PUBLIC MEETING 30TH JANUARY 2014

CONCERNS ABOUT

PRINCESS OF WALES AND NEATH PORT TALBOT HOSPITALS

SUMMARY

The meeting was held at the Best Western Heronston Hotel in Bridgend and was attended by 100 people. A number of others expressed interest but were unable to attend. It was chaired by Peter Walsh, Chief Executive of the patient safety charity Action against Medical Accidents (AvMA). The meeting was addressed by Mr Gareth Williams, who lost his mother at Princess of Wales Hospital after she had suffered "appalling" standards of care. Her case had prompted Health Minister, Mark Drakeford, to commission an independent review of care at the hospitals. Numerous family members spoke of similar experiences. Mr Paul Roberts, Chief Executive of the ABMU Health Board attended and gave a brief address apologising for what had been serious lapses in standards; giving assurances that steps had already been taken to improve things, and committing to continue to work to improve standards, listening to the experience of patients and families.

Key themes arising from the meeting:

- Most people attending had experience of extremely poor care and had lost loved ones.
- Most cases involved care of elderly patients, but other categories of patients had also been affected.
- Problems extended beyond Princess of Wales/Neath Port Talbot to other hospitals under ABMU Health Board.
- End of life care and care of patients with diabetes were particularly recurring themes.
- Almost all who spoke had had a negative experience of trying to use the complaints procedure/Putting Things Right scheme.
- Many who spoke felt that they had been dealt with dishonestly. In some cases this had been confirmed by subsequent investigations, for example by the Ombudsman.
- There was consensus at the meeting that the majority of staff working in the Health Board's hospitals were professional, caring and doing their best to do a good job under difficult circumstances. There was no question of demonizing staff in general. Rather, there was a joint interest in getting to the bottom of how the problems came about.
- Two 'whistleblowers' – staff who had worked within the Health Board and had had serious concerns about standards also attended and showed great empathy with the

experience of others present. There was recognition that staff need to be listened to and protected when raising concerns.

- There was a strong consensus that the review currently being commissioned by the Health Minister was inadequate to get to the root causes of the problems. There was a need to hear directly from patients/their families about their experience and from staff about their concerns.
- There was strong agreement that a public inquiry into the failings of the Health Board overall was required.
- It was also generally accepted that some issues arising from the experience locally required a Wales-wide response. In particular, the "Putting Things Right" scheme needed to be reviewed and improved.
- There was a strong feeling that there needed to be accountability for the situation having been allowed to arise and continue. Many present called for the resignation of the Chief Executive and others at the Health Board who were responsible for upholding standards.

Next steps:

- The majority of those present wanted to join together as a group to maintain pressure for a public inquiry. Planning has already started for the "ABMU Victims Support Group"
- AvMA offered to facilitate communication between group members; share its experience of the Mid Staffordshire and other public inquiries; and to take up issues of joint concern with authorities. However the charity and the ABMU Victims Support Group would remain entirely separate and independent of each other.
- AvMA will help pull together a dossier of people's experiences. People are therefore requested to send a short summary of their experience/key concerns, or relevant reports such as an Ombudsman report to AvMA: chiefexec@avma.org.uk
- For those with ongoing complaints, inquests or potential compensation claims, AvMA's free advice service was available (Helpline, Monday to Friday 10 am – 5 pm 0845 123 2352). AvMA could also introduce people to accredited clinical negligence solicitors if required.
- A number of those present were already being represented by a number of different solicitors. AvMA would encourage discussion between the various firms to explore the possibility of a 'group action'.
- A meeting will be organised shortly for those wishing to play an active role in campaigning for an inquiry and improving standards (a planning committee).
- Other members of the group would be kept informed of developments and further opportunities for everyone to get together may be organised.

Peter Walsh 05.02.14