there are homes at this moment, in Islwyn for instance, that are in trouble. What are you doing temporarily to overcome this, because to relatives and everybody involved, it is a very emotional time?

[269] **Mr Brindle:** One of the lessons learned from Southern Cross and other issues of service provider failure, which I touched on earlier, is that the current legislative basis that our inspectorates work under requires them to consider each setting as a separate thing. So, if you take the example of a care home that is struggling, perhaps that is because there is turnover in management and the staff are less experienced than they might wish them to be.

11:45

[270] The commissioner of the local authority may find a problem emerging there. It may not be at a level that is so chronic that it is cause for the inspectorate to use those powers to close or directly intervene, but would cause it to monitor.

[271] If that same provider has five, six, 10 or 100 other homes, the current legislative basis does not give them the flexibility and freedom to draw inferences from that home to the other homes that it provides, but my analysis of the issue with Southern Cross Healthcare Group plc and other similar examples is that they are inter-related. The service distress that happens in one setting has a knock-on consequence, potentially, for another setting, so, by changing the legislative basis for the inspectorate to work to be able to consider that provider and service in the round, it would strengthen the inspectorate's ability to intervene at an earlier stage, and to direct a service that is provided in multiple settings in a way that it cannot currently do. I think that would be to the benefit of the commissioners and to service users, because that means that the inspectorates would be better placed to tackle some of those issues.

[272] **Gwyn R. Price:** Do you think that the former is robust enough financially, because it looks a little bit like asset-stripping, and these are human beings involved here? They come in and take, say, 10 homes over, and, within a short period of time, three or four of them are closing down.

[273] **David Rees:** [*Inaudible*.]

[274] **Mr Pritchard:** One of the key proposals in the White Paper is to build, from a local authority level, an understanding of what is happening in the social care market in Wales. At the moment, we have some of that information, but we do not have a clear national picture that politicians and Ministers can look at and therefore make judgments and decisions about on the basis of. We want to have a system that allows Ministers to have that information and intelligence to make a decision and ask, 'If that is the trend, what do we need to do about it?' That is one of the key proposals in terms of the sector's stability issues.

[275] In terms of the viability of individual provision within local authorities, that will remain a local authority responsibility, because of the commissioning process. However, we see opportunities at a national and regional level to understand where perhaps the bigger providers stretch across local authority boundaries, or provide particularly specialist care, so that we can understand whether they are presenting real dangers to the future care of users through such things as potential failures in financial management or corporate governance.

[276] **Mr Brindle:** Just to add to that, the intention of the requirement for a financial disclosure and those reports is that it would strengthen the role of the local authority, the commissioner, in doing that job, so that there is a legislative basis for it to have that information, rather than it having to try to negotiate it out of providers each time. So, in order to operate, they would be required to disclose that.

[277] **Gwyn R. Price:** That is very helpful, thank you.

[278] **Rebecca Evans:** In looking at the consultation response form, there are 40 questions, which is quite a high number anyway, and some of the questions are quite detailed and technical and require a good amount of background knowledge of the subject. Are you confident that this is not going to put off lay people from responding and giving their views and concerns to you?

[279] **Mr Pritchard:** The reason that there are 40 questions is because we have consulted our colleagues who work in statistics, who gave us advice on how best to ask questions without them being leading questions, et cetera. For example, whereas I might initially ask what the good and bad things are about doing this, our colleagues have asked us to split those questions. That is just an example. We have provided an easy-read version, which put these into a different format. We also do not require every question to be answered by those responding to the consultation. Hopefully, we allow people, through the last question, the chance to feed in any particular thoughts that they have on the process. Inevitably, we have some more technical questions, because there are some technical issues that we need to address, but, hopefully, there are opportunities for people to respond at whatever level they desire.

[280] **David Rees:** Are there any other questions?

[281] **Mohammad Asghar:** I have a short one. What do you think about this proposal for a new institute of care and support in Wales?

[282] **David Rees:** It is not for them to think about it. They are just there—

[283] **Mohammad Asghar:** These are only proposals. So, I was asking what you think about the proposals.

[284] **David Rees:** It is not for you to answer the Minister’s vision; you are here to answer questions on the White Paper. So, we will leave that one, okay?

[285] **Mohammad Asghar:** All right.

[286] **David Rees:** If there are no further questions, I thank the officials for attending today. You will receive a copy of the transcript for correction of any factual inaccuracies. Thank you once again for attending, it is very much appreciated and we look forward to the consultation and analysis, and perhaps the next stage beyond that. Thank you.

[287] I therefore call an end to this morning’s session. We are scheduled to meet at 1.00 p.m. for the ministerial scrutiny on Healthcare Inspectorate Wales.

Gohiriwyd y cyfarfod rhwng 11:51 ac 13:01.
The meeting adjourned between 11:51 and 13:01.

Ymchwiliad i Waith Arolygiaeth Gofal Iechyd Cymru: Tystiolaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Inquiry into the Work of Healthcare Inspectorate Wales: Evidence from the Minister for Health and Social Services

[288] **David Rees:** Welcome to this afternoon's session of the Health and Social Care Committee. We will continue our work into the inquiry into the work of Healthcare Inspectorate Wales. Under this item, we will take evidence from the Minister for Health and Social Services. Good afternoon, Minister. I welcome Mark Drakeford AM. With the Minister are Grant Duncan, the deputy director in the Department of Public Health and Janet Davies, an expert adviser in quality and patient safety. Good afternoon and welcome, both.

[289] We will start with questions, Minister, and I will ask the opening question. Could you explain to the committee the relationship you have with Healthcare Inspectorate Wales?

[290] **The Minister for Health and Social Services (Mark Drakeford):** In a way, perhaps I ought to make sure that I am clear about what I do not have in relation to Healthcare Inspectorate Wales. I have no part in determining or agreeing how the functions of HIW should be performed, or how its resources are prioritised. It is not part of my portfolio, in that sense, and quite rightly so. No Minister should be responsible for the budget or the direction of an inspector who is overseeing their own bailiwick. So, that lies with the Minister for Local Government and Government Business.

[291] **David Rees:** It provides reports to you.

[292] **Mark Drakeford:** It does.

[293] **David Rees:** However, it is not accountable to you.

[294] **Mark Drakeford:** No, it is not accountable to me. Exactly.

[295] **Leighton Andrews:** Can you explain why the relationship between the Minister for health and Healthcare Inspectorate Wales is so different from the relationship between the Minister for education and the head of Estyn?

[296] **Mark Drakeford:** When HIW was established, back in 2003, the decision was that it would be inside Government. So, HIW staff members are all civil servants and they operate on the Carltona principle that, when they are discharging their functions, they are acting on behalf of Ministers. Therefore, to create a proper separation between what they do and the work that they are inspecting, the ministerial responsibility for the inspectorate is not held by the Minister who has responsibility for the services that are being inspected.

[297] **Leighton Andrews:** Would the operational independence of HIW really be affected if you or a Minister were to supply it with an annual remit letter, for example?

[298] **Mark Drakeford:** I do not think that it would be, but I do not believe that we are far from having that arrangement in a slightly different format. HIW's remit is set out in statute, so it knows what its responsibilities are. With regard to the annual discharge of those responsibilities, it is for it to formulate a work programme that allows it to discharge those responsibilities. It discusses that work programme with Ministers and Ministers are able to have a dialogue about it. However, in the end, the operational autonomy and independence means that it is HIW's job to finalise its own work programme. However, as to whether there should be an annual remit letter that formalises that arrangement, I do not see it being a bad thing.

[299] **Mohammad Asghar:** Further to both questions, Minister, do you agree that the key deficiency of HIW at present is the lack of accountability to the general public, because it does not provide the public with sufficient information for it to make judgments about the effectiveness of HIW?

[300] **Mark Drakeford:** I agree that HIW is part of the public assurance system that we have for the health service in Wales. I agree that it needs to provide information on the work that it does in a way that the public, where the public has an interest in doing so, is able to see how it has gone about its duties, can see what work it has undertaken, can see what judgments it has reached about services, and so on. I said in my written evidence to the committee that there have been some gaps in the organisation's ability to do that effectively. Its website is not what it needs to be, but you probably heard this morning from the chief inspector about the plans it has to make sure that that deficit is remedied.

[301] **David Rees:** It was remiss of me not to thank you for your written evidence, Minister.

[302] **Kirsty Williams:** I would be interested to know, acknowledging that you have no authority to direct HIW in its work programme, whether you have a view, as the Minister, on what a cycle of adequate inspections would look like to provide the public with the reassurance that it wants—especially in the light of Francis and ongoing difficulties in the NHS across the border—and to give confidence to the public.

[303] **Mark Drakeford:** I do not know that I feel particularly comfortable, as the Minister, in having a view on that subject. It is very important to me that HIW is an independent organisation. What if I were to say to you, Kirsty—not that I am about to—that I thought that every 10 years would be fine, thank you very much, and I would not want HIW reporting too regularly or too often on what goes on. In a way, I do not think that it is for me to have that view. What I do have a view on is that when it produces its work programme, I am able to offer comments to the chief executive. It has an annual cycle in some areas of its work, for example. I am able, when it says what it wants to do, to ask it questions about that, to hear its explanations about that, to say to it, as I said in my written evidence, that, from where I sit, maybe the future needs to contain more work in relation to community and primary care services than it has in the past. While it is fair for me to be able to give it my views around what it plans, it is not for me to have a view that it then feels obliged to operate against.

[304] **Kirsty Williams:** Okay. So, would you be comfortable, as the Minister for health, to hear the evidence that we heard this morning from Healthcare Inspectorate Wales? It stated that it would be comfortable doing inspection visits of community hospitals once every three years, but, in effect, what it is able to do at the moment is to inspect only once every five years. It would be comfortable and its aspiration would be to visit district general hospitals at least one every year, and the bigger DGHs more than that, but it is actually only visiting DGHs once every three years. Therefore, there is a big gap between what it is currently doing in terms of inspection and what it feels would be an adequate amount of inspection. Do you not have a view?

[305] **Mark Drakeford:** I have a view on that. I think that that is a different question to the first question that you asked me. It has told you what it thinks its inspection regime should be. Do I think that it ought to be able to fulfil the regime that it thinks is the right one? I think that that is what it should be able to. However, it is no different to any other organisation in having to fit what it does against the many other demands that it has to meet and the resource that it has available to it, and I do not simply mean that in terms of money—as you know, it has been an organisation that has had some challenges in recruiting and retaining staff to carry out its functions. So, if your question to me was about it saying that it ought to be able to

inspect against this sort of time frame, then I think that it ought to be able to do that, but it has to make those judgments and it has to prioritise its work within the constraints that it operates within like anybody else. I am sure it would have said to you this morning that when other demands are made of it, if it is suddenly pulled away from its planned programme of work to carry out some emergency piece of inspection, as in the post-Winterbourne View context, or in the Betsi context, then it inevitably has to make choices about how it deploys the resources that it has available to it.

[306] **David Rees:** Darren is next on this.

[307] **Darren Millar:** This is actually more around the role of the Minister in shaping the work programme of HIW. I appreciate, Minister, that you want it to have its own operational independence and that you do not wish to seek to influence the judgments that it might come to in its reports, or its opinions in its reports, but, of course, you do influence the work programme because you are able to determine when it undertakes homicide reviews, for example; it is you that has to trigger that process—it cannot volunteer to undertake a homicide review even, if in its judgment, it would be sensible to do so. Do you not think that there is an anomaly there in the independence, if you like, of HIW being able to undertake a piece of work that, sometimes, it might be sensibly seeking to do?

[308] **Mark Drakeford:** I think that is an interesting point actually. I think there is a distinction between the planned programme of work, which I have an influence on, like many other people who are able to influence. It is not a shaping influence, but it is a voice that it listens to like it would listen to others. Then there are unexpected, unplanned events and a homicide by a former mental health patient is one of those. I will need to check, Darren; maybe somebody either side of me will know. I think that my understanding is that if a Minister requires HIW to inspect in those circumstances, it must, but I do not know that it is prevented from doing so if a Minister does not instruct it.

[309] **Darren Millar:** Perhaps if there is clarity, it would be helpful.

[310] **Ms Davies:** In terms of the history of homicide investigations, obviously we had a couple before HIW was established and, at that stage, the previous LHBs were asked to commission one. However, obviously with an inspectorate and its independent role, we felt that it was right and proper that we asked the inspectorate to do that. So, over time, whereas we did initially commission those investigations, it is now a standard process. We have clear criteria so that if a patient has been under the care of mental health services in the last 12 months and has allegedly committed a homicide, then it automatically triggers an investigation. Technically, HIW does not have to wait to be commissioned. It is something that has developed over time. At any stage, where we have had a couple of grey areas, we would discuss with it what it thinks and if it decides that it feels that it is right and proper to do so, then it would. It is always at liberty to undertake an investigation without us asking it do so.

[311] **Darren Millar:** Just to clarify, therefore, it is always able to undertake an investigation without a ministerial instruction to commission one.

[312] **Ms Davies:** Absolutely.

[313] **Darren Millar:** That is very helpful in clarifying that point. I have some other points later on, but I will return to them.

[314] **Leighton Andrews:** You rightly said that organisations have to prioritise within the range of the budgets that they have. Other inspectorates have seen significant budget reductions and have had to do that, but I wonder whether there is an issue of scale here in

terms of the budget that is available to HIW for the range of things it needs to perform and I wonder how comfortable you—. Let me not ask you that because I know what your answer will be. Do you have any concerns about the capacity that HIW has to carry out the functions that you would require for it to provide the service that you want from an independent inspectorate?

13:15

[315] **Mark Drakeford:** I have had concerns about its capacity. In the last year, those concerns have been more about its ability to recruit and retain the staff that it needs to discharge those responsibilities than they have been about the quantum of financial resource available to it as an organisation. However, the new chief executive, since coming into post, has been undertaking a thorough review of what she thinks the organisation will need in order to go on discharging its responsibilities into the future. The Minister for Local Government and Government Business who has the budget responsibility for HIW has been in contact with me about the size of its budget and whether the budget allows it to do the range of priority tasks that we require it to do. We continue to be in discussion about that. So, it is an issue that I recognise. The money has not been the issue up until this point. I think that it did not manage to spend its budget last year, but that was because it did not have the staff in place to do so.

[316] **David Rees:** Lindsay, you have a question on this point.

[317] **Lindsay Whittle:** Yes, almost. It is about patients' voices, which I think is what we are talking about.

[318] **David Rees:** No, it is not. Kirsty has a question on this point. I will come back to you.

[319] **Lindsay Whittle:** Alright, I will accept your judgment.

[320] **Kirsty Williams:** I am trying to understand this curious 'it is my responsibility, but it is not my responsibility' issue and the set up. Our understanding is that if HIW wanted to place an organisation into special measures, unlike Estyn, which can do it on its own, HIW can only do it with your permission. How do you square that with this curious mixture of how it is accountable to you or not accountable to you?

[321] **Mark Drakeford:** I am sorry, but I may have been struggling to try to put this as clearly as I should have done. In order to secure the operational autonomy and independence of HIW, it is very important that the line of accountability for it as an organisation and the budget decisions made about it are not held by the Minister whose work that organisation is inspecting. Hence, those things lie with the Minister for local government because these people are civil servants. They are inside the Government. When they are carrying out activities then, they are carrying them out on behalf of Welsh Ministers. They cannot act apart from Welsh Ministers, because they are, in Carltona, doing it as a Welsh Minister would do it. So, when it is a special measures decision, they have no separate legal personality from the Minister. Hence, if they wish to place an organisation in special measures, they have to use the flow of legal authority that comes from the Minister to them to their action and, therefore, they have to make sure that they have that authority to do so.

[322] **David Rees:** I know that I had a couple of questions on special measures. So, I am going to ask Gwyn and then Darren to ask their questions on that issue first.

[323] **Gwyn R. Price:** Everyone this morning was trying to find out and clarify what the interpretation of a special measure was. I know that Kirsty nipped in and took my question on

that, really, with regard to the current system of ministerial responsibility. I think that you have explained, Minister, that there is a distinction between one and the other.

[324] **Mark Drakeford:** On the general point that Gwyn made, I have followed a bit of the debate that the committee has had around this and there is no doubt that the Betsi report, conducted jointly by the WAO and HIW, threw up the fact that there is insufficient clarity at the moment about what we mean by special measures, what are the various measures that could be taken, at what point can they be triggered and who has responsibility for triggering them. If I may, I will contrast it with my understanding of the social services world, where, for many years, we have had an agreed protocol signed by the Welsh Government and the Welsh Local Government Association. So, if a social services department is thought to be in need of intervention, there is a clear document that says exactly how those concerns are to be raised in the first place, how they are to be understood, at what point the chief inspector of social services has powers to act, at which point it arrives on a Minister's desk and what the intervention measures might be. We lack that in the health service. I know that I have powers under sections 27 and 26 of the National Health Service (Wales) Act 2006. They allow me, for example, to remove individual members of a board. They allow me to say to a board, 'In future, your responsibility for that service'—dentistry, let us say—'in future, you are not going to be responsible for dentistry in your area. I am giving that responsibility to a different health board, because I am not satisfied that you are discharging that responsibility adequately'. Both of those seem to me to be examples of what a special measure might be. However, during the time of the Betsi Cadwaladr report, I felt strongly that I did not have a sufficiently codified set of arrangements around what special measures might be. Hence, we have asked WAO and HIW, with the Welsh Government, to sit down and do a piece of work about that. That group has been meeting. It is meeting again tomorrow. I think that the WAO said to the committee that, early in the new year, it hopes to be able to publish a document that does exactly what I think the committee has been looking for, and I have been looking for as well.

[325] **David Rees:** Darren, do you want to ask the questions on special measures? Then Lindsay can come in.

[326] **Darren Millar:** I know, Minister, that you have been at pains to point out the need for HIW to maintain its operational independence, et cetera. To be fair, it indicated to us that, whatever its interpretation of special measures had been, whenever it had made recommendations around special measures, it had not been prohibited from having those implemented. I appreciate that decisions over special measures may well lie with Welsh Ministers, because they are civil servants and part of the Welsh Government as an organisation and they do not have what I think you described as an 'independent personality', which is an interesting description.

[327] **Mark Drakeford:** It was 'legal personality'.

[328] **Darren Millar:** There is nothing to stop you, however, giving greater emphasis to that distance by delegating permissions to HIW, is there, on a permanent basis, as a ministerial decision, in order to allow for more confidence in the system? Is that something you would be prepared to consider?

[329] **Mark Drakeford:** I think it is a fair point that has been made, because almost everything that HIW does is done in exactly the way that you described, and then there comes a point in the process where the seriousness of what it intends to do requires a specific ministerial sign-off of that decision. Have we got the point on the scale in exactly the right place? Well, I think there is a debate to be had about whether more could be delegated in the way in which you describe. However, it is probably only the 5% top end of the things that HIW does that requires specific ministerial sign-off. Everything else it does it does on that

delegated basis, that is, although it is acting on behalf of Welsh Ministers, it acts without direct recourse to Welsh Ministers for ministerial sign-off. So, I am happy to think about it, but I do not think—

[330] **Darren Millar:** So, just to help me and the rest of the committee understand the process, if HIW feels that it may be necessary to make recommendations to put a part of the NHS under a special-measure-type arrangement, what are the discussions that take place within Government about that?

[331] **Mark Drakeford:** I have never personally been in that situation, so I do not have direct personal experience to draw on. My inference, from what HIW said to you this morning, which was to say that it has never made such a proposition and that proposition not been upheld, is that it is not much of a discussion really, because, in a practical world, what Minister would wish to put themselves in a position of having their chief inspector say to them that an organisation needs to be in special measures of some sort and the Minister say, 'Oh, I don't think so'?

[332] **Leighton Andrews:** It is usually the other way around.

[333] **Mark Drakeford:** So, I doubt that there is, in practice, a great deal of iteration. It is more that you rely on the advice of that organisation and, if it comes to such a serious conclusion as that, as a Minister, you will back that conclusion.

[334] **David Rees:** We will probably come back to this point at some time in future once we know the outcome of the discussions between WAO, HIW and the Government. Lindsay is next.

[335] **Lindsay Whittle:** Thank you, Chair. Minister, I just want to ask about public engagement and how we listen to the voice of the patient. You and I will know, and every member of this committee will know, that, if you go to any hospital or any ward the walls are festooned with letters of thanks, cards of gratitude and boxes of chocolates. That is a very good thing, but, of course, that is not news. Only poor service is news, and I know that you have said this very week in the Chamber that the vast majority of patients leave hospital very grateful indeed, but the issue is about the poor care. How can we ensure that Healthcare Inspectorate Wales is seen and considered to be important and a trusted source of assurance for patients and the public, because I believe that the majority of the patients who receive poor care—and they are a minority of our patients in total—do not have a clue who Healthcare Inspectorate Wales is? It is important that we raise public awareness for the minority of instances where there is poor care.

[336] **Mark Drakeford:** Thank you for that. One of the strengths of HIW has always been that, well before this became a fashionable thing to do, it set out to make sure that lay inspectors were a very important part of the way that it goes about its business. In 2003 and 2004, when it was being set up, the then chief inspector was very keen that lay members of the public, who do not come with an expert's eye and who are not part of the world that they are inspecting, would be an integral part of what it does. I think that has been the strength of the organisation all of the way through.

[337] For individual members of the public, the difficult thing to explain to people who are not part of that world is that HIW does not take up individual cases where things have gone wrong; it is not an ombudsman service in that way, and it is not a CHC service either. So, it is part of the landscape, but it is not the whole of the landscape. Where individual complaints are taken up, primarily, outside the hospital itself, it is via the CHCs, which have an advocacy service and which do very good work, I think, in that area, and, when the internal processes have been exhausted, the recourse for individuals is to the ombudsman. What HIW does is not

to take up individual cases, but to inspect whole services, and sometimes it is doing it on a routine and planned basis and sometimes it is doing it because either it has been alerted from the outside or its own unplanned inspections have given it cause for concern that a whole service needs to be reported on. However, I agree with what Lindsay Whittle has said: that, when it does that work, it is important that the results of that work are accessible to the public and that people have confidence that, if there is a cause for concern, not about the individual care of an individual patient, but about a service issue, and that we have a robust, independent and capable inspectorate that will go in there and report on it in an entirely open way.

[338] **Lindsay Whittle:** I cannot say, as committee, that we have been enamoured with the evidence that we have heard from community health councils to date, but the Patients Association has highlighted to us a concern that there are insufficient mechanisms in place to tackle poor care, where it occurs, and, if the Patients Association feels that, there is something wrong, is there not?

[339] **Mark Drakeford:** I thought that the point that the Patients Association made that had some validity, and has been echoed by some other witnesses whom the committee has heard from, lies more in our ability to have confidence that, when HIW has made an inspection, and when it has made recommendations and required organisations to do things, it is able to go back to make sure that those things have happened. Partly because it has not been reporting on everything that it does in a timely fashion, and partly because it has been stretched to do other things, then those witnesses who have said to you that it is not always possible to be sure that HIW does not just inspect and walks away, but inspects and comes back to make sure that things are done, have shown that part of what it does that needs strengthening.

[340] **Lindsay Whittle:** That is what will inspire patient confidence.

[341] **Mark Drakeford:** Yes, in turn.

[342] **David Rees:** I have a question from Rebecca and then Elin.

[343] **Darren Millar:** May I just ask a follow-up question about the capacity to follow up? My question relates directly to that.

[344] **David Rees:** I will come back to you. Rebecca is next.

[345] **Rebecca Evans:** With regard to the capacity of HIW to undertake all of its functions, are you satisfied that some of the functions that it is responsible for could not be done better by other bodies?

13:30

[346] **Mark Drakeford:** I am very happy to look at that issue, and I know that it has been raised with the committee previously. I will take just one minute if I may, Chair, to remind Members of the original history of HIW. HIW is a product of the very first term of the Assembly. In those early days, Welsh health services were inspected by CHI, the Commission for Health Improvement. A number of the inspections that CHI provided were very unsatisfactory indeed. The then director of the NHS, Ann Lloyd, was very determined that we create a health inspectorate of our own that understood the way that policy in Wales was being developed, and that was close enough to the ground to be able not to have the wool pulled over its eyes when it went into organisations, but we did not have the powers in our own hands at that time to legislate. So, the legislation that set up HIW had to be carried out on our behalf at Westminster, and there were some inevitable compromises along the way in getting HIW set up.

[347] Since then, it is fair to say that it has had some additional responsibilities accreted to it, because it was there, and therefore it was a place where something that needed to be done could be done. The question that Rebecca has asked me is: is it time to have a look at that and at the fairly long list of things that HIW is meant to do, and ask ourselves now whether we are confident that it is still the right organisation to be doing all of these things? There is the review of inspection, audit and regulation more generally, and I think it is a proper question to raise in that context. There might be things now, 10 years later, that HIW has picked up along the way that we could allocate elsewhere in order to help it with some of the prioritising issues that we have been talking about.

[348] **Rebecca Evans:** For information, Minister, HIW told us this morning that the statutory supervision of midwives, for example, does not necessarily fit well with the other work that it does.

[349] **Mark Drakeford:** No, I think that that would be—

[350] **David Rees:** Darren, you had questions on capacity.

[351] **Darren Millar:** Yes. Would the capacity of HIW be better met if, and how does it relate to, if you like—if you can see where I am going with this—the quality and safety improvement branch within your own department? What joint work do they do?

[352] **Mark Drakeford:** The relationship between the two can be described in a number of different ways. First, it is the Government's responsibility to set the healthcare standards for Wales. I announced in the aftermath of the Francis review that we would renew and review those healthcare standards—we are going to go out to public consultation on them early in the new year—and then those are the health service's standards that HIW must inspect against.

[353] I remember being concerned, in the early days of HIW, that health bodies would say to us that these were HIW standards. Well, actually, no, they are not HIW standards; they are the health service's standards that we expect the health service to match. The HIW's job is to inspect against them. So, there is a relationship between what we do in Government and what HIW does in that way.

[354] The second way in which there is a relationship is this: it is very important to always remember that HIW is just one strand in the broader picture of quality assurance that we have in Wales. I know that you have taken evidence from other inspectorates about how the work of different inspectoral bodies relate to one another, but health boards themselves have very important responsibilities in ensuring that their services are up to standard and up to quality. They have all recently published their annual quality statements, for example, to show what they are doing themselves. Then, from the Welsh Government's perspective, we have a series of things that we do to make sure that we have assurance that those things are being done. There is the chief nursing officer's annual report, for example, that she produces against the quality standards. So, there is an iterative relationship in that way too, in that they are not on their own and are not the only thing that we rely on. The way that they report against the standards has to be seen in that wider context of the work that other organisations—outside and inside Government—are doing.

[355] **Darren Millar:** I am not quite sure that that answered my question, Chair. I was asking specifically about the quality and safety improvement branch and how that relates to and follows up, perhaps, the work of HIW. Is that clearer?

[356] **Mark Drakeford:** I will ask Janet to give you the details on that.

[357] **Ms Davies:** In terms of the work that we do within quality and safety, we obviously

monitor an awful lot of issues in relation to quality and safety data, for instance serious incidents, healthcare acquired infections, pressure ulcers, et cetera. So, for a number of things that you will see in the tier 1 delivery framework quality and safety aspects, we would keep an eye on those from day to day. So, it is very much day-to-day monitoring of the NHS through the performance management framework. Through that work, we share that with HIW. We have bilateral meetings with it so that there are no surprises in the system, and it is all about helping to build that intelligence about what we know about an organisation, where there may be concerns, and how we help shape, perhaps, HIW's work. Ditto, it will share information with us, so that, in our routine performance meetings with the LHBs and trusts, when we talk about quality and safety, we are equally informed. It is a sort of bilateral arrangement in terms of making sure that we are keeping a really close eye on what is going on from day to day.

[358] We follow up all incidents with the health boards to make sure that they are thoroughly investigated and that they can demonstrate their learning. We try to pick up themes and trends for making sure that, if there are issues where we see non-compliance in patient safety, for instance, we are picking that up. So, we have a lot of day-to-day checking going on in terms of making sure that services are safe and of high quality.

[359] In terms of the HIW reports, as they are published they all come in through our team so that we are able to track the actions in those and make sure, again, that we are feeding those into quality and delivery meetings with health boards and trusts. It is a sort of cycle of activity.

[360] **Darren Millar:** Just to clarify, you support the follow-up of the recommendations to ensure that the health boards are addressing the issues that have been raised, if they are quality and safety issues, of course.

[361] **Ms Davies:** We do not go into every single individual action, but more of the generic issues and the themes, issues and trends that are coming out, and we triangulate all of that information with other sources as well. So, it is a matter of what we are seeing from ombudsmen's reports and from coroner reports. It is about how we are looking at what we know about an organisation in the round and whether there is evidence that they are demonstrating improvement. Clearly, now, the annual quality statements are also the public vehicle for which we can test and triangulate that information against whether they are saying clearly what they have done well in the year, what they need to improve, and whether they have clear priorities going forward. Again, we use that to track progress.

[362] **David Rees:** Leighton has a question on this.

[363] **Leighton Andrews:** All of the budgets for the three inspectorates are held within local government, but I am struck by the different kinds of relationships that appear to have evolved historically between different ministerial departments and the relevant inspectorates. That is not necessarily wrong, but it is a different process of development. I am just wondering whether you feel that there is now sufficient learning, after 10 years, from other devolved administrations as well, perhaps, in the way that these matters are organised that would be worth considering at this stage.

[364] **Mark Drakeford:** I certainly do agree that the 10-year anniversary of the organisation, particularly as it has been accompanied by a change in the chief executive of the organisation, is a very good point at which to take stock, to think about what has been done well, what needs to be refreshed, and where there is learning, either from other organisations that the Welsh Government deploys or from elsewhere, that we can use to make the organisation as good as it can be. I have an approach myself, which is that pending the review of audit inspection and regulation, which brings all of the Welsh bodies together, that stability

for HIW, as it recovers its recruitment and retention position, as it works its way through some very important priorities that it has, needs, in the short run, a period of stability where it can reflect and make its own views about what it wants to do next. Then the bigger piece of work will pick up some of the points that Leighton has made, which I think are very important at the 10-year anniversary.

[365] **David Rees:** Okay. Thank you. Elin has a question.

[366] **Elin Jones:** Yes. I think that I am still struggling with the accountability issues of Healthcare Inspectorate Wales as a Government department. It seemed this morning that, sometimes, the healthcare inspectorate itself was struggling with its accountability and almost wanted to be accountable to this committee in some of its comments. I completely understand that the inspection role should not be within your department, but I am not as convinced that some of the regulation work of HIW should not be within your ministerial responsibility. So, it is a question that follows up on the points made by Rebecca earlier: are you going to take this opportunity to consider the appropriateness of some of the regulatory functions that Healthcare Inspectorate Wales has amassed over time, to relocate them back to a more appropriate department in terms of ministerial responsibility? I have another quick question. Have you any idea why Healthcare Inspectorate Wales has a chief executive rather than a chief inspector? That just strikes me as one of the differences.

[367] Finally, on the Francis report and recommendations, you have obviously made statements on how the Welsh Government is responding to that, and Healthcare Inspectorate Wales obviously has a role in that response. Who is it, then, that challenges and directs the expectation of change within Healthcare Inspectorate Wales to deliver on many of the recommendations of Francis? Is it you or it is the Minister for local government?

[368] **Mark Drakeford:** I will take those in order, if I can. On the regulatory responsibilities of HIW, they were acquired over time, like the midwifery issue, and I am very open to looking to see—and, obviously, we would do it with the Minister for local government—whether any of those functions can now be better located elsewhere, leaving HIW to concentrate on other things. There will always have been a case as to why HIW has had those responsibilities. Members of this committee will be very well aware of some of the travails of the national midwifery council, and the fact that it is known not to have been able to discharge its responsibilities in the recent past, therefore some extra work had to be found elsewhere. So, the things that it does have not just happened completely by accident; they have tended to happen in isolation. It is a good moment to think about that and whether things can be done elsewhere.

[369] The reason it has got a chief executive rather than a chief inspector, I think, is part of the compromise of the original Act of Parliament. You have to remember that, back in 2003, there was still quite a lot of nervousness at the other end of the M4 about whether Wales was capable of doing lots of different things for itself. Also, some chief inspectors are Crown appointments, are they not? They were not keen to add to Crown appointments of that sort. So, I think it is to be found in its history—its early history in particular.

[370] In relation to Francis, I think that no one single person has the job of making sure that HIW does the work that we need it to do in relation to Francis. Lesley Griffiths remains accountable for the overall operation of HIW, but, as I said, it generates its work programme, but I as a Minister, members of this committee—anybody, really—is entitled to look at that work programme and say, ‘What has HIW done to make sure that it is fulfilling this part of it? How can demonstrate that it is doing other things that we want it to do?’ That is the sort of discussion that I am able to have with HIW, provided always that at the end of that it is they who decide what they do, not me.

[371] **Elin Jones:** When you say 'they', is it signed off by the Minister for local government, then? Or is it totally independent of any ministerial sign off?

[372] **Ms Davies:** Yes, as I understand it.

[373] **Mark Drakeford:** It does not come across my desk, I know that.

[374] **David Rees:** Perhaps, just for confirmation, you could let us have a note on that.

[375] **Mark Drakeford:** Yes, we will do that.

[376] **David Rees:** Kirsty, your question is next.

[377] **Kirsty Williams:** Well—

[378] **David Rees:** Do you not have a question?

[379] **Kirsty Williams:** I have a question on something else, if I may.

[380] **David Rees:** That is fine.

[381] **Kirsty Williams:** I am wondering, Minister, whether you could outline what your expectations of CHCs are in regard to their relationship with HIW. When they gave evidence, they said that the previous concordat had not worked, and there was a new one, and the only evidence that they could bring forward that the new one would be better was because there had been a change of personnel. Also, they reported that only three of the CHCs routinely provided information on work that they had undertaken to HIW, and even if the work undertaken had given them cause for concern, it did not necessarily mean that the CHCs passed that on to HIW. What is your expectation of the role of CHCs in their relationship with HIW?

13:45

[382] **Mark Drakeford:** Well, I think it is a changing role, and it may not yet be fully fixed. I think that the CHCs said to you that they were taking a new concordat to their board. Earlier this week, I attended part of that meeting. I did not go there for that purpose; the reason I went there was that I wanted to underline, with that national board, my determination to implement the Marcus Longley review of CHCs, and probably the most important part of that review is to strengthen the hand of the national board in relation to the quality oversight that it has of individual CHCs. I think it was Cathy O'Sullivan who came to give evidence to you, and she has been acting as the chief executive of the board in recent months. I want to move rapidly to a position where it has a new, publicly appointed chair, where it has a full-time chief executive, and where the relationship between what it does and what HIW does can be put on a better footing.

[383] What I cannot do—at least what I think the Welsh Government cannot do in future—is to go on paying twice for the same thing. I want a regularised sense of what CHCs do and what HIW does. I read Carol Shillabeer's example of an unannounced inspection by CHCs on Monday that was followed by an unannounced inspection by HIW in the same part of the organisation on a Tuesday. That cannot be sensible. In an era when there is no money to do so many of the things that we would really like to do, as I say, we cannot afford to pay for the same thing twice. So, I will be looking to the new national board, operating to regulations that I will be bringing forward to the Assembly in the coming months, to operate at a more strategic level in having a relationship with HIW in which what they do is different, but that they work together, they share the information, and they are not tripping over one another.

Rather, in the different jobs they have to do, they combine to give public reassurance in the way that Lindsay was describing, in that there are people out there, independent of the health service, looking at what goes on and capable of raising any concerns when they are there to be raised.

[384] **Rebecca Evans:** With the move to more integrated health and social services, how do you intend to ensure that the inspection regime is fit for purpose, to inspect new models of working?

[385] **Mark Drakeford:** Thanks, Rebecca. I think that that has been a powerful theme in the discussions that the committee has been pursuing, and it will be a very useful one, I hope, when your report comes to be written. I said in my written evidence that I thought that HIW needed to move in the direction of putting greater attention on community, primary and, therefore, integrated services in that area. I think that you heard from CSSIW that there are good examples already of them working jointly on pieces of work. There is a very good piece of work published in the last few months that some members of the committee might be interested in looking at. It is about safeguarding deprivation of liberty standards for people who do not have mental capacity. It is quite a fascinating read to see how these responsibilities are being discharged, and the work was done jointly by the two inspectorates. At the moment, they are capable of coming together and doing good joint work on areas of integrated care, but I think that there is more that will need to be done in the future. The pattern of the inspection needs to match the changing pattern of service here, and we are moving into an era of greater integration, we hope, and inspection regulation will have to follow that. Also, the audit that we talked about earlier involves CSSIW and HIW, as well as the WAO, and I will be looking to that report to help us to make sure that it is streamlined together.

[386] **Rebecca Evans:** Powys Teaching Local Health Board expressed concern that having two separate organisations undertaking inspections could lead to some services falling through the gaps. Beyond working closely together, would you consider that there might be a case for one inspection organisation?

[387] **Mark Drakeford:** I remain convinced of the need to have a separate standalone health inspectorate in Wales. I think there is too much work beyond the integration agenda that is health-specific and very important to patients for us to be able to point to an organisation that has the expertise in the health field to provide that. So, I am not persuaded, depending on whatever arguments come up, that a single joint inspectorate covering both fields is the best way forward. I do think that there are an increasing number of areas where the inspectorates will need to work together, and we need to provide them with the proper framework to make sure that they are able to do that.

[388] **David Rees:** Lynne, you have a question.

[389] **Lynne Neagle:** Thank you, Chair. We heard concerns last week, Minister, that, although Healthcare Inspectorate Wales is encouraging organisations to move towards self-assessment, that needs to be externally validated, and that progress in this area had been slow. Do you have any comments on that?

[390] **Mark Drakeford:** What I would say on that is that I am big supporter of peer assessment. It needs to go on inside organisations and between organisations, and I think it gives us a way of having risk-based and proportionate external assessment when you have good evidence from that type of activity. I am not saying that all health organisations in Wales do it as well as they should, and HIW has done a lot of work to try to improve the way that peer review and self-assessment can be improved inside the Welsh NHS. However, I am very persuaded by some of the things that you heard last week as well, that, alongside peer

review, you must have external validation and challenge. When it works well, it operates as a powerful way of people wanting to make sure that their services are as good as possible. When it works badly, it becomes cosy and collusive, and people sign off each other's work programme on the basis of, 'I won't challenge you if you won't challenge me'. So, you must always have a light shone from outside on internal processes of that sort to keep them honest. Provided that you have that, I think they are very powerful ways of bringing about improvement.

[391] **Mohammad Asghar:** Minister, your department has a third of the Welsh Government's budget, so we should have the best possible healthcare in this part of the world. However, there are a lot of problems in a lot of areas in the health service. We are listening to the public's perspective, but not to the nurses, doctors and clinicians. They also have problems. With regard to HIW and the relationship with the ombudsman, you mentioned that you do not take special measures. Measures—not special measures—can be taken in certain areas, until internal problems or school reserves are so bad that special measures are taken. God forbid that something similar happens in the health service so that you have to take special measures. How will you cope if something happens and you do not have any information from HIW or the ombudsman?

[392] **Mark Drakeford:** I do not think, Chair, that it is a matter of us not having information; it is much more a matter of saying that what we do not have in Wales is a single-stranded system. We do not rely on any one organisation to tell us the whole story about the health service. We get lots of information from HIW, and we need to make the most of that. We get a different sort of information from the ombudsman, looking at individual service failures. We get information from royal colleges, trade unions, our own quality assurance, and the work that health boards themselves do. What we have to have is a rounded picture, taking all of those things in, so that, if there were to be a failure by one part of the system, we would not be left with nothing to help us to make sure that the system itself was sound.

[393] In Wales, by and large, I think we can demonstrate that we are able to bring together different parts of the system to give us a sharp insight into issues where we need that to be done. The obvious example that you will have heard about is the joint Healthcare Inspectorate Wales and Wales Audit Office report into Betsi Cadwaladr. Once the alarm signals were sounded by internal means, we were able to put that team together quickly, and support it by the external work of the chief nursing officer and the chief medical officer, with their independent rights of reporting. If we only had one of those, I think that what Mohammad Asghar is saying would be true—we would be in big trouble. Luckily, however, we have a distributed system of inspection and that gives it resilience.

[394] **David Rees:** Okay. Go on, Elin.

[395] **Elin Jones:** I just want to ask about the collection of intelligence and the role that your department has in being part of the collection of intelligence, in that health boards and other organisations send all kinds of statistics to your department. What is the role of your department and its officials in raising awareness and passing that intelligence on to Healthcare Inspectorate Wales? It was not really clear that Healthcare Inspectorate Wales was getting all the information from everywhere—in fact, it said that it did not want that, because it would drown in it, almost, and would not see the issues. Does your department have a responsibility or a mechanism to pass on intelligence that it considers could be trigger factors for the healthcare inspectorate?

[396] **Mark Drakeford:** I will ask Janet to give you the actual mechanism.

[397] **Ms Davies:** As I explained earlier, we routinely share information with HIW, such as on serious incidents, and so forth. We also have bilateral meetings with it, between us and the

department. So, we have both a formal and a more informal, if you like, way of sharing information. Clearly, through our responsibility in Government through our delivery framework, we hold the LHBs and trusts to account on a variety of measures, and that information, and progress against that, is all available to HIW.

[398] **David Rees:** I have one final question, Minister, on the intelligence. Are you confident that the timeliness of the intelligence is there? That is a critical element, because we have heard that some of the reports, for example, are very much delayed. So, it is a question of the timeliness of the intelligence that you receive.

[399] **Mark Drakeford:** I think that there is a genuine issue of timeliness, or there has been in recent times, at HIW. I did not hear the chief executive's evidence to you this morning, but I would imagine that she may have said something on that herself. Reports have been delayed too long, and there has been too big a gap between the inspection taking place and the formal final report being available. I know that she wants to address that. What I would say is that my expectation of local health boards, however, is that, where they have had verbal feedback, which they would have had much closer to the time immediately after the inspection, I expect them to take that seriously and to act on that, and not simply to wait until final reports are available when concerns have been raised.

[400] **David Rees:** Thank you. You will receive a copy of the transcript to check for factual inaccuracies. Thank you very much to you, Minister, and to your officials for attending this afternoon and for the information that you have provided.

[401] **Mark Drakeford:** Thank you.

13:58

Papurau i'w Nodi
Papers to Note

[402] **David Rees:** We have the minutes of the meetings of 17 and 23 October. Is everyone satisfied with that? There is a paper to note from the Deputy Minister for Social Services about the revised legislation consent motion on the Care Bill. There is another paper to note from the Deputy Minister for Social Services—follow-up information to the 9 October meeting on unscheduled care and preparedness for winter 2013-14. There is a also a letter from the south Wales plan programme board reflecting on the question that we asked about what would be made public, following the meeting on 3 October. Thank you very much.

13:59

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod hwn ac Eitemau 1 a 2 ar Agenda'r Cyfarfod ar 13 Tachwedd
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting and for Agenda Items 1 and 2 of the Meeting on 13 November

[403] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi) and for agenda items 1 and 2 of the meeting on 13 November.

[404] I see that all Members are happy with that.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 13:59.
The public part of the meeting ended at 13:59.