An Independent Review of the work of Healthcare Inspectorate Wales

The way ahead:
to become an inspection and improvement body

EXECUTIVE SUMMARY

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INTRODUCTION

1. The NHS in Wales and independent healthcare sector providers treat huge numbers of people each year and the overwhelming majority of patients and service users are very satisfied with their care. However, when care goes wrong, it not only leaves people feeling dissatisfied, they may also be harmed. So, a major goal for Healthcare Inspectorate Wales (HIW) is to monitor health services, check their performance and take action where unsafe or poor quality services are delivered.

2. I want to emphasise that the issues identified and the recommendations made to assist the future work of HIW should not be seen as a criticism of the staff of the inspectorate: they are committed and passionate about the work they do to promote and protect the interests of patients and before the commencement of my Review they were facing their challenges and developing an agenda for change.

3. In the spirit of the Williams Commission which encourages all public services to be learning organisations and innovative, I have looked at useful evidence, distilled the views of stakeholders and made a series of recommendations which will help HIW to improve its effectiveness as a regulator and inspector of healthcare services. I trust that my recommendations are fruitful and help them to move forwards.

4. To support my analysis and findings I consulted with and received information from a wide range of stakeholders, including patients, NHS leaders, the Care and Social Services Inspectorate for Wales (CSSIW), Public Service Ombudsman for Wales (PSOW), the Board of Community Health Councils in Wales and Assembly Members representing all political parties. The full list of contributors is included in Appendix 5. In particular I am grateful for feedback from Dr Bernadette Fuge, Dame Joan Harbison, Dr Jeremy Harbison, Dame Deirdre Hine, Ann Lloyd CBE and Professor Kieran Walshe. Also, I have drawn on relevant literature which can be found in Appendix 8 and a full account of the methodology followed is outlined in Appendix 4.

5. Healthcare Inspectorates in Scotland, Northern Ireland and England recognise that they have a role in not only raising standards at the ward or individual health care body level, but through thematic reviews achieve system-wide improvements across the whole of the country. However, most of HIW’s work is narrowly focused on limited inspection activities and the majority of special reviews of services are reactive to particular concerns or serious incidents. In future, it should not confine itself to taking part in these reviews at the request of other public bodies, it should also set its own strategy and priorities. It should consult widely and decide on a programme of peer and thematic reviews of health services which have the potential to raise the quality of care for substantial numbers of patients and service users.

6. I have proposed a package of reforms and if implemented believe they would place HIW at the cutting edge of healthcare regulation and inspection. It would be a much stronger and independent body better able to promote and protect the interests of patients and service users across Wales. HIW may be able to find smarter and more efficient ways of carrying out inspections, but it is likely it will need extra resources to take on for example, the additional and vital work of scrutinising whether patients are benefiting from the best available clinical treatments and carrying out more national
thematic reviews of services to drive up standards of care. The reform agenda may take between 3 to 5 years to achieve so it will be important to develop a phased approach based on priority setting and sound business planning. HIW will need to demonstrate at each stage of its development that it is making a big impact that its work is making a significant difference to people’s health and well-being. Additional resources may only be gained if it can evidence a substantial return on investment.

7. The context and remit for the Review are detailed below. This is followed by some general principles of healthcare regulation to the work of HIW and the main conclusions and recommendations which should be addressed by the Welsh Government and HIW.

CONTEXT

8. The work of HIW is of considerable importance to everyone in Wales. At various times in our lives all of us use a variety of healthcare services, and as a regulator and inspector HIW's main goal is to ensure that the services we receive are safe, of the highest quality and help return us to good health. As the lead independent regulator and inspector of all healthcare services in Wales its stated purpose is to provide: "independent and objective assurance on the quality, safety and effectiveness of healthcare services making recommendations to healthcare organisations to promote improvements". (Annual Report 2012-13. Foreword). Therefore it protects and safeguards the interests of patients by scrutinising whether healthcare providers are complying with national standards of performance and outcome targets when delivering care and it has the ability to identify and address the underlying causes of failure in a service. However, in March 2014, the Health and Social Care Committee of the National Assembly for Wales (HSCC) produced a report on the work of HIW, highlighting a number of shortcomings and questioning whether the Inspectorate is adequately regulating and inspecting health services across Wales.

9. In light of the Committee's Report and the fact that HIW has been established for ten years, the Minister commissioned this independent Review to look at how the work and responsibilities of HIW could be improved and to make recommendations which would enable him to give it the right tools to be an effective regulator. There is a clear intention to introduce new legislation to strengthen and streamline the remit of HIW.

REMIT OF THE REVIEW

10. The main purpose of the Review was to undertake an independent assessment of the current work of HIW to assess whether it's regulatory and inspection functions need to be reformed and improved.

Purpose:

- To review HIW's existing functions and responsibilities. This will include plotting HIW's history and describing the additional responsibilities that it has acquired during its 10 year history, to determine: if any best sit elsewhere; or if there are any gaps across healthcare settings that need to be addressed.
- To consider the remit of HIW in respect of the NHS and the independent healthcare sector to determine if there is sufficient synergy across the sectors
and application of common standards. This should cover both the inspection and regulatory arm of its remit.

- To draw on the experiences of inspectorates elsewhere, for example, identifying what lessons Wales can learn from methodologies being developed in Scotland, Northern Ireland and England.
- To look at the existing web of legislation underpinning HIW and form a view on where it needs to be consolidated, simplified and/or strengthened, taking into account the changing provision of healthcare services and shift to more community based care.
- To take into account the wider related work, including the Audit, Inspection and Regulation Review, Regulation & Inspection Bill, Community Health Council reform and the relevant actions arising from the Williams Commission, in order to consider the potential implications of this for the operation of HIW.
- To undertake a period of engagement with key stakeholders to seek wider views on the future function and responsibilities of HIW.
- To develop proposals to inform part of a Green Paper setting out the scope for an NHS Quality Bill and make recommendations for any immediate actions that could be put in place ahead of any legislative change.

The review commenced in June 2014 and will report its findings and recommendations in the autumn of 2014.

GENERAL PRINCIPLES OF HEALTHCARE REGULATION APPLICABLE TO THE WORK OF HIW

11. HIW, like other public bodies in Wales needs to fulfil one of the major goals of the Williams Commission, that it should be a high performing organisation delivering excellent services on behalf of citizens, patients and service users. In the following sections I will identify the key ingredients of what constitutes an effective modern healthcare regulator and it is within this context that HIW's existing functions and responsibilities need to be placed; and then look at what it could achieve in future. I want to emphasise that the model presented does not imply that HIW is not meeting all of the standards suggested.

12. Extensive literature resources have been used including:

- The report of Kieran Walshe and Alan Boyd, "Designing Regulation: a Review", which synthesised a substantial body of evidence on regulation, audit and inspection and identified key lessons which can be used to promote successful healthcare regulation; Kieran Walshe “The development of healthcare regulation in England: a background paper for the Mid Staffordshire Public Inquiry”; Walshe and Denham Phipps “Developing a Strategic Framework to Guide the Care Quality Commission’s Programme of Evaluation”. (January 2013).
- Emerging findings from the Audit, Inspection and Regulation Review (AIR) which is looking at the work of the four audit, inspection and regulation bodies in Wales: HIW, the Wales Audit Office (WAO), Care Standards and Social Services Inspectorate Wales (CSSIW) and Estyn which is responsible for education services.
the Commission on Public Service and Delivery, chaired by Sir Paul Williams. (The Williams Commission).

Other sources have been used as appropriate.

13. Where appropriate, I will make recommendations which will help HIW develop its work over the coming years based on an analysis of interviews with key stakeholders and research.

14. To begin with I will look at some general principles of healthcare regulation applicable to the work of HIW.

HIW is a Complex Regulator

15. Some regulators have a relatively simple task having responsibility for reviewing and inspecting a small number of homogenous providers of services. In these circumstances the regulatory task may be easier because it is possible to apply uniform standards and to build up cooperative relationships with those regulated. However, as will be seen in this Review HIW is a complex regulator, responsible for regulating and inspecting a substantial number and complex variety of health bodies across the NHS and the independent sector. Walshe warns that “as the number of organisations to be regulated grows and they become more heterogeneous in size and what they do, the regulator finds it increasingly difficult to understand organisations well and have fit for purpose regulatory methods. There is a risk that regulation becomes increasingly formulaic and transactional in nature”.

16. Its current functions and responsibilities are extensive and its staff need to be multi-skilled and develop knowledge and competence in different areas of work. Another consequence of complexity is that HIW needs to have effective relationships with other regulators and bodies which have overlapping responsibilities for scrutinising healthcare. These include UK bodies and specialist agencies such as the Health and Safety Executive.

The Third Line of Defence: the Limitations of HIW as a Regulator and Inspector

17. The delivery of safe and high quality care cannot be achieved by inspection and regulation alone. The main responsibility for delivering quality care lies with care professionals, clinical staff, providers and those who arrange and fund local services.

18. The King’s Fund approach is that a health care regulator like HIW cannot give an absolute assurance to the public that all health services are safe and effective. Its role is to regulate and inspect services using the best possible techniques, but it must be accepted that quality regulation can only be the third line of defence against serious quality failures.

• The first line of defence is front-line professionals, both clinical and managerial who deal directly with patients: they are responsible for their own professional conduct and competence. They can witness when there is poor care and they must be empowered to speak up and to take actions. In Section 4 of this Review a range of initiatives and recommendations are made on how patient safety and high quality services can be promoted at the frontline, including the coproduction of healthcare, strengthening the voice of patients, the positive use of complaints
information, a zero tolerance approach to breaking Fundamental Standards of Care and a Duty of Candour to underpin the work of all healthcare professionals.

- The second line of defence is the boards and senior leaders of health care organisations. They must create a culture of openness and learning that supports staff to identify and solve problems; and they must have the right information to monitor the quality of care across all clinical interventions and take swift action when there are shortcomings. In Section 7 of this Review a series of recommendations suggest how the performance of NHS Wales could be improved including the transformation of NHS culture, and evaluating and strengthening the governance and leadership of Health Boards.

- The third line of defence is HIW and other external regulators and bodies responsible for scrutinising and inspecting healthcare services and providing assurance and information to the public about the quality of care. Sections 3 and 6 suggest how HIW could become a more powerful regulator and how close collaborative working with WAO, CSSIW, Estyn, the Public Services Ombudsman for Wales and other bodies could protect the public from harm by spotting failures in services at the earliest opportunity; as well as make a contribution to the improvement of services.

(King’s Fund: “Consultation response: A New Start – consultation on changes to the way the CQC regulates, inspects and monitors care. August 2013”).

A Stakeholder Model of Regulation is more likely to improve the Performance of Healthcare Bodies

19. This model emphasises that if HIW is seen as an independent and impartial regulator, not only is its credibility enhanced, it allows it to have more influence and have a greater impact on the performance of those bodies for which it is responsible.

20. Within a stakeholder model the system of regulation takes account of the interests of all stakeholders including healthcare bodies, patient groups, professional associations and the Welsh Government. So, HIW is not captured by any single interest, but collaborates with and balances the interests of all stakeholders acting without fear or favour. Within this model, at times HIW may have to convey unpalatable and unwelcome messages to the Welsh Government and the other bodies it works with. It also recognises that neither HIW nor the Welsh Government can expect to drive performance through using enforcement as the predominant way of trying to achieve change. Openness, and cooperative ways of working are emphasised and HIW should use its status and influence to help health bodies comply with health standards and regulations. This does not exclude the need to take enforcement action when poor services put patients at risk of being harmed.

A Constructive Approach to Inspections: Enforcement and Improvement to Promote High-Quality Care

21. HIW should have collaborative relationships with the health bodies it regulates as long as they strive to comply with healthcare standards; but when they do not, it needs to adopt an assertive and robust approach using its enforcement powers as appropriate. This principle includes the opportunity for health bodies to give feedback on those aspects of regulation, inspections, and health standards which may inhibit innovation or only encourage ritualistic compliance.
22. A healthcare regulator should be flexible tailoring interventions to achieve improvements in the quality of services according to the abilities and capacities of health bodies to make the necessary changes. Some health bodies have the capacity and skills internally to resolve their problems and improve, but others will require external support to move forward. Similarly, in terms of enforcement a flexible approach should be taken. There is a world of difference between a health body breaking regulatory requirements by accident, and those which deliberately flout them, ignore recommendations for improvement and put patients at risk.

Promoting a Culture of Continuous Improvement and Innovation in the Delivery of Health Services

23. The Williams Commission suggests that all public services including health bodies and HIW should continuously search for ways of delivering better services, not just best in class in Wales, but world-class. HIW should do all it can to contribute to health bodies delivering services at the cutting edge of innovation.

24. HIW should fulfil the recommendation of the Commission, “there is a need for a step change in the performance and delivery of public services in Wales”, they need to meet the challenges of the future to improve their delivery for the people of Wales. “Radical change is needed for public services to survive”, we need a 3 to 5 year programme of change, the status quo is not an option. Without change we will see “a progressive failure of services”, and cuts to services and jobs. We need to “invest in reform now, before it is too late”. (P86). “our collective challenge is to move to models of governance and delivery that measure performance against best in class, not best in Wales”, and organisations must seek to improve and to aspire to the best international standards and adopt best practice”. (P2,11).

The NHS is facing a perfect storm: it is experiencing budget constraints, but at the same time there is increasing demand for healthcare and patients and the public are also demanding better quality services.

25. The primary recommendation of the Commission is that there needs to be transformation and innovation in public service delivery, this includes the NHS and HIW must be part of this journey. So, its quality assurance role should not be limited to inspections of individual services, but through thematic and oversight of peer reviews it can test whether LHBs and Trusts are benchmarking their services and delivering the best available treatments to patients and service users: “continuous improvement must be driven through effective performance management and improved regulation”. (Williams Commission page 11). Therefore, health bodies should be positive and proactive in addressing areas for improvement which are identified by audit, inspection and regulation, whether by HIW, WAO, PSOW, and the Medical Royal Colleges.

26. HIW can contribute to the continuous improvement and innovation of health services and like its counterpart in Scotland become not only an inspection, but also an improvement agency–not in the sense of creating improvement plans, this is the responsibility of LHBs and Trusts who should be alert to Welsh Government guidance, Standards for Health and the findings of a wide range of clinical audits and the 1000 Lives Improvement programme which indicate best practice. Rather, HIW scrutinises whether health bodies are following the path of improvement and innovation and aspiring to achieve best in class.
27. The Commission identifies a clear link between the governance and leadership of health bodies and performance. Good governance is about boards and senior managers assessing their own performance and taking actions to improve the delivery of services and to achieve this innovation and measured risk taking must be supported. The Commission’s recommendations, adapted to the work of HIW and WAO suggest that they should work together to ensure that NHS Boards and Trusts deliver improvements in healthcare services by focusing on:

- Evaluating their governance and performance management arrangements and where there are shortcomings offer advice on how they can be improved.
- Evaluating the effectiveness of their internal scrutiny or self-assurance processes to ascertain whether they are robust and if they are focused on continuous improvement.
- Evaluating whether they are adopting innovative healthcare interventions.

A Harmonised Approach to the Inspection of the NHS and the Independent Sector

28. Most healthcare inspectorates have developed a harmonised approach to the regulation of the NHS and the independent sector, the regime being the same for all healthcare bodies, typically based on thorough self assessment of performance, supported by proportionate and targeted reviews and inspections. In Wales, the Health Standards applied to both sectors are virtually the same and they are currently being reformed. It is important that the refreshed Standards remain aligned across all healthcare providers in the NHS and the independent sector.

29. The terms of reference asked me to look at the remit of HIW in respect of the NHS and the independent healthcare sector to determine if there is sufficient synergy across the sectors and the application of common standards. I have found that there are synergies and that the harmonisation of Health Standards and inspection models is justified. For example, DECI inspections are common to both sectors, and HIW takes the same approach when reviewing NHS and independent sector mental health and learning disability care and treatment.

30. Providers, commissioners and inspectorates are working in an increasingly integrated way and in order to plan and deliver effectively for the future, standards and inspection methods used in health should be aligned with social care.

Minimising the Burden of Regulation: Reducing Waste

31. HIW regulation and inspection of health bodies should not distort their priorities, to the extent of them failing to deal with patient issues and concerns. The burden of regulation should be efficient and minimised and should be co-ordinated with other bodies like the WAO, Community Health Councils (CHCs) and Royal Colleges: all of these bodies should share information and the findings of their inspections. The overall aim is to avoid duplication and enhance the impact of reviews and inspections. Health services invest considerable resources, particularly managerial time interacting with HIW and other bodies.

Striking a Balance between Self-Assessment of Performance by Health Bodies and External Scrutiny by HIW

32. HIW should continue to promote a culture of self-assessment by regulated organisations. Traditional regulators kept their distance from healthcare providers
and saw their primary role as inspecting and policing the sector and taking enforcement action. The modern view is that in many respects the best form of regulation is self regulation: healthcare bodies take full responsibility for monitoring and managing their own performance and thoroughly assess the extent to which they comply with health standards and other guidance. Within this framework, the role of HIW is to test or check the validity of self-assessment.

33. However, the Health and Social Care Committee (HSCC) suggested that there should not be an over reliance on self-assessment and that HIW should clarify its programme of external validation. (P10). This issue is explored throughout my review, but is particularly linked to my recommendation that HIW publishes a Statement of Risk.

34. In the light of the Francis Inquiry Report highlighting poor leadership by the health board, HIW should have a clear overarching goal: with the WAO and others assess the governance, leadership and management of health bodies.

Intelligence-Led and Targeted Inspections

35. There is a move away from a uniform approach to inspections where the aim is to inspect all health bodies with the same regularity to selecting bodies for review or inspection based on their performance. HIW should continue to collect a wide range of evidence or data about the performance of particular health bodies, both from the providers themselves and other sources and target inspections where issues or concerns are identified.

36. This requires considerable effort on the part of all regulators with a responsibility for scrutinising healthcare services, there is a need to share the right information at the right time to maximise the opportunity of identifying services at high risk of failure. However, there still needs to be a minimal level of inspections of services, and HIW has made decisions on how frequently various services should be inspected (these will be referred to in Section 2). If health bodies know that there is a reasonable chance of an unannounced inspection, it encourages them to self–assess their own performance and make improvements without waiting for HIW to identify non-compliance.

37. The choices are to inspect services directly, for example at the ward level, or at strategic or board level to check if self-assurance systems are in place to ensure high quality services are delivered. A balance needs to be struck between individual and strategic level inspections: only focusing on individual wards is costly in terms of resources, but also limited. Good practice in one ward of a hospital may not be typical, there may be many other services which are performing badly but left undetected.

38. The length of the inspection and the number of inspectors involved, including specialist staff, depends on which services are seen as high risk and other factors such as size and complexity. So an acute hospital, with a number of high risk services, may require a combination of several inspections of different wards as well as an assessment of overall governance and leadership.

39. In general, it would be best if HIW focused most of its resources on high-risk health services, but tailored its frequency and intensity of inspections according to whether performance is outstanding or problematic i.e., not having a standard/universal
approach. And to carry out less intensive and less frequent inspections of low risk services; but again a tailored approach, targeting particular providers where there is underperformance.

**Equality and Human Rights approach to Regulation**

40. Many regulators seek to promote equality, diversity and human rights and integrate these principles into all of their regulation and inspection activities. Inequalities exist in access to healthcare services for different groups of people, including Travellers and Lesbian, Gay, Bisexual, Transgender people (LGBT) and it is important to look at how HIW can quality assure services so that people irrespective of their ethnicity or lifestyle receive the same good quality care as anyone else. There is a need to tackle inequality whenever it is found during the course of inspections and reviews.

**MAIN CONCLUSIONS**

41. The Executive Summary contains the main conclusions and recommendations. Detailed information is provided in the Main Report in the following sections:

- General principles of Healthcare regulation applicable to the work of HIW.
- The functions and responsibilities of HIW - NHS, Independent Sector, Mental Health Services and other functions.
- Strengthening the role of HIW – making a bigger impact.
- Promoting patient safety and high quality services.
- Assessing the quality of healthcare services.
- Improving the effectiveness of the collaborative system of healthcare inspection.
- Improving the performance of NHS Wales.
- The integration of health and social care – achieving seamless services for patients and service users.
- Capacity issues and the reform of HIW.

**The functions and responsibilities of HIW: The Removal of Non-Core Functions**

42. HIW was established in 2004 and given the responsibility to conduct inspections of NHS bodies and services, and this now includes the seven Local Health Boards and three NHS Trusts. Over the years it has acquired a wide range of additional responsibilities including the review of independent sector, mental health and learning disability facilities.

43. The terms of reference required that HIW’s functions should be reviewed, to determine whether any should be added or removed. Neither HIW nor the stakeholders consulted have identified any gaps in the current regulation of healthcare services, so there appears to be no need for it to take on any new
responsibilities in the immediate future. Many have expressed concerns that HIW has too few resources to meet its wide and complex range of responsibilities. In particular, that it is failing to keep people safe in hospitals and it is not carrying out enough inspections of high risk settings because it has to monitor too many services. The majority of HIW’s 32 responsibilities covering the NHS in Wales and the independent sector are coherent, but I have found that there are 4 functions which HIW should cease to be responsible for:

- The Supervision of Midwives.
- The Assessment of Nursing Agencies.
- Deaths in Custody Whilst Serving a Sentence in a Welsh Prison.
- Homicide Reviews: Those Committed by Mental Health Service Users.

44. Removing these functions will only release limited resources, the funding of the supervision of midwives is dedicated to this responsibility and will be lost, and the resources expended on the assessment of nursing agencies is negligible. HIW will be able to expand its inspection of healthcare services but not significantly. Over the coming years the Welsh Government should recognise that HIW must have a single minded goal of scrutinising the safety and quality of healthcare services and should avoid adding responsibilities which would dilute this focus.

(Recommendation 11)

Clarifying the Role and Purpose of HIW

45. The core purpose of HIW is not well understood and clear enough, in particular it is not sufficiently patient or citizen focused. It should create a new statement of purpose encapsulating its role as a strong independent body which puts patients and service users first. The overriding aim is to ensure that through inspections and reviews of healthcare services people are not only protected from being harmed, but also receive the best treatment and care possible.

(Recommendation 12)

HIW should publish a Statement of Risk explaining how it will prioritise inspections and reviews of healthcare services which pose the greatest risks to patients and service users

46. HIW should carry out a risk assessment of all of the services for which it is responsible, identifying which settings pose the most risk of harm to patients and those where the risks are less. Services where patients are at the greatest risk of serious harm should be highlighted and prioritised.

47. The Statement of Risk will show:

- Which services are being examined more frequently and thoroughly to ensure that they are meeting required quality and patient safety standards. Also, that minimum inspection schedules of high risk services will never be compromised because of capacity problems. If there are temporary resource issues it will be able to justify delaying the inspections of lower risk services.
- The minimum frequency of inspections it will carry out of all NHS and independent sector bodies.
- Beyond the minimum frequency a tailored approach will be taken. Outstanding services will be visited less often, allowing resources to be targeted on particular providers where there are concerns.
48. The Statement of Risk could include a discussion of the most appropriate inspection regimes for children, older people, people with learning disabilities and those with mental health issues as all of these groups often find it very difficult to voice their concerns, particularly if they are living in closed institutions or residential settings. Informed by its collation and analysis of intelligence, HIW should develop a proportionate risk-based inspection programme.

(Recommendations 6,19)

Evaluation of the Work of HIW: Assessing Whether Regulation and Inspection Delivers Significant Outcomes for Patients and Service Users

49. An effective healthcare regulator should have a positive impact on the performance of healthcare organisations it is responsible for scrutinising and help raise the quality of services provided to patients. HIW should evidence the outcomes, benefits and impact of its work in the following ways:

- It should inform the public of how successful it is in the efficient use of its resources. For example, how quick and responsive it is to patients and service users, the healthcare bodies subject to inspection and review as well as other stakeholders. These include traditional efficiency measures of inputs and outputs such as the number of inspections carried out, number of announced and unannounced inspections, the number of inspections involving clinical experts or patient experts and so on. The number of “customer care” measures should be minimised to allow scarce resources to be used to evaluate significant outcomes.
- It should measure the impact of inspections and reviews and show how they achieve better outcomes for patients and service users. In particular, that healthcare bodies adapt their work and improve their performance as a result of inspections and recommendations for improvement, resulting in safer and better quality services being delivered. It would be especially useful for HIW to build in what works/benchmark standards to help a health provider understand the extent to which their performance is near to "best in class". As part of self–assessment, health bodies would be required to evaluate their services by measuring important outcomes and rate their own performance against the benchmarks. HIW's role would be to give advice to health providers to help them evaluate their services accurately, then test their validity through inspections, and undertake follow-up work to determine whether progress has been made over time.
- HIW should prioritise the evaluation of peer and thematic reviews as they can often make a bigger impact than individual inspections, highlighting significant lessons for the whole of the NHS and the independent sector bringing benefits to patients across the whole of Wales.

(Recommendations 15,16,17)

Strengthening the Independence of HIW

50. HIW must be seen by the public and its major stakeholders as a strong, independent and impartial regulator and inspector of healthcare services. In carrying out its work it must show no fear or favour to anyone. At times it should be able to take decisions which are unpalatable and unwelcome to the Welsh Government or the health bodies it works with. There is a clear disagreement amongst stakeholders of whether HIW is independent of the Welsh Government or not. The balance of views is in favour of strengthening HIW’s independence and giving it more powers. So, it should be able to take independent decisions on the
most appropriate enforcement actions in relation to NHS bodies without having to make a request to the Minister for Health and Social Services. Consideration should be given to the range of options which would make HIW a more independent inspectorate, looking at other models including Estyn, as well as the Auditor General for Wales and the Public Services Ombudsman for Wales.

(Recommendation 13)

Promoting patient safety and high quality services

51. HIW will be able to ensure that patients and service users are receiving the best and safest care possible by scrutinising whether health bodies are successfully operating existing initiatives as well as through the implementation of a number of reforms.

These include:

- Scrutinising the effectiveness of LHB’s and Trusts implementation of mechanisms of gaining feedback from patients and carers such as patient surveys and expert patient groups.
- Scrutinising the effectiveness of complaints systems, whether frontline staff are empowered to resolve concerns at the earliest opportunity and Chief Executives and Boards gather sound information on complaints, put it at the top of their agenda and take actions to improve the quality of care.
- As the majority of Community Health Councils and many LHB’s and Trusts do not provide HIW with data on complaints, a statutory duty should be placed on both bodies to routinely share information with the inspectorate.
- There should be a zero tolerance approach to breaching Fundamentals of Care Standards. The current Standards are in the process of being reformed but are likely to include many of the existing elements. They are a basic set of requirements that should be at the core of any service supporting the delivery of compassionate and safe care. Serious harm can be caused through poor care including malnutrition, dehydration, pressure sores, inadequate hygiene, medication errors, failing to assist patients when they need to go to the toilet and not responding to alarm buzzers. The Welsh Government should consider developing tougher and more robust regulations to reinforce the reshaped care standards, applicable to all health care providers in both the NHS and independent sectors. HIW would scrutinise the implementation of the Standards and consideration should be given to increasing its enforcement powers where breaches take place.
- The Welsh Government should include an explicit Duty of Candour in the refreshed Health Standards in order that HIW will be able to assess the extent to which service providers are open and honest about their mistakes, why they have occurred, and what they have done to put things right. HIW will also assess whether Local Health Boards are providing good governance: that information is not only shared with patients, but also with HIW at the earliest opportunity and that safer services are delivered as a result of learning from errors. A key aim of the Duty of Candour is to promote the transformation of healthcare services, moving away from a blame to a learning culture enabling the delivery of safer and better quality care. It will be the responsibility of all providers to establish the duty from ward to board level. It is essential that senior managers and boards empower frontline staff to identify what has gone wrong and support them to make improvements. Staff must be open and honest with service users about their care and treatment, including when it goes wrong and they are
harmed. People should be given an explanation of why it happened and offered an apology as well as an appropriate remedy.

- The Welsh Government should develop regulations to allow HIW to carry out prosecutions where professional healthcare staff give false or misleading information.
- Where appropriate, HIW should be more willing to use its enforcement powers particularly where patients are put at serious risk of harm in both the NHS and independent sector.

*(Recommendations 21,22,23,24,25,26)*

**Promoting Better Clinical Treatment and Care across Wales**

52. Currently, HIW has a limited role in scrutinising whether effective clinical treatments are provided to patients. Its core inspection programme focuses on Dignity and Essential Care Inspections (DECI) and Infection Prevention and Control inspections of individual wards in acute and non-acute hospitals (including mental health and learning disability hospitals) and these are of vital importance to patients. Their aim is to ensure that patients benefit from life maintaining care including adequate intake of food and fluids and the remaining requirements of the Fundamentals of Care Standards; and that they are looked after in a clean and hygienic environment to avoid catching a hospital acquired infection. However, in future HIW should also scrutinise whether health bodies are providing the most effective clinical treatments to patients. This can be achieved in four ways.

53. Firstly, new Health Standards are being developed and they should go beyond requiring minimal levels of service quality. In addition, they should direct health bodies to aspire to benchmark standards of clinical treatment and care across all areas of activity. HIW’s role would be to scrutinise whether this approach is being followed by LHBs and Trusts and to offer expert advice, disseminate best practice and stimulate learning. All healthcare providers across Wales should be following international benchmark standards of good care. The Welsh Government coordinates 33 national clinical audits of medical conditions including diabetes, kidney disease, various cancer conditions, a range of heart ailments and mental health conditions and healthcare providers should be seeking to achieve the standards which have been set. HIW’s role, in collaboration with Public Health Wales and the Medical Royal Colleges would be to provide objective and independent scrutiny assessing the extent to which each health body is implementing them and if they are continuously self-assessing their performance in order to drive up standards of care.

54. Secondly, HIW could scrutinise whether the lessons promoted by the 1000 Lives Improvement programme are being delivered during the course of individual inspections or reviews.

55. Thirdly, HIW should carry out national peer, thematic and special reviews of clinical treatments as well as care services as they can improve the quality of services for patients and service users across the whole of Wales. For example it should support and quality assure the peer review model where clinicians across the country self-assess their services against a set of best practice standards and in consultation with expert colleagues make improvements in order to drive up standards. The recent excellent example of the peer review of cancer services
could be repeated with other clinical conditions such as diabetes, strokes and cardiac diseases.

56. Finally, HIW should consider the value of developing a framework for assessing the quality and safety of all healthcare services. The framework could reflect significant patient outcomes, and be aligned with new refreshed Health Standards, the self-assurance systems that health bodies use to measure their own performance and clinical indicators used by professional regulators and Royal Colleges. (Recommendations 8,18,27,28)

Enforcement and Improvement to promote high quality care

57. HIW should cease to be a safety net regulator, limiting much of its activity to the inspection of individual healthcare services. A focus on compliance alone limits it to taking action to detect and tackle poor quality care: most of the lessons provided to the rest of Wales only come from narratives about poor practice. It needs to fulfil two roles, not just making sure that healthcare providers comply with Welsh Government Health Standards and guidance, but also play a leading part in helping health bodies deliver excellent standards of care through collaboration with others including professional regulators such as the General Medical Council, Nursing and Midwifery Council, the Medical Royal Colleges and Public Health Wales, the Wales Audit Office and Care and Social Services Inspectorate Wales.

58. By expanding peer and thematic reviews across a wide range of health services or clinical conditions it will ensure that people wherever they live in Wales receive care which emulates international standards of best practice. The overall goal is to carry out inspections and reviews which bring the greatest benefits to patients and service users by supporting the greatest improvements in the quality of care. All services can benefit from understanding what excellent practice looks like as well as how to avoid service failure.

59. HIW can contribute to the continuous improvement of health services and like its counterpart in Scotland become not only an inspection, but also an improvement body – it is the catalyst for not the main driver of improvement as the responsibility for creating and delivering healthcare plans is the responsibility of LHBs and Trusts. Rather, HIW scrutinises whether health bodies are following the path of improvement and innovation and aspiring to achieve best in class. (Recommendation 36)

Promoting Patient Safety and High Quality Healthcare Services through Coproduction

60. The Welsh Government, health bodies and HIW should put patients and service users at the heart of healthcare delivery and the regulation and inspection of services. Professional healthcare staff and citizens should share power and plan and deliver services together. The needs of patients come first and genuine involvement, discussion and negotiation should take place. The Welsh Government should consider the merits of developing a legal duty to involve service users in the governance and scrutiny programmes of HIW.
61. HIW should continue on its journey of involving patients, carers and service users in its work as they can help target which services should be inspected as well as use their experience to drive service improvements. It should:

- Establish a panel of service users to inform all aspects of its work programme, ensuring that a balance of views is obtained by including diverse and often underrepresented groups.
- Find ways to engage with and listen to people who are vulnerable and socially excluded.
- Involve and obtain feedback from third sector organisations such as Carers Wales, MIND Cymru and Citizens Advice Cymru.
- Act on the results of patient surveys to understand people’s direct experience of care.
- Involve service users, carers and citizens as partners in scrutiny and inspection activities. Professionals don’t always know best, patients and service users are experts as they directly experience services, know their shortcomings and can contribute to their improvement.
- Establish user panels to provide evidence and views prior to inspections and then to validate or comment on inspection reports. This could be a joint activity with Community Health Councils.

(Recommendations 20,33)

Strengthening the Collaborative System of Health Care Inspection

62. The Francis Report emphasises that when public bodies responsible for protecting the interests of patients fail to collaborate the consequences can be disastrous. Senior managers, the board, inspectorates and regulators failed to coordinate their activities and did not detect and prevent serious and systemic failures in care resulting in at least 400 people dying unnecessarily. They were working in silos and did not share information about complaints and abuse. The overriding goal of the collaborative system of healthcare regulation and inspection that exists in Wales should be to do all in its power to prevent a Mid–Staffordshire tragedy from ever occurring here.

63. HIW can only maximise its role of promoting and protecting the interests of patients by playing its full part in the collaborative system of healthcare regulation, inspection and audit. It does not have sole responsibility for the review of healthcare services so has entered into a voluntary arrangement, in the form of Inspection Wales, with other bodies to promote joint working including the Auditor General for Wales (AGW), CSSIW, and Estyn (collectively known as the AIR bodies).

64. However, evidence to the Health and Social Care Committee, the AIR review, and many stakeholders consulted during this Review suggest that the current system is not working well enough. Both the AGW and CSSIW expressed doubts about HIW’s capacity and ability to work collaboratively with them and other external review bodies. The Auditor General for Wales stated that he could not rely on HIW as sometimes it does not carry out an agreed inspection or review.

65. The voluntary arrangements which underpin the work of Inspection Wales have not supported effective collaboration and the coordination of work programmes between the 4 AIR bodies and at times this may leave patients and service users at risk because a review is not carried out. The Welsh Government should explore how
collaborative working could be strengthened by reviewing current arrangements for cooperation and how they might be reformed through creating a statutory duty. In particular the model of the Local Government (Wales) Measure 2009 which supports collaborative working by the AIR bodies in their review of the performance of local authorities may have relevance to the health sector.

(Recommendation 29)

Establishing a Collaborative Early Warning System to Prevent Systemic Failure in Healthcare Services

66. A major goal if not the most important one for HIW, is to create an early warning system to detect widespread systemic neglect or poor treatment of patients. As the Andrews Report shows we cannot always rely on the Board of an NHS body to ensure that safe and high quality care is delivered at the frontline. Therefore, it is essential to have an effective collaborative early warning system in place to detect failure which has not been identified and remedied at the local level. External scrutiny bodies and others are at the heart of this system.

67. There are 33 bodies involved in collaborative working and sharing information, with varying degrees of participation through Concordat Cymru, Healthcare Summits and the NHS Wales Escalation and Intervention Arrangements. This is a highly complex information network, perhaps it is unavoidable given that the NHS is one of the largest public services in Wales? However, there is a risk that HIW staff may be overloaded making it difficult to spot where services are going wrong.

68. In future it would be useful to take stock and evaluate how successful the current information arrangements are and consider whether any adaptions are needed. How well do they complement each other and is there any overlap and duplication of effort? And are they sufficient to spot at an early stage failures in care such as those identified in the Andrews Report?

(Recommendations 30, 31, 32)

Reform of Community Health Councils: to Strengthen their Role in the Collaborative System of Healthcare Inspection

69. CHCs have an important part to play in promoting and protecting the interests of patients having a right to enter and inspect NHS premises, including GPs, dentists, hospitals, pharmacies and care homes providing NHS care as well as be consulted about any changes in health services in their local areas. Also, they fulfil an advocacy function by providing independent advice to individuals who have problems with NHS services. CHCs must have a higher public profile as too many people do not know of their existence and offer much more advice and support to people who have concerns and wish to make complaints about their healthcare.

70. There has been much criticism that CHCs and HIW have worked in isolation of each other, so in future there must be a statutory duty placed on both bodies to enable better sharing of inspection and complaints information. In order to ensure maximum collaboration and economies of scale, CHC members should provide the lay element of HIW inspections This will enhance target–led inspections and of great importance contribute to the early warning system designed to tackle systemic healthcare failures.

(Recommendations 34, 35)
Improving the Performance of NHS Wales

71. HIW can help improve the performance of NHS Wales in the following ways:

- A real challenge for parts of the NHS is to get rid of a defensive blame culture where patients' complaints are not dealt with properly and staff are fearful of speaking out. It is the responsibility of Boards and senior leaders to support staff at all levels to continuously improve the quality of care by welcoming and taking action on feedback from patients. The Standards for Health which are in the process of being refreshed should include a requirement for HIW to scrutinise the culture existing in health organisations to assess whether an open and learning culture is in place supporting staff to deliver excellent standards of care.

- Where appropriate HIW should go beyond individual inspections of services and carry out thorough reviews to assess the overall governance and leadership of health bodies to understand how successful they are in quality assuring all of the services they provide.

- Many boards find it difficult to performance manage the health services for which they are responsible because they are not provided with sound and clear data and information. Weak self-scrutiny processes undermine the ability of boards to fully understand what is happening at the frontline of care delivery. Consequently, the external scrutiny of performance by the Welsh Government and HIW is also compromised. So, it is essential that the Welsh Government, the Boards of LHBs and Trusts, HIW and others agree on the essential information which should be collected by all health bodies across Wales: what core information will support effective analysis – for example mortality and morbidity data for different clinical interventions and complaints data. These are critically important outcomes which should be at the heart of health bodies’ self-assessment processes and HIW’s inspection activities.

(Recommendations 37,38,39,40)

The Integration of Health and Social Care: Achieving Seamless Services for Patients and Service Users

72. It will be increasingly important for HIW and CSSIW to collaborate and coordinate their activities to scrutinise the performance of health and social care organisations to assess the quality of integrated care, whether people are receiving seamless services when they move between primary care, hospitals and social care. HIW's developing role of quality assuring primary care, particularly GP practices will make an important contribution to the evaluation of the effectiveness of pathways of care and the implementation of coordinated treatment plans.

73. A key question is whether patients and service users would benefit if HIW and CSSIW were merged. This is not straightforward as both inspectorates are responsible for scrutinising a complex array of bodies and there needs to be a clear understanding of how much or little there is in terms of duplication or overlap.

74. So, a thorough cost benefit analysis should be undertaken to assess whether the potential benefits of a merger are significant and substantial.

(Recommendations 41,42)

Capacity Issues and the Reform of HIW
75. Of the 32 responsibilities allocated to HIW a recommendation has been made to remove 4 of them. However, this will release negligible additional capacity and will not allow HIW to significantly increase its inspection activities. For some time HIW was lacking in resources, but now that it is fully staffed it believes that it can carry out more frequent visits to a wide range of settings. When one looks at the trends over the past few years in terms of the frequency of inspections of all services for which it is responsible, one can see that some of them were visited rarely and for those with higher frequency targets, visits were sometimes delayed and on occasions did not happen. So, the current targets may be seen as stretching and ambitious. (See Tables 1, 2,3 and 4 in Section 2 of the Review). In addition, this Review includes a number of recommendations which if implemented would add to HIW’s workload. For example the suggestions that it should substantially increase the number of peer and thematic reviews and scrutinise the extent to which boards are implementing the best available clinical interventions for patients. All of these recommendations are designed to make HIW a more effective inspector, better placed to protect patients from harm as well as stimulate improvements and innovations which will raise the quality of healthcare. There is a concern that over the coming years that resources may be spread too thinly over the extensive range of services which HIW is responsible for and big impact national thematic reviews will not be carried out.

76. Any request for more resources would need to show value for money: HIW should evaluate its work and provide evidence that it is achieving positive outcomes for patients and service users.
RECOMMENDATIONS FOR THE WELSH GOVERNMENT AND HIW

There are 25 recommendations for HIW, 14 for the Welsh Government and 3 for joint consideration. The recommendations are set out below under the relevant Section headings from the Main Report.

SECTION 1: GENERAL PRINCIPLES OF HEALTHCARE REGULATION APPLICABLE TO THE WORK OF HIW

1. The Welsh Government should ensure the new NHS Health Standards include a requirement for NHS Wales to take actions which will result in the most efficient and best services being delivered to patients and service users. Where appropriate, HIW and the WAO should jointly scrutinise the governance and leadership of health bodies, in particular measuring the extent to which their activities are driven by the goal of continuously improving services and aspiring to achieve world-class standards.

2. HIW should continue to share information and coordinate inspections and reviews with the WAO, Community Health Councils, professional regulators and Medical Royal Colleges in order to avoid duplication and enhance the impact of their activities.

3. HIW should publicise its equality and human rights approach to its inspection activities and protect and promote the interests of people from diverse backgrounds and those who are often marginalised and socially excluded.

SECTION 2: THE FUNCTIONS AND RESPONSIBILITIES OF HIW

4. HIW can make a major contribution to the safety and care of patients by holding boards to account for the clinical performance of doctors through the medical revalidation process. Therefore it should give high priority to working with the General Medical Council to ensure that Health Board leadership and governance of Responsible Officer Regulations is effective.

5. HIW and the Welsh Government should explore the usefulness of audit tools developed by the Royal College of Physicians and consider whether they should be built into the new Health Standards which are being developed; and whether they could contribute to HIW’s inspection programmes.

6. HIW should develop a proportionate risk-based inspection programme informed by its collation and analysis of intelligence. The inspection programme should include:

   • closer working with CHC’s will be essential to ensure the best use of information and intelligence at individual ward level or other settings.
   • learning lessons of good practice from the Welsh Government’s use of spot-check visits to a substantial number of hospital wards which assessed the safety and quality of care and use these to inform their development of short-form DECI inspections. This would allow a greater number of inspections to be carried out.
• continuing with its new approach to cleanliness and infection control to prevent hospital acquired infections. It should remain a top priority and capacity issues should never compromise its ability to deliver this aspect of its work.
• finding resources to increase the number of inspections it undertakes of GP practices.

7. HIW should formalise its agreements with the following bodies:

• The General Pharmaceutical Council, which is the principal regulator of the pharmacy profession in Wales; and report on the effectiveness of pharmacy regulation across Wales in its Annual Report.
• The General Optical Council, which is the principal regulator of the optical profession in Wales; and report on the effectiveness of optical regulation across Wales in its Annual Report.

8. HIW should expand peer, thematic and special reviews as they can improve the quality of care for patients and service users across Wales. Thematic and special reviews in particular should be further developed as they can identify solutions to problems in one service or locality that can be taken up by the whole of the sector. At the same time the regulation and inspection of healthcare services should not be compromised.

9. The Welsh Government should:

• develop healthcare regulations in line with the principles of the White Paper on the regulation of social care services. The regulation and registration of independent healthcare providers should move to a service-based model of registration, instead of the registration of individual premises. This would be a sensible reform and create efficiencies for both providers and HIW as well as increasing alignment between the health and care sectors.
• ensure that only one set of health standards applies across the NHS and independent sectors. HIW should work with NHS Wales, the independent sector and the Welsh Government and all other relevant bodies to develop a coherent set of standards that link with social care standards.

10. In relation to work in Mental Health and Learning Disability settings HIW should:

• increase the volume of inspections of NHS inpatient facilities to better protect the interests of patients who have a mental health problem or learning disability.
• focus its inspection model more on evaluating patient outcomes and less on scrutinising whether appropriate processes have been followed.

11. The Welsh Government should remove HIW’s responsibility for the following functions:

• supervision of midwives and the transfer of this function to an alternative host organisation should be progressed with urgency.
• carrying out homicide reviews where homicides have been committed by mental health service users. Other healthcare inspectorates across the UK do not fulfil this function, it is recognised that specialist clinical expertise is required, therefore reports are commissioned from equivalent LHB bodies. If the current
commissioning arrangements are to continue then the Welsh Government should consider the resource implications.

- contributing to the investigation of deaths in Welsh prisons. By their nature, these investigations are time-consuming, frequently require specialist clinical expertise and sometimes the resources which need to be allocated to them mean that HIW has had to reduce important inspection activities. The Prisons and Probation Ombudsman could obtain specialist clinical advice from Local Health Boards.
- assessing nurse agencies. Although this will have little impact on capacity within HIW it will help to remove duplication with the work of CSSIW.

SECTION 3: STRENGTHENING THE ROLE OF HIW: MAKING A BIGGER IMPACT

12. HIW should refresh its Statement of Purpose to make it patient and citizen focused. The public should clearly understand that its role is to ensure they receive the best quality treatment and care, as well as protect them from being harmed. Also, the Statement of Purpose may want to give greater emphasis to HIW’s role of promoting Wales-wide improvements and innovation in healthcare, that it could be much more than an inspector of individual services.

13. As part of the proposals for the Green Paper, Welsh Government should consult on the following:

- giving HIW a full range of enforcement powers including putting an NHS healthcare provider into special measures without recourse to the Health and Social Services Minister. This will help enhance HIW’s independence and assure the public that it is a strong and impartial regulator and inspector.
- the range of options which would make HIW a more independent inspectorate, looking at other models including Estyn, as well as the Auditor General for Wales and the Public Services Ombudsman for Wales. At the same time, it would be sensible to take into account the possible merger with CSSIW when exploring these options. The public could be consulted on all of these matters including a consideration of the benefits and disadvantages of creating a single regulator with responsibility for health and social care.

14. HIW should further develop and publish a Communications Strategy, which will allow it to communicate more effectively with the public. It will be able to provide evidence that it is delivering a highly valuable service on their behalf. Increased interaction with patients and service users through multi–media formats will provide valuable information to support target led inspections of services where concerns are raised.

15. HIW should include more information in its Annual Report on the outputs and efficiency of work processes which serve patients, service users and other stakeholders. The number of customer care measures should be minimised, to allow scarce resources to be used to evaluate significant outcomes.

16. HIW to evaluate the effectiveness of their inspection and review models, to not only gain a better understanding of the performance of healthcare providers, but also as a means to help them improve the quality of inspection activities. Providers should have the opportunity to give feedback on whether HIW’s scrutiny of their service is useful, and to what extent it helps them identify those aspects which need to be improved.
17. HIW to measure the outcomes of its most important areas of inspection: showing how its inspections have had a significant impact on the safety and quality of healthcare services by helping providers improve their performance.

18. The Williams Commission recommends that if a standard of good practice is identified it should be adopted by all relevant health bodies across the whole of Wales to bring to an end unnecessary variations in the quality of services. Any departure from this principle would have to be justified. So, it would be highly beneficial for the Welsh Government to include this requirement in the refreshed Health Standards and for it to become part of HIW’s regulatory regime.

SECTION 4: PROMOTING PATIENT SAFETY AND HIGH QUALITY SERVICES

19. HIW, after consulting with stakeholders, should publish a Statement of Risk outlining its approach to regulation and inspection. It should explain the minimum frequency of inspections and reviews it will carry out of both NHS and independent sector bodies and put this within the context of its capacity to meet these targets.

20. The Welsh Government should:

- consider the merits of developing a legal duty to involve service users in the governance and scrutiny programmes of HIW. They will have a say in the design, implementation and monitoring of its regulatory activities. Directly listening to the voices of patients and carers can help identify care which contributes to good health and well-being as well as unsafe and unacceptable care. HIW would be required to report to Welsh Ministers on the involvement of citizens, including children and young people, in its decision making and strategic operations.
- reflect the principles of Prudent Healthcare, patient involvement and improved outcomes for patients in the refreshed Health Standards which are in the process of being developed and become part of HIW’s regulation and inspection regime. The role of HIW would be to scrutinise whether a health body is delivering outcomes for patients which they believe to be important to their health and wellbeing.

21. HIW should review the implementation and effectiveness of LHBs and Trusts service user strategies, in line with the Welsh Government’s guidance A Framework to Assure Service User Experience, to determine whether they are genuinely involving patients and carers as a means of improving the safety and quality of services.

22. The Welsh Government should place a statutory duty on LHBs, Trusts and CHCs to routinely share complaints information with HIW. This will enhance HIW's ability to fulfil its responsibility to quality assure health bodies performance in relation to dealing with concerns and managing incidents in line with the Doing Well Doing Better – Standards of Health Services in Wales; and to spot serious and systemic failure in health care at an early stage.

23. The Welsh Government should consider developing tougher and more robust regulations to reinforce the reshaped care standards, applicable to all health care providers in both the NHS and independent sectors. HIW would scrutinise the implementation of the Standards and consideration should be given to increasing its enforcement powers where breaches take place.
24. The Welsh Government should include an explicit Duty of Candour in the refreshed Health Standards in order that HIW will be able to assess the extent to which service providers are open and honest about their mistakes, why they have occurred, and what they have done to put things right. HIW will also assess whether Local Health Boards are providing good governance: that information is not only shared with patients, but also with HIW at the earliest opportunity and that safer services are delivered as a result of learning from errors.

25. HIW should always carry out follow-up actions when inspection results indicate this is necessary and in the most serious instances of service failure, should be more robust in the use of its enforcement powers, and publish data on how it has used these powers in its Annual Report.

26. The Welsh Government should:

- develop regulations to allow HIW to carry out prosecutions where professional healthcare staff provide false or misleading information.
- develop regulations which impose time-limited registration on services which have failed to comply with regulations and standards. This would exert significant pressures on providers to improve their performance.

SECTION 5: ASSESSING THE QUALITY OF HEALTHCARE SERVICES

27. HIW should consider the value of developing a framework for assessing the quality and safety of all healthcare services. The framework could reflect significant patient outcomes, and be aligned with new refreshed Health Standards, the self-assurance systems that health bodies use to measure their own performance and clinical indicators used by professional regulators and Royal Colleges. The framework should be common to the work of both HIW and CSSIW as patients and service users are increasingly receiving integrated health and social care services. Clear information would be provided to members of the public and inspection reports and results would encourage improvement and innovation by providers.

28. HIW should scrutinise whether:

- Health bodies are providing the most effective clinical treatments to patients. Patients not only want to benefit from being looked after in line with essential life maintaining care such as being fed, hydrated and being assisted with going to the toilet as necessary, but they also want to receive the best available clinical treatments.
- Lessons promoted by the 1000 Lives Improvement programme are being delivered during the course of individual inspections or reviews; or they could be the subject of national thematic reviews.

SECTION 6: IMPROVING THE EFFECTIVENESS OF THE COLLABORATIVE SYSTEM OF HEALTHCARE INSPECTION

29. The voluntary arrangements which underpin the work of Inspection Wales have not supported effective collaboration and the coordination of work programmes between the 4 AIR bodies and at times this may leave patients and service users at risk because a review is not carried out. The Welsh Government should explore how collaborative working could be strengthened by reviewing current arrangements for cooperation and how they might be reformed through creating a statutory duty. In
particular the model of the Local Government (Wales) Measure 2009 which supports collaborative working by the AIR bodies in their review of the performance of local authorities may have relevance to the health sector.

30. The collaborative information system consists of Concordat Cymru, Healthcare Summits and the NHS Wales Escalation Arrangements and there may be scope for clarifying how they complement each other as well as assessing whether there is any overlap and duplication of effort. HIW, Welsh Government and other bodies should consider if the current information system is as streamlined and efficient as it could be. Also, it will be useful in future to take stock and evaluate the success of the information sharing system and determine whether any changes are needed.

31. The collaborative early warning system should become the central organising principle of the work of Concordat Cymru. It must have high status and profile amongst all members and its aims and methods of working should be published across the whole of the health and social care sector.

32. HIW should evaluate the effectiveness of the early warning system and include this in its Annual Report.

33. HIW should increase collaboration with third sector organisations which offer advice and advocacy to patients and carers to gather more information about any concerns they may have about the quality of healthcare services e.g. Carers Wales, MIND Cymru and Citizens Advice Cymru.

34. HIW and CHCs to hold listening events in local communities as well as involve experts by experience in their inspection teams when an in–depth review of a particular hospital or LHB is taking place.

35. The Welsh Government should consider reforming the work of CHCs in the following ways:
   - CHCs must prioritise their patient advice and advocacy service and reduce waiting times.
   - The remit of CHCs should extend their advice and advocacy role to provide seamless support to people who use both health and residential social care services.
   - There should be a statutory duty for both CHCs and HIW to share information about complaints and other intelligence with each other.
   - In future CHC members should provide the lay element of HIW inspections.

SECTION 7: IMPROVING THE PERFORMANCE OF NHS WALES

36. HIW should carry out more national thematic reviews of healthcare services. All providers across Wales should be following international benchmark standards of good care and HIW’s role would be to scrutinise whether each health body is implementing them; and if they are continuously self-assessing their performance in order to drive up standards of care. It would be testing whether the self-assessments of performance are valid or not and by working with Public Health Wales and other expert bodies, identify lessons from highly successful providers which could benefit all patients and service users if implemented across the whole of Wales.
37. The Welsh Government should include an evaluation of culture of health bodies in the revised Standards for Health Services in Wales. This would require an assessment of governance and leadership of Boards and allow HIW to consider whether Boards are empowering and supporting staff to deliver excellent standards of care.

38. Where appropriate HIW should give priority to carrying out joint reviews with the WAO of the governance, leadership and performance of LHBs and Trusts; and consider asking the PSOW to offer his expertise.

39. The Welsh Government, LHBs, Trusts, HIW and others should:

- Agree on a common data collection and information system, to be used at the local level, to cover the whole of the NHS in Wales. This will result in the Boards of LHBs and Trusts receiving sound and easier to understand information; as well as more informed data being fed into the various elements of the Welsh Government’s performance management framework and information provided to HIW. It will also allow for comparisons of performance and lessons learnt to be disseminated across Wales.

- The local data collection system should include a suite of clinical outcomes in line with national audit requirements which will enable citizens to understand how well services are being delivered locally.

40. HIW should validate whether Health Boards and Trusts are following benchmarks of best practice and performance managing healthcare services to the highest possible standards.

SECTION 8: THE INTEGRATION OF HEALTH AND SOCIAL CARE: ACHIEVING SEAMLESS SERVICES FOR PATIENTS AND SERVICE USERS

41. HIW and CSSIW should work together to develop an integrated inspection framework to scrutinise the performance of health and social care organisations. The aim would be to assess the quality of integrated care, whether people are receiving seamless services when they move between primary care, hospitals and social care in registered settings.

42. The Welsh Government should consider the issue of a merger between the two inspectorates. The coming years will see a transformation in the delivery of both health and social care services. As both the NHS in Wales and local government will experience reorganisation, patterns of delivery and commissioning will change, and once settled the possibility of a merger could be explored. A thorough cost benefit analysis should be undertaken on whether a merger is appropriate.