Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Dignified Care: Two Years On

The experiences of older people in hospital in Wales

An independent voice and
champion for older people

The Older People's Commissioner for Wales

The Older People's Commissioner for Wales is an independent voice and champion for older people across Wales. The Commissioner and her team work to ensure that older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services that they need.

The Commissioner and her team work to ensure that Wales is a good place to grow older, not just for some but for everyone.

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Foreword

In 2011, my predecessor undertook a Review into the treatment of older people in hospitals in Wales. This was in response to having been contacted by a significant number of people who had experiences of care that fell far short of what they had a right to expect. The subsequent 'Dignified Care?' report focused on twelve specific areas where improvement was needed. This report, 'Dignified Care: Two Years On', considers the progress made against these twelve areas and the priority that is now afforded to ensuring that quality of care is an integral part of the NHS in Wales.

When 'Dignified Care?' was published, there was not the focus that there now is upon the dignity and respect accorded to people in hospital and the safety and wider quality of care of patients within the NHS. Dignity and respect, and the safety and quality of care of patients across the UK, now has the national profile it should have always had.

Numerous subsequent reports and enquiries have been a 'wake-up call' for the NHS across the UK leading to all parts of the NHS re-examining the safety and quality of care provided and the extent to which people are treated with dignity and respect.

Health Boards, Velindre NHS Trust and the Welsh Government have shown me evidence of a wide range of actions and initiatives underway that are designed to improve patient care and are making a positive impact in many instances and, as Commissioner, I meet with many people, both in and outside of hospital, who tell me about the excellent care they have received, how well they were cared for, how they were supported when they felt most vulnerable, and how caring staff were to them.

However, I also meet with, and am contacted by, people who raise serious concerns about the quality of care they have received and failures to treat people with dignity and respect. The impact of these failures on individuals and their families is often devastating. Safe, effective, high quality care that respects the dignity and rights of individuals should not be an aspiration – it must be the norm, not just for some but for all older people and, more than that, all users of the NHS in Wales.

Whilst I recognise and welcome the action that has taken place in Wales since 'Dignified Care?' was published, and its impact, the NHS in Wales must now rapidly build upon this action to improve treatment and care, not just for some but for all patients across Wales. The pace of improvement must also increase in a range of key areas such as dementia and continence care.

The NHS in Wales must strengthen its accountability and transparency. It must put into the public domain clear and easily understood information, at a local level, about how it is performing in meeting the needs of patients, where it recognises it still needs to improve, and when that improvement will be delivered. Early work has begun on this within Wales, which I welcome, but this must be treated as a priority.

The NHS in Wales must also act swiftly to improve its understanding of the experiences of older people in hospitals. Health Boards and Velindre NHS Trust, who are accountable for the safety of patients and quality of care, must use patient voices and experiences to drive not just initiatives, but on-going and continuous improvements in care. There is evidence that this is underway, but there is still a considerable way to go.

Sarah Rochira
Older People's Commissioner for Wales

Overview

Since the publication of 'Dignified Care?' in 2011, there has been increasing public and professional concern about, and focus on, the way in which people are treated when in hospital and whether they are routinely being cared for with dignity, respect and compassion. There has also been increasing media coverage of significant failures in care, both commissioned and wider organisational failures across the UK. This has led to a fundamental re-examination of the quality of care being delivered to patients across the UK.

There are significant differences between the healthcare system in England and Wales, particularly in terms of commissioning, regulation and inspection and in the relationship between devolved government and the NHS in Wales. In Wales we have not seen failures of care within individual hospitals on the scale that we have seen in England.

However, there can be no room for complacency and the Commissioner and many others, both individuals and organisations, including the Public Services Ombudsman for Wales, Healthcare Inspectorate Wales (HIW) and professional bodies, have spoken publicly and published reports about significant and repeated failures in care, both at an individual and ward level, which in their own right have been devastating for individual patients and their families. The Commissioner and others continue to be contacted by individuals whose care has fallen very short of what they have a right to expect.

As part of preparing 'Dignified Care: Two Years On', the Commissioner required the Welsh Government, Health Boards and the Velindre NHS Trust to report their further progress against the agreed action plans relating to the Commissioner's twelve identified areas for improvement.

Since the publication of 'Dignified Care?' in 2011, there is evidence of a wider focus within Wales on the safety and quality of patient care. The Welsh Government has made dignity and respect within Welsh hospitals a Tier 1 priority within its delivery and performance management framework for the NHS. HIW has also regularly undertaken unannounced Dignity and Essential Care Inspections. In January 2013, additional guidance was published for the specific standard on Dignity and Respect, one of the Healthcare Standards set out in the Welsh Government's 'Doing Well, Doing Better – Standards for Health Services in Wales'. Also in January 2013, the Welsh Government published 'Safe Care, Compassionate Care: A National Governance Framework' to enable high quality care in NHS Wales. This states: "Whilst complex and multi-faceted, our system will have one defining characteristic. The Welsh NHS will put the patient, the family, the citizen, the community at the centre of all our work. We will listen to those who use our services, we will engage with them as we plan

improvements, we will address their concerns and we will respond to their personal as well as clinical needs. Our vision is one of a Welsh NHS which is safe and compassionate."

'Safe Care, Compassionate Care' requires all health organisations in Wales to publish an Annual Quality Statement, starting in 2013, that informs the public how they are ensuring and improving patient safety and quality of care and that people are treated with dignity and respect. In addition, the Welsh Government has given a commitment to publish an annual overall Quality Statement for the NHS in Wales, starting in 2014.

The Welsh Government has, from this year, also introduced a new standardised Framework for Assuring Service User Experience to find out what patients think about their care.

In July 2013, the Welsh Government published 'Delivering Safe Care, Compassionate Care' in response to the Francis Report. This sets out a clear vision and actions, both immediate and medium term, intended to ensure that all patients in Welsh hospitals receive safe, dignified and compassionate care at all times. It acknowledges that harm to patients does at times happen and commits itself to eradicating this.

Health Boards, the Velindre NHS Trust and the Welsh Government were able to evidence that the Commissioner's twelve recommendations and the wider issues of safe, high quality and dignified care are being taken seriously. Most Boards are increasingly strengthening their governance and scrutiny arrangements in respect of the quality of wider safety and quality of care.

Overall, the Commissioner saw evidence of action being taken across Wales designed to improve the quality of patient care and dignity and respect accorded to patients. There was evidence that continued positive activity against the twelve recommendations is taking place with some demonstrable impact on patients' experiences. Active steps are also being taken to strengthen the voices of patients. Section 4 provides examples of some of the actions underway and full submissions are available on the Commissioner's website.

However, there can be no room for complacency. Whilst there is now a much stronger focus on dignified care, both in terms of policy and practice, we are still very far from from being able to routinely assure and evidence that all older people in Wales will always be treated with dignity and respect in hospital. Specifically:

- There is a need for further improvement in order to ensure that ward managers at all Welsh hospitals are equipped and have the authority to ensure that they are delivering safe and compassionate care at all times.

- The pace of change and improvement in dementia services is still too slow and more needs to be done to ensure that staff are provided with the right tools, support and training to improve their knowledge, understanding and quality of care.
- The recently launched All Wales Continence Bundle must be swiftly implemented across Health Boards so that there is a positive impact on patients' experiences, given the importance of continence support in maintaining patients' dignity.
- More needs to be done to ensure that older people do not experience problems when leaving hospital due to poor forward planning or lack of consultation and involvement of the patient in decision making.
- The appropriate use of volunteers on wards to support patients and staff needs to increase significantly given the potential of volunteers to enhance the patient experience.
- There is a clear link between staffing levels and the safety and quality of care on hospital wards. Routine and public reporting about the adequacy of staffing levels must be an immediate priority for the Welsh Government and the NHS.
- More must be done across the NHS to ensure that patients are communicated with in a way that reflects their abilities, preferences and needs and that their right to privacy is maintained.
- There is an urgent need to improve how NHS organisations learn from poor practice, and how they use this to prevent avoidable harm or distress to patients.
- Health organisations should routinely and publicly demonstrate that staff always have the skills needed to undertake their roles effectively and are properly supervised and appraised.

The NHS in Wales must significantly strengthen its understanding of the patient experience whilst in hospital, at ward level, and be able to measure the impact of the wide range of actions now underway upon the patient experience. This must be done on an on-going basis and used to drive not only the development of initiatives aimed at improving care but also the systematic embedding of a culture of continuous improvement.

Health Boards must routinely assess the safety and quality of their care, with dignity and respect a fundamental and integral part of high quality care, and be able, in their annual quality statements, to provide the public the reassurance it has a right to expect.

Background

In 2011 the Older People's Commissioner for Wales published 'Dignified Care?' which investigated the experiences of older people in hospital in Wales. This set out serious concerns about the way in which some patients were being treated within Welsh hospitals. The report concluded that:

"Fundamental change is needed. Patients need to know what quality care is, and staff need to be supported by systems and resources to empower them to meet patient's expectations. Poor practice should not be tolerated. The attitudes, behaviour and emotional intelligence of staff on the wards are crucial. We need strong, positive leadership at all levels and a system which builds in dignity and respect as the cornerstone of high quality care."

As part of the original review, Health Boards, Velindre NHS Trust and the Welsh Government were required to produce action plans addressing twelve specific areas of care identified as needing significant improvement. These plans were assessed by and agreed with the Commissioner and published in November 2011.

NHS organisations were subsequently required to report on their progress in implementing these plans, as were the Welsh Government.
In the first twelve month follow up assessment, 'Dignified Care: One Year On', which was published in 2012, the Commissioner focused on three questions:

1. Is dignity and respect now being taken seriously?
2. Is there evidence of work underway that clearly relates to the twelve recommendations in the report?
3. Is there substantive evidence that the experience of older people in hospitals has improved?

The Commissioner's conclusion from this was that:

"My report shows that dignity in care is now being taken more seriously than ever before by the NHS and the Welsh Government, and I am now satisfied that all of the bodies reviewed have significant work underway against their agreed detailed action plans.

"What I will now be focusing on over the next eighteen months, as Commissioner, is obtaining clear evidence from the NHS and the Welsh Government of real improvements in patient care and patient experience at the ward level."

It was agreed, following the first assessment of progress with the Welsh Government and the NHS in Wales, that a second progress report would be published in 2013.

To assist the Commissioner in her assessment for the second progress report, a reporting template was created that asked more specific questions and for supporting evidence to demonstrate that Health Boards, Velindre NHS Trust and the Welsh Government have made significant progress against the agreed action plans. In addition, the Commissioner was looking for evidence that:

1. Dignity and respect is being taken seriously and is a corporate priority.
2. There is on-going improvement in patient experience of care at the ward level.
3. Poor practice is being proactively identified and dealt with, lessons are being learned from this, and good practice is being shared and rolled out .

Each Health Board/Trust and the Welsh Government were again asked to provide evidence of further improvements they had made against their action plans and also to provide an overall assessment of their progress.

The Health Board and Trust responses were shared and discussed with HIW and the Wales Audit Office so that the responses could also be considered against the work of these bodies. In addition the general views of other stakeholders such as the General Medical Council, the British Medical Association and the Royal College of Nursing were sought.

The Commissioner also sought the views of older people directly to inform her understanding of the experiences of older people within Welsh hospitals.

Health Board and Velindre Trust Responses

Recommendation 1 – Stronger ward leadership is needed to foster a culture of dignity and respect

There is evidence that there is progress being made against this recommendation across Wales. Health Boards and Velindre Trust are prioritising this work and positive initiatives have been developed. The recommendation includes reference to the need for ward managers to have the support of specialist consultant nurses especially in dementia care and continence care, and it is encouraging to note that such posts have been created in some areas.

Positive examples

In Betsi Cadwaladr University Health Board the Tall Poppies scholarship programme is a bespoke leadership development programme that is a combination of formal taught sessions and experiential learning. It includes action learning sets, together with educational/research sessions with an increased amount of exposure to leadership opportunities internally and externally to the Health Board.

In Aneurin Bevan Health Board, piloting of the Perfect Ward principles has been carried out. A key aspect of the project is that the Ward Sister/Charge Nurse has protected time to fulfil his/her leadership role. The ward also needs to be established to meet acuity/dependency needs of the patient group.

In Abertawe Bro Morgannwg University Health Board, continence link nurses and dementia champions have been identified, trained and are running workshops and developing bespoke training. Positive feedback has been received from staff and relatives.

This recommendation states that ward managers should have the authority to create a culture of dignity and respect and that this must include being able to make decisions about the necessary staffing levels on their wards. However, findings from a Royal College of Nursing survey of 2086 UK nurses (428 in Wales) reported that 46% of UK ward sisters said they were unable to authorise additional staffing even though it was their clinical judgement that this was necessary in order to achieve safe staffing levels.

Therefore, despite progress being made, there is a need for further improvement in order to ensure that ward managers at all Welsh hospitals are equipped and have the authority to ensure that they are delivering safe and compassionate care at all times.

Recommendation 2 – better knowledge of the needs of older people with dementia is needed, together with improved communication, training, support and standards of care

This recommendation is being prioritised by all NHS organisations, with evidence of a number of targeted and innovative schemes and resources, including the appointment of specialist staff such as dementia care co-ordinators and nurses, but progress is not consistent across Wales.

The 1000 Lives Plus programme has produced a set of data collection tools specialised for different care settings to measure quality improvement targets in assessment and support. Action plans have been developed for each of the four priority areas identified in the National Dementia Vision for Wales to create dementia supportive communities: improved service provision, early diagnosis and assessment, improved access to information, and delivery of dementia awareness and on-going training to all frontline health and social care staff.

Positive examples

In Aneurin Bevan Health Board intergenerational work (between pupils at a local school and a ward in Chepstow Community Hospital) has developed a suite of 'activities' for older people with dementia to engage with whilst in hospital.

The Butterfly Scheme was introduced and fully launched in Withybush Hospital in Hywel Dda Health Board. It includes an education drive for all staff, a butterfly symbol that goes above the bed, a carers document, and a Reach Out to Me document. Three dementia co-ordinators working across Hywel Dda have trained 1,000 NHS staff in fifteen months and implemented the Butterfly Scheme and the Alzheimer's Society's "This is Me" life history document. Both the Butterfly Scheme and 'This is Me' are available in Welsh. These initiatives have also been taken up in other Health Boards across Wales.

In Powys teaching Health Board, a Dementia Board has been set up and a joint action plan with Social Services is being developed.

However, the pace of change and improvement in dementia services is still too slow and more needs to be done to ensure that staff are provided with the right tools, support and training to improve their knowledge and understanding of dementia. Older people continue to identify that there is a lack of awareness of dementia and that staff need more training and skills to understand and manage dementia and the challenging behaviour it can bring.

Some Health Boards have identified dementia champions and though positive in itself these champions are not always accessing the relevant specific training on dementia. Older people also struggle to access the specialist dementia services and support they need. As the number of older people in Wales and the number of people living with dementia continues to grow, all NHS organisations need to deliver meaningful and sustainable improvements in the hospital care of older people with dementia.

The National Audit of Dementia Care in General Hospitals 2012-13: Second Round Audit Report and Update (which covers Wales and England) concludes that:

"There are positive findings within this report. Dementia champions are now in place in most hospitals, and the majority of hospitals have begun to collect personal information about people with dementia to help improve care. More people with dementia are now having their essential health needs assessed and we are seeing dementia care feature much more in hospital training strategies. A reduction in the use of antipsychotic drugs, some of which increase risk of death, was found. These are all welcome steps forward.

"Further improvement is required and there remains a gap between written policies and actual practice. Too few patients are being assessed for delirium risk and for cognitive function, and may therefore fail to receive vital care. Despite more systematic collection of personal information about patients' needs, preferences and communication requirements, this is often not recorded in the patient notes, so staff remain unaware of how best to care for the individual. Discharge plans often fail to record important details about on-going health needs. At the point of audit, only 36% of hospitals (in Wales this is only 17.6%) had a fully developed care pathway in place, and we recommend that hospitals now address this with urgency. In terms of dementia awareness, there remains a huge need for much better staff training and support if we are to provide comprehensive, safe and dignified dementia care across the board."

None of the hospitals that took part in the audit had mandatory dementia training for staff, and this is an area that needs to be improved.

Evidence suggests that there are notable improvements being made at an organisational level. However, these changes need to be implemented swiftly and consistently and monitored effectively across Wales, so that older people with dementia no longer experience a worsening of their condition while on a hospital ward. We need to make sure that person-centred dementia tools and services become normal practice and that poor dementia care is no longer tolerated.

Recommendation 3 – lack of timely response to continence needs was widely reported and is unacceptable

Evidence was provided on a range of activities and initiatives taking place to manage patients' continence needs. Whilst there were some positive examples, these did not demonstrate that enough attention is yet being paid to the effective management of continence needs across Wales. Older people continue to experience unacceptable and poor levels of care and assistance in this important area.

Positive examples

In Powys teaching Health Board, continence nurses are being included in the multi-disciplinary clinic for people with long term conditions and in neuro-rehabilitation clinics.

In Hywel Dda Health Board the physiotherapy service links closely with the continence service and participates in pathway developments and also ensures that patient continence goals are incorporated into their treatment plans.

In Aneurin Bevan Health Board, the Patients' Panel conducts annual 'Call of Nature' continence audits. Continence champions complete an accredited training programme and increase awareness and promote good continence care amongst health care support workers.

Poor continence management was identified as a key concern in the 'Dignified Care?' report in 2011 and the Welsh Government and NHS have since developed an All Wales Continence Bundle. This was launched in June 2013 and provides nurses with tools to support the improvement of the patient experience and dignity in care. It includes assessment tools to identify immediate needs and the need for support in the longer term, an audit tool to measure how well staff are responding to patient needs and a questionnaire, which will be used to get feedback about patient experience.

It is expected that this will provide the necessary impetus for the improvements needed and the Commissioner expects to see evidence from the Health Boards and Velindre Trust that they are monitoring progress on how the tools are being used and that there is a positive impact on patients' experiences given the importance of continence support in maintaining patients' dignity.

Recommendation 4 – the sharing of patients' personal information in the hearing of others should cease wherever possible

While there is some evidence that this recommendation has been acted on, significant progress still needs to be made to ensure that patient privacy is respected and that often sensitive information is not shared inadvertently. There are undoubtedly challenges for some hospitals, not least because of the design and layout of some hospital wards, but it is essential that more attention is paid to the rights of patients and that creative ways are found to ensure that these rights are met wherever possible.

It is important that staff stop and think about patients' privacy and how they can facilitate this, even when it is not always possible to create a separate space. Staff interpersonal skills are key: staff sitting by patients' beds and not talking loudly whilst standing over them, for example. Patient status boards operate in some Health Boards and these can help to reduce the amount of personal information that is spoken on the ward.

Positive examples

In Cwm Taf University Health Board, use of a variety of symbols and cues on patient status boards identifies patient needs, including Welsh language, visual impairment, and confusion and cognitive impairment.

In Velindre Trust, a quiet room has been created in the new Radiotherapy department.

In Hywel Dda Health Board, the EARWIG campaign (Everyone Always Remember Where Information Goes!) raises awareness of the need to be mindful about the need for confidentiality in the communication of information.

Recommendation 5 – too many older people are still not being discharged in an effective and timely manner and this needs urgent attention

There is evidence that discharge planning is being carried out more thoroughly in some areas and is taking into account patients' circumstances more fully. While this is leading to more positive outcomes, it is not consistent across Wales.

Positive examples

In Powys teaching Health Board, the Virtual Ward has been implemented within the community teams and initial patient feedback has been very positive.

In Cwm Taf University Health Board a single point of referral to MDT re-ablement services has improved discharge times and there have been no delayed transfers of care due to not being able to provide equipment.

In one hospital in the Betsi Cadwaladr Health Board area, a discharge support nurse makes home visits post discharge to those who have required intensive discharge planning support due to complex issues, giving patients and their family a chance to discuss their hospital experience.

However, older people still report problems with hospital discharges. These problems include:

- Delays in discharges due to a variety of reasons including awaiting assessment for, or lack of access to, equipment, community health or social care services, therapies and also funding issues.
- Lack of involvement in discharge planning.
- Poor communication with patients and relatives.

Progress across Wales is inconsistent and more needs to be done towards ensuring that older people do not experience inappropriate hospital discharges.

Recommendation 6 – the appropriate use of volunteers in hospitals needs further development, learning from successful initiatives

There are interesting and innovative volunteer initiatives being run in some hospitals across Wales, but they need to be expanded and developed further. They are, as yet, both patchy and not sufficient to demonstrate that this recommendation is being acted on widely enough to make an effective and sustained impact on patients' experience in most wards and hospitals.

Positive examples

The 'Robin' volunteer scheme was initially developed in Glan Clwyd hospital - where volunteers wear red t-shirts and work on wards and outpatients departments. They assist patients by running errands for them, befriending them, and assisting with activities and at meal times. This scheme is now being rolled out, not just in other hospitals in Betsi Cadwaladr Health Board, but in other Health Boards.

In Abertawe Bro Morgannwg Health Board area, Age Cymru have a monthly drop in desk at Neath Port Talbot Hospital and are working with the three localities to develop patient advocacy and support particularly around discharge.

At Velindre Trust, two volunteers designed and maintain a sensory garden which provides a 'haven of tranquillity' for patients and their families.

In Cardiff & Vale University Health Board, volunteers are actively involved in patient experience work and activities including Macmillan information centre, speech and language project, library service and stroke centre.

Recommendation 7 – staffing levels have to reflect the needs of older people both now and in the future

Across Wales hospital staff work hard and are dedicated to providing good patient care in often pressurised environments. Clearly there is a link between the numbers and skill mix of nursing staff and the needs of patients on a given ward at a given time. This impacts not only on the quality and dignity of the care patients receive but also sometimes on the outcome of their stay in hospital.

Positive examples

Powys teaching Health Board has triangulated the Powys Professional Judgment modeling of staffing against the RCN recommendations for staffing on Older Peoples wards and the results of the Safer Nursing Care Tool monitoring. The work informs on-going budgeted staffing levels and supports vacancy management processes.

In Cwm Taf University Health Board, Transforming Care wards have, on average, increased improvement to direct patient care time by 19%. This has showed continued improvements to reductions in pressure areas developing, patient falls, medication errors, complaints and some hospital acquired infections.

Positive examples (cont.)

Velindre Trust sets staffing levels as 1 patient to 1.55 whole time equivalent staff as the minimum, which is higher than the recommended nursing establishment. It has also identified specific additional roles including a dementia lead, critical care lead and two patient safety champion nursing posts.

Concerns about staffing levels at Welsh hospitals have been expressed by various organisations, such as the Royal College of Nursing, over the past few years and in the 2012 NHS Wales Staff Survey only 26% of employees felt that there were enough staff for them to do their job properly, with 55% of staff disagreeing with this statement. In April 2013, findings reported from a UK wide survey by the Royal College of Nursing showed that 71% (1,481) of UK nurses surveyed think staffing levels are not adequate.

The Health Board responses show that while some attention has been given to this recommendation there was insufficient evidence of demonstrable and sustained improvements in this area.

The Welsh Government activity on tackling the issue of staffing levels and skill mix includes the development of acuity tools in acute medical and surgical settings for nurse staffing and these are now being implemented and will be rolled out next year. A programme of work will then be implemented to extend this to other settings. It recognises the important contribution by healthcare support workers and will take steps to ensure that they too receive the right training to fulfil their roles confidently and competently. It has also announced extra funding to secure further acute medical and surgical ward nurse posts.

Given that ward staffing is such an important issue in terms of the quality, safety and compassion of care in Welsh hospitals, the pace of improvement needs to be quickened and there also needs to be routine and public reporting about the adequacy of staffing levels by all Health Boards and Velindre NHSTrust.

Recommendation 8 – simple and responsive changes to the ward environment can make a big difference

The evidence demonstrates that some Health Boards and Velindre Trust are taking action to improve the ward and hospital environment and these are to be welcomed, but there are still many areas that need improving.

Positive examples

In Abertawe Bro Morgannwg University Health Board, new service models are being piloted in response to issues identified in relation to catering and cleaning. Joint appointments have been made to enable a more focused approach to housekeeping duties. Results have indicated an increase in national standards of cleaning scores and infection control audit scores, and improved satisfaction with the Catering Service.

In Hywel Dda Health Board, a public engagement scheme, Siarad Iechyd/ Talking Health, continues to influence changes within hospital settings. The group developed a new approach of symbolised colour coded signs which have been rolled out across the Health Board. By using colour zones and easily recognisable symbols, all patients have been able to work out more easily which department they need and how to get there. Users with poor literacy skills were able to easily use the new signs to find their way to departments and feedback among patients and visitors was very positive, with less confusion and, as a result, no time wasted trying to find where they were meant to be. The project won the 'Citizens at the Centre of Service Re-Design and Delivery' award at the NHS Wales awards.

Cardiff & Vale University Health Board has an on-going programme of work upgrading the bathroom and toilet facilities in response to patient feedback. Feedback also indicates that patients feel safe and that ward areas are mostly clean and uncluttered.

In Aneurin Bevan Health Board, a fast track process has been introduced for ward sisters and charge nurses to access prompt provision of low cost equipment e.g. buzzers, signage etc.

Whilst acknowledging the challenges of working in sometimes unsuitable physical environments, a stronger focus needs to be given to simple but effective changes that enhance patients' dignity and privacy. For example, provision of single sex bathroom and toilet areas seems to pose a particular challenge in some areas. Other identified areas of concern include a lack of privacy; noise levels, especially at night; poor standards of decoration, linen and furniture and lack of day room facilities.

There are simple and relatively low cost improvements that NHS organisations could make that would greatly improve the patients' experience of being in hospital and the Commissioner expects to see more being done in this respect.

Recommendation 9 – effective communication can raise patient expectation and involvement and can improve their hospital experience

There is evidence of a range of activity taking place to try and ensure there is effective communication and involvement. However, this is not always translating into sustained good practice on the wards or enhancing patients' experiences.

Positive examples

Cardiff & Vale University Health Board have developed an enhanced skills programme for healthcare support workers which focuses on how they respond to patients, relatives, or staff who are in emotional distress. They have also focused on communicating with people with sensory loss and run a number of initiatives, including training on sensory impairment for pharmacy staff in terms of medicines management, occupational therapy for people with hearing loss and the use of sensory gardens. The Health Board is embracing the Shared Decision Making approach where clinicians and patients make decisions together using the best available evidence and patients are treated as equal partners in their healthcare.

In Betsi Cadwaladr University Health Board, lay volunteers carry out patient surveys and one specifically on communication showed mostly positive results particularly in terms of patient involvement in, and understanding of, their care.

In Cwm Taf University Health Board, 'relative rounding' takes place where nursing staff proactively approach relatives during visiting times to answer questions or concerns. The Health Board are engaging with community groups working with people with sensory impairments in order to receive feedback and further develop services.

Patients are not always asked how they wish to be addressed or their preferred language, and communication needs for those with sensory loss continue to be overlooked in some areas. There is also insufficient evidence of the effective involvement of patients in decision making about their treatment and care.

This recommendation needs to be given further attention and a higher priority by NHS organisations to ensure that all patients are cared for with dignity and respect at all times while in hospital.

Recommendation 10 – the experience of older patients, their families and carers should be captured more effectively and used to drive improvements in care

The evidence demonstrates that there is innovative work taking place across Wales to capture and act on patient experience and feedback, and Health Boards and Velindre Trust are taking this recommendation seriously. The new Framework for Assuring Service User Experience and the patient experience core questions, produced as part of the Welsh Government's actions on 'Achieving Excellence, The Quality Delivery Plan', should assist Health Boards and Velindre Trust to continue to progress and improve work in this area.

Positive examples

In Velindre Trust, there have been clearly identified improvements in response to patient stories e.g. improvements in psychological support services by appointment of a clinical psychologist and implementation of a depression screening tool; provision of a prayer room; protected patient meal times and a snack service for Chemotherapy patients.

Cardiff & Vale University Health Board has an agreed framework to describe and capture the experiences of patients. The Health Board uses a proactive and extensive range of methods of engagement, including use of real time surveys, '2 minutes of your time' surveys, patient stories, online surveys and HIPO surveys (health improvement patient outcomes).

In Powys teaching Health Board leadership walk-rounds are taking place that include specifically focussing on the experiences of patients, carers and relatives. Mechanisms are in place to ensure timely responses to, and learning from, issues identified and reporting outcomes to the Board.

In Cwm Taf University Health Board, actions resulting from patient feedback include improvements on one ward in cleanliness and staff meeting and greeting patients' visitors.

Some of the evidence submitted, however, does not sufficiently demonstrate how information is being used or how it is having a real impact on patients' experience and ensuring improved outcomes for patients and carers. It is also unclear how patients' experiences are being used routinely to inform and systematically drive forward on-going improvements in care. More learning needs to take place not only at a ward level but at an organisation wide level, with much clearer reporting on how patients' experience is influencing and changing the way care is delivered. Overall, there is insufficient progress against this recommendation and the Commissioner expects to see improvements over the coming months.

Recommendation 11 – good practice should be better identified, evaluated and learnt from to bring about improvements in care

It is obviously important that good practice is effectively identified and shared to enable wider learning and improvements in care across Wales. The national improvement programme, 1000 Lives Plus, supports organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales. This programme has achieved significant improvements within NHS Wales over the past few years.

Positive examples

In Hywel Dda, four Parkinson's Nurses, one covering each of the four general hospital sites, meet regularly to share common work areas and best practice. They have identified the significant benefits of this way of working and the model will be extended further. A pilot of Intentional Rounding on a medical ward resulted in a significant reduction in falls amongst at risk patients and this will be rolled out across the Health Board.

In Velindre Trust, patient safety champions regularly share good practice, both within the organisation and externally. This includes work on pressure sores, mouth care and slips, trips and falls. Good practice presented at the 2013 Quality and Safety in Healthcare International Forum included the 'Mission Possible' project, which investigates staff attitudes towards incident reporting and how to develop a positive and reflective 'no blame culture'.

Abertawe Bro Morgannwg University Health Board implements a number of improvement schemes under the Managing Successful Programmes methodology. The Innovation, Support and Improvement Science programme is piloting a Service Transformation Team that offers dedicated support to clinical teams wanting to redesign their services.

While there is some encouraging evidence from NHS organisations it is patchy and does not demonstrate how they are systematically spreading and embedding good practice throughout all their services or working together to spread good practice across NHS Wales. The evidence also indicates that processes for learning from poor practice need strengthening in some areas, especially where there are repeated recurrences of events identified via complaints, claims and incidents.

Recommendation 12 – all those working with older people in hospitals in Wales should have appropriate levels of knowledge and skill

While there are some positive examples, the evidence suggests that this recommendation is not yet being taken sufficiently seriously and that staff in some areas are not always receiving the training they should. Generally, details were lacking in many of the reports from Health Boards and Velindre Trust about the uptake and outcomes of any training activities.

In some organisations it appears that, for various reasons, staff are not accessing training on specialist areas such as dementia and continence, and this even applies to staff who are supposed to be 'champions' in these fields. Clearly it is a fundamental part of a Health Board or Trust's responsibility to ensure that all of its staff are properly trained, supervised and appraised for the jobs they are doing. Whatever the organisational or logistical challenges, organisations must ensure that their staff are properly trained and their performance monitored.

The Commissioner expects to see significant progress in this respect and for organisations to account routinely and publicly for the performance of their systems of staff training, supervision and appraisal.

Positive examples

In Cwm Taf University Health Board, dementia and continence care training is being reviewed to ensure it addresses the issues identified through complaints and incidents, is evidence based and meets the needs of staff. The Health Board provides a comprehensive Training Information and Workbook on 'Thinking Differently about Patient Dignity' for those attending Dignity training.

In Hywel Dda Health Board, there has been a significant improvement in the provision and uptake of POVA training in the last two years. In addition, a review of professional standards has taken place in two District General Hospitals as a result of complaints, external reviews and the Francis Inquiry report. An action plan has been produced and progress with implementation is being monitored.

Powys teaching Health Board are running a rolling programme of Tissue Viability Seminars leading to accreditation for registered and non-registered staff in the areas of Pressure Damage Prevention, Wound Care and Leg Ulcer Management.

Welsh Government Response

The Welsh Government was asked to report on five specific recommendations in 'Dignified Care?'. For this second progress report it was asked to provide a response on each of these recommendations, providing a summary of:

- Action underway
- Assessment of the impact and outcomes from the action taken and further areas for improvement
- Next steps that have been identified to continually improve in this area over the next eighteen months

The Welsh Government was also asked for an overview and assessment of the evidence submitted by the Health Boards and Velindre Trust in relation to:

- Whether dignity and respect is embedded as a top priority with effective scrutiny and assurance processes in place
- Whether sufficient action is being taken, where performance is going well and where action needs to increase
- Which recommendations were proving to be the most challenging and which had prompted the most significant change
- Whether the patient experience was improving sufficiently

The evidence submitted and overview given by the Welsh Government demonstrates that there are a range of activities and positive initiatives taking place across Wales in relation to the recommendations in 'Dignified Care?'.

The Welsh Government considers that dignity and respect are well embedded as priority areas across NHS organisations and dignity in care is a Tier 1 priority under the NHS Wales Delivery Framework for 2013-14. It considers that effective assurance processes are in place, including monthly delivery and performance meetings with each NHS organisation, and six monthly Joint Executive Team meetings.

The Commissioner expects the Welsh Government to continue to monitor Health Boards' and Velindre Trust's action plans following the 2011 'Dignified Care?' report and take responsibility for ensuring that there is continuing progress and that NHS organisations are indeed working towards completing the recommendations in this financial year.

While there is evidence of the development of a comprehensive system of assurance across NHS Wales (Delivering Safe Care, Compassionate Care) there is the need for more clarity on how this works in practice and also how the experiences of patients are having a direct impact in improving services at all levels of the system. The impact at ward, board and national policy levels needs to be more explicit to demonstrate that patients are really at the heart of NHS Wales.

Dementia

The Welsh Government provided evidence of a range of activities that are taking place at national level and dementia care has been identified as a strategic priority by the Welsh Government. We know that the Welsh Government has made a number of commitments to make 'immediate improvements to dementia services in Wales' (National Dementia Vision for Wales, 2011) but change has not happened quickly enough for many older people with dementia on hospital wards.

Information on the 1000 Lives Plus programme 'Improvements in Dementia' demonstrates that there is positive work going on and that experiences are being shared. Evidence on the impact of such work and the outcomes for older people with dementia on hospital wards needs to be more effectively recorded and monitored to ensure that the progress made to date is sustained and that further improvements are on-going.

The Welsh Government requirement for each Health Board to have a dementia action plan has been positive and means that dementia is now considered core business.

However, it is difficult to compare progress across the different action plans, as each Health Board has different priority areas and objectives. It is also hard to determine how quickly positive changes are being implemented and monitored across Health Boards.

The Royal College of Psychiatrists National Audit of Dementia Care in General Hospitals 2012-13: Second Round Audit Report and Update (which covers Wales and England) details some significant improvements but there are still many areas of concern where services are underdeveloped. Although the Royal College Audit suggests there is still some way to go, it is encouraging that the Welsh Government has driven the requirement for action at a strategic local level, but this must translate into significant and sustained improvements in the experience of patients and carers.

The Commissioner would like to see further progress on the application of the Mental Capacity Act and the use of Independent Mental Health Advocates.

The Commissioner expects to see evidence of tangible and sustained progress in the delivery of the Dementia Vision and subsequent Action Plans to ensure that there are improvements in the hospital experiences of older people with dementia.

Staffing levels

The Welsh Government provided a range of examples to demonstrate that it is confident that there are appropriate staffing levels and deployment of staff to deliver safe, high quality care. It has evaluated the Health Boards/Trust assurance frameworks and is content that all have reporting arrangements from ward to board level and that robust systems are in place to ensure that nurse staffing levels are at a safe level.

The Welsh Government has also provided assurances that it is continuing to consider and test out options in terms of nurse acuity tools, with the aim of a tool for adult acute in-patient settings being ready by April 2014. The tool is a new assessment process to determine the right staffing levels and skill mix to meet patient need. The process will enable nurses to assess the severity of patients' conditions, whether they are likely to deteriorate, and what their ongoing needs will be, when determining the required staffing levels and skill mix. Work on different acuity tools for different settings is being prioritised over the next two years. Since 2012, a set of principles for nurse staffing levels has been in place and these are being implemented until the acuity tools are in place. It has also announced extra funding to secure further acute medical and surgical ward nurse posts.

Capturing experiences of older people more effectively and using them to drive improvements in care

The Welsh Government's report refers to the recent 'National Survey for Wales' and the positive results it revealed in terms of patient satisfaction and experience with the NHS. Whilst some of the findings are indeed positive and to be welcomed, the survey is quite general in terms of the questions asked and, as such, the results should be set against other measures of satisfaction in reaching an assessment of how well the NHS in Wales is performing in this respect.

The Welsh Government response refers to the 'Fundamentals of Care' audit tool. The collection of evidence of the patient experience is embedded in the tool and NHS organisations report to Government by highlighting the percentage of compliance against each standard for both operational and user experience. The tool is being reviewed and in its response to the Francis report the Welsh Government has indicated that it will integrate 'Fundamentals of Care' and the Standards for Health Services in Wales into one overarching framework.

The work carried out as part of the Welsh Government's actions on 'Achieving Excellence, The Quality Delivery Plan' has resulted in the development of a Framework for Assuring Service User Experience and the introduction of core questions for NHS organisations to use to complement their local patient experience mechanisms. This is to be welcomed. As a result of the Commissioner's reporting requirements on 'Dignified Care?' and the Framework being produced, NHS organisations report on patient experiences and the actions taken are now being routinely sent to the Chief Executive of NHS Wales as part of regular monitoring processes. The review of these reports from May 2013 shows a mixed picture in terms of the information recorded and service improvement identified as a result and it is hoped that this reporting will improve as NHS organisations develop experience in this area.

In addition, the recent 1000 Lives Plus 'white paper' on 'The Listening Organisation' aims to support organisations to move from simply gathering feedback to really listening to and acting on feedback – both solicited and unsolicited. It is hoped that use of these tools will enable NHS organisations to provide more meaningful data on patients' experiences and to use this information to drive further service improvements, at both a local and national level.

It is positive that NHS organisations are capturing patients' experiences in a variety of ways and, in many cases, acting on this information to make changes and drive forward improvements. However, there needs to be recognition that some of the mechanisms for doing so are limited and can be too focused on looking at patient satisfaction, rather than the broader patient experience. Generally, the response from, and national activity by, the Welsh Government evidences that this recommendation is being taken seriously and that improving patient and carer experience is fundamental to the work of the NHS. However, improvements are still needed and the Commissioner will continue to monitor progress.

Good practice

The Welsh Government referred to a range of mechanisms in their report that provide the opportunity for good practice initiatives to be shared and learnt from to effect improvements in hospital care.

The 'Fundamentals of Care' audit includes a section where organisations record areas of good practice that are then shared internally as well as on an all Wales basis via the national summary report. It also includes opportunities and plans for improvement.

The Welsh Government states that the current healthcare standards, 'Doing Well, Doing Better: Standards for Health Services in Wales' and the supporting guidance provides the structure and tools for organisations to make changes and improvements in care. Similarly, they evidence the use of these standards for the basis of inspections by Healthcare Inspectorate Wales as verification that the standards are being used effectively, with action plans being produced and monitored.

In their submission, the Welsh Government made reference to the 1000 Lives Plus national improvement programme that supports organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales and provided examples of a number of improvements as a result of the Transforming Care programme that operates under 1000 Lives Plus. These included protected mealtimes, a Welsh language version of 'This is Me' leaflet for those with dementia, and an increase in direct care with more focus on pressure ulcers and falls prevention. 1000 Lives Plus provides extensive opportunities for the sharing of good practice and a wide range of improvement resources and initiatives, though it is not clear how widely these opportunities and initiatives are taken up or resources used.

However, as stated earlier, the evidence from NHS organisations is patchy with regard to how they are systematically spreading and embedding good practice throughout all their services or working together to spread good practice across NHS Wales.

Staff knowledge and skills

The Commissioner welcomes the new pre-registration nursing curriculum that requires all nursing students to spend 50% of their time on practice placements. It is positive that an All Wales Governance Aligning Nursing Skills Framework is being developed to identify the skills base and continuing professional development (CPD) needs of the nursing establishment specific to the needs of the patient they care for. Reference is also made to updating training requirements for Health Care Support Workers and exploring running a pilot of the training resource on 'Growing Older in Wales' funded by Age Alliance Wales. It is concerning, however, that the only information provided by the Welsh Government on the percentage of appraisals being conducted in NHS organisations was in relation to doctors – and only 52% of these had an annual appraisal in 2011-12.

There were some positive findings in the 2012 NHS Wales Staff survey, which showed that the majority of staff (86%) said they were happy to go the extra mile at work and 82% felt their role made a difference to patients. However, of concern is the 35% of nurses who said they have moved into clinical areas

where they have not felt confident or competent to work. The potential impact that this could have on patient care and safety is a significant risk that needs to be addressed.

Similarly, in a policy briefing in 2012, as part of work on their 'Time to Care' campaign, the RCN reported that in 2011 there was a 16% reduction compared to 2009 in the proportion of their members receiving any CPD, with only 75% of their members receiving it.

Overall there is not yet sufficient evidence to show that all staff caring for older patients have the appropriate levels of knowledge and skills, or that sufficient progress has yet been made in developing specialist training for such staff and there is a need for more attention to be paid to this recommendation.

Next Steps

This second progress report shows that the recommendations made in 'Dignified Care?' in 2011 and the action plans developed and implemented by NHS organisations have had an impact in improving the care of older people in hospital and that the Welsh Government, Health Boards and Velindre NHS Trust now give a much higher priority to ensuring that the NHS in Wales provides everyone with safe, high quality, dignified and compassionate care. The Commissioner welcomes the Welsh Government's commitment to place much more information about the performance of the NHS in Wales into the public domain on a routine basis and the introduction of annual quality statements.

However, this progress report also shows that much more needs to be done and there are still too many cases of poor care being experienced by older people and of the NHS in Wales failing to get the basics right.

The Commissioner expects the NHS in Wales to significantly strengthen its understanding of the patient experience whilst in hospital, at ward level, and be able to measure the impact of the wide range of actions now underway upon the patient experience. This must be done on an on-going basis and used to drive not only the development of initiatives aimed at improving care but also the systematic embedding of a culture of continuous improvement.

All Health Boards and Velindre NHS Trust, who are accountable for the safety and quality of patient care, must routinely assess the safety and quality of their care and be able to provide the public the reassurance it has a right to expect. It is the Commissioner's view, and the Welsh Government has agreed, that future reporting of progress against these areas for further improvement will now be included within the new Annual Quality Statements and be embedded within the Standards for Health Services in Wales that NHS organisations have to comply with and which are used by HIW to assess the quality of care. This will ensure that the areas for further improvement identified by the Commissioner become part of the routine assessment and scrutiny of the NHS in Wales.

The Commissioner will make ongoing public assessments of the new Quality Statements published by NHS organisations and the Welsh Government. The onus will be on those bodies, through these reports, to evidence to the Commissioner, and more importantly to older people, that improvements in care are on-going and continuous, that patients' voices are being sought and listened to and that Boards are discharging their duties effectively in respect of their accountability for ensuring that care is safe, effective and that patients are treated with dignity and respect.

The Commissioner will, in addition, continue to keep under review the wider

quality of care of older people and the progress made by the NHS in Wales and where she considers that that there is not sufficient progress being made or there are continuing cases of poor care or treatment that indicate a systemic problem in a particular area she may undertake a further formal review into those specific aspects of care. It is the Commissioner's view that the Welsh Government should also seriously consider converting the current Standards for Health Services into regulations that Health Boards are legally obliged to comply with, together with clear consequences and sanctions for non-compliance.

The focus there now is on dignified care and the wider safety and quality of care must not be allowed to fade in the future and NHS Wales must be able to demonstrate routinely and publicly that it is providing the best care possible while also dealing robustly and quickly with any situations where there is evidence that this is not being achieved. At its heart, the NHS in Wales must have a culture that refuses to accept or tolerate poor care and considers failures to learn as unacceptable.

At its best, our healthcare in Wales is outstanding, and we have many dedicated healthcare staff, but still, too often, we are failing to get the basics right.