National Assembly for Wales

Health and Social Care Committee

The work of the Healthcare Inspectorate Wales

Evidence from a Dignified Revolution – HIW 01

EVIDENCE TO SUPPORT THE HEALTH AND SOCIAL CARE COMMITTEE INQUIRY INTO THE WORK OF HEALTHCARE INSPECTORATE WALES

ABOUT A DIGNIFIED REVOLUTION (ADR)

ADR was established in 2008 by a group of individuals who want to improve the care that older people receive whilst in hospital. The impetus to establish the initiative was driven by the distress that these individuals had experienced because of the poor care that their relatives had received whilst in hospital, and their concern that others might find themselves in the same situation.

A Dignified Revolution is focused on:

- ensuring that dignity and respect of older people is a key priority for all health and social care professionals
- encouraging the general public to challenge rather than tolerate unacceptable attitudes and inappropriate care

We achieve this by:

- Speaking at conferences
- Giving talks to local groups
- Publishing a monthly electronic newsletter which is circulated to around 10,000 people across the UK
- Writing articles for publication in health and social care journals,newsletters, newspapers and magazines
- Media interviews, including BBC, GMTV, etc.
- Running training workshops

ADR networks with like-minded organisations and groups. For example:

- Cure the NHS
- Department of Health Dignity Campaign
- Action on Elder Abuse

ADR also lobbies to draw attention to the indignities that some elderly patients and their relatives experience in hospital. For example:

- Nursing & Midwifery Council
- Healthcare Inspectorate Wales
- Older People's Commissioner (Wales)
- Council for Health Regulatory Excellence
- Health Boards in Wales
- Chief Nursing Officer

The terms of reference of the Health and Social Care Committee inquiry is to focus on:

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

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

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

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

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

- Safeguarding arrangements, specifically the handling of whistleblowing and complaints information.

Below is evidence that A Dignified Revolution is submitting to the Health and Social Care Committee for consideration in its inquiry into the work of Healthcare Inspectorate Wales.

LEGAL POWERS

A Dignified Revolution (ADR) has met with Healthcare Inspectorate Wales (HIW) on a number of occasions in the past 5 years. At the meetings mentioned above ADR has expressed concerns that HIW does not have the legal powers that it requires to hold NHS organisations to account when it is failing to deliver services effectively. HIW disputes this and over two years ago the Assistant Director of HIW said that she would provide a briefing outlining HIWs legal powers. We are still awaiting this briefing.

REAL TIME EVIDENCE

At a meeting earlier this year HIW investigators told us that they struggle to gain real time intelligence on which to organise their dignity spot checks. Responding to Ombudsman's reports and media reports is too late. We suggested that they liaise with the Older People's Commissioner's office and voluntary organisations such as Age Concerns/Age Cymru's, Alzheimers etc. all of which receive complaints from members of the public about NHS care. We also drew their attention to the fact that we receive real time experiences from the relatives of carers that could be used. The inspectors expressed an interest in our case studies but have never followed up and asked us for them. It would therefore be interesting to know whether they have communicated with the other organisations that we suggested.

ENGAGING WITH THE PUBLIC

HIW should be using various communication channels to make the public aware that it can contact them directly so that it can intervene when patient safety is being compromised, rather than carrying out random unannounced spot checks, which we understand are not always unannounced, as frontline staff have informed us that they knew HIW were going to visit.

RESPONDING TO POOR STANDARDS OF CARE

In our view HIW is not fit for purpose because it does not hold NHS organisations to account for their failings. For example, in April HIW published a dignity spot check report following a spot check in Morriston hospital. It has been posted on HIWs website but there is no action plan alongside it, or any indication of how HIW is monitoring the hospital to ensure that improvements are being made.

We asked HIW when the action plan would be posted on its website. On 13 June an inspector informed us that "*we published our Dignity and Essential Care Inspection (DECI) report in April 2013. However, we are awaiting a completed action plan from Morriston Hospital in response to our report and once this has been received we will ensure it is published in due course".*

We responded to ask whether a timescale is set for the Health Board to respond. HIW replied to say. "*You are correct we do set a timescale for the Health Boards to provide an action plan in response to their DECI report. In the case of ABMU, they have not met this timescale. However, we are currently in liaison with the Health Board regarding both the delay and to ensure their action plan fully addresses the requirements of the recommendations we have made. Ultimately we aim to work with the health board to ensure their action plans fully meet the requirements as a priority over the promptness of their response.* On 14 August there is still no action plan on HIW website

This is not the first time HIW has posted reports on its website without an action plan from the hospital concerned. There is no action plan posted for the spot check reported in February 2013 in relation to Prince Charles hospital.

And, in November 2012 we wrote to the former director of HIW to share our concerns about reports of spot checks being posted on HIW website. We were concerned because we know that members of the public visit it and it can be quite distressing if they see problems and no indication that they have been rectified, particularly if they are to be admitted to the ward in question.

ADR shared a case that it had come across where an individual was due to be admitted to a ward and went on the HIW site looking for information. The person in question was quite distressed on finding an inspection report but no follow up visit to show that the failures identified had been addressed.

The former director responded to say that *your email has made me think that we should encourage members of the public to contact us if they have any specific queries regarding any of our reports. We do need to include more follow up information so that people can see where improvements have been achieved (or not as the case may be) and HIW will be seeking to put this in place in the New Year*.

Clearly, this idea was not passed on to the new Director of HIW as reports are still being posted without action plans or any indication that HIW is monitoring to ensure that health boards are rectifying the failings that have been identified.

Also, HIW does not, as far as we are aware, encourage members of the public to contact them.

We also suggested to the previous Director of HIW that it could use CHCs to check that action has been taken rather than rely solely upon updated action plans. ADR received no response to this suggestion.

Early in August 2013 we contacted the Director of HIW to ask what action it was taking to address the media reports of:

- Patient neglect in two hospitals in the ABMU health board
- Royal College of Surgeons and Royal College of Physicians reports in relation to Cardiff and Vale LHB

We were particularly concerned because we were dealing with a similar current case to the one in ABMU, which we shared with HIW. The director responded to say:

We have noted the BBC news article and will be using the information included within the report to inform future work at Abertawe Bro Morgannwg University Health Board (ABMUHB). Additionally, HIW is planning to meet directly with ABMUHB shortly to discuss the issues raised by the BBC report. In view of this, I would be very interested to learn more about the case that you are currently dealing with in order to further inform our discussions with the Health Board.

This response did not fill us with the confidence that any immediate action would be taken, particularly as HIW does not appear to have been able to get the health board to provide an action plan for the Morriston hospital report (mentioned earlier) within the timescale that HIW sets. On 1 August the Director of HIW told us:

we have received a draft action plan and have asked for further clarification on a number of points, which we are due to receive at the end of next week!

SAFEGUARDING

In 2010 HIW published a report on its views of protecting and safeguarding adults in Wales[1]. It was reported that:

The relatively low POVA referral rates from primary and secondary care highlight that there are issues in relation to the level of understanding of NHS staff of what constitutes a safeguarding issue and in particular what is abuse.

NHS organisations and health professionals have difficulties grasping that poor practice and abuse occur within healthcare organisations themselves and this leads to abuse being underplayed as poor practice or a complication of treatment.

Some hospital and community staff have little awareness of their responsibilities under POVA or professional codes of conduct.

HIW recommended that POVA awareness training and what to do if abuse is suspected should be mandatory for those working in NHS organisations. Update training should be undertaken at least every three years and NHS organisations should test and evaluate the effectiveness of training on a regular basis; at least annually.

ADR regularly receives correspondence from members of the public who are concerned about the poor care (abuse) their relatives have been subjected to. This includes:

- Being told to use an incontinence pad, when they are not incontinent, rather than being taken to the toilet
- Being left in soiled sheets for hours on end which puts patients at risk of pressure sores
- Serious pressure sores developing, which could have been prevented
- Wounds not being dressed regularly which then become gangrenous
- Being subjected to verbal and physical abuse
- Being denied medications
- Being denied food and fluids

Such correspondence leaves us with the view that staff are still not aware of their responsibilities under POVA or their professional code and that HIW has not followed up to ensure that the recommendations that it made in the safeguarding report have been implemented.

In our view, it is pointless wasting time and money on spot checks and action plans if they are not policed to ensure that changes are being made, and from recent reports it is evident that the inspectorate is not doing its job properly. If it has legal powers it needs to use them to send a clear message that poor standards (abuse) will not be tolerated and that individuals/organisations will be held to account. Until this happens there will be little public confidence that HIW is fit for purpose.

Care and Social Services Inspectorate Wales

Though not relevant to this review Care and Social Services Inspectorate Wales also posts reports of failures on its website, with no indication that it is monitoring that services are addressing the failures highlighted. We have been in touch with the Chief Executive of the inspectorate to draw attention to this as it is not only unhelpful to those looking for care services, it is also unhelpful to the service providers who have taken on board and made improvements.

From ADR's experience of issues arising at the interface of health and social care there appears to be disjointed working between HIW and CSSIW.

ADR does not wish to give oral evidence.

A Dignified Revolution
info@dignifiedrevolution.org.uk
www.dignifiedrevolution.org.uk
August 2013

References

1. Safeguarding and Protecting Vulnerable Adults in Wales: A review of the arrangements in place across the Welsh National Health Service http://www.hiw.org.uk/Documents/477/Pova%20web%20e.pdf