



## **Trusted to Care - 2015 Review**

**Professor June Andrews - Director, Dementia Services Development Centre, University of Stirling**

**Mark Butler – Director, The People Organisation Ltd.**

*August 2015*

# Trusted to Care – 2015 Review

## An Independent Assessment of Progress

### 1 Introduction

The *Trusted to Care* Report published in May 2014 set out the conclusions of a review of aspects of care and practice at the Princess of Wales and Neath Port Talbot Hospitals, which form part of Abertawe Bro Morgannwg University Health Board (ABMU).

It made fourteen recommendations for improving the care of frail older people in those hospitals, together with a further four recommendations to address wider issues raised by the review for action by the Welsh Government.

[www.gov.wales/topics/health/publications/health/reports/care/?lang=en](http://www.gov.wales/topics/health/publications/health/reports/care/?lang=en)

### 2 Trusted to Care

*Trusted to Care* identified what needed to happen to achieve acceptable standards of quality and safety. The recommendations, taken together, provided a road-map for the ABMU Board to follow, setting out a series of clearly-identified actions which were required to resolve the main underlying problems of clinical and organisational practice. In some areas the action was to be taken immediately; in others action was required to be completed within one year of publication of the report. Mark Drakeford, AM, Minister for Health and Social Services in the Welsh Government, decided that all the recommendations should be fully implemented as a single package within the year from May 2014.

This report provides an objective assessment of whether this requirement has been achieved in respect of ABMU. It does not cover the recommendations relating to the Welsh Government itself as this was not part of the work we were commissioned to undertake.

“Trusted to Care – 2015 Review”, commissioned by the Minister, looks at the progress against each of the fourteen specific recommendations and supporting guidance, and in addition considers the Board’s self-evaluation of progress against these tasks and other improvements that ABMU has been implementing in the time since the publication of *Trusted to Care*.

### 3 Review Process

This assessment, like the original report, has been undertaken by a Review Team led by Professor June Andrews, Director of the Dementia Services Development Centre at the University of Stirling (DSDC) and Mark Butler, Director of The People Organisation (TPO).

The assessment took place during June and July 2015 and combined qualitative and quantitative analysis to reach its conclusions. The Review Team again visited both hospitals and spoke to staff, managers, patients, volunteers, external voluntary and statutory organisations, non-executive board members, staff representatives and relatives. It observed clinical areas and attended management and clinical meetings, as well as bringing together groups of clinical and support staff to discuss current practices relevant to the recommendations. The Review Team requested, received and

examined all necessary documentation, processes and reports to complete the Review, including interrogating the self-assessment of progress published by ABMU itself in May 2015.

<http://www.wales.nhs.uk/sitesplus/863/opendoc/270788>

#### **4 Report Structure**

The Report is in four sections

**Section 1 Headlines.** This provides a short summary of progress on the recommendations in *Trusted to Care* with the comments of the Review Team.

**Section 2 Setting the Scene.** This provides more detail on the wider context and background of the last year against which progress at ABMU should be seen and on the methodology of the review.

**Section 3 Assessment of Progress.** This provides a detailed assessment of the strategic themes and recommendations from *Trusted to Care*, bringing together a self-assessment undertaken by ABMU with the independent assessment made by the Review Team.

**Section 4 Conclusions.** This provides a short summary of progress and recommended action.

## Section 1 Headlines

**The public can be reassured that care of frail older people in the two hospitals is much improved from the situation described in “Trusted to Care” in 2014.**

**Action taken by the Board over the last year has addressed the main issues which had led to unacceptable quality of care and standards of services at that time.**

**More action however needs to be taken in several areas to meet all the specific recommendations made in Trusted to Care.**

There have been many positive and necessary improvements against all four areas of care concern that gave rise to the *Trusted to Care* report. These areas are hydration, medication, complaints and professional accountability.

The Board of ABMU have clearly taken *Trusted to Care*, its recommendations and their responsibility for action, seriously and acted with conviction. This is no less than should have been expected given the issues the report raised.

The leadership in ABMU are to be congratulated on maintaining a clear leadership focus and commitment to action in the face of other competing priorities. Infrastructure and project management were put in place quickly with sufficient authority to drive the action needed for each recommendation. Proper governance arrangements were instituted, including clarity of leadership and accountability for delivery of changes at Board level. Transparency and openness around accountability were supported by changes to communications and increased engagement with the public and with stakeholders. Changes were implemented quickly to clinical leadership roles at Board level and a new management structure for implementation has been designed.

There has been a lot of activity in the name of *Trusted to Care*.

**Progress has been made on all 14 recommendations.**

**6 recommendations have been completed either fully, or there are clear plans for implementation sufficiently in place to give confidence they will deliver the required change. *(These are identified by the Rating A in the table below)***

**8 recommendations still require more work. Plans here are not yet fully in place but sufficient action has been taken to provide reassurance in relation to essential change and standards of care. *(These have the Rating B in the table below)***

**A clear deadline for delivery on these outstanding issues now needs to be set to ensure all the action to improve care and safety in the two hospitals are taken as required.**

There follows a summary assessment for each of the Recommendations in *Trusted to Care*. More detailed assessments are included in Section 3 of the Report.

Recommendation from Trusted to Care	Assessment Summary
<p>1. The Board should create a set of clear standards for the care of frail older people in Accident and Emergency, general medical and surgical wards within the two hospitals, within three months of receipt of this Report, and audit them quarterly thereafter.</p>	<p><b>Not fully delivered but adequate plans in place for delivery in 2015. (Rating A)</b></p> <p><i>Review Team has concerns over the connection between the standards and audit processes. We accept delay in part due to high levels of public and staff involvement and expect this recommendation to be fully achieved when the dashboard goes live later in 2015. It is recommended that a deadline of December 2015 is set for the dashboard implementation.</i></p>
<p>2. The Board should develop a quality and patient safety strategy that focuses on the realities of care, connects the Board to the experience of patients, monitors standards in practice and shapes Board decisions accordingly.</p>	<p><b>Complete. (Rating A)</b></p> <p><i>Review Team is reassured that the Board is committed to enhance decision-making processes around patient experience and standards in future. We feel the outcome measures for the strategy show an appropriate emphasis on the measures of outcomes from the point of view patients, and already provide a good basis for improved governance.</i></p>
<p>3. The Board should identify clear steps to generate a culture of care built on public involvement in the setting and monitoring of standards, and in the resolution of ethical issues and practical choices that arise from the need to make decisions within limited resources</p>	<p><b>In progress. Further action needed. (Rating B)</b></p> <p><i>Review Team has seen evidence of improvement in establishing public involvement as part of the organisation's culture. We believe more action is needed to involve the public in creating realistic expectations at ward level about levels of care, especially when adverse circumstances arise beyond the control of the staff.</i></p>
<p>4. The Board should implement a skills and knowledge programme to ensure all staff operating in its hospitals understand and are equipped to meet their obligations to older frail people.</p>	<p><b>Only partially complete. Key elements of recommendation not addressed. More assessment of impact needed. (Rating B)</b></p> <p><i>Review Team is impressed by the scale, reach and pace of general training but</i></p>

	<p><i>more work is needed to assess the impact and value of such training on the patient experience, in improving professional practices and on staff confidence. More targeted training for higher skilled staff is also needed to achieve improved standards.</i></p>
<p>5. The Board should run an intensive education programme on delirium, dementia and dying in hospital.</p>	<p><b>In progress. Issues remain on design and delivery of programmes. (Rating B)</b></p> <p><i>Review Team feels the focus is now on the right priorities but not at the right level of intensity, after a slow start. More involvement of medical staff is necessary if this recommendation is to be met fully in 2015.</i></p>
<p>6. The Board should develop more cohesive multi-disciplinary team practice in the medical wards at the two hospitals, built around shared responsibility and accountability for patient care and standards of professional behaviour.</p>	<p><b>Good progress. (Rating B)</b></p> <p><i>Review team sees good progress of multi-disciplinary team practice involving nursing staff, unqualified staff, pharmacy and therapy staff. We feel more progress with medical staff is still required, noting the positive contribution to this of new consultant appointments already made and planned.</i></p>
<p>7. The Board should introduce a coaching scheme for front-line clinical leaders provided by senior people from outside the two hospitals</p>	<p><b>Recommendation not met. New Plan required. (Rating B)</b></p> <p><i>Review Team recognises steps have been taken to increase aspects of coaching but we do not feel the programmes to date meet the specific requirements identified in Trusted to Care and the explanation for not meeting the recommendation in full unconvincing. This should be rectified as a matter of urgency.</i></p>
<p>8. The Board should adopt a zero tolerance approach to the improper administration of sedation and medicines for all clinical staff, drawing a clear line in the sand within three months of the publication of</p>	<p><b>Complete. Exemplary corrective action taken. (Rating A)</b></p> <p><i>Review Team feels this is exemplary work which should be upheld as a best practice example in Wales.</i></p>

this Report	
9. The Board should address hydration, mobility and feeding practice for all older patients and publish audited results on a quarterly basis.	<p><b>Complete. Excellent progress. (Rating A)</b></p> <p><i>Review Team welcomes the way publishing of results has helped reinforce improvement.</i></p>
10. The Board should review how well ward accommodation supports care for those with dementia, delirium, cognitive impairment or dying at both hospitals, covering physical design of the clinical spaces and equipment available.	<p><b>Incomplete. Capital investment issues remain. (Rating B)</b></p> <p><i>Review Team notes an increase in awareness and sees some small changes have been achieved, but feels more focus is needed on an environment plan which distinguishes between low cost changes which are within the grasp of the Board and capital planning for step-change which will require government level action.</i></p>
11. The Board should simplify and strengthen management and clinical accountabilities and review ward staffing procedures to guarantee the right clinical and support staff are in the right place to meet the needs of older people at that time.	<p><b>Good progress made. Further plans already in place. (Rating A)</b></p> <p><i>Review Team congratulates the Board on progress so far on the complex and centrally important issue of staffing levels and deployment. This was always likely to take more than one year and we are reassured that proper priority is being given on a continuing basis.</i></p>
12. The Board should overhaul local procedures on adverse incidents and complaints to build greater staff and public trust and confidence in their effectiveness.	<p><b>Good progress made. More action needed. (Rating B)</b></p> <p><i>Review Team is impressed by the reduction in process times but feels more work is needed to ensure proper sensitivity and responsiveness to the nature and substance of each individual complaint.</i></p>
13. The Board should introduce a fully operational 24/7 approach to services including diagnostic services, pharmacy, therapies and social work.	<p><b>Well-advanced. Clear plans to complete. (Rating A)</b></p> <p><i>Review Team recognises the level of thought already given and changes already made to meet the challenge of 24/7 operations. We feel reassured that further improvement will follow during 2015-16 if</i></p>

	<i>investment is made.</i>
14. The Board should decide what has to be done for ABMU genuinely to “put local citizens at the heart of everything we do”, using external creative expertise.	<p><b>Strong engagement process for public and staff on Values. Role of citizens needs more open thought. (Rating B)</b></p> <p><i>Review Team understands the positive results being seen from the approach to public engagement taken in the last year at ABMU. This has required considerable effort. We believe however there is not enough evidence of direct public involvement in clinical and organisational practice and understand this may follow in future plans. Independent assessment of the value and impact of ABMU’s approach is needed.</i></p>

*Trusted to Care – 2015 Review* is not just about the observations of the Review Team. It is about the views held by the majority of staff, and by other stakeholders. In every NHS system of this size, there will always be times when things go wrong, and patients and families feel that the care they received was not as they had expected. It is not credible that all complaints and adverse incidents will cease as a result of *Trusted to Care* or the improvement work that has taken place so far. However the context has changed. A fair summary is that overall care in the two hospitals continues to be exemplary in part, and there has also been real improvement in those areas where there were previously significant failings. All agree that this is a work in progress.

On publication of *Trusted to Care* the Minister of Health and Social Services instructed the incumbent Chair and Chief Executive to address the issues identified and to implement its recommendations in full. We are clear that the decision to embrace the report fully, and not to change the two key leadership roles in the Board, has proven correct. Momentum and pace were, as a result, able to be injected quickly into necessary action, without unhelpful distraction. This has been maintained throughout the year. In the next year the same level of effort needs to continue, with a greater focus on measurable improvements. The actual impact of some of the action taken so far on improving outcomes for the local population is not yet being measured as a routine part of the way the Board works.

It would be wrong to criticise the Board too heavily for not fully implementing each of the recommendations in full. It is important to recognise that, in our view, sufficient progress has been made on standards of treatment and care to give confidence that the remaining areas of action will also be addressed.

The way *Trusted to Care* was reported in the media, and the way it featured in political discussions at the time of publication, caused obvious damage to the reputation of the hospitals. Some of this negative impact was unavoidable given what the report revealed. It is encouraging to see the



determination shown over the last year by the leadership and staff in the Board, and others outside the hospitals, to do what is needed to change public perception. The Board however must be careful not to promote an unrealistically positive impression about what can be expected at the two hospitals. This runs the risk of placing a different sort of pressure on staff. The public will almost certainly feel let down in future when their experience does not match overstated public statements about what can be expected at the hospitals. The Board needs to encourage critical learning about the services provided in its name. These should be from different sources, including external assessments on how things really seem to staff and the public. The Board also needs to place citizens more at the heart of what it does.

**There is good news here.** The public should feel significantly reassured about improvements in the quality of care and treatment for frail older people with cognitive impairment, which have been made in the two hospitals over the last year. We hope that this message is widely reported and also engaged with maturely in political discussion.

**This does not mean ABMU should be considered to have a completely clean bill of health in relation to frail older people in the hospitals.** There remains variation in patient experience between wards and services, especially at Princess of Wales Hospital. And more needs to be done on a continuing basis to improve standards and professional practices, especially where this requires team-working between nursing, medical, other clinical staff and managers.

Those involved are to be congratulated for work so far, and to be encouraged to keep improving, as they try to increase confidence, trust and respect in local and national communities. Some further recommendations are made in this report to support progress in that direction. These are chiefly in relation to capital planning, continuous involvement of local citizens directly in the organisation, and some areas of education, training and coaching.

**Our overall conclusion is the chances of serious problems recurring have been reduced greatly by action already taken at ABMU. We believe that further improvement can be expected from plans that are now in place for the future, which are in line with the recommendations of the *Trusted to Care* report.**

**Progress should be reviewed again in a year.**

## **Section 2 2015 Review - Setting the Scene**

### **Purpose of the Review**

The purpose of this Second Review report is to assess independently what progress has been achieved, since *Trusted to Care* was published in May 2014. Specifically the Minister for Health and Social Services commissioned an assessment of the fourteen recommendations relating to improvements in the care of frail older people with cognitive impairment at both the Princess of Wales and Neath Port Talbot Hospitals.

### **National Context**

This further assessment, as with the original review, should not be seen entirely in isolation. There have been a number of wider changes to the Welsh health and social care system during the last 12 months. These have included national initiatives relevant to the themes of *Trusted to Care* including standards of care, workforce planning and staffing, hydration and public health, mental health, social services, scrutiny arrangements, accountability and reporting arrangements. In addition there have been further serious issues raised in public in relation to care standards, services and governance failures elsewhere in Wales. The Review Team was not commissioned to review progress on the four specific recommendations for action by the Welsh Government and these wider issues lie beyond our remit. Our focus has been exclusively on assessing progress on each recommendation relating to ABMU.

### **ABMU Board Response to *Trusted to Care***

Throughout this second review the Board made clear that they had already identified concerns in advance of the commissioning of *Trusted to Care*. These included issues arising from mortality rates, Ombudsman Reports, negative patient feedback and other indications of poor care at Princess of Wales Hospital. In October 2013 the Health Minister commissioned us to undertake an independent, external review of care, following widely publicised concerns raised by members of the public about the quality of care at Princess of Wales Hospital and Neath Port Talbot Hospital.

Members of the Board made it clear to us that publication of *Trusted to Care* gave significant added urgency to their work to improve services. They told us they welcomed the report as it made it clear they needed to act with greater focus and determination. The publicity surrounding *Trusted to Care* was painful for the Board and its staff, but it provided a strong message that no one in the Board could ignore.

The Board appears to have responded quickly and with a sense of shared purpose to change both the reality of care and its perception. This is evident in the formal Board papers at the time, as well as in the specific action taken subsequently. A dedicated Task Force was set up in May 2014 reporting directly to the Chief Executive, which has taken the lead in coordinating action on the recommendations in *Trusted to Care*. There has been regular reporting on progress at different Board subcommittees and to the Board as a whole. Non-Officer Board members have been active in both addressing issues and in pressing the Executive for action.

The overall approach taken by the Board seems to have been to apply the recommendations across the whole Board, not just the two hospitals.

The coordinated response to *Trusted to Care*, tagged “Action after Andrews”, has been prominent on the Board’s website and in high-profile and confident communications inside and outside the Trust and to partners. In summary the Board has sought to turn a negative situation into a positive opportunity to reconnect with its staff and the public, and thereby improve standards of care.

## **Board Strategy**

*Trusted to Care* recommended that the Board’s current leadership should be given the support and responsibility for delivering the changes necessary. There has been significant and demonstrable progress over the past year.

The Board has stated

*“...that to truly change the culture of our organisation and fully implement everything within the Report (not just the recommendations), given the complexity of the Health Board, this is not a one year programme but one which will take 3-5 years to fully embed.”*

The Review Team support the Board in taking a long-term approach. This was what we intended. We fully support the commitment by the Board to a cultural change programme which promotes shared values and consistent behaviour as the cornerstone of a positive culture of care. This approach should not be used as an excuse, however, for non-delivery against each recommendation. These recommendations were designed to be implemented as a whole package, within a year, to provide the foundation for the longer-term transformation needed.

Overall the Review Team supports the approach that has been taken by ABMU in placing the specific recommendations in a longer-term strategic context whilst at the same time driving forward a plan of action with dedicated infrastructure and Board support.

The Board was faced with a difficult set of dynamics and the Board has sought to manage the situation with conviction. The Chief Executive in particular has shown courage and responsibility in engaging directly with the public.

**The focus for this review is simply to establish whether each recommendation has been met and a sufficient level of change secured.**

## **Review Methodology**

This assessment, like the original report, has been undertaken by a Review Team led by Professor June Andrews, Director of the Dementia Services Development Centre at the University of Stirling (DSDC) and Mark Butler, Director of The People Organisation (TPO). Shirley Law, Director of Learning and Development at DSDC provided specialist clinical input and research and administrative support was provided by DSDC staff. Further details on the team members are in Appendix 1.

The assessment took place during June and July 2015 and combined qualitative and quantitative analysis to reach its conclusions. The Review Team again visited both hospitals and spoke to staff,

managers, patients, volunteers, external voluntary and statutory organisations, non-executive board members, staff representatives and relatives.

We observed clinical areas and attended clinical and non-clinical meetings, and met with managers and other staff, as well as bringing together groups of clinical and support staff to discuss current practices relevant to the recommendations. We received confidential correspondence from staff and families.

The Review Team requested, received and examined all necessary documentation, processes and reports to complete the Review, including interrogating the self-assessment of progress prepared by ABMU.

<http://www.wales.nhs.uk/sitesplus/863/opendoc/270788>

## **Attitudes**

We were conscious of, and understand, the driving need that must be felt to see no further negative publicity or attention. This was evident in many of the staff we spoke to, although others were clear they wanted to see real change not just the appearance of change. All agreed that public perception needs to become more positive to rebuild trust and confidence.

Against this background it is important that the leadership of ABMU (and some of its stakeholders in the Third Sector) resist the temptation to give an impression of positive and rapid progress unless it is accurate and truly justified.

There is almost an inevitability that attempts to present progress in a positive light will be greeted on the one hand by sceptics with continuing cynicism, or will be warmly welcomed on the other hand by anyone keen to make sure nothing that can be seen as negative is reported.

The Review Team did come across and discounted examples of both the desire to present everything as positive and also a level of continuing cynicism. We were also approached by a number of complainants wishing us to hear their stories. These mostly all fell outside the time period or topic areas of *Trusted to Care*. We read each complaint we received and directed them to the proper channels.

The Board has pledged to be open, honest and transparent about progress. This is an important part of moving forward. There is evidence of openness increasing in the governance of the organisation, not least through the systematic and regular reporting of progress to Board Committees and to the Board itself, throughout the year.

The Board also made its own self-assessment of progress “Progress Report – One Year On” which they shared with us. This 77 page report

- sets out a number of strategic themes and a broader approach to change that is being implemented by the Board
- identifies leadership and management responsibilities for delivery
- looks at achievements and progress on each of the specific recommendations made in *Trusted to Care*
- records the challenges faced in making progress on each recommendation

- summarises further action if needed
- provides a summary of whether the recommendation has been met .

Our Assessment draws on this corporate report and on the internal and public reporting and measurement of progress made during the year. We have also made full use of qualitative information from discussion with staff and stakeholders, from observation and from comparative information to provide an objective assessment of progress against the specific recommendations.

The timing of the ABMU report is understandable and helps meet a need for openness on the anniversary of the Report. Positively it has meant the Board had already drawn together relevant information and data in addition to what had been routinely reported to the Board during the course of the year. Less helpfully it has set a level of expectation, including whether recommendations had been met, which could have waited for our independent assessment.

There are differences in our conclusions on some recommendations from those of the Board and we address these in the report.

## Section 3 – Assessment of Progress

Our intent in this report is to make a sound, independent assessment on progress against each recommendation.

*Trusted to Care* made a number of comments about generic issues which we believed had to be addressed by the Board, as well as making specific recommendations for change, accompanied by guidance on how that change should be taken forward. This approach was designed to be positive and helpful.

We are using the same approach in this report with the same aim.

The Assessment is in two parts;

- **Progress on Strategic Themes (3.1)**
- **Progress on Recommendations (3.2)**

### 3.1 Progress on Strategic Themes

We start our assessment by considering some of the overarching themes before moving to the specific recommendations.

#### **3.1.1 Leadership and Structure**

*Trusted to Care* highlighted that the organisational structure was unclear, causing confusion over accountabilities and responsibilities. In February 2014 ABMU changed the management arrangements for Princess of Wales Hospital and created a Hospital Director supported by a local management and clinical leadership structure. This approach gave immediate improvement in accountabilities.

Management arrangements for the whole Board have been changed and the new Executive Director roles were filled in 2014, (with three new directors appointed from outside the organisation). Immediate changes to ward leadership roles have also helped remove some of the barriers to communication, leadership and improving standards. Further recruitment as part of the new management structure was underway at the time of our visits in June and July 2015.

We feel that this process of structural change has been taken forward at a reasonable pace. Changes to leadership have in our view already made an impact in terms of collective responsibility and professional focus. We are reassured that there is a clear intent for further managerial change to make a lasting difference at ward level.

#### **3.1.2 Values**

*Trusted to Care* challenged ABMU to demonstrate how they would put citizens at the heart of everything they do. There will be a further assessment of how far they have moved towards that position later in this report, but in their written submission they describe undertaking since the beginning of 2014 an “organisation-wide structured listening exercise, surveying patients, their carers and relatives, staff and other stakeholders”. In early 2015 the Board launched a Values and Behaviours Framework, based on this engagement. The Board has set out expectations for the next

three years focused on embedding these values in recruitment and staff appraisal. They contain a set of the standards and behaviours that all staff are expected to demonstrate.

The values are set out as

- *Caring for each other – in every human contact in all of our communities and each of our hospitals*
- *Working together – as patients, families, carers, staff and communities so that we always put patients first*
- *Always improving – so that we are at our best for every patient and for each other*

It is clear there has been a concerted effort around this work. We explore our concerns about how well this meets the specific recommendation about placing citizens at the heart of the organisation under Recommendation 14 below.

### **3.1.3 Workforce Issues**

Levels of staffing, staff attitudes and professional standards contributed to the problems of quality and care on the two wards which were investigated in *Trusted to Care*. Changes have been implemented to address each.

ABMU has stopped holding nursing and other clinical posts vacant as a cost-saving mechanism and the vacancy rate has reduced. Recruitment and retention of nursing staff across the UK is a significant challenge but ABMU is working towards achieving the Chief Nursing Officer's principles and fully establishing nursing teams. The Board is supporting ward staff with the creation of additional roles to free up their time to care – in the form of ward hostesses, administrative support and a team of specially trained Healthcare Support Workers to provide individual support for patients with a high level of cognitive impairment. These improved staffing plans are part of the Board's three-year Integrated Medium Term Plan submitted to Welsh Government and are to be commended.

Staff told the Review Team of the perceived benefits from this way of working. Those new support staff that the Review Team met were highly motivated and knowledgeable, and justly proud of their new knowledge about dementia and frailty in hospital.

Nevertheless, the positive effect of additional staff and improved levels of sickness absence has been counterbalanced by higher rates of staff leaving. The Board explained their plan to help address these issues by working with local Universities to develop a joint approach to recruitment and retention, as well as improving educational provision and placements to attract more applicants. But it was not immediately obvious to the Review Team how well this is working.

Staff described how hard the huge amount of negative publicity about the hospitals had been, and colleagues had left as a result. As one said to us

*"... ABMU became a very difficult place to work...I was told that ... my career would be tarnished by the stigma... it needs to be considered how it has impacted on the staff.... On further thought, it was not the actual written report that impacted on morale, as these were the facts. It was how the report was used by (others)...."*

The Review Team noted an understanding from staff that an unintended negative consequence of openness about any NHS difficulties is public posturing and attempted scapegoating of individuals. This phenomenon has been particularly virulent in this case.

The creation of the fourteen-point recovery process was seen by staff as being helpful by focussing attention on improvement rather than on blame and punishment. Unnecessary damage to the confidence of local people was described as something that has threatened to undermine excellent work on tackling staffing issues.

The Board highlighted that its mandatory training framework has been revised to include dementia and to address other skill gaps highlighted in *Trusted to Care*. To date over 10,000 staff have received dementia awareness training. We raise some concerns about the value and impact of this training in Recommendation 4 below. Release of staff is a significant challenge and the planned implementation timescales have been slower than desired as a result.

#### **3.1.4 Standards**

Immediately after the publication of *Trusted to Care* the Health Board defined a range of “never” events and initiated a zero tolerance to these. They focused on the deficits observed by *Trusted to Care* in hydration, nutrition, toileting and medicines management. The Board has developed what they define as “care standards for older people”.

It is worthy of note that the Board has been commended by the Wales Commissioner for Older People and she is planning to use the process they developed to produce care standards for care homes in Wales. However, this document, which resembles a series of pledges, should not be confused with the sort of clinical standards of care that can provide auditable information to underpin the assurance that the Board needs. The Board must be in a position to have a grasp of the standards that are being provided in their services. The “dashboard” which summarises data as part of formal governance processes is a better tool. Unfortunately the dashboard at ABMU has been slow to be developed and has yet to be properly tested.

The Board has also been checking to make sure that care given to patients is appropriate and that the worst failures outlined in the report are not continuing. They have a rolling schedule of unannounced spot checks carried out by senior nurse managers at night and weekends, so that the Board can be assured about the care provided. There is a particular focus on “never” events and improving standards of care.

There have been many improvements which will be highlighted in the rest of this report. Worthy of note is the hugely improved management of prescribing, storage and administration of medicines, and awareness of staff about their duties and responsibilities, including team work between pharmacy staff and ward staff. This is now at the level one would ordinarily expect, but the work that had to be done to bring it to that level is a significant achievement.

#### **3.1.5 Stakeholder Engagement**

Transformational change of the type needed at ABMU depends on clarity about the role of stakeholders of all sorts in making this happen.



We are aware that stakeholder engagement is something which the Board had been actively addressing before the publication of Trusted to Care. A lot of this engagement activity with staff and with the public related to service change in the context of local and national initiatives. This has continued over the last year and is not directly relevant to our report. We have confined our comments to issues specifically relevant to our recommendations in Trusted to Care.

We recognise that there is a commitment by the Board to the principle of engagement. A lot of activity has taken place in its name, some of which has attracted positive comment from other including the Welsh Audit Office. However we would also comment that it is important for relationships not to be overstated or presumed, and for there to be a continuing openness to independent assessment of the effectiveness of what is being done.

It was helpful to learn that service agreements with third sector organisations now incorporate the standards of care for older people. The Board expects these and other published values to be implemented for all patient contact with the third sector. We did not look at this area in detail. However we urge the Board to be sure it is spending enough time ensuring these commitments deliver improved outcomes for people living with dementia. We saw no specific evidence this was the case.

Engagement has to be judged ultimately by its effectiveness. We are clear that there remain issues of trust between the Board, members of the local population and some of the Board's own staff.

### **3.1.6 Physical Environment**

Some clear changes have been made to improve the way space is used on the wards. These have tended to be small scale physical improvement, guided by assessments audit processes and tools and supported by investment in immediate change. In addition we understand there are plans to create an exemplar ward at Princess of Wales Hospital and to make further changes to the environment of care which will require more significant structural change. This still feels like work in progress, with recognition by the Board that more work is needed beyond these basic changes.

We accept that the poor design of environments for people with cognitive impairment at the Princess of Wales may well require a level of capital investment which will be challenging. It may well require investment from partners and backing from the Welsh Government. We have been told that a business case is in preparation. We have not seen this, but we hope such an approach will be strongly encouraged and supported by the Welsh Government. This is where proper public engagement can prove invaluable in encouraging the political to change what is seen as acceptable for people with dementia. If capital is needed then it should be secured, as to do otherwise will mean perpetuating care environments which add to dementia and delirium, rather than help reduce them.

There is little point investing heavily in staff and public understanding if there is not a matching commitment to make important capital investment decisions as well. Plans need to be drawn up with staff and public involvement. Just as importantly debate is needed with politicians on how necessary resources can be secured. This is one example of what we mean by putting the citizens at the heart of everything – something we recognise neither the public nor politicians might be fully willing to embrace.

### **3.1.7 Strategic Themes - Conclusions**

**The Review Team have been impressed by the clear strategic commitment to transformational change and the commitment to turn this into a plan for practical change across ABMU. Real progress has been made as a result. This goes beyond the specific recommendations included in *Trusted to Care*.**

We are pleased to note the improvement in care we have seen in the two hospitals, the better complaints handling and the concerted attempts which have been made to get to grips with underlying workforce issues.

We do have some reservations about the degree to which this momentum can be maintained as other priorities demand time and resource. We are not convinced about the actual value and impact of the dementia training or the scope of direct public engagement. We would like to see more objective assessment of impact and outcomes during the next year.

We are however reassured about the serious intent of a Board which recognises both what has been achieved and what still needs to be done as follows:

*“We believe we have achieved a huge amount in the past year to address the issues raised in Trusted to Care, but we recognise that we still have more to do...”*

*The publication of Trusted to Care was a watershed moment for ABMU Health Board and whilst it was hard to read, it has helped to focus everyone working here and those of us leading the organisation on doing better for our patients and communities.”*

We now turn to the specific recommendations.

### **3.2 Progress on Recommendations**

The Review Team identified 14 recommendations for action by the ABMU Board. These were accepted in full and provided a comprehensive plan of action to address identified shortcomings in the two hospitals and enable a significant improvement in quality and patient safety in ABMU beyond the immediate focus of older people.

All recommendations were accompanied by further explanatory notes, suggestions and clarification.

The Health Minister Mark Drakeford said at the time “I again want to emphasize that the review team has said this report must be read and accepted as a whole.... I am determined all the recommendations will be delivered.”

#### **Recommendation 1**

**The Board should create a set of clear standards for the care of frail older people in Accident and Emergency, general medical and surgical wards within the two hospitals, within three months of receipt of this Report, and audit them quarterly thereafter.**

*These should be in the form that sets standards for all clinical staff irrespective of professional*

*background and provides the basis for skills and knowledge development and audit. There are reference points for the development of such standards in the work of Healthcare Improvement Scotland. The Board should clarify what data it really needs to take a proactive approach to the public's experience and the quality of the services ABMU provides to older people. Data would begin with screening for commonest conditions at the point of admission to hospital especially cognitive impairment so that the appropriate care can be provided through admission and into discharge.*

*Other key data would include length of stay, adverse incidents by age and cognitive impairment, capacity, complaints, use of catheters, antipsychotic drugs and sedation, hospital acquired incontinence, nutritional status, and deaths where the cause was not the reason for admission.*

### **Review Team Assessment**

There has been a lot of work undertaken on standards of care over the last year in ABMU. Real progress has been made. This is highly commendable. We recognise that these are early steps in what will be a longer-term process for improving standards. This work, involving professional and representative bodies, should be encouraged to continue. We hope that our comments are seen as positive by everyone involved, as we are reassured that plans to address outstanding issues are in fact largely in place.

The Board's report at the end of 12 months describes how new standards were constructed and communicated to staff, patients and others and also what procedures were introduced. They state that standards are audited via application of the Ward Assessment Toolkit and through the reporting of the older people's dashboard to the Quality and Safety Committee on a bi-monthly basis. There is a commitment to screen for cognitive impairment on admission through Emergency Departments or other assessment areas. This forms part of the medical clerking and nursing assessments.

There has been a significant improvement in the open discussion about what constitutes appropriate care for frail older people with cognitive impairment with staff and with the public. This is to be welcomed. We are not sure however that the work so far provides the basis for auditable standards relating to the practice of professional clinical staff working at all levels of the organisation. That is what Trusted to Care recommended.

Our central concern is that the document labelled "Standards of Care" resembles a Charter for Older People in hospital, rather than a set of measurable standards. Such a Charter is not a bad thing, but it falls short of what is needed. It also potentially opens up room for public dissatisfaction and could reinforce cynicism about what can be expected as a result. For example, where it says it will do something positive, like take care of my skin and not damage it, this could evoke a response by many people who think this should go without saying.

There is a tendency in a number of the current set of standards towards over-generalisation. This increases the importance of having in place a dashboard which tracks specific progress objectively. However, from what we have seen, the design and content of the dashboard still has some way to go before it meets proper governance and audit requirements. We look forward to seeing evidence

in future of an effective connection between precise standards, sound data and corrective action, working effectively from Board to ward, and vice versa.

We were reassured by plans to make further progress. These plans should allow the Board, through development of the new dashboard, to focus on areas of excellence as well as areas of difficulty if they arise. The Review Team accepts that the timescale set for the creation of precise standards may have been tight and a lot, involving others from outside ABMU, has been moved forward. However, in retrospect maybe too little time has been spent on working through how necessary improvements and outcomes will be measured. The focus on the values and general principles has left important work on hard-edged dashboard lagging behind. This can easily be corrected by a change of focus.

Returning to the “Standards of Care”, it is quite clear that in any hospital, anywhere, the exigencies of the service will at times give rise to what NICE has described as “red flag” issues. This might be for example where care staff are diverted because of unexpected absences in a winter flu crisis, or a sudden unexpected deterioration in a patient. An elderly visitor might collapse. In any hospital such an unexpected clinical or staffing crisis in a ward area might unfortunately lead to a patient soiling the bed, not being fed, or not getting their medication at the right time because staff are diverted. Our question raised by *Trusted to Care* has been about how staff inform families when such a thing happens, how they express it, and the extent to which a general statement of warning can be made to local citizens about the likelihood of such red flag events.

If the family finds out about it by accident, they are likely to be disappointed and blame the hospital or individual staff member for failing to do what was expected. The “Standards of Care” in that sense are incomplete because they describe what will happen if everything is going well. A second document about what ought to happen, when things unavoidably do not go well, could make a huge difference to people’s expectations. It would enable an important discussion with local citizens. This could even make local people feel able to offer help. For example, it could make open visiting a vital contribution to care. How to do this without reducing confidence in the professional service on offer to the public is an important challenge which the public themselves are best placed to help think through.

The “Standards of Care” for ABMU do not sit on their own. They may become a missed opportunity if the huge investment in public communication does not extend to being open about the challenges facing the future, aging population. One key issue here is the need for families, friends and volunteers to contribute actively to achieving “Standards”.

## **Recommendation 2**

**The Board should develop a quality and patient safety strategy which focuses on the realities of care, connects the Board to the experience of patients, monitors standards in practice and shapes Board decisions accordingly.**

*The Review Team were reassured about the personal commitment of the Chairman to looking*

*objectively and purposefully at changing the culture and focus of the Board in line with this recommendation. There are clear commercial and public sector models which would provide useful reference points for doing so. It is not for the Review Team to recommend a particular model but it is highly recommended that patients and their representatives are involved in the creation of the ABMU strategy. The quality strategy should be sensitive to the needs of patients with dementia and reflect the importance of environment and meaningful activity in maintaining their safety.*

### **Review Team Assessment**

This recommendation lies at the heart of strategic improvements needed. It is also something which will take time. We feel this recommendation has been largely fulfilled.

We are particularly pleased that in January 2015 the Board published a strategy which sets out the steps they will take to improve the quality of services and to achieve excellence. The Strategy describes a sensible time-scale, allowing proper consideration of what is necessary, rather than simply attempting to present an overly positive profile to the world.

This strategy, as *Trusted to Care* recommended, has been influenced to an extent by looking outside the NHS for examples of best practice. We would encourage the Board to maintain and extend these reference points over the next year if it is to achieve the type of long-term change which will genuinely transform thinking and doing at ABMU.

The Annual Quality Plan developed for 2015-16, sets out the steps towards the achievement of four strategic quality objectives, focusing on priorities aligned to those areas where there is evidence of a need to further improve and develop:

- Improving collection and use of Patient Reported Experience Measures (PREMs).
- Improving the way collection and use of Patient Reported Outcome Measures (PROMs)
- Further developing our stroke services by reconfiguring the patient pathway. Improving the way they identify and manage a patient whose condition deteriorates by rolling out across all hospitals and wards the 'sick patient' initiative
- Implementing the all-Wales Do Not Attempt Coronary Pulmonary Resuscitation (DNACPR) policy.
- Implementing Electronic prescribing and administration (EPMA) system in acute care.
- Rolling-out the Big Fight campaign– Targeting *Clostridium difficile* infection and antibiotic resistance in primary care.
- Improving risk assessment and support mechanisms to prevent those who are known to our mental health services from attempting or completing suicide.

There is always a danger that quality and safety is not treated in a genuinely strategic way and simply involves an escalating number of projects without an overall sense of organising intelligence and shared purpose. This danger remains at ABMU, but work to date suggests the Board are alive to the risks involved. What is less clear is whether the Board will have the courage and commitment to be able to align their financial and resource allocation to address clinical quality and safety priorities in the face of competing demands and political imperatives.

### **Recommendation 3**

**The Board should identify clear steps to generate a culture of care built on public involvement in the setting and monitoring of standards, and in the resolution of ethical issues and practical**

## choices that arise from the need to make decisions within limited resources

*The Review Team suggest that the Concern Clinics although an interesting response to the need to reconcile previous issues of concern highlighted by the public do not in themselves provide a credible enough basis for genuine public partnership. The Chief Executive should consider establishing a Professional Standards Task Force which would meet weekly to provide a new focus on supporting front-line staff with ethical/resource issues that present risk to patients. The Task Force would involve nurse, medical and finance leaders to review incidents and complaints and report on issues to the Quality Committee. Staff, the public, patients and relatives would be able to report issues which they felt compromised professional practice or care standards on a 24/7 basis. The Review Team believe that this innovative mechanism would provide a more constructive and practical approach to enabling and supporting staff than current processes with their emphasis on “whistleblowing”.*

### Review Team Assessment

This recommendation was about the creation of a culture shaped by public involvement. We were clear about what was needed. Although there has been a lot of activity, we do not believe it has yet achieved its potential. We had hoped to see something genuinely innovative.

It is important that the work to date which has involved professional and representative organisations is given the credit it deserves. These stakeholder groups have a real role to play in moving standards forward and the work at ABMU has recognised this. Trusted to Care recommended an approach which went further. It may be that the leadership in ABMU have not understood fully what was intended or not embraced it as fully as other recommendations.

The Board reported that a formal evaluation of the Professional Standards Taskforce was due at the end of June 2015. This has not to our knowledge taken place. It will be helpful to see this happen as a matter of urgency.

From what we understand meetings have been held at 08:00 in the morning so that staff can attend following night shifts, during a day shift or before the start of a shift. Attendance at the meeting by the members has been good. The senior team seems to have developed a shared awareness of the concerns, incidents and Patient Advice and Liaison Service (PALS) reports for the previous week. And the senior team has been more aware and supportive of actions being taken to address themes appearing in reports e.g. falls and pressure areas. The reviews have supported the approach being taken in the Princess of Wales hospital to identify areas under strain and step in with support and action. No individual members of staff have attended with professional issues, but they have asked members of the group to raise issues on their behalf.

On the face of it this seems positive. However there is no evidence that the public has been directly involved in the work of the Standards Task force. The recommendation was intended to involve the public directly in working through genuine ethical dilemmas, for example where staffing levels are compromised. Where and when can the public be told about this sort of situation? Clearly in the

climate as it stands, the political repercussions of stating where there is a problem are overwhelming. Arranging for open visiting and having families in to help at mealtimes is one solution to the problem. But is this presented at an “extra” or are we ever able to say honestly that there is a problem? The question remains whether staff are still forced to try to solve problems without being open about the fact that there is one, or even what it is.

The Board also reported on an impressive and extensive programme of staff and patient engagement events during the summer of 2014. These looked at what they would like to see “more of” and what they would like to see “less of” and to describe what an “ideal” local NHS would look like. The “See it Say” it campaign for staff and the public was launched in mid July 2014. Typically issues were picked up within 24-48 hours and action taken. Staff brought up concerns that had previously been raised with line managers but had not been resolved. Positive outcomes from this work are reported. For example as a result of the campaign issues have been picked up and resolved, particularly on the Princess of Wales site, where the support of the Patient Advice and Liaison Service (PALS) is said to have been vital. The “See it Say it” Campaign has now been succeeded by a single feedback mechanism for the public “Let’s Talk” and the “Raising Concerns” process for staff, which replaces the All Wales Whistleblowing policy. A subgroup of the Partnership Forum was approached to get the views of staff on the proposed Staff poster to address the requirements of the new All Wales Raising Concerns policy. The poster was agreed by staff-side and approved by the *Trusted to Care* Steering Group. This effort is to be commended.

The potential replacement for the patients, families and public posters were discussed at the Stakeholder Reference Group, the Third Sector Network and the Disability Reference Group. These groups felt the posters needed to be more balanced and encourage more positive feedback as well as registering concerns. They also needed to reflect the organisation’s values. New revised arrangements were therefore approved by the *Trusted to Care* Steering Group and have now been formally launched throughout the organisation. The idea that various stakeholder groups wanted to soften the public posters risks confusing the message. A message encouraging positive feedback is good. A message indicating that we need to be urgently informed when the service is not good is a different message. We have a concern that the stakeholders are in danger of not been watchful enough watchdogs.

There is also a sense that staff are oversensitive to criticism. The Review Team is very sympathetic to the fact that unfair, personal attacks were made after the publication of *Trusted to Care*. It may be that the capacity to respond robustly to inaccurate or damaging comments about the service or the hospital or even personal comments is a training need for staff. It is unlikely, even with levels of renewed confidence in the hospital that was reported to us, that any NHS service will escape public opprobrium in future, as part of political processes. How to behave professionally while protecting oneself against personal pain is another work skill that has to be developed across Wales.

#### **Recommendation 4**

**The Board should implement a skills and knowledge programme to ensure all staff operating in its hospitals understand and are equipped to meet their obligations to older frail people.**

*The Programme should cover all permanent and temporary clinical staff working with older people.*

*The Board should set its own timeline for this, but it is suggested that the Programme should be completed by all relevant staff within 6 months. The Programme should include the following elements:*

*For all currently employed clinical staff – a recognised, mandatory programme combining core clinical, care and nursing standards (including pain management, hydration, continence, mobility, restraint, medication) and practical legal and ethical issues relating to older people and their families*

*For all new staff (including junior doctors on rotation) - inclusion of mandatory standards on those issues and information in induction*

*For temporary staff (including agency staff) - the Board must put in place arrangements which provide audited assurance that those staff working temporarily are fully aware of their obligations towards older people and the specific standards operating in their working areas*

*Seminar series – we recommend a seminar series on patient-recording, medication and legal and ethical issues involved in care of older people.*

## **Review Team Assessment**

The Review Team recognises the effort involved in releasing staff for training. This has clearly been, and continues to be, an issue in ensuring priority staff groups develop the knowledge they need. We are however disappointed at the progress on implementation here.

The decision was taken by ABMU to narrow the focus of training by interpreting ‘relevant staff’ in the recommendation as applying to a number of under 700 clinical staff in just the two hospitals. This recommendation was intended to apply across the entire Board with the “relevant staff” being defined clearly in the recommendation as being three categories of staff – all clinical staff, all new staff and all temporary staff.

The use of team briefing and existing meetings to raise general awareness is a reasonable approach, although there appears to have been no process for assessing the impact of this training.

It is the mandatory training where we have most serious concerns. At one level it is encouraging that 100% of the 450 staff who have been involved so far (at the time of assessment visits in July 2015) are reported as feeling positive about the sessions they attended and virtually all learned something. However implementation of the type of programme we envisaged to embrace all clinical staff has not been developed or delivered as required. This is disappointing given overall effort that has been made to make progress following Trusted to Care.

We would caution the Board about doing any further promotion about its success in training staff in dementia until this situation is addressed with a better plan with more systematic evaluation of impact.



The approach taken, involving dedicated sessions run by clinical facilitators, does seem to have yielded useful information about the continuing need for training on safeguarding, deprivation of liberty, capacity and consent and pain management. The idea of developing a one-day programme at Neath Port Talbot combining dementia training with frailty clinical skills development, featuring frailty assessment, simulation and management of clinical deterioration, makes a lot of sense.

A three hour workshop may be sufficient for some staff but not for others. Discussion took place with the ABMU team about whether “sheep dipping”, such as the partial programme to date, provides the right way forward. By this expression we mean putting every member of staff, regardless of discipline and previous knowledge, through the same educational process. It is to be expected that staff will have different educational needs in this area. There is not enough scope in the design and delivery of training so far to allow this to happen. Some staff expressed their frustration about the “one size fits all” approach. This view needs to be heard by the Board.

The Board’s self-assessment is silent on how temporary staff, including agency staff, have been trained in the last year and we could find no evidence of progress on this issue being reported to the Board. This now needs to be addressed urgently as these staff, in spite of increased permanent staffing levels, may still prove critical to overall quality of care for frail older people.

We understand the third element of the recommendation - the seminar series – has not been designed or started. Whilst we understand that the Board felt the seminar series should be shaped by learning from the training it is not good enough that one year on this has not received the attention required.

In summary it appears no action on this recommendation was ever planned to meet the implementation deadline of 6 months. As a result the purpose of the recommendation – to have greater confidence about the clinical knowledge on dementia and frailty in ABMU – has only partially been met.

### **Recommendation 5**

**The Board should run an intensive education programme on delirium, dementia and dying in hospital.**

*The Programme should be developed and implemented fully with 9 months of publication of the report and should include the following elements:*

*Unqualified staff – training equivalent to the Best Practice Programme*

*Doctors – all junior doctors to receive 2 hours induction training with all other doctors receiving mandatory refresher training every 5 years*

*Qualified nurses and Allied Health Professionals – three levels of standards*

- *every ward to have a qualified dementia specialist nurse (post graduate certificate level);*

- *every nurse and AHP to be dementia “competent”.*
- *every member of staff, including administrative and volunteers, to receive accredited dementia “awareness” training*

## **Review Team Assessment**

### Delirium and Dementia

The Self-Assessment Report by the Board includes a lot of detail about delivery of three levels of training in respect of delirium and dementia at ABMU. It gives a strong story on aims of the programme, numbers trained, processes followed, validation by academic partners and plans for future development. It sounds impressive and extensive in its ambition and reach. Some of it has already been put forward for awards.

We wanted to make sure that all this activity met the specific requirements of the Trusted to Care recommendations. Our conclusion is that although aspects of the programme are certainly worthwhile, and progress has clearly been made in a number of areas, we have concerns that the training may not be meeting the real needs for knowledge in staff at ABMU. We also wonder if its beneficial impact may be being overstated. We recognise this will not be well-received as a message but we believe that training represents probably the biggest area of weakness in implementation. It is paradoxically also the recommendation which is being promoted as being the most successful.

The knowledge of dementia that is needed is the knowledge that lets staff to do their specific job alongside people with dementia. Basic awareness is essential for catering and cleaning staff. But basic awareness that is suitable for them is not suitable for nursing and other clinical staff, who are starting from a different knowledge base and who have a different role. However, we were told that for many clinical staff this base level was a significant learning experience. Doctors who did not expect to learn something did. This is extremely disconcerting. Although the Review Team had doubts during the initial report about the level of knowledge of this complex, challenging and increasingly common condition, we had not quite anticipated how low the level of knowledge was.

*Level one training (dementia awareness training for staff).* This is being badged as equivalent of Dementia Friends training available from the Alzheimer’s Society. This seems to us an odd benchmark to use in the NHS as this is training that you would give to a member of the public or a bus driver who might rarely come into contact with a person with dementia, and only then for a short time. It is concerning that ten thousand staff in ABMU would be considered to be at such a level that this training would tell them what they don’t already know, or in fact tell them what they need to know. As *Trusted to Care* made clear, up to half of patients in most clinical areas at any time may have dementia or a related condition. They will be in regular contact with people with dementia and need more awareness than an equivalent of the Dementia Friends training will deliver. We do not see how this can have the desired impact on creating greater knowledge at the level needed.

*Level two training (Skilled practice for Clinical Staff).* The numbers who have been trained at this level are a good start. Our interest here was whether the training was at the level claimed for it. The report on Quality Assurance claims mapping onto to a University of Stirling learning programme (Best Practice). Such a benchmark is important as Best Practice as programme has been through significant external validation and accreditation, and has been annually checked against that

standard for over five years. No evidence of how mapping was undertaken has been provided. We would therefore be concerned if the ABMU training were rolled out further. We suggest the programme is reassessed by experts in dementia training, not least because it is not clear what is meant by “mapping” or what has been done.

The Review Team is disappointed that the specific recommendation, that a clinical person such as a nurse from each ward should have dementia education at certificate level, has been ignored or misunderstood. We have been given information about a new role of Dementia Champion in ABMU, where the member of staff, sometimes not a qualified clinician, is given training and this title. This matters as the report says these Dementia Champions are responsible for competency assessment of the taught programme. We are concerned about the knowledge, skills and credibility of this varied cohort of staff. The Review Team met with an enthusiastic and interested group of staff, but they were quite disparate, both in their knowledge, experience, level of power and influence, and capacity to do something on top of their day job. These Champions had never met each other before we invited them to meet with us. Champions might be a good idea. They must not be set up to fail, as they clearly have the potential to work together as a valuable resource within ABMU.

We saw no record of anyone doing the post-graduate certificate level education that was an important plank of the recommendations. It was as if the level of knowledge that a Champion could get in their short training was regarded as equivalent. It is not. A Champion is not a Dementia Specialist Nurse. This may be illustrated by thinking of another condition. ABMU has a cancer nurse specialist who may be called upon to advise doctors or other clinical staff on complex or unexpected aspects of cancer. ABMU does not report one single dementia equivalent, although *Trusted to Care* recommended that there should be one on every ward. Rather the Board claims in its self-assessment to have exceeded this target, without having achieved it at all.

It will be interesting to see how the longitudinal study on the dementia passport, which has been commissioned with Swansea University, assesses impact over time, although we note this seems to be currently about only Level 1 training.

We have also found it difficult to establish the level of reach the training has had across all three levels of medical staff. Although the self-assessment report indicates that “we will continue to look at ways to specifically address how we engage with medical staff” this really is not a strong enough commitment to address the problem.

### Dying

It is unfortunate that the work with Cruse to do the training of dying in hospital has had to be stopped because of design and delivery problems. But we are reassured that since February 2015 the new joint approach involving Cruse and the Board’s palliative care team, has been in place, albeit reaching a lower number of staff than originally intended.

### **Recommendation 6**

**The Board should develop more cohesive multi-disciplinary team practice in the medical wards at the two hospitals, built around shared responsibility and accountability for patient care and**

## standards of professional behaviour.

*Issues to address here include the need for greater clarity of responsibility for staff, greater focus on the skills and capacity of clinical teams needed to deliver safe and effective patient care and treatment and action to maximise the benefit of the clinical “encounter” on the wards – increasing the frequency and timing of contact of senior doctors each day. The Review Team specifically recommends the adoption of a risk assessment protocol if staffing levels fall below a safe level, as assessed by the nurse in charge at the time, and the options for resolution and escalation improved over current practices*

### Review Team Assessment

Real progress has been made in improving team-working at Princess of Wales. There remain differences between wards. Further development of the Ideal Ward concept and the ward assessment toolkit should make further improvements and bring greater consistency, where needed.

It is worth repeating the self-assessment here as it accurately reflects both progress and identifies remaining issues with which we agree. The majority of areas have made good progress in relation to implementing their action plans. Some progress made includes:

- Refurbishing of patient bathrooms
- Equipment such as soft closing bins and appropriate signage have been sourced
- Notice boards renewed and de-cluttered
- Introduction of flexible visiting, allowing families, carers and loved ones to provide emotional and practical support for longer periods
- Nurse recruitment has enabled ward managers to work in a more supervisory capacity to monitor standards and provide leadership to their teams
- Good uptake of Action After Andrews Learning Skills and Knowledge education programmes
- Work has commenced on outside spaces to improve the external environment for patients and their families
- Introduction of orientation boards
- Individualised and personalised care planning
- Call bell and lighting improved
- More nurses through new approaches to recruitment, e.g. open recruitment days on each acute site, utilising social media to advertise open days
- Improved medical engagement in Board Round process.

Areas where progress will require further time or a contingency plan include:

- Insufficient number of side rooms for patients at end of life
- Lack of storage areas on some wards
- Not all areas are 100% compliant with PDR process but plans are in place to address
- Capital investment required to renew flooring in some areas
- Lack of progress in implementing Board round process in some areas due to lack of social worker allocation and new medical staff

Our major concern is about medical engagement, which has been generally poor. It is clear to us that nursing, therapies, pharmacy and managers have all participated well and found the Ideal Ward

process useful. Progress is being supported by other initiatives including a risk assessment protocol for safe staffing level. We note that action is in hand through a series of leadership summits for medical staff to be delivered by the Chief Executive, Medical Director, Chairman and Director of Nursing and Patient Experience.

Plans for future action shared with us, including developing standards and awards, are sensible. However we do have concerns about ward improvement work where more significant capital investment is required. This issue has already been covered elsewhere.

### **Recommendation 7**

**The Board should introduce a coaching scheme for front-line clinical leaders provided by senior people from outside the two hospitals.**

*The value of an external system of reference and support is that it will help build confidence and feed into appraisal and professional assessment processes. A twinning process with another Board would make this reciprocal and could form the basis for a national network of clinical leadership coaching over time.*

### **Review Team Assessment**

The self-assessment report from the Board shows significant re-interpretation of what is required. The original report specifically recommended that coaching be provided for front-line clinical leaders by senior people from outside the two hospitals. Instead of this, the Board's report describes problems they have had with developing a pool of accredited coaches within the staff group and report that this has in fact failed.

It is worth noting here that the recommendations in *Trusted to Care* as a whole were designed to work together, not to be regarded as a selection of good ideas from which one might pick and choose.

The fact that it is reported that medical staff have not accessed the type of coaching they need adds further weight to concerns in the rest of this report that medical staff are not being effectively engaged. The Human Resources staff should guard against the idea that doctors are somehow different from other staff and also against the mistaken assumption that *Trusted to Care* was about nurses.

The *Trusted to Care* recommendation also suggested a twinning process with another Health Board which would involve reciprocal arrangements. This was not suggested in ignorance of the existing offering available from Academi Wales. If ABMU was content that Academi Wales provided a suitable alternative they would have made sure that it was accessed by other than senior staff. At more operational levels, the potential of exploring twinning relationships with neighbouring health boards was apparently discussed through the All Wales Assistant Directors of OD Network and "*was not supported at this time*". It is interesting that this informal group of staff felt able to overturn a clear instruction from the Minister, without concern being expressed in the self-assessment report by ABMU.

We feel that, one year on, insufficient effort has been made to address the coaching element of this recommendation. This is not good enough.

### **Recommendation 8**

**The Board should adopt a “zero tolerance” approach to the improper administration of sedation and medicines for all clinical staff, drawing a clear line in the sand within three months of the publication of this Report.**

*A mass education project is needed where nurses, doctors and pharmacy staff are reconnected with their personal professional responsibilities and the consequences of not following professional codes and hospital policy. Each nurse should be reissued with their professional code of practice. The Board needs to decide its policy using the suggestions e.g. for disposable medication pots made in the Report.*

### **Review Team Assessment**

We are impressed with the action taken here and feel this is in many ways an exemplary approach to implementing change rapidly in order to address a failure in a clinical process, where it has been shown to be necessary. This was evident in what we saw and heard during the assessment visits. Everyone involved in taking decisive action should be congratulated.

The proposed next steps covering practical education and improvements to the physical environment, which are planned, are exactly what are needed. This means ABMU is now at the level at which we would hope every normally-functioning Board would be operating in respect of this issue.

### **Recommendation 9**

**The Board should address hydration, mobility and feeding practice for all older patients and publish audited results on a quarterly basis.**

*The negative impact of prolonged (more than five hour) Nil by Mouth requirements for older people can be devastating. A review of current practice could act as a rallying point for the public and staff to work out together what would work on each ward or clinical area. The suggestions on snacking and feeding included in the Report are provided as being helpful. The further recommendation is that an approach is tested which included an automatic offer of water to patients in any clinical encounter, or offer of care.*

### **Review Team Assessment**

We are happy that the right action has been taken and the main requirements of this recommendation have been met.

Changes at ward level, including flexible visiting and encouragement of help by families at mealtimes, have been endorsed. We picked up a range of different reactions by staff to the new regime, and it will take continued advocacy by senior staff and by dementia champions to overcome some negative reactions to the opening up of the wards.

We note that initiatives which support proper feeding on wards, including snacking, have been introduced. We urge ABMU to set a definite date for introducing more finger food to increase options for patients and relatives.

The package of training to support the new nil-by-mouth protocol, and to increase knowledge and confidence around swallowing amongst nursing staff, are worthwhile. We believe this should make a practical difference.

### **Recommendation 10**

**The Board should review how well ward accommodation supports care for those with dementia, delirium, cognitive impairment or dying at both hospitals, covering physical design of the clinical spaces and equipment available.**

*It is counterproductive to invest in the skills and knowledge of staff if the environment is actively harmful to care. It is suggested this should be externally validated using established international standards leading to a programme of change and development. Audit tools are available and on line guidance.*

### **Review Team Assessment**

This recommendation was about physical design of the environment and equipment. A number of environmental priorities were identified, following publication of our report, by a consultant nurse, who used the Kings Fund Audit tool. The level of detail provided by the assessments was poor. We would recommend the DSDC's own validated audit tool instead and welcome the commitment made by ABMU to do so in future.

A number of physical improvements have since been made to the wards at Princess of Wales Hospital following discussion with other external expertise on signage. We have seen plans for a proposed Ideal Ward and we are advised that work is underway to quantify more capital-intensive requirements. This is good to hear but we are concerned any significant environmental change, dependent on larger amounts of capital, might lose momentum. Progress on the plans should be specifically checked again no later than Easter 2016.

In addition we recommend continued work on a range of areas that would not cost a great deal, for example:

- *Clutter* – the ward areas we inspected were still often cluttered with out of date and unnecessary notices, and other signs and notices that were difficult to read. For example, one dementia specific set of notices had been printed in a large font but with a shadow effect on the print, which could make the reader feel that they had developed blurred vision.

- *Sound* – more effort should be taken to reduce noise. Call bells that did not work have been repaired but consideration should be given to silent call systems. In addition audible alerts for essential equipment need to be calibrated so that they are responded to, or silenced as appropriate. Laundry trolleys in constant use were observed with wheels that are so small that they rattle unpleasantly.

The recommendation about equipment was not so much about the rummage boxes and other low-tech items that seem to have presented a challenge to infection control. By equipment we meant for example

- Personal iPods to provide playlists for entertainment and distraction
- Wireless headphones for the TV to reduce noise in the bays
- Clocks with large displays or day/night displays to help orientation, in places that can be seen from the bed space
- Lighting controls that can be operated by the patient
- Devices that let staff know that someone has got out of bed without making a noise or requiring the person to call for them

Although a good start has been made on environmental changes, much more can be done, quite quickly, drawing on external help to deliver what is needed.

#### **Recommendation 11**

**The Board should simplify and strengthen management and clinical accountabilities and review ward staffing procedures to guarantee the right clinical and support staff are in the right place to meet the needs of older people at that time.**

*This must involve a combination of increased confidence for the staff in charge of clinical areas to call upon resource when needed and for the whole clinical team to share responsibility for ensuring the right staff for patient levels of need. Workforce planning is crucial.*

#### **Review Team Assessment**

This is an area where considerable progress has been made under difficult circumstances. The national shortage of nursing staff has been effectively mitigated with introduction of new roles, such as housekeeping, to reduce the burden of care for nurses.

The retraining of nursing staff to undertake swallowing assessments has widened the range of staff who are able to undertake tasks that might otherwise have necessitated a long waiting time.

The introduction of open visiting should also make a difference to the staff burden as soon as staff have increased their confidence in how to manage difficult situations such as crowding or noise. Implemented well open visiting also should increase the range of activities that relatives, visitors and volunteers can undertake alongside professional staff.



More involvement of medical staff as part of the multidisciplinary team is now needed to generate further progress.

### **Recommendation 12**

**The Board should overhaul local procedures on adverse incidents and complaints to build greater staff and public trust and confidence in their effectiveness.**

*The recommendation is for a well-organised protocol and training based around supporting staff at local level to act as key workers for issues raised with them (including formal complaints), who remain in contact with those raising issues about care and treatment even if the matter becomes a medical negligence concern. The key workers could be any clinical person with appropriate training who could increase the speed of resolution and educate the public on what can be expected, moving from a handling system to one which actively promotes resolution. This would connect to and support the national review of complaints but it could provide a distinctive rallying point for culture change around the experience of care.*

### **Review Team Assessment**

At the time of the original *Trusted to Care* visits in 2014, the Board had already initiated a review of complaints-handling in the face of a level of unacceptable backlog and of poor quality engagement with the substance of complaints. Changes were also underway by the time the *Trusted to Care* report was published.

Since then there has been a reduction in formal complaints and a significant increase in the number of informal complaints recorded at ABMU. The Review Team share the Board's belief that this demonstrates that patients and their relatives are being encouraged to raise concerns earlier. This is a positive step in the right direction, provided there is the right process for learning lessons and engaging with complainants in place as well. The Public Services Ombudsman for Wales has also commended the Board for the rigorous investigation process they now apply.

As part of the methodology of *Trusted to Care* the review team met a number of complainants relevant to the review. A number of complainants also brought concerns to the attention of the Review Team at the time of this second review. The situation has completely changed from the year before. Their concerns were serious and worthy of investigation, but in contrast with the previous visit, investigation was already under way by the ABMU Board in what seemed an efficient and effective manner. The speed of complaints handling has been transformed for the better.

One significant opportunity to improve has been missed. Complaints data collection needs to change so that it is more related to specific areas of concern. The Review Team suggests that it is important for the Board to receive reports in future which specifically highlight patterns drawn from complaints for patients who are old, frail or cognitively impaired, in order to note and deal with any trends about vulnerable people having poor experiences. This would require a change in the method of recording, but this amounts to very little extra effort. Such data are important going

forward if the Board is to be forewarned that the sort of problems that gave rise to *Trusted to Care*, or their equivalent, are re-emerging.

A further potential problem which must be guarded against going forward is the danger that high-speed and efficient responses can give the impression of dismissiveness and haste, rather than taking seriously the desire for clear corrective action and organisational learning, which lies behind many complaints.

### **Recommendation 13**

**The Board should introduce a fully operational 24/7 approach to services including diagnostic services, pharmacy, therapies and social work.**

*The specific action here should include the joint review by the Medical and Nurse Directors of basic care for inpatients including senior medical cover and clinical decision-making responsibility; weekend services by speech and language therapists and pharmacy; the establishment of proper bed management team with authority to act and protocols which reduce the pull of junior doctors away from wards to A&E for extended period. In respect of A&E there could be a powerful role for nurse specialists to provide connective links between specialist clinical expertise, analysis of “frequent fliers” and the introduction of more direct admission to and from care homes where patients are known to the system, but this lies beyond the remit of this Review.*

### **Review Team Assessment**

Care and safety for frail older people has improved out of hours as a result of changes made in the last year. Although we could see no evidence of the joint Director-led review process recommended in *Trusted to Care* having taken place, good progress has been made. We feel ABMU is well on the way to providing services in a way that recognises the need for staff from different backgrounds to work together as a team, whatever the work pressures and staffing issues which may be affecting each component service.

Some of the main components for seven-day support services, including pharmacy, scanning and out of hours reporting, have been supported with extra resources. There appear to be plans in place to meet broader demand for acute services and to provide solutions to outstanding problems, such as availability of therapy staffing and levels of therapy knowledge in medical and nursing staff out-of-hours. These look sensible and practical. To maintain momentum it will be important for further planned investment in out-of-hours services now to be seen through.

There remain a number of problems with social services which lie beyond the direct control of the Board. These are a subject of real concern. Social services do not appear to have bought-in to delivering a set of support services on a seven-day basis. We understand this is the subject of ongoing discussion between health and local authorities. The absence of social work at times when the service is needed means more patients are staying unnecessarily in hospital. This is increasing the chances of people with dementia experiencing irreversible and avoidable deterioration. There

seems to be an unhelpful misconception amongst some that keeping a person in hospital is saving money in the community. As one doctor told us:

*“It is not an economy for the local authority to delay taking them on... (In response to a question)... Yes, in fact, the sooner they take the patient home once the medical intervention is finished, the less expensive the client will be for the social work bill going forward.”*

*Trusted to Care* spelt out why changes to hospital and clinical leadership at the Princess of Wales Hospital out- of-hours was vital to resolving many of the problems we saw in the operation of the wards. We also stressed the key role of more and better bed management and action has been taken by ABMU in both areas.

We are pleased these changes have been implemented, with a visible improvement in professional and operational leadership leading to better levels of support available to front-line clinical staff responsible for frail older people.

#### **Recommendation 14**

**The Board should decide what has to be done for ABMU genuinely to “put local citizens at the heart of everything we do”, using external creative expertise.**

*It is easy to say that the public should be at the heart of everything we do but much more difficult to make happen, especially in complex health settings. This recommendation is therefore **not made lightly**. It is made in the belief that ABMU, because it has now to develop a new level of trust with its local population, is ideally placed to work through what such a commitment really means with its staff and with local people. This is a different and more constructive place to start than with concerns or complaints. The Review Team believes that this process will provide a rallying point for staff to reenergise and reengage with their working relationships with local citizens and would provide a much better guarantee that standards are set and met in the way local people and the staff themselves want. The recommendation is for external support to be used to ensure that both creativity and resilience which will be needed to overcome obstacles in the way of achieving a cultural change, is supported from the outset, without the distractions from everyday responsibilities.*

#### **Review Team Assessment**

The line taken by the Board in its public statements and in its self-reporting has been that the organisation has always had a good track record of engagement and consultation with the public. They also recognise that *Trusted to Care* provided added momentum and urgency to their plans to achieve a new level of trust and engagement with public and with staff.

The resulting engagement strategy has focused during 2014-15 primarily on the first of three stages of change to which the Board is committed, namely:

- *Develop culture – turning leadership commitment into values transformation*
- *Develop shared values to connect the public and the staff*

- *Align values to organisational processes and measurement.*

With the support from an external consultancy, listening events were held with the public, with public representative organisations, with stakeholder organisations and with staff. From these statements of values and behaviour were distilled that were then approved by the Board in January 2015. Managers were trained in advance of the listening exercises about engagement. Pledges by staff about what the values mean to them were used. A cascade process has started since May 2015 to bring the values alive across the organisation.

This is all commendable and has clearly taken a lot of effort. We do not doubt the conviction with which this has been developed and has been implemented so far. The clear three-stage process makes sense and should deliver measurable results, a greater expression of shared values, and direct changes to professional practice. It needed to be done. It may even result in greater development of increased trust. However it is not what the recommendation in *Trusted to Care* intended, nor what is still required.

The Board does not yet seem to have a clear view about what is meant by “citizens” and what role they might, could or should play in respect of health and social care. Public engagement has not been about changing fundamental relationships around care and services. The engagement process really needs to look far more at the potential for a different way of organising services, of sharing responsibilities, of making decisions on policy, priorities and resources, and of enabling local people to take greater active responsibility in the care of people with dementia.

This would require more than a listening exercise, however well run, otherwise power and authority remains overwhelmingly with the organisation. This all too often leaves the way services run largely unchanged. We recognise this positioning of citizens at the heart of things might have been a lot to be thinking through at a time when visible action was inevitably going to be seen as taking priority. It might even be beyond what even a competent Board might be expected to generate on its own. But, if so we would need an explanation for that and to understand plans for addressing the shortfall.

The drive on values was only part of what we hoped would be taken forward in ABMU. To be clear we believed that there was a genuine opportunity to re-think what role citizens could and should play in clinical and organisational decision-making, and to build trust around that. We hoped the Board would allow the public in, not simply listen to them. Citizens can then help shape the way the hospitals work and play an active role in the clinical practices that define the quality and safety of local services. The outcome of such an approach would be to make care a much more collaborative exercise - one where families feel able to play a valued role in care and treatment, as they would at home in the care of their relatives. Exemplary dementia practice is based on this.

This transformational approach may be what the Board actually has in mind. If so, it needs to be better articulated and understood. At the moment the ambition seems to be about increasing engagement along largely familiar lines, relying too much on patient representative organisations. This is a good foundation and such organisations play a really important role.

But the Board also needs to embrace a vision which genuinely allows relationships to be thought about afresh with citizens at the heart of everything - directly rather than indirectly.

This may seem daunting. However the Board, with its broader responsibilities for community as well as hospital services, is still in an ideal position, to help citizens understand what dementia means to them and what they themselves need to do to secure improvements for local people with dementia.

## **Section 4 Conclusions**

**The public can be reassured that care of frail older people is much improved over what it was.**

**Immediate and necessary improvements have addressed the main issues which had led to previously unacceptable quality of care and standards of services.**

**More action is still needed in several areas to meet all the recommendations made in Trusted to Care.**

The Board is to be commended on taking a strategic approach, with radical improvement as its clear long-term focus, without taking its eye off creating visible change quickly where it is needed.

*Trusted to Care* made recommendations which have been taken seriously and the majority of them have been implemented in full, or there are plans to deliver them in acceptable timescales.

We have raised a number of areas where further work is needed, especially in respect of developing knowledge where it is needed, or where issues remain with capital funding, level of investment, measurement and prioritisation. These comments should not take away from the impressive progress made to date.

We also feel that in some areas such as training and values work there has been a lot of effort which could have been targeted to greater effect. Equally we believe that there are opportunities to think differently about the role of citizens in relation to dementia care which should not be missed.

We would caution against the temptation by the Board for over-promotion of what they see as success. There is still, as the Board itself recognises, some way to go before the challenge of being “Trusted to Care” can be truly celebrated.

**Professor June Andrews - Director, Dementia Services Development Centre, University of Stirling**

**Mark Butler – Director, The People Organisation Ltd.**

*August 2015*

## **Appendix One – Review Team**

### **Professor June Andrews**

**June Andrews is the Director of the Dementia Services Development Centre, based at the University of Stirling.** An experienced NHS nurse executive director, and Senior Civil Servant in the Health Department, she was Board Secretary of the Royal College of Nursing and in 2012 was given a lifetime achievement award by the four Chief Nursing Officers of the UK for her work in dementia care improvement. Professor Andrews is internationally recognised for her contribution to continuous improvement in health and social care systems, and her revolutionary approaches to change. In 2013 she was recognised by the Health Services Journal as one of the Top 100 most Influential clinicians in the UK and also separately as one of the 50 most inspirational women in the National Health Service. Her book, *Dementia- the One-Stop Guide*, has become a best-seller since publication in 2015

### **Mark Butler**

**Mark Butler is the Director of The People Organisation Ltd.** In a career of just under 30 years Mark has held positions as a Chief Executive in the NHS in England, the Director of Human Resources for Scotland and a Senior Civil Servant in the Scottish Government, and Secretary and Registrar of the University of St Andrews. Mark has also held a number of Non-Executive roles. As well as being Director of The People Organisation, Mark teaches at Edinburgh Napier University and is a Visiting Fellow of the University of Stirling. He was appointed to the UK Review Body on Doctors and Dentists Pay in April 2012. He is a qualified mediator. The People Organisation works with individuals and organisations to increase the impact of what they do. It focuses on futures thinking, organisational development, conflict resolution and mediation, governance development, public involvement and employee engagement.

### **Shirley Law**

**Shirley Law is the Director of Learning Development at the DSDC.** She was awarded the Mental Health Nurse of the Year Award at the nurse of the year awards in 2013 by Nursing Standard and RCN publishing. Shirley has personal experience of dementia as carer for her mother. She has worked in the NHS in hospitals and the community, and the independent sector and in Marie Curie care. She has been shortlisted and a finalist in UK national awards for her work through the Mental Welfare Commission, Health Service Journal, Times Higher Education and Nursing Times awards. She was also commended in the Scottish Health Awards. She devised and manages the Best Practice Programme for health and social care workers which has over 6,000 students completed in the UK and beyond.