

## **Review of the arrangements for clinical governance and patient safety within the provider services of Powys Local Health Board**

### **1. Background**

This review was carried out in response to a request from Mrs Ann Lloyd, the Chief Executive of NHS Wales. Mrs Lloyd asked the Clinical Governance Support and Development Unit (CGSDU):

***To review the current arrangements for clinical leadership, clinical management and patient safety within Powys Local Health Board (LHB) and to make recommendations, where appropriate, for improvements in these areas.***

CGSDU was asked to undertake the review in **two phases**:

**Phase 1** was intended to focus on the Board's and management team's role in discharging its responsibility and accountability for ensuring patient safety and the effective management of clinical services.

**Phase 2** was intended to review patient safety and the management of clinical services at the hospital / service level.

### **Phase 1 and the Interim Actions**

**Phase 1 was completed in July 2007** and a progress report was published by CGSDU (available on the Powys LHB website). The report identified:

- weaknesses in the Board's systems and processes for ensuring patient safety in community hospitals;
- a breakdown in communication with some General Practitioners (GPs) and communities on how to move forward to provide a modern health care service in a widespread rural community
- the fact that the vast majority of Powys residents receive their healthcare from GPs and /or district nurses, health visitors, therapists and other health care workers in the community; or when necessary, from consultant led services in the District General Hospitals (DGHS) that surround Powys.

However, during Phase 1, **a series of serious incidents relating to patient safety** in the community hospitals and in two of the Minor Injury Units (MIU) were drawn to our attention.

### **Safe services as locally as possible**

Some General Practitioners said that allowances had to be made in rural areas and that clinical care standards could not be the same as elsewhere. But having read the complaints received from patients over the last year concerning standards of care and clinical incidents, it is quite clear that the patients expected the same standards as other NHS patients; that is safe services as locally as possible, rather than local services as safe as possible.

### **Interim actions to improve patient safety**

The patient safety incidents in the community hospitals could not be ignored, and it was necessary for the Local Health Board, supported by CGSDU, to take the following interim actions to improve patient safety:

- To look for ways of providing a safer, local, rural Minor Injury Service for the people of Builth Wells and Newtown, in view of the serious patient safety incidents that had occurred in these units.
- To seek current professional advice and provide guidance on the provision of safer surgical services, in view of the surgical incidents that had occurred
- To review standards of nursing care and the co-ordination of medical care in Newtown Hospital following four incidents of unacceptable standards of care of vulnerable patients, and the coroner's comments concerning the care of an acutely ill patient
- To improve patient safety through strengthening the management of provider services

### **In parallel**

The LHB would engage GPs, the County Council and the public in developing a health and social care model for Powys for the future, and CGSDU would undertake Phase 2 of the Review, taking every opportunity to brief all stakeholders on progress to date, and to engage them in discussing options for the future.

## **2. Progress with the interim actions**

### **Services that have been improved and made safer**

The management team has been strengthened and the Board has succeeded in; providing safer MIU services in Newtown; providing safer surgical services, and in engaging with the County Council in taking forward joint working, initially with the Builth community.

#### **2.1 Safer minor injury service in Newtown**

The LHB and the local GPs have agreed to provide the Minor Injury service from the GP surgery. This means that minor injury patients are seen by nursing or medical staff more familiar with treating sudden onset of illness or injury. The opening hours of the surgery are well known, and because the service is based in a surgery rather than a 'hospital', patients will have a better understanding of the limitations of what can be provided, thus avoiding delays in calling an ambulance and getting to a District General Hospital (DGH) when it is necessary. The LHB, ideally with the support of the Community Health Council, should continue to publicise the new arrangements to ensure that patients are aware of the changes.

#### **2.2 Safer surgical services**

At the end of September 2007 the LHB agreed to discontinue all inpatient surgery in the two community hospitals that undertake surgery; Brecon and Llandrindod; pending advice and guidance on the future of safe surgical services. Day case surgery is continuing in the two hospitals.

### **Services that continue to give cause for concern**

The Board has yet to provide a safer MIU service for the people of Builth Wells. It has not proved possible to ensure safe arrangements for medical handover in Newtown: and isolated nursing services, and the lack of systems and processes to support assessment and diagnosis of changes in a patient's condition remain a concern.

#### **2.3 Minimal progress in providing a safer minor injury service for the people of Builth Wells**

In Phase 1 of the review we became aware of serious patient safety incidents occurring in the Builth MIU. The average number of minor

injury patients is very low; approximately one per day, but the GPs did not feel able to provide the service in their surgery. The clinical lead has suggested that arrangements should be made for the one patient per day to be treated in Llandrindod Hospital and this should be addressed without delay.

#### **2.4 Standards of nursing and medical care in Newtown Hospital**

A serious incident concerning a patient in Newtown Hospital, and the Coroner's comments concerning care, drew our attention to problems with the co-ordination of consultant, GP, and Out of Hours<sup>1</sup> medical care, and with the standards of nursing care. Furthermore this followed four previous serious incidents relating to unacceptable standards of care involving vulnerable patients.

Training has again been provided by the LHB for the nursing staff, and there is evidence of improvement in the standards of general nursing care, but it is too early to say whether the improvement is embedded.

A further incident has since occurred in Newtown Hospital, which resulted in a marked delay in correctly diagnosing an injury and transferring an elderly mental health patient to the District General Hospital. The unit only has 10 beds, and it does not have the systems and processes to support staff in assessing patients' injuries, that one would expect in a larger hospital.

More significantly, there has been a further incident in which an Out of Hours (OoH) doctor admitted a patient to Newtown Hospital and did not inform the consultant. Therefore the patient was in hospital over a weekend without the consultant being aware of her presence. This lack of handover between medical staff greatly increases the risk of failing to notice deterioration in a patient's condition, and was a key factor in the previous case.

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<sup>1</sup> Out of Hours on call GP services

## Phase 2 of the Review

### 3. The Approach

Phase 2 of the Review commenced in September 2007. It reviews patient safety and the management of clinical services in the following:

- **In patient services in community hospitals;**
- **Minor injury services;**
- **In patient mental health services;**
- **Consultant led community services.**

We report on the patient safety and clinical management issues for each service, and make recommendations.

#### 3.1 The process

Our **findings are based** on interviews and conversations with approximately 150 people, either individually or in groups, including Board members, members of the management team, GPs and consultants, clinical leads, matrons and senior nurses, the Powys County Council Board, the Chief Officers and representatives of the two Community Health Councils, representatives of the ambulance service, the voluntary sector, 'Shropdoc' the GP co-operative provider of OoH medical services in much of the county, and staff organisations.

We used the interviews and discussions:

- to brief individuals and groups on the outcome of Phase 1 of the Review including the patient safety concerns and action taken
- to gather further information on patient safety and the management of clinical services at the hospital / service level
- to encourage and facilitate discussion on potential future models of care in Powys

We thank everyone for the open and constructive way in which they have participated in this review. We were well received by all the groups we visited. People appreciated being briefed in person on the patient safety issues and the progress to date, and whilst not all agreed with the outline proposals for change in service management and / or location; they all valued the directness of the approach.

## 4. Context

The challenges faced by Powys LHB were described in the Phase 1 progress report. They included the LHB's dual commissioning and providing role which has proved to be extremely difficult; a sparsely populated county of 130,000 with a high proportion of elderly residents, and a tendency for people to identify themselves with one of the 15 communities rather than with the county, or indeed with the shires.

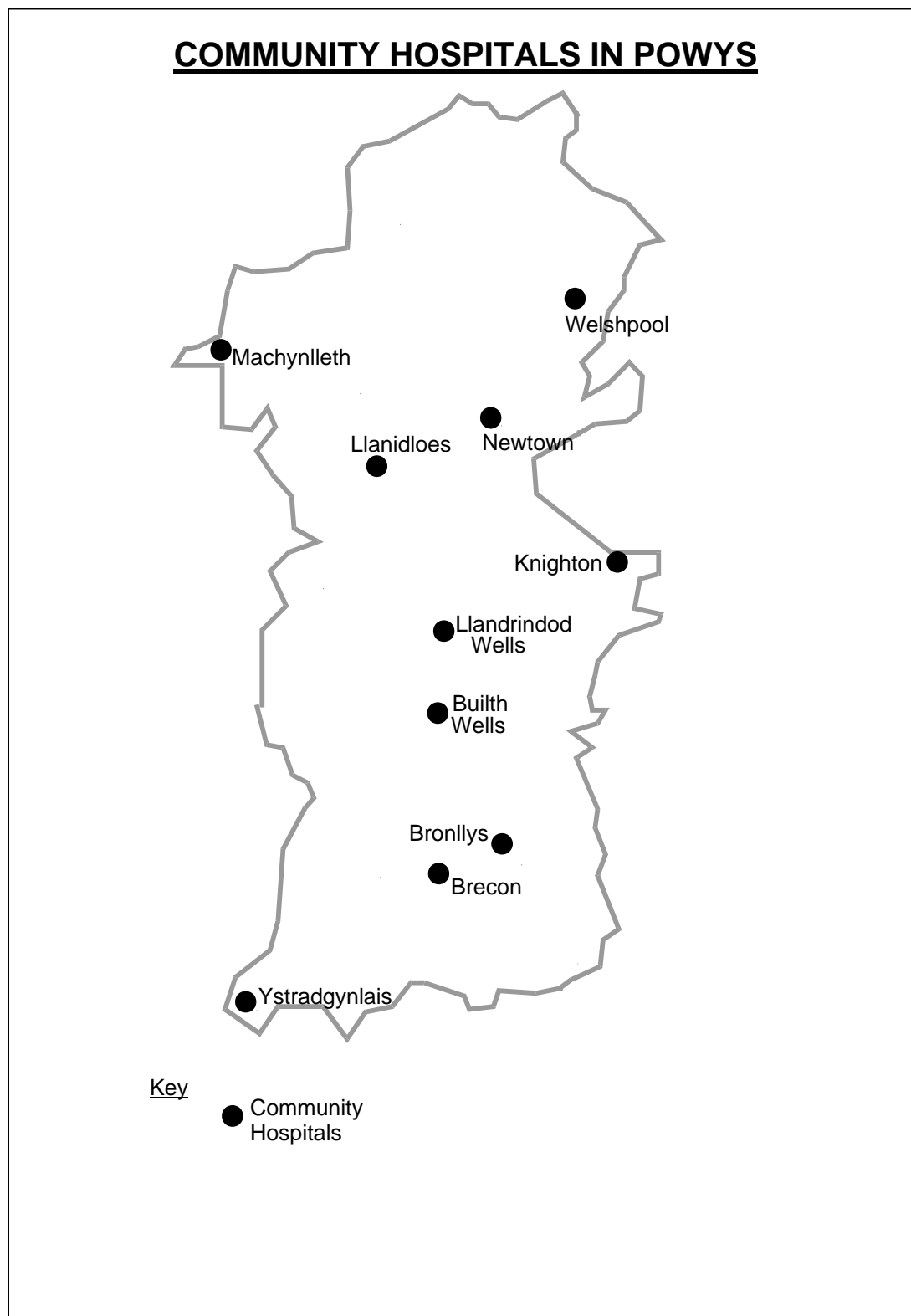
### 4.1 The Community Hospitals

There are no district general hospitals in Powys, but there are ten community hospitals.

- They have a total of 221 open general beds:
  - 116 beds are used by General Practitioners, and the LHB has service level agreements to the total value of £1.2 million with 10 General Practices to provide medical care for patients in those beds, from Monday to Friday in normal working hours. Medical cover in the evenings, nights and at weekends is provided mainly by 'Shropdoc', an Out of Hours (OoH) co-operative of GPs; many of whom are from Powys practices. The cost of the OoH service is in excess of £2 million. This includes OoH medical cover for the community hospitals and the GP service.
  - 105 beds are used by the Age Care consultants with medical care provided by three consultants. They are supported Monday to Friday by non consultant doctors and some GPs, and by the OoH service for the rest of the time.
- Seven of the hospitals have Minor Injury Units.
- In addition, there are 24 beds for people with acute mental health problems in Bronllys Hospital, together with 10 rehabilitation beds. And a total of 38 beds for older people with mental health problems between Brecon, Llandrindod, Newtown and Ystradgynlais Community Hospitals. Medical services for mental health in-patients are provided by six consultants.

### 4.2 Location of the hospitals

A map showing the location of the community hospitals is attached. Ystradgynlais can be found in the far south west of the county, and Machynlleth in the far north-west.



## Section 1 – In-patient services in Community Hospitals

### 5. **Wide variation in the dependency of patients in community hospitals**

One of the first points drawn to our attention was the wide variation in the seriousness of the conditions of the patients admitted to the community hospitals by GPs. The patients range from those who are acutely ill to those who do not need to be in a hospital.

For the purposes of this report, an example of an acutely ill patient would be a patient with pneumonia, possibly requiring intravenous antibiotics and hydration; and patients who cannot be described as medically stable, and therefore require access to 24 hour hospital medical care.

Below we describe the different levels of care provided in Powys hospitals.

#### 5.1 **Powys hospitals caring mainly for patients admitted for social reasons or for nursing care**

Some GPs told us that they no longer admit patients requiring 24 hour hospital medical care. Instead they only admit patients requiring nursing care, or patients the GP believes should be admitted for social reasons. The **Builth** Clinical Lead told us that his practice has consciously made this decision in the interests of patient safety.

The GPs in **Llanidloes and Knighton** are very committed, but recognise the limitation of the medical cover available, of diagnostic services, and the isolation of their units, and therefore have moved towards admitting patients, whose needs can be met with 24 hour nursing care rather than medical care. There is no consultant service in these hospitals.

#### 5.2 **Powys hospitals with GPs caring for acutely ill patients in collaboration with consultants**

In **Bronllys and Llandrindod** the GPs work closely with the consultant in elderly care, and if patients are acutely ill the GPs tend to transfer the patient to the care of the consultant. The GPs themselves provide medical care for the nursing care level patients.

Some anaesthetics and endoscopies are carried out by General Practitioners in Llandrindod.

### **5.3 Powys hospitals where the GPs care for acutely ill patients themselves**

There is no consultant service in **Welshpool** and the GPs admit and care for **acutely ill** patients themselves, for example, patients with pneumonia requiring intravenous antibiotics and hydration. They also care for nursing care level patients.

Welshpool has an endoscopy suite and the procedure is carried out by a GP and by visiting consultants.

In **Brecon**, there is a consultant Age Care service, but the GPs tend to admit and care for **acutely medically ill** patients themselves, including those requiring intravenous therapy, only referring to the consultant those patients likely to require a long stay.

**Surgery and anaesthetics** are undertaken in **Brecon Hospital by GPs**, some in collaboration with external consultants, and some by the GPs themselves. Anaesthetics are given by one of the GPs and, separately, by visiting consultants.

In **Machynlleth** hospital there are some acutely ill patients and the GPs tend to look after all their patients themselves.

### **5.4 Powys hospitals where all patients receive consultant led medical care**

In **Ystradgynlais** and **Newtown Hospitals** all medical care is led by the age care consultants, with support presently provided by GPs. In Newtown the patients have been predominantly social and nursing care patients, but there are some acutely ill patients.

### **5.5 Patients transferred back to community hospitals from District General Hospitals**

Patients are transferred back to community hospitals from District General Hospitals to complete their recovery, some of whom were said to have been transferred rather too soon, given the level of care that could be provided.

## **6. Acutely ill patients and patients requiring access to 24 hour hospital medical care**

First we will consider the care of the acutely ill patients; patients transferred to community hospitals from District General Hospitals, and surgical patients.

All acutely ill medical patients and surgical patients in the NHS could normally expect their care to be provided by a consultant and his or her team providing 24 hour medical cover, with access to diagnostic, therapy and support services, to ensure safe standards of care.

### **6.1 The lack of appropriate medical care for acutely ill patients in Powys community hospitals**

In **Welshpool** and **Brecon** the care of acutely medically ill patients is not consultant led. Many of the GPs providing care have developed additional skills, and they are very committed, but nevertheless one would expect them to be part of a consultant led team which they are not. And their involvement is limited to the normal working day, Monday to Friday; some 40 hours per week. The remaining 128 hours are covered by the Out of Hours service.

### **6.2 The lack of appropriate hospital medical care for acutely ill patients in the evenings, at night and at the weekend**

The acutely ill medical patients in all the community hospitals are dependent for their medical care at night and at the weekend, on a GP Out of Hours (OoH) service. The main service provider, Shropdoc, is a provider of OoH on call GP services, but it does not undertake to provide skills above those expected of a 'normal' General Practitioner. Therefore the acutely ill in-patients do not have access to the level of medical care that they need for some 128 hours of each week.

### **6.3 Some OoH doctors lack technical skills and experience**

Frequently, the OoH GPs are from the locality and experienced in providing community hospital care, but this cannot be guaranteed. There have been difficulties, for example, patients with blocked intravenous lines, when neither the nurse nor the on call GP had the skill to replace the line. Nearby paramedic ambulance staff are sometimes asked to come into the hospital and set up an intravenous line. Other examples include; patients being transferred at night to a DGH when a small stitch was required; a reluctance on the part of the OoH GP to complete hospital admission notes, and an understandable reluctance to prescribe drugs not familiar to them, but regularly used in the hospital. The last two examples leave nurses in a difficult situation.

#### **6.4 Difficulty in the medical 'Handover' of patients to the OoH service**

Handover of patients to whoever will provide medical care out of hours cover has become a very important issue in all hospitals. The General Medical Council has provided very firm guidance in the most recent edition of 'Good Medical Practice.'<sup>2</sup> Senior Shropdoc staff are aware of this but admit that 'there is not an easy answer to doing it well.'

There have been a number of incidents associated with inadequate handover, including the one leading to marked criticism by the coroner, and we remain concerned that this continues to be a very significant area of risk.

#### **6.5 GP accountability poorly defined**

General Practitioners are independent contractors and those working in the community hospitals do not have a well defined line of accountability to the LHB. Service Level Agreements (SLA) between the practices and the LHB are in place but they do not specify the level of accountability, nor the level of involvement expected.

In consequence, the GPs who admit patients to the hospitals have widely varying interpretations of their accountability and required level of involvement.

In one of the hospitals a GP from the Practice spends a whole morning seeing every patient, whereas elsewhere a GP would 'pop in for a couple of minutes'. In the absence of written contracts or agreements to define the level of involvement, it is difficult to seek to improve the service where this is needed.

### **Conclusion**

Acutely ill patients should be cared for by an NHS trust consultant led team, providing 24 hour medical cover, and supported by a health service infrastructure for acute services. This would support patient safety through access to diagnostic services, acute service back up, and the monitoring of standards. We believe the provision of services by NHS trusts will allow the current GPs and other local staff to contribute fully to the service within a framework that will support them and their development.

GPs currently in training are unlikely to have the skills to contribute to the care of acutely ill patients in hospitals, and therefore the longer term provision of these services will be more secure in the hands of NHS trusts.

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<sup>2</sup> General Medical Council, 2006. Good Medical Practice.

## **7. Surgery in Brecon and Llandrindod community hospitals**

There has been a long tradition of operative surgery, gynaecology and, more recently endoscopy, being undertaken in Brecon and Llandrindod hospitals. Much of the operative work and general anaesthesia has been undertaken by GPs with special experience, employed by the LHB for these surgical sessions. Consultants from Gwent, North Glamorgan, and Hereford NHS Trusts have also been involved in the operative work.

A series of surgical incidents were drawn to our attention in Phase 1 of the Review.

In our interim report we noted that all surgery should be consultant led; that the complexity of running modern theatres has increased in recent years and therefore theatres should be managed by an experienced anaesthetic or surgical directorate; and that surgical in-patients should have access to 24 hour anaesthetic and surgical staff, because even the most routine surgery can give rise to post-operative complications.

The Local Health Board responded promptly, and made the services safer by limiting surgery to day surgery.

### **Moving forward**

It will be essential in the future for surgery to be provided by NHS trusts experienced in managing surgery, anaesthesia, and operating theatres that can subject surgery in Brecon and Llandrindod to the same safety, risk, and quality criteria as in their own hospitals.

It would be for any trust managing these services to be sure of what can be safely provided, but within those parameters there is the potential to increase appropriate activity.

We believe the provision of services by NHS trusts will allow the current GPs and other local staff to contribute fully to the service within a framework that will support them and their development.

GPs currently in training are unlikely to have the skills to contribute to the care of acutely ill patients in hospitals, and therefore the longer term provision of these services will be more secure in the hands of NHS trusts.

## **8. The Community Hospital Age Care Consultant Service**

There are three Age Care Consultants and they use a total of 105 beds in six hospitals. The hospitals are Bronllys, Llandrindod, Ystradgynlais, Brecon, Newtown and Machynlleth.

### **8.1 Medical cover**

The Age Care consultants and the GPs who assist them are very committed and provide a range of services to older people, including assessment, in-patient care, rehabilitation, and open access. Their services are held in high regard. The consultants provide cover out of hours but the geography means that this usually can only be telephone advice. They rely on the OoH GP service for any direct medical care that patients may require.

### **8.2 Fragility of the service**

The consultants themselves recognise the fragility of their services. They depend on retired colleagues and good will for cover during leave periods. There have been long periods of short term locum cover, and the non consultant staff are not formally linked into a wider NHS team. There are staff shortages, particularly therapy staff, and there are no nurse practitioners who, the consultants believe, could make a significant contribution to the Age Care service.

### **8.3 Consultants views on future provision of the service**

The consultants have drafted some reflections on the 'future provision' of the Age Care service. They said that, community hospitals are now meeting much less of patients' medical needs than in the past, and this trend towards more reliance on District General Hospital type care is likely to continue with further medical advances.

They acknowledge the difficulty of recruiting suitable medical staff in the future, and accept the need for a reduced number of inpatient hospital sites, but draw attention to the need for rehabilitation services.

They foresee the need for a, Community Geriatrician in the future to work with patients in the community and care homes rather than in hospitals as they do now.

They suggest that the service should be more community orientated with an emphasis on health promotion and rehabilitation for older people in collaboration with social services, and they refer to the Rhayader Home Support model, as good practice.

**Conclusion**

We support the Age Care consultant's views that the service should develop a stronger community focus in closer collaboration with social service colleagues. We recognise the consultants' total commitment to the service in Powys, and wish to build on this model, such that their services become part of the local Rural Health, Rehabilitation and Social Care Centres described later in this report. However, if their service is to continue it needs to be provided by NHS Trusts. This will ensure that they have the infrastructure to support patient safety and 24 hour care, and it is the only way that the fragility of the service can be overcome.

In addition, NHS trusts would provide medical staff with a directorate structure and more sustainable arrangements for leave and development, and trusts would be more likely to attract therapist staff in particular.

**9. The Nursing Services in Community Hospitals**

The nursing service in the community hospitals has developed considerably in the last year or two. There is regular audit of nursing standards and improvement in leadership in some hospitals. However, a number of incidents continue to occur. These, are at least in part, due to the challenges that remain.

The spread of the in-patient service across 10 hospitals leads to low throughput, minimal pressure on beds, and slow turnover; which in turn leads to a reduction in skills, and, in the ability to recognise deteriorating patients.

Nursing skill mix and staffing are not optimum, and sickness absence is high. Staff may have difficulty being released for training, and flexibility to cover sickness absence is reduced, leading to reliance on temporary staff.

These factors combine to create a fragility of service prone to intermittent closure. Thanks to the flexibility and willingness of the staff to cover, there is minimal disruption.

**Conclusion**

The current situation of 10 nursing workforces spread thinly over the county is not sustainable, and places nurses in an unacceptable position. There is too little experience for nurses to maintain the wide range of skills expected of them; from acute emergency care to the rehabilitative care of the elderly. In order to develop their skills, nurses providing acute care need to be part of an acute care directorate outreach from an NHS Trust, whilst nurses providing rehabilitative care and nursing care to the elderly need to be based in the community or in care homes.

## 10. The therapy services in the community hospitals

The high proportion of elderly residents in Powys means that re-ablement and rehabilitation services, based as locally as possible, are essential for maintaining independence and mobility.

There is a committed **physiotherapy and occupational therapy** service available in many of the communities, and they provide excellent services; but because of the small number of these staff, sickness when it occurs causes a major problem and some services may have to be suspended.

The **Speech and Language Therapy** is essential for people with swallowing difficulties, as well as people with speech and language difficulties. This important service is inadequate at the present time due to staff shortages, and recruitment has been difficult for some time. Last year there was no service in parts of the north of Powys.

### Conclusion

The therapy services need to be developed and secured. Given the wide geographical spread of Powys and the relatively small number of staff this may be best secured by recruiting and retaining the staff through neighbouring NHS trusts, but basing them in communities. Alternatively, if rapid progress is made in developing different models of community care, there could be a case for employing them locally.

## **Recommendations relating to the care of acutely ill patients, surgical patients, Age Care Consultant patients, and patients transferred from District General Hospitals to Community Hospitals in Powys**

- 1. We strongly recommend that arrangements are made for clinical in-patient services for acutely ill patients, surgical patients, Age Care Consultant patients, and patients transferred from District General Hospitals to Community Hospitals in Powys, to be provided by NHS trusts as soon as possible.**
- 2. In the interests of clinical governance and patient safety, all the acute clinical services in an individual community hospital should be provided by a single NHS trust.**
- 3. In order to provide sufficient nursing and medical cover to support patient safety, the number of hospitals providing acute care should be reduced as soon as possible, consistent with effective public engagement. The total number of Powys patients requiring acute care in these groups could be accommodated in one centre, but the distances in Powys would suggest at least two, and possibly three, centres; as well as separate provision for the people of Ystradgynlais and Machynlleth. The centres would provide the optimum location for the 'Home from Home Birth Units' referred to later in this report.**

As we say elsewhere in the report, the public will need to be engaged in considering the model of service provision in Powys, and the staged transition, but in the interim, we recommend that;

- 3.1 The acute services in the two hospitals in south Powys, Bronllys and Brecon, should be provided by one trust and services in the two hospitals in north Powys, Newtown and Welshpool, should also be provided by one trust, to permit fusion over time.**
  - 3.2 In the case of Ystradgynlais and Machynlleth, we recommend that arrangements are made for acute services to be provided by NHS trusts near to those hospitals. Machynlleth already has strong links with Aberystwyth.**
- 4. In the interests of patient safety, the trusts commissioned to provide the services for these groups of patients in Powys should employ the staff providing the services. This will ensure clear lines of accountability and have the benefit of giving staff a larger peer group, more opportunities for continuing professional**

**development; cover when they are on leave, and should improve recruitment and secure staffing for the services. In the case of GPs, this will mean employment for their sessional commitment to the service.**

- 5. We recognise that these recommendations may cause anxiety to current members of staff. Therefore, we recommend that the LHB should fully engage with staff in shaping the future model of care consistent with safe services, and at the same time work closely with the relevant staff organisations and trade unions.**

We acknowledge that some NHS trusts might find the challenge of providing services in relatively small centres unattractive. Therefore, taking these arrangements forward is likely to require the support of the Welsh Assembly Government.

## **11. Patients who do not need to be in a hospital**

We move now to consider the patients who do not need to be in a hospital

From the information given to us by consultants, GPs and senior nurses, we estimate that **at least half of the patients in the community hospitals do not need to be in a hospital**, and would not be admitted to a hospital if they lived in another county. Instead their needs would be better met through support in their own home, or if necessary, through short or longer term admission to a care home.

These patients may be found in all the community hospitals and we readily acknowledge that in many instances the admission is well intentioned, and would have been more usual in the past. But admission to hospital has been shown not to be in the best interests of elderly patients, and today, health services seek to avoid admission if at all possible.

### **11.1 The reasons given for admitting the patients**

#### **Social reasons**

Some patients are admitted for social reasons, meaning that they could have remained at home and been visited by their GP; if they had family or short term community support. This group of patients includes elderly people living alone with a short illness such as a chest infection.

#### **Nursing care**

Others are admitted because they need nursing care, which, in other areas, would be provided at home by the district nursing team with community support, or if necessary, in a nursing home.

#### **Admissions for diagnostic tests**

And still others are admitted for tests, most of which could be carried out in a GP surgery or in a modern primary care centre nearer to the patients home; or in the case of tests such as X rays, as an outpatient at the hospital.

### **11.2 Need for adequate transport**

Attending as an out patient would require adequate patient transport, which we were told is not always available. But we were also told that in parts of Powys, ambulances are used to take patients to hospital for blood tests, which could be carried out in a GP surgery. Providing the tests locally would make more ambulances available.

### **11.3 Admission to a hospital should be avoided if possible**

Admission may make the carrying out of tests and the regular visiting of elderly people easier for their doctors or nurses, but in today's health service every effort should be made to avoid admitting elderly people to hospital if possible. Admission has been shown to cause elderly people to become disorientated. It seldom solves their problems, and the longer they stay the more difficult it can be to enable them to return home again to independent living.

### **11.4 Perverse incentive to keep beds full**

We are concerned that in a number of hospitals there appears to be a perverse incentive to keep beds full, seemingly to justify the existence of the hospital.

We were told that it was difficult to find any reason why some patients had been admitted to some hospitals or why they were kept in hospital when they were ready to go home. A reliable source told us that not a single patient in a hospital that day needed to be there. We were given data to show that the length of stay in one hospital has doubled in the last 10 years. And we were told that nurses were asked to keep beds full in some hospitals.

This is unacceptable.

### **11.5 The challenge of providing services for elderly citizens and others in rural areas**

We appreciate that in rural areas where community services are under developed, and short term care is not always available, the community hospitals have provided a valuable service in the past and have traditionally filled this gap. Furthermore there is great attachment to the buildings themselves, but this attachment may now be holding up the development of modern Rural Health, Rehabilitation, and Social Care Centres, that could benefit both the elderly and the younger residents of rural communities.

The community hospital beds in Powys cost approximately £2000 per week. The Wales average cost for a rehabilitation bed in 2006 in a District General Hospital was approximately £1400. The nursing home that currently provides beds to Powys GPs costs approximately £700 per bed per week. Transferring the care of those patients who need nursing care to a care home setting would provide the patients with a better environment, and release resources to develop extended local health, rehabilitation, and community care services to benefit all members of the community.

## **11.6 The citizen model and independent living in the community**

An outline proposal for service development jointly drawn up by GP Practice representatives from Llanidloes, Hay and Talgarth, and Builth and Llanwrtyd refers to 'The Citizen Model'. This is taken from the 'Making the Connections – Delivering Beyond Boundaries'<sup>3</sup> report on transforming public services in Wales, and it requires organisations to focus 'on outcomes for the citizen'.

Most 'citizens', including elderly people, prefer to be independent and to remain in their own home if at all possible, therefore health and social care services should support the citizen in their own home rather than turning them prematurely into a patient, by admitting them to a hospital.

## **11.7 Providing a full range of local health and social care services to rural communities** **- A Rural Health, Rehabilitation and Social Care Centre**

As much health, assessment, rehabilitation and social care should be provided as locally as possible.

This means developing services in the community and building capacity around health and community care centres. For the purposes of this report we will call such a centre a 'Rural Health, Rehabilitation and Social Care Centre'. The centre would combine GP services, the taking and collection of samples for diagnosis, re-ablement and ambulatory rehabilitation services, and sufficient district nursing, therapy, and community support services to enable people to remain in their own homes as far as possible. The Age Care Consultants could make an important contribution to the service.

In addition, the centre should provide services for specific patient groups such as patients with diabetes, chest diseases, cardiac disease, mental health problems, etc; and consultant clinics, to reduce the need for patients to attend the District General Hospital for out-patient appointments.

## **11.8 Need for community support or access to short term beds**

The GPs go on to recommend the need for acute short stay nursing home beds. We recognise the difficulty faced by GPs visiting elderly people who live alone and cannot look after themselves during, for example, an episode of illness such as a chest infection.

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<sup>3</sup> Welsh Assembly Government, 2006. Making the Connections – Delivering Beyond Boundaries.

Ideally the GP should be able to ask for short term community support to enable the person to remain at home during the illness, but if that is not possible, patients may need access to short term care beds. These should be as near to the patient's home as possible, and are likely to be in a care home.

This model already exists in Llangattock where the GPs have access to this type of bed.

The admission should be short term and time limited. If a patient is not well enough to go home after 5 days they should be properly assessed by a consultant or therapist member of the Age Care consultant service.

### **11.9 Care home provision**

If it becomes necessary to admit people to a care home, this should be as near to their local community as possible. Currently there is limited care home provision in Powys. This is an opportunity to develop modern care home facilities that can provide differing levels of care, from low levels of nursing care to intensive nursing care. Beds for local people with dementia should also be considered, to enable them to remain in their communities. Such a home is usually provided and managed by the County Council or by a private provider, but we recommend strong links to the Rural Health, Rehabilitation and Social Care Centre.

### **11.10 Palliative care**

Some GPs made particular mention of the need for community hospitals beds for palliative care. This needs careful consideration since the aim of modern palliative care is to provide as much care as possible in the home, and indeed Powys does provide home based palliative care for patients. The requirement for in patient care should be small and could be provided in the intensive nursing care beds described above.

### **11.11 The way forward**

The paper produced by the GPs states that active involvement with Powys County Council is required to develop a sustainable model for each community, and we fully endorse that view. The LHB should engage the County Council, local communities and GPs in determining the future model of health and social care in each community. Once models have been agreed, the changes will take time to implement, with some communities ready to move forward before others.

Good progress is already being made in Builth Wells and we strongly recommend that a similar exercise of engagement should begin as soon as possible with the people of Llanidloes and of Knighton, to consider how best to move towards a model of rural health care that will benefit everyone.

Taking these ideas forward will require the interest and support of the General Practitioners. The GPs in Llanidloes are very interested in working with the LHB and the County Council to develop a re-ablement and rehabilitation service, and other services based locally. Llanidloes could therefore be a useful pilot for the development of a Rural Health, Rehabilitation and Social Care Centre. It already has the benefit of in-reach consultant clinics from NHS trusts in obstetrics and gynaecology, ophthalmology, orthopaedics, paediatrics, and oncology.

Equally we understand from community representatives that Knighton is interested in developing a modern approach to local rural healthcare.

### **Recommendations to meet the health and social care needs of the local community including the people who do not need to be in a hospital**

- 6. The LHB should work with the County Council to engage local communities and the General Practitioners in determining the future model of health and social care in each community. The model should provide the fullest range of health and social care services locally, and enable people to remain in their own homes as far as possible, with access to local care home beds when needed.**
- 7. The LHB may need to review its capacity to lead engagement with its communities towards new models of care, and if necessary increase that capacity.**

## Section 2 – The Minor Injury Services

### 12. Past reviews and incidents in the Minor Injury Units

A number of serious patient safety incidents in Minor Injury Units were drawn to our attention in Phase 1. And we noted that there have been previous reviews of MIU services in 1997, 2000 and 2002. All identified patient safety concerns and long standing low attendance in most of the units.

#### 12.1 Low attendances confirmed – staff unable to maintain skills

We have now reviewed data from the seven remaining Minor Injury Units in Powys, and can confirm that all have low attendances, with only Brecon having an average of more than 10 new minor injury patients a day in 2006/7; sufficient to enable an emergency nurse practitioner to maintain skills.

However, the majority of units have become an extension of the primary care service, providing services normally undertaken in GP surgeries, for example, ECGs, dressings, blood tests, etc., and this takes up most of staff time.

Builth, Llanidloes, and Machynlleth have an average of up to 2 new minor injury patients per day and are not sustainable as stand alone MIUs. The other units; Ystradgynlais, Llandrindod, Newtown and Welshpool see between 3 and 8 new patients per day.

Such low attendances mean that staff cannot maintain their skills. Most of the nurses providing the MIU service normally staff the wards and are skilled in care of the elderly, and asking them to change to MIU nurses, increases the risks for the nurse and her patients. Furthermore, the ward is frequently left short staffed while nurses attend to patients in the MIU, again increasing the risk to patients.

#### 12.2 The LHB consultation on the future of Minor Injury Services

The Board is currently engaging with the public to determine the future model of MIU services, and intends to take proposals to the Board in May, and to consult formally in June, July and August.

In the light of these findings, and in the interest of safe services, we believe this is an area where the Board needs to make rapid progress.

**Recommendations for providing safe minor injury services in the smaller units; for engaging the public on the future model of service outlined in this report to include Minor Injury Services, and for revisiting primary care services**

**8. We invite the Board to reconsider its position in relation to the MIU consultation, and in the interests of safe services, to proceed at once to ask General Practices in Llanidloes, and Machynlleth to provide the MIU service to their communities. We understand discussions are already underway with the GPs in Ystradgynlais, and arrangements should be made to secure a safe service for the people of Builth Wells in Llandrindod Hospital.**

**9. We strongly recommend that the public are given information on why the serious incidents occurred in the Minor Injury Units and why those risks continue, and that the opportunity should be taken to engage the public on both the future of the MIU services and the recommendations in this report for acute services to be provided by NHS trusts in two or three locations.**

**10. We recommend that the Board engages GPs in agreeing arrangements for the provision of primary care services so as to avoid the risks associated with ward staff leaving patients to provide these services.**

The CGSDU is willing to meet with additional communities and stakeholders to explain the seriousness of the patient safety issues, and the rationale and necessity for change.

## Section 3 – Mental Health Services

### 13. The in-patient services

The in-patient services comprise 34 acute and rehabilitation mental health beds in Bronllys Hospital, and 38 in patient beds for older people with mental health problems including dementia, in Brecon, Llandrindod, Newtown and Ystradgynlais hospitals. Newtown is currently closed to admissions.

#### 13.1 Medical care

The in-patient services are supported by an establishment of five consultant psychiatrists for adults, and two consultants for older people, although these numbers have been affected by long term ill health and vacancies, necessitating the frequent use of locum consultants. Some consultants are based in the north of the county and some in the south, and given the small numbers this makes the service very fragile.

The service in Bronllys is supported by doctors in training, with the consultants on call for advice only. This is not satisfactory, but we understand the explanation that the distance makes it impossible for a consultant on call in the north to travel to the south and vice versa, because of the distances.

#### 13.2 The geographical spread – a problem for patients and staff

The huge distances between the north and the south of the county present problems for patients and staff. For example, an older person sectioned under the Mental Health Act in the north may have to be taken to Bronllys to be seen by a junior doctor and then be taken back to the north.

Similarly, when there are no beds in the south, patients from Brecon can be sent to Shelton in Shrewsbury, rather than for example, Gwent, because the LHB has a contract with Shelton.

But conversely the local police force has declined to accept Shelton as 'a place of safety' for patients in the north, because it is in the West Mercia police force area. Therefore patients have been brought south to Bronllys.

Distance affects staff as well. When a mental health manager has to meet staff in the north, the journey takes 2 hours each way.

### **13.3 The Bronllys Unit**

The Unit is busy and is frequently short of staff and bank and agency staff are employed, which is known to increase risk. There is a view that not all the patients need to be there, and some psychiatrists are said to have high admission rates. Delayed transfers of care are also a problem and some of the rehabilitation beds have been blocked for a very long time, which means that patients cannot be discharged from the acute unit.

The 2002 report noted that staff in Bronllys appeared isolated and were reluctant to visit and / or work in other units. Since then there has been a serious incident of a suicide and the coroner was very critical of senior management and the standards of care.

The management team has recognised the affect that this had on staff and has provided training and support, but we continue to note a very defensive attitude to questions relating to practice. Many of the staff came from hospitals that have closed and we were told that they do not really feel part of the LHB. There appeared to be a lack of a sense of direction, and we were told that nothing moves forward.

### **13.4 In patient services for older people with mental health problems**

These are very small units with no more than 10 beds in each of the four hospitals. It is extremely difficult for staff in such isolation to develop modern care for patients with dementia and other mental health conditions, in some cases despite best efforts. This may in part account for the incidents of poor treatment that have occurred in one of the hospitals.

## **Conclusion**

The challenges of distance, medical staffing, the on call arrangements and the supervision of junior doctors, the shortage of nursing staff, the isolation of the services, and the need for clinical leadership to develop new patterns of care and take the adult and older people's mental health service forward, cannot be met by the LHB.

## **14 The Community Mental Health Service**

Modern psychiatry has a much greater emphasis on community mental health care, and a collaborative approach with the County Council is essential.

New approaches to providing mental health care in the community are being developed in Powys and we were told of very effective joint working with social services in relation to older people's mental health services, although more progress needs to be made in relation to joint working for adult mental health services.

The community mental health teams vary widely, of necessity, to reflect the culture of the population they serve, for example, the needs of a valley post industrial society in Ystradgynlais, and the needs of a rural community in Welshpool.

There are benefits to all staff, doctors, nurses, and allied health professionals being employed by secondary care mental health providers so that there are clear lines of accountability and participation in those organisations' appraisal and patient safety and quality of care activities.

Equally we appreciate the need for partnership working with the County Council and therefore a case could be made for some non-medical staff to be employed by a community mental health service provider.

### **Recommendations for the provision of mental health services**

- 11. As with acutely ill patients, mental health patients in Powys deserve the same level of service as elsewhere in the NHS. Therefore, consistent with our earlier recommendations, the acute mental health service for adults and the mental health service for older people, should be provided by experienced secondary care mental health providers. In our view the geographical issues will necessitate the involvement of more than one provider. They should be capable of re-invigorating the service, providing the staff with development opportunities and taking the service forward.**
- 12. The LHB should explore options for the effective management of community mental health services that will promote best practice and patient safety.**

## Section 4 – Consultant led community services and maternity services

### 15 Community paediatric services and children's services

The consultant led community paediatric services have problems of isolation and limited infrastructure.

Powys LHB provides community based consultant led children's services. The two paediatric consultants are based, one in the north and one in the south of the county. They are 50 miles apart and work largely alone.

The consultant in the south provides the Named Doctor child protection service for the whole of Powys as well the community paediatric service to south Powys. One of the consultants had links with Neville Hall Hospital until 4 years ago. The other is newly appointed and has links with Wrexham Hospital for continuous professional development purposes but neither consultant is part of a wider paediatric directorate. The newly appointed consultant has no staff grade support, and limited nursing support. Originally there were two staff grade doctors, but that is no longer the case.

The volume of work is said to be overwhelming and it is not possible to complete all the tasks, and the lack of Speech and Language Therapy staff adversely affects the children's service.

As well as the problem of providing community paediatric services to such a difficult geographical area with limited infrastructure there is a particular problem of an exceptionally high number (nearly 300) of Looked After Children (LAC) resident in homes and schools in the county. The majority of these are referred from outside Powys including many from England.

The exceptionally high number of LAC children is a concern to the Safeguarding Children Service as well. A second LAC nurse has recently been appointed, but the service is overstretched.

#### Conclusion

We do not believe that it is appropriate for consultants to work in isolation.

Being dependent on two geographically isolated consultants makes this service very unstable. We understand the need for the service to have close links with the local authority and social services, but believe that the medical staff should be employed and managed within one or more NHS trusts. The trusts should have paediatric directorates and well established patient safety

and quality of care structures, as well as capacity to provide continuous professional development and cover for leave and absences.

### **Recommendation**

**13. The paediatric community service should be provided by one or more NHS Trusts, and the consultants should be employed by the trusts within a directorate managing other consultants in paediatrics.**

## **16. Child and Adolescent Mental Health Services**

A high proportion of the LAC children have challenging behaviour, and many require Child and Adolescent Mental Health Services (CAMHS).

CAMHS services are isolated and equally fragile. There is one consultant in the north providing seven sessions, and a locum consultant in the south, with limited infrastructure.

### **Recommendation**

**14. The Child and Adolescent service should be provided by one or more NHS Trusts, and the consultants should be employed by the trusts within an appropriate directorate.**

## **17. Maternity Services**

The maternity service in Powys is midwifery led. It is well established and enjoys a national reputation at the UK level for good practice. The midwives link with the obstetricians in the neighbouring trusts around the county, and the obstetricians from those trusts hold antenatal clinics in Powys. The women of Powys are therefore not disadvantaged, and enjoy a high level of service from the two professions specific to the maternity service, working in partnership across boundaries; and the midwives link with General Practitioners to keep them informed of progress.

The service demonstrates what can be achieved through collaboration with District General Hospitals (DGH). Powys women receive most of their care locally from midwives and visiting obstetricians. If it is safe, they are given the option of having their babies at home or in a 'Home from Home Birth Unit'; so called so as to avoid giving women the impression that these are hospitals. Alternatively, women may choose to have their babies in the DGH, and in most cases return home soon after to the care of the local midwife.

The midwives regularly update their skills by working in the link obstetric units, in NHS trusts. Without this regular contact there would be a danger of isolation and the potential loss of skills.

Practice and outcomes are regularly audited and the midwives have the benefit of supervision.

The midwifery service has been effectively managed by the LHB together with District Nursing and Health Visiting. Quality of care in all three services is monitored. The district nursing service cares for some 300 patients in their homes, many of whom are more dependent than the patients in community hospitals.

### **Recommendation**

**15. We recommend no change to the management of the midwifery, district nursing or health visiting services. The good practice of monitoring standards and outcomes of care should continue.**

## **18 Overall conclusions**

Overall, we found the provision of safe services for patients in community hospitals to be compromised, for the following reasons;

- The lack of consultant cover or oversight for those patients in the care of General Practitioners
- The lack of appropriate 24 hour on site medical cover for acutely ill patients, surgical patients and consultant patients in Community hospitals. The Out of Hours medical cover is currently provided by a service established to provide primary care not acute hospital care.
- The lack of infrastructure to support secondary care patient services, for example diagnostic and support services.
- The fragility of services that cannot be sustained in the long term, for example; exceptional personal commitment on the part of some staff to maintain services, and reliance on retired medical staff to cover annual leave.
- Numerous centres and small populations leading to difficulty in sustaining a critical mass of staff to support the service, especially the smaller staff groups such as therapists.
- Relatively few in-patients and low attendances spread across 10 small hospitals, making it difficult for staff to maintain expertise or acquire experience in some specialties such as MIUs.
- Relative isolation of some groups of professional staff from their peer groups.
- High levels of sickness absence in many units. All leading to fragility of services.
- A geographic spread that makes it impossible to run some services effectively as one. For example, mental health services, where the consultant on call could be in the north of the county, whilst the patient is in the south – a 2 hour drive away.

The majority of these reasons became apparent from the range of clinical incidents drawn to our attention in Phase 1 of the Review. During Phase 2, a further series of incidents and concerns have been brought to our attention, notwithstanding the tremendous effort made by staff to provide high quality services.

We have confirmed the low attendances, the fragility of staffing, the difficulty of providing services across such a wide geographical area, and the adverse impact of a lack of secondary care infrastructure on the safe delivery of secondary care services, in particular appropriate medical cover. These we believe are contributing factors to the incidents that have occurred.

## **19 Looking back**

Community Hospitals have made a huge contribution to the health and welfare of the people of Powys during the last century, and in some cases the century before that. But they now find themselves unable to meet the standards that people rightly expect from a modern health care service.

They are trying to provide two extremes of service. On the one hand, some hospitals are trying to provide services for the acutely ill, without the appropriate medical care and infrastructure that such care requires.

On the other hand the hospitals have been trying to meet the needs of elderly residents, who could be supported in their own homes, or if necessary, in a care home. And because the hospitals have been filling this gap, more appropriate services such as extended primary and social care centres with access to beds have been slow to develop.

We recognise the energy that has gone into seeking to preserve the health service in Powys as it is, and we appreciate that in the absence of clear alternatives, people will want to hold on to what is there. But that has led to delay in moving forwards in Powys, and means that many elderly people, who could by now have better home based services, are still being admitted to hospital; and some acutely ill patients continue to be at risk in community hospitals.

## **20. And looking forward**

Our recommendations to the LHB consist of three levels of service; the District General Hospital level, the Intermediate Centre level, and the local Rural Health, Rehabilitation and Social Care Centre level.

### **20.1 District General Hospitals**

Patients requiring more complex medical or surgical inpatient or diagnostic care, or emergency care will continue to receive that care in neighbouring District General Hospitals.

## **20.2 The Intermediate Care Centres**

We recommend the development of two or three centres in Powys for intermediate care with services provided by NHS trusts. These will provide services for appropriate acutely ill patients, surgical patients, and age care consultant patients; presently cared for in Bronllys, Brecon, Llandrindod, Welshpool, and Newtown Hospitals. In addition, the centres will provide Minor Injury Services, as well as a full range of out patient, diagnostic and rehabilitation services.

We recommend that neighbouring trusts are approached to provide services to the people of Ystradgynlais and Machynlleth, given the distance from central Powys.

## **20.3 Rural Health, Rehabilitation and Social Care Centres**

The third part of the model is designed to provide as much care as possible locally. The services within the Rural Health, Rehabilitation and Social Care Centres would have to be agreed locally, but are likely to include GP services, rehabilitation services, district nursing, community support, and out reach consultant services; plus locally based care home beds both for short term and longer term care.

If such a model were adopted, the people in the more isolated areas, for example, Knighton and Llanidloes and their surrounding areas; would receive most of their care locally, but if they did need DGH care, they would be able to return home as soon as possible, with local community and health care support if needed. The model is equally applicable to the other towns in Powys and could bring the same benefits.

## **20.4 The Transition**

Moving from the current model to the new model will require the engagement of the community, the GPs, other health care professionals, social services, and others; and unquestionably as much energy as past public engagement.

The first stage will be to agree the model that will best meet the community's needs.

The transition from the old to the new will have to be staged and incremental, and we strongly recommend that the first communities to move forward should be those that are interested in doing so; so that others who are less certain have the opportunity to see how it could work. But the work should begin as soon as possible in the interests of all Powys residents.