

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

End of phase 1 – progress to date and next steps

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 and management team's role in discharging its responsibility and accountability for ensuring patient safety and the effective management of clinical services. Originally we had planned to produce a report at the end of phase 1.

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

In the event, a series of serious clinical incidents relating to patient safety were drawn to our attention during phase 1 and it was impossible to ignore them.

Consequently we need to move forward to phase 2 - to address some of these issues as soon as possible, and to review similar services that may have similar problems.

A report will be produced at the end of phase 2.

2. Process

Our **findings are based** on a review of documents provided by the LHB and interviews with 25 people including non-officer members, members of the management team, GPs and consultants. We thank everyone for the open and constructive way in which they and the LHB have participated in this review.

3. Context

In addition to the interviews we needed to take account of the context and the particular challenges that the LHB face. The Powys LHB came into being in 2003. The LHB was responsible for **both commissioning and for providing services including hospital based services**, and this was unique in Wales

Population and communities

Powys has a population of approximately 130,000. It is **sparsely populated** and has a high proportion of **elderly residents**.

The county is divided into three shires, but people are more likely to identify themselves with one of the **15 communities** in the county.

Hospitals and services

There are **no district general hospitals** in Powys, but there are 10 community hospitals.

- They have a total of 229 open general beds:
 - 121 beds are age care consultant beds with medical care provided by three consultants supported by General Practitioners.
 - 108 beds are General Practitioner (GP) beds, 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 the GP beds, and to support the consultants. Medical cover in the evenings and at weekends is provided by Shropdoc and other out of hours providers.
- Eight of the hospitals have Minor Injury Units.
- In addition, there are acute and rehabilitation mental health beds in Bronllys Hospital and beds for older people with mental health problems in four other hospitals. Medical services for mental health in-patients are provided by six consultants.

4. Earlier Review of standards of patient care in 2002

There was an earlier review of standards of patient care in Powys. It took place in 2002, prior to the establishment of the LHB.

It found:

- A lack of strategic direction and co-ordination.
- Some community hospitals were providing a level of care comparable to nursing home care, whilst others were admitting patients with serious conditions that couldn't be adequately cared for in hospitals lacking on site medical cover.

- Lines of accountability for managing care and ensuring safe practice were not clear
- There were concerns relating to mental health services.
- Some of the Minor Injury Services were found to be high risk with very differing levels of expertise, and low attendance in a number of units which meant that staff with expertise were unable to maintain their skills.

But the 2002 review concluded that Powys had the potential to be at the forefront of extended primary care developments, the provision of community care and of outreach secondary care of the highest standard, provided effective partnerships between the GPs, out of area trusts and the new LHB were established.

In consequence, the Powys Local Health Board inherited a very challenging situation in April 2003, but one with huge opportunities.

5. The Current Review

NHS Boards that provide services, and Powys is such a Board, are required to ensure that high standards of safe clinical care are provided and that a clinical governance framework is in place to monitor the quality and safety of care. In fulfilling this function Boards must ensure that management arrangements are in place to enable the clear delegation of responsibility to senior executives.

Therefore phase one **focused on the Board's role** in ensuring and monitoring safe and effective clinical care, and on the **Management Team's role** in managing provider services and ensuring effective clinical management and safe patient services.

In addition during phase1 a **series of clinical incidents** were drawn to our attention, and we will consider the implications of these.

6. The Board

Powys was the only LHB to have been given a combined commissioner and provider role, that exceptionally included the provision of hospital based services. During the interviews, **the vast majority of Board members interviewed said that it had proved extremely difficult to combine the two roles**. There appear to be a number of reasons:

6.1 The magnitude of the agenda

The Board agenda is long and the main focus is on commissioning; a key responsibility of the LHB, and therefore provider issues did not receive the attention they required.

We soon realised that in fact, non-officer members had little or no awareness of the serious clinical incidents that had occurred during the last year in the community hospitals and in the minor injury units.

They give the following reasons why this information did not reach members;

- Firstly, reports on Clinical Governance, patient safety and complaints were at the end of the agenda, and some members have to leave early to travel long distances – we believe the LHB is already addressing this issue and we welcome that
- Secondly, the LHB is to be congratulated on its good work in recording reported incidents and complaints, but this information is not presented to the Board. Instead the Board receives a report from the Clinical Governance Committee mainly reporting on the management of incidents and complaints. As a result, not even the private session of the Board is given sufficient information to alert them to the seriousness of some of the incidents.
- Lastly, the report to the Board is not presented by an Executive Director, thus the Board does not have the opportunity to question a director about steps taken to avoid incidents happening again.

For these reasons the Board's ability to monitor services and ensure patient safety was limited

6.2 The size and composition of the Board made it difficult to properly discuss provider issues

The Board has 30 members and associate members, whereas a trust board has 12 members. The majority of those interviewed felt that the LHB Board was too big to allow proper debate of provider issues. Comments included; 'too big a gathering to work out how to deal with provider issues', and, 'not designed to manage a provider organisation'.

6.3 The potential conflicts of interest when debating provider issues

The LHB composition of the Board creates difficulties and potential conflicts of interest for many non-officer and associate members of the Board, particularly in relation to any service change. Some are employed by the LHB; some are local councillors representing different shires; some are GPs working in practices that receive payments for their community hospital work; some are directors from external trusts with contracts with the LHB; some are from the voluntary sector, and one member is a trade union representative.

The Board Minutes do not indicate that these conflicts of interest have been acknowledged, but there are some indications that members may have found difficulty in managing them. For example, some members have reportedly abstained from the majority of votes on strategic change and organisational development during the past year.

6.4 Lack of awareness of the corporate role of board members of LHBs

The strong identification with local communities and hospitals may also account for the fact that a significant number of non officer members were not aware of their accountabilities, and responsibility as Board Members, to act corporately.

Indeed there appears to be a general view in the wider community that members are there to represent different interest groups, rather than to act as a statutory board. Many said that, as non-officer members they need to be confident that Board colleagues will respect the corporate role so that confidential matters concerning patients and services may be shared and fully explored.

6.5 Cultural issues in Powys

Most of the Board had thought initially, that the combined commissioner / provider role made sense because Powys did not warrant an LHB and a trust. They saw the LHB's role positively, as co-ordinating primary care, whilst commissioning and monitoring intermediate and secondary care. But in practice the majority of GPs interviewed saw their community hospital work as an extension of their local primary care service, and tended to resist being held to account for their hospital work by the LHB in its commissioner role.

The various attempts to engage GPs in strategic change have not been successful in respect of the GPs in the four communities affected by reconfiguration Builth, Llanidloes, Haygarth, and Knighton. The LHB would say despite best efforts, whilst the GPs from the four communities would say that they have not been appropriately consulted or engaged.

As far as we can ascertain, the GPs in one community have spoken positively about the proposed changes, but there has been no comment in public from the GPs in 10 of the 15 communities. And it will be important to hear their views.

So for the reasons outlined above the vast majority of the Board had come to the view that the current arrangements in place for managing the combined commissioner and provider role is not an effective model for Powys.

7. The Management Team

7.1 Team working and achievements

The LHB has a single Management Team to fulfil both the commissioner and provider functions. Initially there was a very positive and collaborative atmosphere and the team made significant improvements in clinical services.

However, the constant struggle to address both agendas led to frequent role changes and the then Chief Executive acknowledged that they had not found a satisfactory structure, and currently the management team do not feel that they are functioning as effectively as they could as a team.

7.2 Lines of accountability

There are also problems with lines of accountability. Clear lines of accountability are essential for safe services, but at least half of those interviewed were uncertain as to who was responsible for provider services.

The management change last September transferred the responsibility for managing the community hospitals, mental health services and women and children's services from executive level to three operational managers. This was not and is not satisfactory, particularly at a time when there has been a series of clinical incidents and staff shortages in some services. Nevertheless we must pay tribute to the three operational managers who have worked tirelessly in an effort to fulfil that role. However, provider services should be overseen by an executive director.

There was also a lack of clarity as to who was responsible for standards of care in each of the community hospitals.

7.3 Different views as to the importance of clinical governance

Within the Management Team there were differing views with respect to clinical governance issues. This led to much debate amongst the team and some management decisions that gave us cause for concern.

7.4 Weaknesses in decision making structures and processes

Our impression is that the LHB, partly because of its dual role, has struggled to find and effectively use the right structures both for operational and strategic management.

8. Matters relating to patient safety drawn to our attention

Although in phase one, we did not set out to review clinical services and practice it was impossible to ignore certain serious clinical incidents and patient safety issues drawn to our attention either by those we interviewed or through patient complaints or incident reporting mechanisms.

Minor Injury Units (MIUs)

A critical incident occurred in one of the smaller minor injuries units in Builth. The incident resulted in disciplinary action. However, we do not feel that this action would necessarily prevent similar incidents from occurring in the future.

There has recently been a very serious incident in the Newtown MIU. Again a staff member has been held accountable, but this does not address the underlying problem, that staff see far too few patients with Minor Injuries to develop or maintain skills.

In addition people with serious emergencies tend to go to MIUs because they do not appreciate the limitations of the service, and this creates a delay in getting urgent treatment.

There are also frequent unscheduled closures of the MIUs due to staff shortages and significant numbers of patients arrive when the units are closed. This means that nurses are drawn from wards leaving insufficient cover for inpatient care.

And most significantly, in some of the smaller units the average number of new minor injury patients is little more than one a day, and this means that staff cannot gain experience and maintain skills.

There have been previous reviews of MIU services in 1997, 2000 and 2002. All identified patient safety concerns and long standing low attendance in the smaller units.

We will review the MIU services in Phase 2 and explore ways of providing a safer service

Recent surgical incidents requiring transfer

Our attention was drawn to surgery in Powys by reports of 5 recent clinical incidents. Four involved unexpected serious complications requiring transfer to a District General Hospital because they required 24 hour resident medical care and access to high dependency care.

Serious incident in a community hospital

A serious incident concerning a patient in Newtown hospital, and the Coroner's comment concerning care, drew our attention to problems with the co-ordination of consultant, GP, and out of hours medical care, and with the standards of nursing care. Furthermore this follows four previous incidents relating to poor standards of care involving vulnerable adults

Accountability for medical care should be well defined

Concern about patient safety at the UK level highlighted the issue of accountability of clinicians, particularly doctors, for the quality of their work.

Powys LHB finds itself in the unusual situation of having care for which you are responsible, provided on your premises both by independent contractors and consultants from neighbouring Trusts, and further work is needed to ensure that there are clear lines of accountability for the care of individual patients.

Safe services as locally as possible rather than local services as safe as possible

We listened with care to arguments from some General Practitioners that allowances had to be made in rural areas and that health 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 patients in Powys expect safe services as locally as possible, rather than local services as safe as possible.

9. Notwithstanding these concerns, it is important to recognise that the vast majority of care in Powys is delivered to a high standard

Primary Care

Most patients receive most of their treatment from their General Practitioners and primary care services in Powys have always been of a high standard.

Furthermore 4 practices; Llanfyllin, Welshpool, Llanfair Caerinion and Montgomery are piloting an extended Local Care Team service, and five more practices have expressed an interest. A clear sign that services for patients in Powys are developing and moving forwards.

Chronic disease

Another team has been working to develop local services for patients with chronic disease, such as diabetes, chest disease, and heart disease; so that these patients can remain at home instead of going into hospital for care.

Depression

Still another team has been developing locally based services for people with depression.

Consultant led elderly care in community hospitals

And for elderly patients requiring assessment or hospital care, there is a very well regarded consultant led service in Powys hospitals.

So you can see that the vast majority of services used by patients in Powys are of a high standard and developing. And, in the few services where there are concerns, we will seek ways of providing the services more safely.

10. Moving to phase 2 of the review and the next steps

There are some interim actions that need to be taken

- It is clear from complaints and concerns that the patients the Board represents expect a safe service as locally as possible
- Therefore we will begin immediately to look at ways of providing a safer, local, rural minor injury service to the people of Builth Wells, and Newtown, and we will review the other MIU services.
- We will seek current professional advice and provide guidance on the provision of safer surgical services
- In collaboration with the LHB we will look at the standards of nursing care in Newtown Hospital and in other community hospitals; and arrangements for the provision of medical care

In parallel the aim also

- is to support the LHB and its new Chief Executive in separating arrangements for managing the provider function of the LHB; and
- to address the key commissioning role of engaging GPs, the Local Authority and the public in developing a health and social care model for Powys for the future, building on the work already begun in the Local Care Teams and the community teams.

Powys has a population that has a very real interest in health and social care provision; GPs who are very committed to their populations and interested in developing primary care; active Leagues of Friends and fully engaged Community Health Councils, and an LHB that is committed to providing safe services as locally as possible. These are positive ingredients for modernising and developing health and social care in Powys.