



# Trusted to Care

An independent Review of the  
Princess of Wales Hospital and Neath  
Port Talbot Hospital at Abertawe Bro  
Morgannwg University Health Board

**Professor June Andrews**  
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## **Executive Summary**

### **Independent Review of Princess of Wales Hospital and of Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board**

#### **Introduction (Section 1)**

This report sets out the content and conclusions of an independent review into 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).

The Review was undertaken between December 2013 and April 2014 by the Dementia Services Development Centre (DSDC) and The People Organisation (TPO) at the request of Mark Drakeford, AM, Minister for Health and Social Services in the Welsh Government.

This report is about quality and patient safety. It is designed to be constructive. It includes a narrative and analysis of what the Review established, identifies a number of areas of concern and makes a series of recommendations for action. These recommendations largely consist of remedies which the Review Team believe are within the grasp of the local NHS leadership to achieve working with their local community.

Although the Review is specifically about two hospitals within AMBU, the Report also reflects on specific broader issues which relate more generally to the NHS in Wales, and the Report therefore also makes recommendations for action by the Welsh Government.

ABMU has not at any point been “another Stafford”. But no one should be in any doubt that there are aspects of the care of frail older people which are simply unacceptable and must be addressed as a matter of urgency through action by the Board of ABMU and by the Welsh Government.

The Report provides a thorough account of the work of the Review Team and is intended to be read, and engaged with, as a whole.

#### **Review Remit and Process (Section 2)**

The Review Team was 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 remit for the Review concentrated on four areas:

- the culture of the care of older patients, particularly in the medical wards
- the administration and recording of medicines, particularly how medicines are administered to patients who are cognitively impaired or have other challenges taking medicines orally
- how professional nursing standards are protected and delivered consistently and how the Health Board responds to lapses in delivery of these standards
- the response to complaints, how they are handled by the Health Board and how professionals are held to account for lapses in care identified through investigation including Protection of Vulnerable Adults (POVA) investigations.

The Review Team visited the hospitals on a number of occasions over a four month period and spoke to a range of people including staff, managers, patients, volunteers, external voluntary and statutory organisations, non-executive board members, local elected representatives, staff representatives, health department officials, police officers and relatives. It visited people in their homes, observed clinical areas during the day and night-time, and attended clinical and management meetings.

### **Review Findings (Section 3)**

Section three of the Report identifies a number of serious concerns about the quality of care and patient safety, and about clinical and managerial processes within ABMU. ABMU has not at any point been “another Stafford”. But no one should be in any doubt that there are aspects of the care of frail older people which are simply unacceptable and must be addressed as a matter of urgency through action by the Board of ABMU and by the Welsh Government.

The Review Team focused on the current position in the hospital and reports of previous experiences of older people in the care of ABMU over a three year period. Some of the poor professional practice which was evident in the past is still happening on some of the wards of the Princess of Wales and Neath Port Talbot Hospitals today. This is unacceptable and requires immediate concerted action, in addition to the required longer-term cultural and behavioural change. It is important to make it clear that these concerns are not of a scale to warrant action being taken by the Minister in respect of the current leadership of the Board.

The issues of concern relate to

- variable or poor professional behaviour and practice in the care of frail older people
- deficiencies in elements of a culture of care based on proper respect and involvement of patients and relatives
- unacceptable limitations in essential 24/7 services leading to unnecessary delay to treatment and care
- lack of suitably qualified, educated and motivated staff particularly at night
- adversarial and slow complaints management
- disconnection between front-line staff and managers and confusion over leadership responsibilities and accountabilities
- problems with organisational strategies on quality and patient safety, capacity development and workforce planning.

The picture is more nuanced than this list suggests. This is made clear in the full Report. There are examples of exemplary practice throughout both hospitals.

The sense the Review Team developed was that some staff in certain wards felt ill equipped to meet the needs of patients with dementia and other frail older people and were unclear of what to do about it. This was not true of all wards or even shifts, with the variation depending on specific circumstances. There was a sense of hopelessness and “learned helplessness” and the resulting variation in care seems to result from the lack of immediate advice and support from senior clinical leaders when needed, the apparent failure to act or provide feed-back on reports of problems and

incidents, the absence of basic knowledge and know-how and a fundamental lack of clarity from managers about what was expected of staff.

The Review Team were also concerned about the way staffing levels in the medical wards were determined as this seemed unconnected to the level of dependency and need on a ward at a specific time. There was a sense of a last minute nature of staffing of wards with staff in charge seemingly working in isolation to secure the skills needed to cover shifts, especially at night. During the day care on wards was not helped by the absence of effective bed management arrangements, coordination between disciplines and departments and the timing and frequency of doctors' ward rounds.

The impression the Review Team gained was that the current leadership of the Board are sincere in their intent to make the necessary improvements. Although corrective action has in some instances already been started by the leadership of ABMU, the conclusion of the Review is that much more needs to be done across a wider scope, and with greater urgency, than is currently the case.

#### **Recommendations for Action (Section 4)**

Recommendations are linked to the general themes of the full report and are brought together in Section Four of the Report.

The Board and the Welsh Government will be able to address the problems identified by the Review Team if they respond to the recommendations which are based on the following central issues

- making sure both NHS staff and the public understand the needs of older people within a hospital setting
- creating an organisational culture which enables staff to practise professionally with confidence at all times, both individually and collectively
- developing a consistent, whole-organisation approach to quality and patient safety which uses intelligence and data about services and experiences as the basis for decision-making, action and change
- making sure professional staff operate in cohesive clinical teams
- embracing strategic organisational development and rigorous workforce planning – the right staff in the right place at the right time
- investing in an effective psychological contract between the organisation and its staff which allows them to shape what ABMU does and how it does it
- involving citizens in the way standards are set, and care and practice monitored, as fundamental to the way ABMU works and is seen by local communities
- creating simpler clearer lines of accountability and reporting
- operating key services including diagnostic services, pharmacy, therapies and social work on a 24/7 basis
- adopting a fresh approach to complaints based on openness, early dispute resolution and mediation

Detailed recommendations and commentary are included at Section 4 of the Report which together provide an action plan to address issues identified by the Review Team.

### These are the main recommendations for the Board of ABMU

#### The Board should

1. create a set of clear standards for the care of frail older people in Accident and Emergency and general medical and surgical wards within the two hospitals, within three months of publication of this Report, and audit them quarterly thereafter
2. 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
3. identify clear steps to generate a culture of care built on more creative 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
4. implement a skills and knowledge programme to ensure all staff working in its hospitals understand and are equipped to meet their obligations to frail older people
5. run an intensive education programme on delirium, dementia and dying in hospital
6. 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
7. introduce a coaching scheme for front-line clinical leaders provided by senior people from outside the two hospitals
8. adopt a “zero tolerance” approach to the improper administration of medicines for all clinical staff, drawing a clear line in the sand within three months of the publication of this Report
9. address hydration, mobility and feeding practice for all older patients and publish audited results on a quarterly basis
10. 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
11. 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
12. overhaul local procedures on adverse incidents and complaints to build greater staff and public trust and confidence in their effectiveness
13. introduce a fully operational 24/7 approach to services including diagnostic services, pharmacy, therapies and social work
14. decide what has to be done for ABMU genuinely to “put local citizens at the heart of everything we do”, using external creative expertise

### The main recommendations for the Welsh Government

#### The Welsh Government should

1. commission a strategic campaign to increase public and professional understanding that regular hydration and feeding are as important as hand-cleaning in promoting well-being for older people in hospital

2. review the effectiveness of health scrutiny and quality reporting processes relating to the care of frail older people
3. commission ABMU to develop a model dashboard and guidance for Board assessment of care of frail and elderly people for adoption across NHS Wales by the end of 2014
4. institute a further independent review of provision for older people within a year of the date of this Report.

The Report also includes comments on the role of national operational and planning priorities, on the effectiveness of national health inspection and quality reporting processes and on the Community Health Council (CHC) which are directly relevant to the remit and are relevant to effective remedy and future prevention.

### **Conclusions (Section 5)**

There is also no question that where issues of serious concern are raised there should be appropriate mechanisms for investigation and resolution. However the collective responsibility of those inside the system, those charged with regulation and the public should be not be to catch out and blame, but to identify, correct, prevent and resolve issues constructively, so that the way hospitals work and services are provided improves.

ABMU has not at any point been “another Stafford”. But no one should be in any doubt that there are aspects of the care of frail older people which are simply unacceptable and must be addressed as a matter of urgency through action by the Board of ABMU and by the Welsh Government.

The Review Team would like to thank all the staff and members of the public who generously gave their time and shared their views, experiences and information so freely. Without such openness the Review Team would not have been able to reach the conclusions and offer the recommendations which should directly and decisively improve the care and support for older people in the Princess of Wales and Neath Port Talbot Hospitals.

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## **Full Report and Recommendations – April 2014**

### **Independent Review of Princess of Wales Hospital and of Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board**

#### **Section 1 Introduction**

**1.1** This report sets out the content and conclusions of an independent review into aspects of care and practice at the Princess and Wales and Neath Port Talbot Hospitals, which form part of Abertawe Bro Morgannwg University Health Board (ABMU).

**1.2** The main focus for the Review is an assessment of the current strategies and provision relating to the care of older people in the two hospitals, including those with dementia. Subsequently this was extended to include a further short process involving a "look back" at specific issues arising from the main Review. This Report covers both the main Review and the additional "Look Back".

**1.3** The Review was undertaken between December 2013 and April 2014 by the Dementia Services Development Centre (DSDC) and The People Organisation (TPO) at the request of Mark Drakeford, AM, Minister for Health and Social Services in the Welsh Government.

**1.4** The Report provides a detailed and thorough account of the work of the Review Team which is intended to be read, and engaged with, as a whole.

## Section 2     Review Remit and Process

### Remit

**2.1** The full remit of the Review was published in advance in the Welsh Assembly.<sup>1</sup>

**2.2** The main purpose of the Review has been to arrive at an independent assessment of the current fitness for purpose of care in the two hospitals in relation to relevant evidence-based standards. The approach taken by the Review Team has been to identify key areas of strength, which can be built upon, and also areas of potential risk, where further action is recommended.

**2.3** The Review first looked at the care of older people at the time of the Review. This Report focuses in detail on these designated areas -

the culture of the care of older patients particularly in the medical wards  
the administration and recording of medicines particularly how medicines are administered to patients who are cognitively impaired or have other challenges taking medicines orally.  
how professional nursing standards are protected and delivered consistently and how the Health Board responds to lapses in delivery of these standards  
the response to complaints, how they are handled by the Health Board and how professionals are held to account for lapses in care identified through investigation (including POVA investigations).

**2.4** On conclusion of this first phase the Review Team undertook the requested look back at how complaints have been handled in the past, and focussed on complaints about the hospital care of older people over the previous three years to provide a perspective on the current situation.

**2.5** The Review is a qualitative review based on a range of processes including observation, engagement, interview and review which are designed to approach issues from different perspectives and therefore allow the Review Team to arrive at a set of measured and shared conclusions and recommendations.

### Review Team

**2.6** The Review was conducted jointly by the University of Stirling and The People Organisation. The University team was led by Professor June Andrews, Director of the DSDC and included Shirley Law, Director of Learning and Development for the DSDC, who led on clinical care.<sup>2</sup> Mark Butler, Director of The People Organisation, brought experience as a public sector leader, governance specialist and mediator.<sup>3</sup> Specialist knowledge and support on the Welsh context was provided by Caroline Oakley, Director of Nursing & Midwifery in Hywel Dda University Health Board<sup>4</sup>. The team was selected for their independence, experience and expertise.

### Review Process

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<sup>1</sup> The full remit is attached at Appendix one

<sup>2</sup> details of the Dementia Services Development Centre in Appendix two

<sup>3</sup> details of The People Organisation in Appendix three

<sup>4</sup> details in Appendix four

**2.7** The Review Team visited both hospitals and spoke to staff, managers, patients, volunteers, external voluntary and statutory organisations, non-executive board members, local elected representatives, staff representatives, health department officials, police officers and relatives. It visited people in their homes, and observed clinical areas during the day and night-time and attended management and clinical meetings. The Review Team requested, received and examined all necessary documentation, processes and reports to complete the Review. Confidentiality has been maintained at all times as far as was possible within the control of the Review team.

**2.8** The Review took place over a period of four months to the end of March 2014. This was a time in which the ABMU leadership initiated a number of organisational changes. System strategies and management shifted in many ways during that time, with changes in the hospital management structures, staffing changes, and complaint handling including the introduction of new “concerns clinics” locally by ABMU. An all-Wales review of the complaints system was also announced by the Health Minister during this period.

### **Context**

**2.9** The Review operated in an environment of divisive public comment and campaigning activity. There was speculation expressed through the BBC, and other broadcast and print media, with questions raised in the Welsh Assembly and through social media. Sensitivities around the remit of the Review were intensified by potential criminal prosecution of NHS nursing staff (a situation which was unresolved at the time of conclusion of the Review), and several public meetings in which calls for the resignation of the current Chief Executive of the ABMU Board were made. Much of this debate was formulated as being in the aftermath of the public enquiry by Robert Francis QC into the care of patients in Mid Staffordshire NHS Foundation Trust. It was framed as the question “Is ABMU ‘another Stafford’?”

### **Comment**

**2.10** It is not obvious how other Welsh hospitals might stand up to a similar process of scrutiny and that must be addressed by the Department of Health and Social Care in the wake of this Report. These are just two of the hospitals that provide a range of primary and acute services under the aegis of the Board.

**2.11** This Report expresses clear and well-founded concerns about aspects of the culture and quality of care in ABMU. There is evidence that lack of clinical knowledge and poor hospital organisation increases length of stay for older and frail patients at ABMU. Adverse incidents are made more likely for many older patients because of these factors. However, unlike the Staffordshire example of a failing system, the situation in ABMU is remediable if our recommendations are accepted and implemented. This Report will show that in the view of the Review Team, it is not ‘another Stafford’. This is a different situation. There are significant differences in scale and complexity of the problems and the time period over which the serious concerns have arisen, even if there is some similarity in the apparent causes.

## Section 3 Review Findings

**The Review Team has a number of serious concerns about the quality of care and patient safety in the Princess of Wales Hospital and Neath Port Talbot Hospital, and about clinical and managerial processes within ABMU.**

**3.1** The Review Findings are presented as a single narrative with the four specific elements of the remit being used as organising themes. The full recommendations are gathered together in Section 4.

**3.2** This Report includes anonymised quotations from staff and others whom the Review Team met or heard from. These are in italics.

*My first impression was of a chaotic atmosphere. Staff appeared stressed and not in control. They told me that they were six senior staff down, with one suspended and one on sick leave. The agency staff nurse had not appeared. There were patients calling out, one stuck in bed with bed rails and one lady said to me "I am in Hell". There were more beds in the bays than was planned for. The consultant only visits a couple of times a week, and the out-of-hours cover was described by the nurses as "hit or miss". Staff were not confident about caring for confused people. Newly qualified staff weren't being supervised and junior doctors came and went with very little interaction with the nurses. The noise and clutter was over stimulating, with TVs on but not being watched, and an atmosphere where there were too many people – doctors, cleaners, nurses, all in the patient space at once. (Review Team member)*

### **Theme 1 - The Culture of Care of Older Patients, particularly in medical wards**

**3.3** A "culture" of care can be defined both by what care is provided and how it is provided. There is no set limit to the amount of care that an elderly patient might need or want, and but in reality there are limits to what can be provided. Along this spectrum difficult decisions have to be made and this has to be clear to the public who should share in making these decisions.

**3.4** The current culture of care of any hospital is defined by what staff and management seem to regard as acceptable along that spectrum. Clearly some of the public, relatives and patients do not agree with what ABMU hospitals have decided they are able to provide. It would be helpful if the hospitals made their definition more clear and specific and shared it with the public in order to get mutual agreement on what is feasible and can be expected within existing resources.

**3.5** What is feasible is not always a technical question. We can illustrate this using three examples from what the Review Team members know by experience and have observed in the hospitals.

“nil by mouth” orders are part of normal clinical care (the patient is temporarily not allowed by the staff to swallow anything)

patients do not always accept the care offered (the patient may not be ready or willing to take food or tablets at the time they are offered)

management of continence or moving and handling are complex (the patient may need to go to the toilet but be too disabled to go alone and staff are not free at that moment)

**3.6** It is a matter of fact that all of these situations will occur from time to time in any hospital. Even though they recognise that these situations might occur, a lay person or relative or journalist might simply not accept them. They may ask questions for clarification about a particular hospital setting -

How long is it acceptable in this hospital for a frail elderly patient to go without food, water and medication?

When is it acceptable to miss a dose of medicine in this hospital because the patient is unable or unwilling to swallow it at the time the nurse offers it?

When and how often is it acceptable in this hospital to instruct a continent patient to urinate or defecate in their bed onto a continence pad?

The answers to these questions might be framed in terms of exceptional circumstances or it might be said that these events should never, ever occur. The local concept of a “never” event is defined by the culture of the system. There are some things that hospitals can commit to “never” happening. Patients are unlikely to disagree with those standards, however high or expensive. However, there may be disagreement about what “sometimes” will happen because of the constraints under which the system operates.

#### **“Sometimes Events”**

**3.7** ABMU hospitals need to be open with patients and relatives about what things “might” happen, which we will call “sometimes” events. If those possible situations are unacceptable to patients, relatives, the media, or decision-making bodies, discussion needs to take place to find a resolution. Openness and transparency is vital. If the hospital system decides that it cannot always prevent those “sometimes” events, it at least needs to instruct front line staff how to handle those events when they occur and what to say about them, rather than going into denial or blaming individual staff when they are uncovered. If it has been made clear that certain things are perhaps not possible, there is a limit to the guilt or blame for front line staff. The public need to decide whether the hospital system is failing to do all it can, or whether this is the best for which patients can hope under current circumstances. This would be a resource issue where the decision about what to do under the circumstances is an ethical one.

**3.8** **The Review Team believes that even though some public expectations are in some respects unrealistically high locally, the hospital is still not meeting the standards that should be expected.**

It was reported to the Review Team that older patients were kept nil by mouth for longer than we would have expected. Reports from families of missed medicines that had been recorded as having been taken by the frail elderly patient were not unusual. We were shocked to be told of numbers of older patients who had been instructed to “go to the toilet” where they lay. Although some of these allegations remain unsubstantiated the Review Team found the accounts given by relatives and staff sufficiently credible to support our conclusions.

**3.9** The Review Team found it difficult to imagine the circumstances in which these situations were acceptable, and as a result felt that the attention to these things should be coming from the professionals in ABMU and the Board, not the complaining relatives. These adverse incidents should be brought to the attention of the families involved, and explained or apologised for, not swept under the carpet. The Review recommendations suggest a mechanism for making this happen, which would be the responsibility of clinical leaders.

**3.10 The Review Team found a muddle in the culture of care.** On the one hand there are unpleasant but unavoidable hospital hazards and on the other there are practices that are the result of disorganisation and poor training. It is this muddle that subsequently gives rise to shame and demoralisation of front line staff and makes it difficult to be clear and open about which complaints are reasonable and which unreasonable.

*The nurses don't look you in the eye. They know it's wrong. (Patient's relative)*

**3.11** Some of the complaints about care of older people are about incidents where the hospital could say in advance "we are sorry but this is something that might sometimes happen here". In individual cases families and patients could then take their own protective action. If patients and relatives find the overall situation unacceptable they can work with the hospital system to find a way of improving the culture and provision to become one that the local people *do* find acceptable.

**3.12** The Review Team have spoken to relatives who find it hard to understand that the basic care of older people in the hospital appears to be at a lower level than the care package that was being provided at home.

*Dad has someone to help him wash and dress every morning at home, but in hospital they left him with the cloth and a bowl to wash himself. I found dried excrement on his legs ...when we got him home. He can't see or reach round behind him. If I had known I'd have got the carers to come in and see to him in the hospital. (Patient's Relative)*

**3.13** The Review Team suggests that in cases where the level of care in hospital is not equivalent to that arranged at home for frail elderly patients, the management of this (for example the family coming in to provide bathing and feeding) should be worked through properly with the family and agreed with them.

### **Patient Safety and Ethical Decision Making**

**3.14** There is a popular misconception that care in hospital is more intense than care that can be provided at home and it is therefore, somehow, better and safer. It is important for the hospital to make clear that sometimes fundamental aspects of being cared for in hospital are inevitably worse than if care could be provided at home. A patient is only in hospital if care at home is not possible, not because care at home is worse. If this is made clear then families and the community can work to support those elements of care that are difficult to provide well in hospital settings such as exercise, mental stimulation or a good night's sleep.

**3.15** If the hospital said, "We sometimes do not have time to feed frail elderly patients," the shared response with the community might include

- Open visiting to allow families to come and help at mealtimes
- Freedom for families to prepare and store simple meals at the hospital
- Setting up of a cadre of meal time volunteers
- Imaginative solutions for continuous snacking and finger food availability to make sure that older patients are not restricted to the option where they have to sit up and manage a knife

and fork meal three times a day even if they have no appetite at the time and place it is served

A public mutually agreed decision that some other hospital activity is stopped in order to allow more attention to eating and drinking

If the hospital conceals or denies the problem, the only possible community response is outrage, and that does not feed patients.

**3.16** The management of public expectations by the hospital system is important as part of the culture of care. Embarrassment and concealment of failure to provide care that is acceptable to or demanded by the public can only lead to time-consuming and debilitating arguments over things in the past that cannot now be changed. The Review Team found individual people, even those who were hurt and disappointed by what happened to them and their relatives, sympathetic to the difficulties that NHS staff face every day. This should provide a real opportunity for ABMU.

**3.17** Delay in response to concerns and lack of openness by ABMU in the past have given rise to a feeling that bad things were happening that went beyond the well-known resource pressures that are generally understood to exist. Relatives speculated about criminal activity and deliberate harm, even in cases where the Review Team thought there was no evidence of it. The Review Team did not accept that there had been cases of euthanasia in ABMU, as suggested to them, but could understand why that conclusion might have been drawn in the absence of prompt and open responses to concerns about how older people had been cared for when they were dying.

#### **Care for Dying**

**3.18** The Review Team is still concerned about how death is described in terms of “withdrawal of care”, in a relatively unsophisticated way in ABMU. It seemed that it was often not explained well that a patient was dying, what dying looks like or how death happens. In particular ABMU doctors need more education about how to manage and talk about death and dying in hospital.

*The specialist McMillan nurse was with me explaining that Dad was dying and explaining about the morphine that would make sure he had no pain as he passed away, and right then a doctor stuck his head round the door and announced that he was just about to give him some intravenous antibiotics “to pep him up”. I was stunned. (Patient’s Relative)*

**3.19** This is in itself a cultural issue at ABMU in the light of research that shows a third of all hospital patients at any time are in the last year of their lives. A lot of people do go to these hospital when they are about to die. There is nothing unusual in this and that needs to be communicated in a sensitive way. The death of a patient in hospital is shocking to a family particularly if they have not been prepared for this eventuality. They are more likely to be suspicious if the hospital has a reputation of not reporting adverse incidents that might give rise to hastening of death. ABMU has both of these problems.

**3.20** Care in ABMU, in particular in the Princess of Wales Hospital, is being provided in a busy, noisy, unfamiliar environment full of strangers. By definition the patients are unwell and not able to look after themselves or able to show each other as much consideration as they would if they were well. Some of the undesirable elements of a hospital admission are unavoidable, but good nursing and

medical care can ameliorate some of the worst elements. The Review Team visited ABMU at different times of the day and night and talked to staff and noted a sense of helplessness about elements of the environment that they should have been able to improve upon such as noise, random activity and clutter. The Review Team gave advice and coaching at the time of the visits, but even some of the simplest recommendations given in real time appeared to be beyond the power of the staff. Medical and nursing staff in the Princess of Wales Hospital appeared not to know about ameliorating the common problems in care of frail older patients, including management of continence, delirium, mobility, nutrition, dementia, hygiene, and fear. This has to be rectified urgently. If they understand better what is needed, they will be better advocates for their patients when the system presents practical problems.

*We couldn't look to the nurses to care for mum. They had no power. They couldn't get a doctor when we needed one. They couldn't get medicines over the weekend, or a swallowing test. My mum had no medication or food or water for days. (Daughter)*

**3.21** Clinical staff, including nurses, need to be able to use the power and influence that they should already have, but seem unable to exercise in the current regime in ABMU in order to ensure the right care at the right time for their patients.

#### **The View from the Board**

**3.22 The Board itself is lacking in attention to specific issues that affect frail elderly patients.**

There is a steering group that focusses on dementia issues but they were not monitoring the number of people with dementia in the Board area or aware of how many of those people have the formal diagnosis. Diagnosis is fundamental for opening the access to advice and support for avoiding hospital admission and receiving particular care during an admission. Although the chair of that committee said that they believed that 50% of medical inpatients are affected by dementia there was little evidence of special activity or procedures to support those patients or any measures to avoid hospital admission, or measures to support families at home. The Butterfly Scheme was often cited as a response to dementia but on observation the implementation appeared patchy or ineffective. This was compounded by a failure to screen for indications of dementia at the point of hospital admission – a situation about which board members appeared unaware. This situation is as relevant to the Director of Finance as the clinical directors because it creates unnecessary expense in the inpatient areas so his focus on this should be keener.

**3.23** It would help if the Board were to invite a presentation at every one of their meetings from a relative or patient who is frail and elderly and has had an uncomfortable experience of the current service. It was often said to us at ABMU that there is a need to celebrate excellence. This is true. However the Review Team thinks that there is a danger of complacency at Board level if ordinary good care is reported to the Board as if it is exceptional. **A fierce level of attention and focus must be kept in ABMU on avoidable tragedies in the system, however minor or infrequent they may be.** A good culture of care for older patients assumes that “good” is baseline and maintains its focus on any adverse variation.

### Environment and Culture

**3.24** It is important at this point to comment on the physical environment of the Princess of Wales Hospital. The state of the environment is in itself an expression of culture. Where research exists on environmental issues it must be respected in these two hospitals which are currently and will increasingly be used frequently by people with dementia. **Failure to do this with a level of conviction is a significant governance risk.**

**3.25** Over 95% of people with dementia are older or very old and will have the common impairments of ageing, but a reduced capacity to compensate for those deficits. The environment could and should be changed in ABMU to make that compensation. Many patients are disabled by the hospital environment particularly in the Princess of Wales but even in the newer Neath Port Talbot Hospital, even though small changes could reduce that disability and reduce the cost of care immediately. Absence of urgency in dealing with these matters appears to be related to fragmentation of responsibilities.

*That revolving front door has been out of order for a while. We asked about a sign but they said they could not do one because of the language thing. We see people every day struggling up to it but we can't do anything. (Volunteer)*

**3.26** The Review Team witnessed avoidable environmental hazards which need to be audited and dealt with and about which staff knew but said they could not influence. Some of those changes would be very low cost, like removing all irrelevant and illegible notices, dampening the noise of bin lids, removing doors that always bang shut when used but are not fire doors, switching off bleeping monitors that are not required. ABMU staff appear unaware of the significance of light levels for all older people. In the view of the Review Team it was within the power of the staff to make simple improvements. It says a lot about the absence of a positive culture of care when staff don't see how they can improve the environment from the point of view of the elderly, frail, and easily agitated patient. A policy about bed moves out of hours could be implemented that would make any such move between 8pm and 8am automatically an adverse, reportable incident at Board level.

**3.27** The Review Team observed medical ward layouts with bays where extra beds were placed against the wall in bays, and the chaotic atmosphere made it difficult to concentrate and think. **Vulnerable elderly patients will remain at risk if the bed numbers are not reduced in some of these areas and other changes made.**

**The culture of care leaves much room for improvement.**

### **Theme 2 - The administration and recording of medicines, particularly how medicines are administered to patients who are cognitively impaired or have other challenges taking medicines orally**

**3.28** Clinical staff, in both hospitals, seem unaware of serious problems with administration and recording of medicines. Improvement in how medicines are administered to patients who are cognitively impaired or have other challenges taking medicines orally needs action by nurses, pharmacists and doctors.

*Nurses have to wait until another staff member has finished with the trolley before they can give out their medicines – so some patients never get their medicine on time. The chaotic atmosphere increases the risk of drug errors. Patients that probably have dementia were being prescribed antipsychotics without a proper risk assessment. The inappropriate use of sedation for “aggression” was observed. Nurses are administering medicine who don’t know the procedure or policy about mental capacity and one said she did not know what to do if a patient without capacity refused medication. (Review Team member)*

**3.29** The Health Minister made it clear to the Review Team that he was concerned about historic complaints that medicines were not properly administered to frail older people in these hospitals. It had been alleged to him that in the past unwell older patients in ABMU had been found with medicine pots containing prescribed pills that had just been left near them on a locker or table. These confused or immobile patients were unable to take their pills without supervision or assistance and so did not get their medication at the right time, if at all. Abandoned pills had been pointed out at various times by relatives, other patients and visitors, and other staff members. The danger of this practice is that a different confused patient may be harmed by accidentally taking the medicine. The medicine could get lost, or dropped on the floor, or into the bedclothes. If the patient’s condition gets worse because they missed a dose, the prescribing doctor may assume that the initial dosage has been too small and make a decision to increase or change the prescribed medicine which could cause an overdose or other harm.

**3.30** The rules about administration of medicines by nurses are clearly set out by the body that registers and regulates nurses and midwives<sup>5</sup> - the NMC (Nursing and Midwifery Council). A registered nurse is required to ensure that the patient gets their medicine as prescribed and the signing of the medicines record/prescription chart is a formal record that the nurse has witnessed this. On any occasion in hospital when the patient is deemed capable of handling their own pills this “self-medication” must be agreed with medical staff and based on a risk assessment that is written down. A nurse cannot honestly sign that any pills have been taken unless he or she has witnessed this.

**3.31** **The Review Team was therefore dismayed at the extent to which doctors, pharmacists, nurses and managers in ABMU knowingly tolerate this hazardous, prohibited and unjustifiable practice in spite of hospital policies that prohibit this.** The nurses are at the point of delivery of this medication but they are only one part of a chain of responsibility that is failing to protect patients. Many ABMU hospital staff were seen by the Review Team to be aware of and colluding with poor practice - as if they did not understand that they share responsibility for the safety of the patients.

**3.32** When asked, pharmacy staff admitted that they know of this practice but gave little evidence of an appropriate response, citing lack of nursing time as if that might be an adequate explanation, and failing to act. Medical staff appeared to ignore it or have difficulty in stopping it when it was pointed out in both hospitals. On more than one occasion a senior nurse was not aware of the appropriate action to take when they had this practice pointed out among the staff they were supervising by the Review Team. Nor was it recorded as an adverse incident. Relatives reported that no checks were made on the patient affected after a missed dose was discovered. Relatives and staff who asked

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<sup>5</sup> a discussion of the rules is at appendix five

questions were advised “not to bother” about it. **The Review Team offered practical advice and support to staff, but three months into the Review a ward visit resulted in the Team again witnessing this completely unacceptable and dangerous practice.**

*The nurse said to me that I was not to worry. But I was worried because the nurse signed to say she had taken it. (Relative)*

**3.33** The proper administration of medicine should not depend on the intervention of an external Review Team to operate effectively. On each occasion the Review Team did all that was necessary to protect the safety of the individual patient at that time and informed the management of the need to reinforce the message for the whole of ABMU. This is also reflected in our recommendations.

### **The Clinical Team and Medicines**

**3.34** This toleration of lack of care acted for the Review Team as a diagnostic measure of the culture of care in ABMU. It demonstrated to us that there is a disconnection between members of the health care team, an overwhelming sense of powerlessness and a failure of individuals to demonstrate personal professional responsibility. The debilitating public campaign against the hospitals must have had a negative effect on ABMU staff morale and made it more difficult to recruit and retain staff and support staff to make improvements. However given that the public concern has focussed on medicines being left with elderly frail patients it is incredible that existing staff in the whole system would not by the time of this Report have worked together to make sure that it never, ever happens again in ABMU hospitals.

**3.35** The Review recommendations for dealing with this issue at the bedside are practical and could be implemented at once. The records indicate that when this poor practice has been pointed out in the past general education is provided and nurses are warned that it must not happen. That clearly has not worked. As a temporary measure we propose that all medicine pots are signed for and disposed of after dosage, so that nurses better understand that witnessing the swallowing of medicine is part of the procedure and it is easy to identify any nurse who left medicine out. Medicines must not be given out by inexperienced nurses without supervision. Nurses must be given a formal procedure to follow when the patient refuses or fails to take the medicine in the time the nurse has to spend with that patient.

**3.36 ABMU doctors must be required to respond with more urgency to any such incident if the medicine matters. If the medicine does not matter the prescription should be discontinued. There is no middle way.**

### **Ethics in Practice**

**3.37** We also recommend that ABMU doctors and pharmacy staff routinely ask the nursing staff what if any difficulties have encountered by named patients in the taking of medicines. Comments such as “We are not allowed to put the medicine in their mouth” should be investigated and the situation managed to make sure the nurse and patient have confidence, and that the prescriber has confidence that the medicine has been taken and a range of strategies to adopt if the situation is not simple, including being able to call on the expertise of others. This theme of regular review of ethical practice at ABMU is further expanded on later in the report.

**Theme 3 - How professional nursing standards are protected and delivered consistently and how the Health Board responds to lapses in delivery of these standards**

**Nursing Standards**

**3.38** Research shows that the standard of professional nursing care in any clinical nursing team is dependent on the quality of the nursing leadership. Nursing leadership is an issue in ABMU. In the Princess of Wales Hospital, in particular, the structure of nursing management is complex and difficult to understand. Relatives have told us that it was difficult to work out who was in charge and not surprisingly nursing staff often felt the same way. The plethora of nursing titles and roles which cross over each other means that a junior nurse or allied health professional has no clear leader or role model to follow and nowhere to go if the person who appears to control the culture of care in their daily work gives them cause for concern.

**3.39** Some clinical areas in ABMU at the time of the Review were still suffering from the effect of the recent arrest and suspension of three nurses over an issue related to glucometer readings and the unresolved criminal proceedings related to that and another complaint. A large number of newly qualified nurses had been introduced to the workforce and as large a number had moved on. Sickness absence was higher than the national average. This would be a difficult situation in which to maintain high standards in any organisation, but the management structures added to the problem.

**Leadership Responsibility**

**3.40** At the most senior level in the Board the nurse director role was being filled on a temporary basis during the review period. The previous nurse director had been seconded to another post and her deputy was acting up. A new nurse director was appointed during the period and will take up post later in the same year. **It cannot be assumed that this newly appointed nurse director will be in a position to take these issues forward with the necessary speed.**

**3.41** Even if he or she has the skills and experience to turn round the ABMU nursing workforce that is struggling with morale, standards and skills it will take some time to deal with the issues, bearing in mind the complexity of the situation. They must not be set up to fail. The Review Team witnessed excellent nursing, and individual nurses who were at the top of their game, but the one element that was lacking in all of them was a collegiate sense of a nursing community that related to patients. The most confident nurses seemed to be focussed in their own specialist areas, where they worked well in teams and had few difficulties, but there was no sense of responsibility for the rest of the workforce outside of their own safe and well-managed “bubble”. It may be that under the prevailing circumstances this would have been impossible for individual nurses to achieve, but a shared responsibility for all patients is needed going forward, if the worst areas are to catch up with the best. **The new nurse director will need help to make this happen, from outside of ABMU.**

**The Problem of “Not Mine”**

**3.42** At the time of the Review nurses were able to say within a clinical ward area that a particular patient “...is not mine...” All the patients in ABMU are the responsibility of all staff, from the fitter

who fixes the rotating door at the entrance, the volunteers who staff the welcome desk, the administrators who move the paperwork around, through all the nursing and other clinical staff right along to the staff who take the patient home, or pass the patient's body back to the family's funeral undertaker. Every patient belongs to every staff member. When staff describe a patient as "not mine" at any point it is an expression of powerlessness and leaves the patient unprotected. **This lack of confidence is more serious where it is exhibited by nurses.**

**3.43** As the Review was asked to consider how professional nursing standards are protected and delivered, it must be said that this has been a problem in the past and at least it is now being noticed if not being fully addressed. The extent to which it can be turned round depends largely on the response by the ABMU leadership to the recommendations of the Review.

It is clear that

ABMU nursing staff need to be given a proper understanding of the legal aspects of recording patient care

Education and processes around administration of medicines need to be tightened up

Delirium and dementia and management needs of frail elderly patients need to be improved

Senior nurses need coaching and management development on how to communicate about and manage resource constraint issues

The new nurse director needs significant external support for changes that will be required based on the findings of this Review

### **Board Governance**

**3.44** Asking the Review to comment on how the ABMU Board responds to lapses in nursing standards begs the question of how the Board would know about them, and what they could have done to assure themselves that they know about nursing standards. The subcommittees of the boards have heavy agendas and lay members have indicated to the Review Team that they are faced with indigestible volumes of data with little serious analysis by executive staff that would help them to understand or alert them to where any nursing problem areas might be. The dementia strategy committee which has been operational throughout this period is one example of where this has happened.

**3.45** The Review Team were also concerned that lapses in care were largely blamed on poor "nursing" standards alone, as opposed to management standards or other clinical standards that are shared responsibilities with other members of the team.

*The nurse said that our mum needed a prescription, but that they could not get it at the weekend because they were not able to access a doctor till Monday. My mum waited three days. If we'd been at our house we could have got it from the emergency doctor straight away. I don't know why she even told me that mum needed it. I wanted it sorted out... not to have the problem described to me. (Relative)*

The lack of availability of doctors is a medical and managerial issue yet nurses alone in the frontline are required to explain it to the patient and relative. This seems unfair.

**3.46** Even so, all nurses are registered professionals and should know what to do if they are ordered to work in a way that is not in the interest of their patient. There is insufficient evidence of nurses bringing lack of availability of other clinicians to the attention of the Board. It could therefore be said that ABMU has required some nurses to work without the proper educational, environmental or organisational resources that they need to be entirely effective. The job of the nurse is to attempt to solve the problem and to report the fact of any risk to the management and make sure that their report is recorded and is acted upon. **In ABMU there is a distance to go until nurses will have the confidence to deal with these situations. The focus for the incoming nurse director must be on creating cohesive, confident clinical teams particularly in the medical wards.**

#### **Information and Openness**

**3.47 The problem for nursing standards in ABMU is that the nursing communications are often unhelpful and misleading from the patient's or relative's point of view.** The dilemma for the future nurse director is whether he or she feels able to encourage the nursing staff to tell the truth about care issues to patients and relatives, but at the same time use their power to sort out problems and understand their responsibility to report them through the correct lines in order to make sure that the Board knows about them. Particularly in the presence of anxious and upset families and patients, nurses should not just shrug and say, "It's the cutbacks," without taking some further action as was reported to the Review Team. Families in this context are not looking for comment. They want to know to do to get the best for their loved ones at the time it is needed. **The Review Team recommends setting up a mechanism for exploring the issues that should not be part of the clinical discussion with patients such as ethical or resource issues.**

**3.48** If such a mechanism existed, the ethical issues that arise out of hours could be resolved at the time, as they need to be. For example action would be taken whenever it becomes clear that, as a result of failure of adequate staffing 24/7, patients are being kept waiting too long for care when they have been admitted, and at times are being kept without food, water and medication as a result. These things have to be made visible and addressed as adverse incidents.

#### **Discretion and Professionalism**

**3.49** This Review Team would never prevent nurses from speaking out in defence of patient care. However, we would wish nurses to consider that when they do speak out, their choice of where and how to do it can cause unnecessary harm to patients and still fail to fulfil the nurses' professional responsibility to report harm and maintain safety.

**3.50 Asking nurses to help maintain public confidence in the system is not "gagging" them.** An important nursing skill is the capacity to raise issues and overcome difficulties without causing unnecessary alarm. It was most disconcerting to observe occasions where nurses were missing existing opportunities to provide an improved professional nursing service themselves, while expressing impotence over factors such as finance and the work patterns of doctors that they saw as causes of harm.

**3.51 Most of what the Review Team would say here about nurses also applies to doctors and other clinical staff.** We would wish that all conversations are only ever about the patient and their care, and questions about how more comfort and assurance can be provided. There is a time and a

place for other conversation and it is not during clinical encounters. Every doctor when talking to a patient with delirium or dementia should offer sips of water during the interview. Every nurse should regularly ask patients if they are comfortable, not always waiting for a call bell. Care standards like this will depend on leaders leading.

### **Skills and Needs**

**3.52 One issue which struck the Review Team was the lack of responsiveness of staffing levels on any shift to specific needs of patients at that time.** There seemed to be no flexibility to add or move staff to support appropriate care for patients with behaviour or mobility issues for example. It was reported to us that unacceptable practice was used to cope with the consequences, such as immobilising patients requiring support and leaving them to soil themselves in their beds. We did not witness but were told that there was sometimes no support in feeding or observation made and recorded when the meals provided were not taken by the older people concerned. It was said that food was left out of their reach. Insufficient attention to basic shift and staff planning is still leading to random and often inadequate care. The inability of certain wards to plan their responses to patient needs is not being helped by ineffective bed management and insufficient numbers of ward rounds, although at the end of the review period changes to bed management were being made

**3.53** In conclusion the Review Team believes that nursing standards have suffered through churn in leadership roles in recent times and that the environment in which they are working has caused significant problems for morale that has in turn affected the power of the nurses to be effective in their care for older frail patients. The solution lies in education about how to care for these patients development of leadership, and improved understanding of fundamentals and the strengthening of teams that is outlined elsewhere in this Report. **Lapses in standards have not been picked up by the Board early enough, and the response has been limited in its effectiveness.**

### **Theme 4 - the response to complaints, how they are handled by the Health Board and how professionals are held to account for lapses in care identified through investigation (including POVA investigations).**

**3.54** What the Review Team found about complaints handling and investigation applies to POVA (Protection of Vulnerable Adults) investigations equally.

**3.55** There are two major questions around any complaint. Is the complaint substantiated, and how was the complaint handled? In this section we are focusing on handling.

### **Complaint Handling**

**3.56** The Review Team examined complaints and spoke to staff about complaints handling and looked in detail about how complaints were reported over the last three years. We looked at complaints that had been taken to the Ombudsman and discussed in detail with the police complaints that had given rise to criminal investigations. It was clear that during a time period immediately before the start of our Review, strenuous efforts were made to clear a backlog of complaints. Successful practices such as using rapid telephone response to complainants to reduce turn round time and the introduction of clinical staff into the complaints handling team to make it less bureaucratic were reported to us.

## Slow and Bureaucratic

**3.57** During the Review and in particular during the “Look Back” process the Review Team interviewed and received written submissions from people who had complaints about both the Princess of Wales and Neath Port Talbot hospitals.<sup>6</sup> Most of the complaints were about the Princess of Wales Hospital and the Review Team concentrated on those complaints relating to older, frail patients. Those complaining were upset in large part about the way that their complaint had been handled. It is clear that complaints management was slower and more cumbersome than anyone would expect. People waited for months in some cases for an acknowledgement and some lost the will to pursue the problem long before the system responded to them. Not least there was evidence of one POVA investigation process that appears to have handled wrongly by ABMU staff giving misleading and confusing messages about whether it was actually happening. Delay, prevarication and misinformation seemed to lead in the end to either the aggrieved person giving up or to them becoming so angry that they became litigious or vexatious.

*The nurse said to me, “Please don’t you shout at me.” But at least something happened that time. (Son)*

## Disappointment and Redress

**3.58** Everyone who is upset does not have a legal case. Every case that is lost is not unfair. Unfortunately, the process of investigation and redress in ABMU tends to push complainants towards believing that they definitely have a “case” as a result of feelings that arise when they are not treated respectfully by the system which makes them feel unfairly treated.

**3.59** The amount of anger expressed by each complainant to the Review Team was not in our judgement in proportion to the severity of the alleged lapses in care. Some relatives are pursuing what appeared on face value to be very serious and credible issues with sad but quiet perseverance. In other cases the noisy determination to pursue the hospital was fuelled by extreme anger about the failure to treat the family with dignity and respect. In more than one example, the family simply did not understand something that might have been easily explained, such as why the patient was transferred between wards. Careful and responsive handling of their concerns at the time would have saved a lot of time and stress.

**3.60** Staff need more education and guidance on how to communicate effectively to relatives and what it is appropriate to say. The Review Team heard disturbing verbatim accounts of what nurses and other staff are supposed to have said. Of course these were not able to be substantiated but they seemed credible in the light of what we observed ourselves in clinical areas.

**3.61** The Review Team met families who appeared to have received little support and information from the hospital, the Community Health Council, the Ombudsman or the Older People’s Commissioner about how to pursue complaints and we signposted them to that help. **It was concerning that with all the disturbing publicity locally about complaints, this information was still not being made easier for them to find.** In examining the files held by one of these families we could see for example that mention was made in some letters about the fact that the CHC was able to offer help, but the family did not understand what help the CHC could offer because the message

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<sup>6</sup> the invitations to people to come forward – appendix six

had not been reinforced enough in advertising or in conversations with health care or complaints staff. Another family which had attended the ABMU concerns clinic was not advised that they might seek legal advice, highlighting a conflict of interest that arises when a Health Board is advising about issues of potential negligence rather than an independent public body.

**3.62** In other cases problems that could and should have been dealt with swiftly, closer to the patient and family and closer to the time of the event were still unresolved and attracting bad publicity thus causing damage to confidence in the current staff and management and affecting the morale and reputation of the hospitals, years after the event. It was clear also that the recent publicity had opened up even older grievances, where the situation had been resolved, but the individual now wished to add their previous concerns to the current concerns, even though proper processes seemed to the Review Team to have been followed many years ago. It also reanimated concerns where people did not like the outcome of the past process. The problem of recent complaints being badly handled goes far beyond the issues currently complained about.

### **“Public Voice”**

**3.63** A campaign to support local people with complaints has raised generalised public and political concerns about the safety of the local hospitals and the competence of the management that have been played out in the local and the UK media. It was important to question whether this group in respect of its constitution, funding and membership is replicating existing support mechanisms or illustrating the need for another support mechanism. The Review Team met a number of members and read papers supplied by them. It was important to hear their grievances, although this did not add to the existing knowledge of how many complaints there are that have not been resolved. The Review Team met people who had grievances but did not want to be represented in this way or to join a campaign that might damage the hospital and the morale of the staff. Not all supporters of the group who met the Review Team had personal live grievances themselves. The attention given to such a group by the media is another indication that the local health system has not set up a credible system to give the public a chance to shape, criticise or defend their local services.

**3.64** The Review Team asked a range of people with complaints from the last three years about what they wanted to achieve. The minority responses included a public enquiry, civil suits against the clinicians or hospitals for compensation, dismissal of senior managers and former senior managers and criminal prosecution of nurses. **The majority said they were more interested in a range of less punitive responses which were about openness and making the system better for the future.**

*I want to make it easier for other people....I want honest answers (Daughter)*

### **The Opportunities for Mediation**

**3.65** Although the absolute number of aggrieved people is a small percentage of those cared for by the hospital, the whole complaints governance system has been tarnished by the negative framing of the public debate and needs to be seen to be changed. There is evidence that the system has not demonstrated what it has learned from individual complaints, even highly publicised and contentious ones. Data is collected but not used, particularly at Board level. The hospitals need to work better across organizational, departmental, management and professional boundaries to clarify accountability and responsibility for those issues that arise through complaints.

**3.66 Not least the hospital needs to talk to patients and carers to demonstrate that they are listening.** This is one of the aims of the “concerns clinics”. The Review Team discussed the recently convened clinics with people who had used them. The ABMU staff who were involved appear to have listened to people without giving practical advice about how to pursue a complaint further, and aggrieved people expressed disappointment that there had been no follow up at the time of their interviews with the Review Team. Some complainants had been made more confused about the adversarial nature of the complaints system, and for others it has pushed them further into thinking of themselves as “victims” of a duplicitous system that uses clandestine processes against them.

**3.67 Hospital staff and people who have been treated well are disconcerted by the failure of the hospitals to robustly defend themselves.** A stronger and more active public defence of the ABMU reputation is needed to prevent damage to the entire system and the need for openness and honesty about where things have gone wrong cannot be over emphasised as part of that, to overcome speculation and rumour. The call for a public enquiry is based on the misleading impression given that a vast number of people have been adversely affected. ABMU needs to be more public in its account of how many people have made justified complaints. The role of the local Community Health Council in this is very important and they have been noticeable by their absence and failure to engage at the earliest opportunity.

#### **The Limit of “Complaints”**

**3.68** How complaints are handled was under review at the time of writing of the report both at a national and a local level. The Review Team had serious concerns about some standards of care for older frail patients, but we must point out that an analysis of the complaints alone would not have brought to light the issues that concerned us. Looking at complaints is an important element in the improvement and maintenance of standards for individual clinical areas and for good governance at Board level. It has limitations as an improvement method, because those who complain are an atypical subsection of the users of the services. It would be wrong to focus only on those issues that are raised by the most articulate and confident and angry people in the local population. Nor should the narrow focus of their concerns divert the system from an overall drive to improve care provision. An unchallenged impression had been given that this Review was a consequence of one family’s complaint, although there had been a number of causes for concern from other sources of evidence and they were being addressed simultaneously. **We feel that complaints have not been handled well, but at the same time too much weight appears to have been given to them in respect of perceived failings in ABMU.**

**3.69** This report has described already how the culture of care for older people in ABMU is one where the system fails focus entirely on their well-being. Medical and nursing education has left clinical staff ill prepared for the care of dementia and delirium even though we were told that locally up to half of patients on a medical ward may be affected by these conditions at any time. Individual health workers, whether clinical or management have avoided personal responsibility for system failures but the complaints system may appear to seek out individuals to blame for things that went wrong. **If the Board response is to focus on improvement, it needs to acknowledge system issues in addition to strengthening the professional understanding of accountability and good practice.**

#### **Education**

**3.70** The Review Team feels that more education and support is needed to educate staff about the need to express concerns about the care of older vulnerable patients and how to go about it. In addition better support and protection is needed for staff who have tried. We met staff who expressed anxiety about speaking out when we were certain that their anxiety was unfounded. It is important that during the time of change, staff do not carry over into the new ways of working any of the learned helplessness that they developed in the old culture.

**3.71** Staff who are trying to resolve issues at the front line level sometimes have appeared to be blocking families' attempts to take their complaints further, while other staff seem to inspire or goad people to make complaints against the hospital as if it has a different identity from themselves.

*The nurse manager begged me not to make it a formal complaint (Relative)*

*It was the doctor who said we ought to complain about the hospital, and we have done that, to be helpful. (Relative)*

### **Accountabilities**

**3.72** The idea of "holding to account" comes through strongly in this system, even in the commissioning of this report.

**3.73** One of the reasons for the length of time it takes to respond to complaints is the bureaucracy of the processes and the introduction of "legalistic" concerns at the earliest stages. It seemed to the Review Team that the health system could lead the way by adopting a voluntary and confidential form of dispute resolution involving an independent impartial person helping to open and improve dialogue and empathy between the hospital and the patients and relatives who use it. The mediator would help staff and hospital service users to broaden the range of solutions to their grievances. They could help collaboration to find solutions.

**3.74 At present, the process seems to be focussed on establishing whether the hospital did something "wrong" and what the hospital is going to do to make up for it.** There is an assumption that there is an objective measure of what can be expected from a hospital. The Review Team is of the view that some of the disputes arise not because the hospital did something objectively wrong, but because it fell below the expectation of the patient or relative. Given that there is no advance agreement of what it is reasonable to expect, the attempt at an adversarial resolution of these issues is often going to be time consuming and ultimately fruitless if the public expectation of a hospital is unrealistic.

**3.75** The relationship of trust and confidence that a community has in its own local hospital is one that comes to the fore if anyone ever proposes to close or downgrade the hospital. An uncritical faith in the power of a hospital can lead to bitter disappointment. Mediation rather than the current complaints system is more likely to produce a result that is agreeable to both parties and will preserve the relationship rather than creating winners and losers. It is significant that the ABMU victims meetings are supported and attended by clinical negligence lawyers.

**3.76** How staff are held to account for complaints in ABMU is difficult to describe. We were told of a characteristic in the recent past where staff stayed for a long time and promotions went to people within the system rather than encouraging new blood.

*The important thing here is to be nice, if you want to get on. (Staff member)*

**3.77** ABMU staff have a very challenging job that it is quite difficult for other people to understand, even though many people feel free to tell staff how they should be doing it. The adversarial climate combined with some professional failures and and expectations that have not been mutually agreed or negotiated is an explosive mix.

#### Quality Strategy

*I've tried to take an interest in the board papers, but they are full of jargon like "care bundles" and meaningless statistics so it didn't tell me anything I wanted to know about or what the board is actually doing. Endless jargon that a looked like a load of rubbish. Never mind Welsh translation – I'd like to know what it all actually means in any language. (member of the public)*

**3.78** One test which the Review Team applied from the start of the Review was the extent to which any serious lapses in care which it saw were, or could have been, seen and acted upon by the Board. AMBU is awash with data but people at all levels, including at Board level, do not feel sure this is the right data or what to do to turn data into drivers for quality improvement and change. There is a danger that reaction to specific events and incidents in the past can come to determine current practice, rather than having standards in place and quality being driven by a virtuous circle of continuous improvement based on knowing "what good looks like", and where the services provided by the Board stand in relation to this.

#### Lapses in Assurance

**3.79 Current assurance processes cannot be said to be fit for purpose.** For example it is hard to see how they would bring to Board members attention the fact that both hospitals appear to be operating a sedation policy which is not acceptable, with sedation being used to enable staff to cope with the pressures of caring for patients over night. Nor that older patients have been deprived of water and food without protection from some staff from all professional backgrounds – something which would be less likely were relatives of patients more respected and involved in care as part of the organisation's culture. Nor that medicines were not reaching patients as prescribed. It is not clear how the Board assurances processes as they currently stand would let the Board know of any instance where a patient had been instructed to urinate in bed due to staff shortage.

**3.80 The volume of undigested data at Board and sub-Board level means Board members are denied the ability to understand and act on symptomatic complaints.** The focus appears to be too much on managing down the numbers of complaints rather than learning the lessons, on national profile and reporting rather than advocating and leading changes that their authority could help secure. Most significantly complaints and other clinical indicators of quality are not currently placed in an adequate explicit quality assurance framework.

**3.81** The current complaints process seems to prevent rather than promote human engagement around issues of concern, creating division rather than promoting resolution through its bureaucratic and centralised and defensive ethos.

**3.82** It is difficult to see how the voice of patients and relatives would reach and influence Non-executive Directors and Board decisions. There is an overreliance on the executive directors to act

as the connective tissue between the Board and what is happening with patient care. This needs further urgent thinking by the Board.

**3.83 The disconnection between the Board and service provision does not seem to have been helped by confused clinical and managerial structures where senior managers, at times during the Review, have seemed uncertain as to who has responsibility for what.** In part this seems to have been caused by having a well-established process for uncontested promotion to management and clinical leadership roles from internal candidates. This has inevitably led to a static and overstaffed middle and senior management structure, with little new blood or testing of skills, compounded by overlap in roles and responsibilities.

**3.84** Although some steps were being taken to address this legacy during the review period by simplifying structures, there still seems to be too much room for separation and confusion between operational and clinical management responsible for patient care.

### **The Partnership Challenge**

**3.85 Throughout the review the Review Team has been struck by the fact that the vast majority of the public and NHS staff wish to be proud of health services in Bridgend and Neath Port Talbot.**

We are left with the strong sense that there is not a prevailing culture in AMBU which recognises sufficiently the positive power of engaging openly with the public and staff. This power should in our view be embraced and harnessed to much greater effect by the ABMU leadership. It is something also which the Welsh Government could be seen to promote and support for the national health system as a whole.

**3.86 The eradication of poor care now and in future is arguably as dependent on creation of an effective partnership with the public and with staff as it is about reigniting the relentless pursuit of professional standards at all levels of the organisation.** This requires something more powerful than current initiatives on public and staff involvement. It requires a partnership approach which values the voice of staff and patients and brings them actively into the heart of decision-making and prioritisation – a powerful and active presence rather than a distant, tolerated one.

**3.87** In many ways ABMU could provide an appropriate setting in which a cultural change programme driven by staff and public involvement could flourish with encouragement and support from the Welsh Government

### **The Role of Advocacy**

**3.88** The Review Team was surprised at the lack of effective advocacy for quality and patient safety. Apart from their role of personal advocacy for patients, the role of the Community Health Council is meant to engage with the local population and give recommendations for improvement on their behalf. The “1,000 Lives” is meant to put the “experience and perspective of people at the centre of improvement work”. Healthcare Inspectorate Wales is aimed to “strengthen the voice of patients and the public”. The picture painted by the latest national Fundamentals of Care report on ABMU is noticeably more positive than the Review Team’s assessment of what actually continues to be the lived experience of older frail patients. This raises questions about both the national reporting and health improvement processes that advocate for patient voices as they currently stand. The Review was set up at a time when the Chief Medical Officer and Chief Nursing Officer for Wales had agreed

actions with the Chief Executive and Chair of ABMU in response to their concerns about governance and there was an announcement of a review of the complaints process, but more attention needs to be given to involvement of citizens and giving them a voice.

**3.89** In conclusion, before turning to wider concerns, the Review Team believes that the Board should as a matter of urgency tackle underlying problems in the care and treatment of older people on the medical wards through

- equipping both NHS staff and the public to understand the needs of older people within a hospital setting
- creation of an organisational culture which enables professional staff to practise professionally with confidence at all times, both individually and collectively
- development of a consistent, whole-organisation approach to quality and patient safety which promotes systematic use of intelligence and data about services and experiences as the basis for decision-making, action and change
- clinical team development and deployment of skills and better organisational development and workforce planning
- commitment to an effective psychological contract between the organisation and its staff which allows them to shape what AMBU does and how it does it, and take greater responsibility for it
- greater involvement of citizens in the way standards are set, and care and practice monitored, as a defining part of the way AMBU works and is seen by local communities
- simpler clearer lines of accountability and reporting for core processes and practices which connect clinical and hospital management objectives more cohesively
- a 24/7 approach to key support services including diagnostic services, pharmacy, therapies and social work
- a fresh approach to complaints based on openness, early dispute resolution and mediation

### **Theme 5 - Wider Concerns**

**3.90** The Review Team has had cause to reflect on whether the situation at ABMU is untypical, unique and local or whether the causes of failures of professional practice and administration in the medical wards is in part attributable to wider issues which also need to be addressed within the NHS in Wales.

#### **On Structures and Ward Functioning**

**3.91** Staff seemed to turn up from different disciplines but unlike any comparable place of work they did virtually nothing during the working day to review how they worked together, could improve services (and then make changes) and focus on what was not working which was affecting the patients, drawing relatives into that discussion. This requires a fundamental re-think of the way clinical leadership works at ward level in the two hospitals.

**3.92** The confused nature of accountabilities needs attention at ABMU. It is not for the Review Team to suggest a revised structure but there are some guiding principles which are offered here to help resolve continuing problems at clinical ward level.

There should be a single point of leadership and accountability for care and treatment at each ward or clinical unit. These leaders should be clearly identified, visible to each other, to

staff and to the public and their views seen as pivotal and decisive on issues of clinical care. These clinical leaders should not have authority limited to the nursing care but should be able to control all aspects of the patient experience. These leaders should have the authority to set and secure the skills needed to meet patient needs at the time and to resolve issues which affect care and treatment at the time.

These clinical leaders should meet regularly and be encouraged to reflect on mutual issues of concern together. This group should be able to have access to Board members as they determine without negotiating hierarchies and be involved fully in the setting of organisational objectives, strategies and policy.

Those in charge of patient services should have access to a single point of managerial accountability.

Central support services and bed management should be offered as a service to all clinical areas on a 24 hour basis to serve the needs of these clinical leaders.

Any structure which ABMU adopts should remove room for conflict between the operational and clinical demands of 24/7 working or ensure there are proper mechanisms for mediation and resolution where conflicts arise.

All clinical leader roles should be filled by competition, supported with individual and collective development to improve resilience, decisiveness and clinical leadership skills, and strictly assessed for competence.

## Financial Impact

**3.93 The Review Team does have a concern that the Board over a number of years appears to have been driven mainly by a model of short-term financial planning required by the operational and planning framework processes in place across the NHS in Wales.** The question should be asked about whether such a relentless focus on financial delivery year-on-year prompted by the national system is distracting NHS Boards from a proper focus on quality and patient safety.

**3.94** AMBU in the past proudly presented itself as being especially effective in terms of delivering on nationally-set financial targets. The Review Team feel that, however admirable and necessary this might have been at the time, the issues which the Review and this Report are addressing now may well reflect an overemphasis on short-term financial targets at the expense of quality and patient safety.

**3.95** It is not too great a stretch to see current muddled management structures, lack of clinical cohesion and failures to have sufficiently skilled and oriented staff working in front-line settings, as being directly traceable to an overemphasis on short-term operational and financial delivery at the expense of the underlying core purpose of providing best possible care and treatment to local people. If so this requires urgent remedial action.

## Capital Resources

**3.96 The ward environments at ABMU are in many ways not appropriate for the care of older people, especially those with dementia, delirium or other cognitive impairment who make up more than half of the patients on many wards.** There is a danger that, in highlighting the need to redesign specific wards to provide an appropriate environment for care, the Report (because it is

public and produced for the Health Minister) will merely lead to resources being redirected from other priorities rather than address the fundamental underlying problem of resource.

**3.97** The Review Team are aware that simply saying more needs to be invested in ward environments can be actively unhelpful if that is all that is said. The recommendation of the Review is we hope more helpful in asking the Board to identify the full capital costs of making the two hospitals appropriate for the care of older people in the context of a change plan that releases revenue, and shifts emphasis from the extremely difficult task of financial reconciliation within current parameters to a more public debate about where the revenue and capital can be secured to meet public expectations.

**3.98** If left to Boards on their own to make “tough decisions” within finite resources without proper incentives and backing to think longer-term about quality and patient safety, complex change and professional skills and capacity development, there is a real danger that the reputation of local NHS services and more importantly the actual care provided to local people will not improve and may well decline further.

### **Public Representation**

**3.99 It is disappointing that there is little evidence of the CHC, as the official advocacy body for local people, providing an active and powerful voice on quality and safety issues in ABMU in recent years.** It has, from the evidence of Board papers, not acted as an effective vehicle for raising issues of concern or for highlighting trends and strategic priorities to the Board or in acting as a partner for quality assurance.

**3.100** This has led to the development of a different and negative type of advocacy, embodied in the public role and space afforded to the ABMU Victim Support Group. The Review Team was concerned to see the way complaints were being allowed to be turned unnecessarily into causes and missions with demands to hold people to account and families casting themselves as victims. The leadership challenge for the NHS locally is to regain the trust of local people which has to go beyond the concern clinics. This looks now, after several months, as though it will require a fundamental rethinking of the way the voice of the people whom the organisation serves is encouraged to play an active role in all aspects of the way the hospitals run.

**3.101** It would be inappropriate for the Review Team to recommend any specific way of achieving this although examples obviously exist which could be used as reference points.

### **National Quality Assurance**

**3.102 The concept of a national benchmarking of quality data should provide a further means of publicly-accountable assessment of quality and patient safety.** It is notable that the most recently published Fundamentals of Care Report for ABMU does not match the picture of care seen by the Review Team over a detailed review over four months. Perhaps this is inevitable given the level of generalisation at which information is reported and analysed. It is beyond the remit of the Review to comment in more detail, but it would be difficult to avoid the conclusion that the Fundamentals of Care process does not actually focus on some of those issues which are fundamental in ABMU. If the continuing issues of poor professional practice were visible in the current reports they would therefore be publicly reported and able to be acted upon.

**3.103** The same concerns must be raised about the effectiveness of Healthcare Inspectorate Wales who seem to have last visited ABMU two years ago and not seen or reported on what would have been at the time highly visible issues of poor practice.

**3.104** Whilst ABMU must take responsibility for those issues which clearly lie at their door there are issues in the wider system which also need to be addressed if the Minister is to be reassured that what has happened at ABMU is not being replicated, unseen, elsewhere within the Welsh NHS.

## Section 4 Recommendations for Action

The Review Team has identified 18 recommendations for action by the ABMU Board and by the Welsh Government. If accepted these provide a comprehensive plan of action which will address identified shortcomings in the two hospitals and could enable a significant improvement in quality and patient safety in ABMU beyond the immediate focus of older people. All recommendations are accompanied by further explanatory notes, suggestions and clarification.

### **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.*

### **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.*

### **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”.*

#### **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.*

#### **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*

#### **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*

### **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.*

### **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 eg for disposable medication pots made in the Report.*

### **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.*

### **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.*

**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.*

**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.*

**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.*

**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.*

### **Recommendation 15**

The Welsh Government should commission a strategic campaign to increase public and professional understanding that regular hydration and feeding are as important as hand-cleaning in promoting well-being for older people in hospital.

*The public understanding of hospital care is based on the assumption that food and drink are important for sick people. A campaign about this should not be a matter of shame any more than a hand-washing one. The reality is that these things are needed.*

### **Recommendation 16**

The Welsh Government should review the effectiveness of health scrutiny and quality reporting processes relating to the care of frail older people.

*The Minister is well-placed to promote a national excellence approach to the care of older frail people in hospital, publishing national standards and requiring skills and knowledge programmes (to match those which will be developed at ABMU) and prioritising audit and assessment of compliance in 2014-15 programmes of inspection and health improvement processes.*

### **Recommendation 17**

The Welsh Government should commission ABMU to develop a model dashboard and guidance for Board assessment of frail and elderly care for adoption across NHS Wales by the end of 2014.

*The idea of a dashboard on services for older people in hospital is a simple way of showing on paper what matters and what progress is being made. This being developed for every NHS Board in Wales by ABMU will provide a proper national focus for improving the governance of care of older people. It will improve Board focus and also provide a further reference point for HIW, the CHC and the public. This development would be a signal demonstration of what good can come from complaints and allow ABMU to re-establish itself as a proud local service that can show the way to others nationally.*

### **Recommendation 18**

The Welsh Government should institute a further independent review of provision for older people within a year of the date of this Report.

*A further Review is essential for the assurance of patients, local communities and staff and to measure the progress that can be made with open acknowledgement of problems, acceptance of help and support and concerted effort.*

## Section 5 - Conclusions

**5.1** The Review Team is concerned that this Report may be seen by some, and be reported by others, as evidence of failure and incompetence which should result in a search for “the guilty” and for “heads to roll”. This is the current bullying language frequently used to vilify those with responsibility for services and care in the NHS and other public services. The view of the Review Team from their experience is that at any given time it is likely that in every Board, indeed in every organisation providing services to the public, there will be lapses in standards and practice in some way. It is very important to say this, in this report, which is about services provided by local people to fellow citizens in their own community. Local and national governance arrangements should provide the reassurance to the public that care and treatment issues, such as those the Review Team have investigated, are routinely identified and action taken without recourse to one-off external reviews.

**5.2** There is also no question that where issues of serious concern are raised there should be appropriate mechanisms for investigation and resolution. However the collective responsibility of those inside the system, those charged with regulation and the public should be not be to catch out and blame, but to identify, correct, prevent and resolve issues constructively, so that the way hospitals work and services are provided improves.

**5.3** ABMU has not at any point been “another Stafford”. But no one should be in any doubt that there are aspects of the care of older people which are simply unacceptable and must be addressed as a matter of urgency through action by the Board of ABMU and by the Welsh Government.

**5.4** If the ABMU Board adopts the recommendations and acts with conviction and determination, there is no reason to believe that the issues raised in this Report cannot be fully resolved within the year, ahead of the further review which the Review Team has recommended be undertaken.

**5.5** The Review Team would like to thank all the staff and members of the public who generously gave their time and shared views, experiences and information with the Team. Without such openness the Review Team would not have been able to reach the conclusions and offer the recommendations which should directly and decisively improve the care and support for older people in the Princess of Wales and Neath Port Talbot Hospitals.

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

*Mark Butler, The People Organisation Ltd*

April 2014

## Appendix one

<http://wales.gov.uk/about/cabinet/cabinetstatements/2013/hospitalreview/?lang=en>

### **Mark Drakeford, Minister for Health and Social Services**

Members will be aware of my intention to commission an external independent review into the care provided at the Princess of Wales Hospital, Bridgend and Neath Port Talbot Hospital. I would like to update Members on the arrangements for this review.

The Health Board is already taking a range of actions to ensure the delivery of safe and high quality care to patients at the Princess of Wales Hospital. Progress is being monitored by the Chief Medical Officer and the Chief Nursing Officer. As a part of these actions an external quality and safety review has been commissioned by the Health Board.

However, I felt there was also a need for an additional independent review focusing on the care of older patients at two hospitals, following a meeting with a family who described their experiences in relation to the care of their elderly relative. The independent external review will consider the care provided at the Princess of Wales Hospital and Neath Port Talbot Hospital and will be in addition to the review already commissioned by the Health Board.

Using an established 'deep dive' review methodology, the scope of the work will cover provision directly related to the care of older people focusing in more detail on the specific areas:

- how professional nursing standards are protected and delivered consistently, and determine how the Health Board responds to lapses in delivery of these standards;
- the culture of care, particularly focusing on the care of older patients in the medical wards;
- responding to complaints, particularly looking at how complaints are handled by the Health Board and how professionals are held to account for lapses in care identified through investigation of complaints (including POVA investigations); and,
- administration and recording of medicines, particularly looking at how medicines are administered to patients who are cognitively impaired or have other challenges in taking medicines orally.

I am pleased to confirm that Professor June Andrews, Director of the Dementia Services Development Centre (DSDC) in the School of Applied Social Science at the University of Stirling, Scotland has agreed to lead this review.

Professor Andrews is a world leading expert in the care of people with dementia and has broad experience in the NHS being a past nurse executive director, has worked as a Senior

Civil Servant in the Scottish Government, she was Board Secretary of the Royal College of Nursing (Scotland) 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. She is internationally recognised for her contribution to continuous improvement in health and social care systems.

The review will commence in December and continue into early next year. The review's findings, together with recommendations, will be made publically available.

The full terms of reference for the review are set out in annex 1.

## **Annex 1**

### **“Deep Dive” review of practice in ABM University Health Board**

**1. Purpose and Scope**  The review to be conducted by University of Stirling Dementia Services Development Centre (DSDC) will provide an independent assessment of the current strategies and provision related to the care of older people, including those with dementia, within Princess of Wales Hospital, Bridgend and Neath Port Talbot Hospital and to provide a report on fitness for purpose in relation to relevant evidence-based standards.

The focus will be on identifying key areas of strength, which can be built upon, and areas of potential risk, where further action might be recommended.

The scope of the work will cover provision directly related to the care of older people at the Princess of Wales Hospital, Bridgend and Neath Port Talbot Hospital focusing in more detail on the specific areas below:

- how professional nursing standards are protected and delivered consistently, and how the Health Board responds to lapses in delivery of these standards;
- the culture of care, particularly focusing on the care of older patients in the medical wards;
- responding to complaints, particularly looking at how complaints are handled by the Health Board and how professionals are held to account for lapses in care identified through investigation of complaints (including POVA investigations); and,
- administration and recording of medicines, particularly looking at how medicines are administered to patients who are cognitively impaired or have other challenges in taking medicines orally.

The focus is on two of the hospitals of the ABM University Health Board: Princess of Wales Hospital, Bridgend and Neath Port Talbot Hospital.

**2. Methodology and Timing** <sup>L</sup><sub>SEP</sub> The “deep dive” uses an established methodology which has been developed over a period of years by DSDC. A Case Study on one of the “deep dives” can be found here <http://www.dementia.stir.ac.uk/case-studies/04-change-deep-dive>

The approach deliberately looks at strategic and practical issues together. The “deep dive” is normally conducted intensively over a short period of time. In part it deliberately follows the direct experience of people using the service and their carers through services and pathways from admission onwards. The methodology involves direct engagement with staff at all key points on this process, thus allowing important changes to be worked through with front-line staff at the time and unlocking immediate changes of demonstrable benefit in priority areas, based on evidence of what is known to work.

During the deep dive activity, specific areas of practice or policy will be identified to be part of the ‘look back’ exercise. The ‘look back’ will help identify how practices have evolved and where further change is advisable to improve standards of care. <sup>L</sup><sub>SEP</sub> The assessment will be undertaken from December 2013, through the early part of 2014 to include the following elements:

- review of key documents and data
- structured interviews with key stakeholders
- sample visits to service providers and partners

The assessment will be undertaken by two named individuals who have led other Deep Dives in the last two years:

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

Mark Butler, Director of Development (DSDC) and Director, The People  
Organisation Ltd

Professor Andrews and Mark Butler will be assisted by the Director of Learning and Development of the DSDC, Shirley Law. Expert contextual advice on the Welsh NHS will be obtained from an independent named associate from Wales to support the reviewers from outwith the Health Board.

## **Appendix two**

The **Dementia Services Development Centre** is an international centre of knowledge and expertise dedicated to improving the lives of people with dementia. We draw on research and practice, from across the world, to provide a comprehensive, up-to-date resource on all aspects of dementia. For over 25 years we have worked with individuals and organisations

to improve the care environments

to make communities dementia-friendly

to influence policy and to improve services for people with dementia

We work across the Eight Domains that make a positive difference to people with dementia and their carers (Ideas, Information, Education, Design, Housing, Change, Creativity and Communities).

DSDC is based in the Iris Murdoch Building at the University of Stirling, is guided by an International Advisory Board and is funded largely from charitable sources.

### **Professor June Andrews**

June Andrews is the Director of the DSDC. 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.

### **Shirley Law**

Shirley Law is the Director of Learning Development at the DSDC and 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.

## Appendix three

### Mark Butler

Mark Butler is the Director of The People Organisation. 

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 was founded with a commitment to outstanding personal service, deep knowledge and expertise, effective implementation, excellent value and ethical practice. 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. Their expertise in these areas connects to the fundamental relationships, behaviours and capacity on which personal and business success depend. They work creatively to reduce the obstacles which inhibit effective working. They have particular interest in making new and innovative connections between the private, public and third sectors. Their approach is based on co-creation with whoever they work with, whether as clients or partners.

## **Appendix four**

### **Caroline Oakley**

Caroline Oakley is the Director of Nursing & Midwifery in Hywel Dda University Health Board. She has 34 years' experience of being a Registered Nurse and held many clinical positions and has been a Director of Nursing in NHS Wales since 2003. Caroline grew up in Pembrokeshire and moved to London to train to be a Nurse, she returned to Wales in 1996. Her particular interests lie in the professionalism of Nursing and Nursing leadership and more recently in how patient experience can influence care.

## Appendix five

All discussion of standards of nursing care must begin and end with the Code set out by the Nursing and Midwifery Council (NMC). The NMC Standards for Medicines Management was first published in 2007 and a new edition with paragraph numbers to make it easier for reference was published in 2010. The code outlines the standards of conduct, performance and ethics for registered nurses. The key elements of the code include very specific injunctions. As a nurse you must make the care of people your first concern, treating them as individuals and respecting their dignity. You must act with others to protect their wellbeing, and provide a high standard of care at all times. Nurses are also required by the code to be open and honest, act with integrity and uphold the reputation of their profession.

When it comes to the delegation of any aspect of the administration of medicinal products, whether delegated to the patient, or a carer, or a care assistant, the registered nurse is responsible, and he or she is accountable to ensure that the patient, carer or care assistant is competent to carry out the task. So, for example, in delegating the taking of a medicine to the patient, the registered nurse must have provided education, training and an assessment that the patient can undertake this task. They must provide further support if it is needed. And they must assess the competence of the patient and review that periodically. All that needs to be recorded. In delegating the administration of medicinal products to unregistered practitioners it can only be for assistance in the ingestion or application of the medicinal product.

The code does not allow a nurse to leave medication with a patient for them to take in their own time unless the patient has been educated and assessed as being capable of undertaking this act. Even if this has all been done, the nurse would still have to have risk managed the issue of leaving medication around which might be ingested by accident by another patient. Also there is a question of when the nurse would record that the medication had been taken and what effect it had. Although the NMC Standards for medicines management specifically mentions supervision of the consumption of controlled drugs, it does not mention supervision of the consumption of other medicines, but stops short at the undefined term “administration” of the medicine. On the subject of medicines management and prescribing the NMC points out that the management of medicines in the UK is governed by a complex framework comprised of legislation, policy and standards, of which the NMC regulatory standards are only part. They set out Standards for Medicines Management but in doing so make it clear that it will be necessary for nurses to refer to local and national policies. It makes particular reference to **Patients who may be confused** saying that they **must not be given custody of their medicines**. The guidance requires that all errors and incidents including near misses should be reported through the National Reporting and Learning System (NRLS) in Wales.

“When considering allegations of misconduct arising from errors in the administration of medicines, the NMC takes great care to distinguish between those cases where the error was the result of reckless or incompetent practice and/or was concealed, and those that resulted from other causes, such as serious pressure of work, and where there was immediate, honest disclosure in the patient’s interest.”

<http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-for-medicines-management.pdf>

## Appendix six

### Independent Review invites families to engage over complaints at Health Board

**Professor June Andrews, who is leading the independent review of patient care within two hospitals in Abertawe Bro Morgannwg (ABMU) Health Board, today asked people who have made complaints about the Princess of Wales or Neath Port Talbot Hospitals in the past three years to come forward and share their experiences with the Review team.**

Professor Andrews from the University of Stirling is leading an independent review on behalf of the health minister Mark Drakeford, the Welsh Health Minister of care at the two hospitals. Now the Review Team, which also includes Mark Butler from The People Organisation, wish to look more closely at the way complaints have been handled in the recent past.<sup>7</sup>

#### **Professor Andrews comments:**

“We want to hear directly from patients and families who made any complaint about the Princess of Wales or Neath Port Talbot Hospitals (ABMU Health Board) between December 2010 and December 2013.

“We want to get a clearer picture about what complaints were made, from local people themselves, and to understand the levels of satisfaction with what happened as a result, particularly about the care of older people.

“We are using a short, simple-to-use questionnaire to gather some information. Then we hope to talk to a number of those who respond about their experiences. Obviously we shall be respecting confidentiality at all times and will only be discussing any detail about the complaints once we have the necessary permissions.”

#### **Making Contact**

**Anyone wishing to contact the Independent Team should use the on-line survey at [www.dementia.stir.ac.uk/ircq](http://www.dementia.stir.ac.uk/ircq). This is the quickest and easiest way and we are happy for people to share this link with others by email.**

If someone does not have easy access to the internet or they have trouble connecting there are the following alternative options:

email Professor Andrews directly on [ProfAndrewsReview@stir.ac.uk](mailto:ProfAndrewsReview@stir.ac.uk) and a link to the questionnaire will be sent directly to you

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<sup>7</sup> The terms of the review are here from the Welsh Government website [www.wales.gov.uk/about/cabinet/cabinetstatements/2013/hospitalreview/?lang=eng](http://www.wales.gov.uk/about/cabinet/cabinetstatements/2013/hospitalreview/?lang=eng)

print off the questionnaire from the DSDC website at [www.dementia.stir.ac.uk/ircq](http://www.dementia.stir.ac.uk/ircq) and post a completed copy to Professor Andrews Review, Iris Murdoch Building, University of Stirling, Stirling, FK94LA. Please make the envelope CONFIDENTIAL  
send a Stamped Addressed Envelope to Professor Andrews Review, Iris Murdoch Building, University of Stirling, Stirling, FK94LA and a questionnaire will be sent out to you.

Anyone needing help to complete the questionnaire could contact the Community Health Council, Water Street Business Centre, Water Street, Aberafan, Neath Port Talbot SA12 6LF (Telephone: 01639 892271) who will be happy to help.

**Please note** that the questionnaire asks for contact details. This is to allow the review team to make contact. Anyone not wishing to be contacted is encouraged to complete the questionnaire but to omit contact details.

### Media Contact

To learn more about this this, please contact

Prof June Andrews  
Dementia Services Development Centre  
University of Stirling  
Stirling FK9 4LA  
Tel 01786 467 740

Email [ProfAndrewsReview@stir.ac.uk](mailto:ProfAndrewsReview@stir.ac.uk)

## Adolygiad Annibynnol yn gwahodd teuluoedd i drafod cwynion ynghylch Bwrdd Iechyd

**Heddiw, gofynnodd yr Athro June Andrews, sy'n arwain yr adolygiad annibynnol o ofal cleifion mewn dau ysbyty ym Mwrdd Iechyd Prifysgol Abertawe Bro Morgannwg, i bobl sydd wedi gwneud cwynion am Ysbyty Tywysoges Cymru neu Ysbyty Castell-nedd Port Talbot yn y tair blynedd diwethaf rannu eu profiadau gyda thîm yr adolygiad.**

Mae'r Athro Andrews o Brifysgol Stirling yn arwain adolygiad annibynnol ar ran y Gweinidog Iechyd Mark Drakeford ynghylch gofal yn y ddau ysbyty. Mae tîm yr adolygiad, sydd hefyd yn cynnwys Mark Butler o the People Organisation, eisiau edrych yn fanylach ar y ffordd y cafodd cwynion eu trin yn y gorffennol agos.<sup>8</sup>

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<sup>8</sup> Mae telerau'r adolygiad ar wefan Llywodraeth Cymru  
[www.wales.gov.uk/about/cabinet/cabinetstatements/2013/hospitalreview/?lang=cy](http://www.wales.gov.uk/about/cabinet/cabinetstatements/2013/hospitalreview/?lang=cy)

**Dyweddod yr Athro Andrews:**

“Hoffem glywed yn uniongyrchol gan gleifion a theluoedd sydd wedi gwneud cwyn am Ysbyty Tywysoges Cymru neu Ysbyty Castell-nedd (Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg) rhwng Rhagfyr 2010 a Rhagfyr 2013.

“Rydyn ni eisiau darlun mwy eglur ynghylch am beth y gwnaed cwynion, gan bobl leol eu hunain, a deall ynghylch pa mor fodlon oedd pobl am y canlyniad, yn enwedig am ofal i bobl hŷn.

“Rydyn ni’n defnyddio holiadur byr, hawdd ei ddefnyddio, i gasglu gwybodaeth. Yna rydyn ni’n gobeithio siarad â nifer o’r rheini sy’n ymateb am eu profiadau. Yn amlwg, byddwn ni’n cadw cyfrinachedd bob amser ac ond yn trafod cwynion yn fanwl ar ôl cael caniatâd i wneud hynny.”

**Cysylltu â’r Tîm**

**Dylai unrhyw sydd am gysylltu â’r Tîm Annibynnol ddefnyddio’r arolwg ar-lein yn [www.dementia.stir.ac.uk/ircq](http://www.dementia.stir.ac.uk/ircq). Dyma’r ffordd gyflymaf a hawsaf ac rydyn ni’n hapus i bobl rannu’r ddolen hon drwy e-bost.**

Os nad oes gan bobl fynediad hawdd i’r rhyngwrwyd neu’n cael trafferth cysylltu, mae dewisiadau eraill ar gael:

e-bostiwch yr Athro Andrews yn uniongyrchol yn [ProfAndrewsReview@stir.ac.uk](mailto:ProfAndrewsReview@stir.ac.uk) a bydd dolen i’r holiadur yn cael ei hanfon atoch yn uniongyrchol  
gallwch argraffu’r holiadur ar wefan DSDC yn [www.dementia.stir.ac.uk/ircq](http://www.dementia.stir.ac.uk/ircq), ei lenwi a’i bostio i Professor Andrews Review, Iris Murdoch Building, University of Stirling, Stirling, FK94LA. Marciwch CYFRINACHOL ar yr amlen  
anfonwch amlen gyda’ch cyfeiriad a stamp arno i Professor Andrews Review, Iris Murdoch Building, University of Stirling, Stirling, FK94LA a bydd holiadur yn cael ei anfon atoch.

Os bydd angen help ar unrhyw un i lenwi’r holiadur, cysylltwch â’r Cyngor Iechyd Cymuned, Canolfan Fusnes Stryd y Dŵr, Stryd y Dŵr, Aberafan, Castell-nedd Port Talbot SA12 6LF (Ffôn: 01639 892271) a fydd yn hapus i’ch helpu.

**Noder** bod yr holiadur yn gofyn am fanylion cyswllt. Mae hyn er mwyn i dîm yr adolygiad allu cysylltu â chi. Os na fyddwch eisiau i unrhyw un gysylltu â chi, dylech lenwi’r holiadur heb eich manylion cyswllt.

**Cyswllt y Cyfryngau**

I gael rhagor o wybodaeth, cysylltwch â

Yr Athro June Andrews  
Dementia Services Development Centre  
University of Stirling  
Stirling FK9 4LA  
Ffôn 01786 467 740

E-bost [ProfAndrewsReview@stir.ac.uk](mailto:ProfAndrewsReview@stir.ac.uk)