EPSO Working Group – Wales Submission

Case

A ward in Wales was closed as a result of serious concerns raised by staff and relatives regarding patient care. Following closure of the ward the health board commissioned an independent inquiry into patient care and claims of abuse.

Healthcare Inspectorate Wales (HIW) had conducted a Mental Health Act (MHA) monitoring visit to the ward three months prior to it closing. The purpose of a MHA monitoring visit is a focused review to assess the way in which the service is delivering within the framework of the Mental Health Act. It does not have a broad remit as is the case with full service inspections. During this visit some environmental and dignity issues were raised. These were raised in direct feedback to health board staff at the time of the visit and were reflected in the letter subsequently sent to health board managers.

What data was available?

Some data is available to HIW that relates to mental health wards in the NHS, this is detailed below.

- Serious Untoward Incidences (SUI) notifications to Welsh Government. SUI notifications are a reporting mechanism for collating serious failings in NHS funded healthcare that may or may not result in death. A serious incident is defined as an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following;
  - unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
  - a never event;
  - a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
  - allegations, or incidents, of physical abuse and sexual assault or abuse; and/or
  - loss of confidence in the service, adverse media coverage.

  The notifications include details of when and where an incident occurred and what happened.

- Concerns raised by staff, families and patients to HIW. People including health workers, staff members, families of patients, patients

and carers could all contact HIW with details of concerns they have about an organisation. These are recorded and actions are taken following receipt of these concerns which may or may not change our inspection programme or lead us to take bespoke action to assure ourselves patients are safe.

- NHS Performance management and monitoring statistics.

- Historical inspection and monitoring reports. All inspection reports are now published on our website, but until recently Mental Health Act (MHA) monitoring reports were not published but only sent to the health board as a letter. This was due to concerns about patient confidentiality.

- Notification about the death of a person detained under the Mental Health Act. Organisations are required to notify HIW of the death of a person who is detained or liable to be detained under the Mental Health Act.

- Intelligence held by other bodies such as Community Health Councils, Mental Health Advocacy Services, Social Services, third sector bodies, are also shared to varying extents with Healthcare Inspectorate Wales.

In advance of the ward closure the only intelligence held by HIW for this particular ward related to the MHA visit undertaken a number of months earlier. No previous visits to the ward had been undertaken within the 12 months prior to this. In advance of the closure of the ward there was no wider data held relating to this ward from any of the sources above.

What data was missing?

Further data and information would have been held on the ward about the patients including detailed care plans. However, this information is not available to the inspectorate other than during an inspection.

Further intelligence could have been obtained from systematic review of Quality and Safety Committee papers and conclusions drawn relating to the presence of (or absence of) information relating to mental health services.

Further intelligence on culture and behaviour may have been available from the universities and institutions overseeing the training of junior medical or nursing and Allied Health Professional staff in mental health services. Particularly in light of their regular surveys of training grade staff.

There could have been wider sharing of complaints and concerns information between the Health Board, Community Health Council and the Inspectorate which could have highlighted a group of relatives and carers making a number of complaints to different agencies over a period of time.

One of the issues highlighted with this ward was a closed culture with staff who were uncomfortable moving on rather than challenging. If the health board had had robust arrangements for monitoring staff sickness, morale, turnover, and conducting independent exit interviews this might have provided warning signs of negative culture at an earlier stage. This intelligence might have also be sourced from union representatives.

Could this have been prevented?

If the potential abuse was recorded and notified through the SUI process (mentioned above) or the Protection of Vulnerable Adults process this would have raised the level of risk attached to this service.

Moreover, if concerns had flowed into the health board, the Community Health Councils or the inspectorate from staff, family members or the patients this would have raised the risk level.

However, without intelligence flowing into the inspectorate, I do not believe it would have been possible for the inspectorate to prevent the incidents occurring on this ward, although it may have been possible to detect earlier and take more robust action

Could we have done anything earlier?

We could have ensured the letter written to the organisation following our inspection was more timely. We could also have been more robust in holding the organisation to account for the actions that it was taking at a senior level to address the cultural issues. This has since been addressed and all letters which require immediate assurance from an organisation have a standard to be issued within 2 days.

Given our concerns about overall governance within the organisation we could potentially have used the services provided to this vulnerable group as a test case of corporate clinical governance arrangements during our governance review.

We could have undertaken our monitoring visits on a more frequent basis. Ultimately all inspectorates must prioritise their work according to the resources available, but it is important that frequencies are transparent and open to challenge.

If we had been publishing the results of our monitoring visits transparently at this time it may have drawn attention to the role of the Inspectorate and encouraged relatives to approach us with their concerns at an earlier stage.[i]

---

[i] Note
This is an academic note written to support the learning of the EPSO Risk Working Group and is not a summary of investigation into actions of any organisations that may be mentioned or inferred within the report.