Public Accounts Committee

PAC(5)-03-19 : 4 February 2019

Inquiry into Governance Review of Betsi Cadwaladr University Health Board: Lessons Learnt

Briefing Pack from North Wales Community Health Council

Document	Comment
HIW Inspection Report – Hergest Unit – January 2016	This report outlines ligature risks present at that time. The 2014 report had found the same risks previously and set out an action plan which was formally agreed with BCUHB. The 2016 report notes the lack of progress despite assurances that the action plan had been implemented. The ligature risks across the Mental Health Estate were not finally addressed until late 2018. Failure to act on HIIW notices of immediate improvement has been, sadly, a regular occurrence.
Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning - Executive Summary of the HASCAS report – comments on Governance Arrangements	"*4.4 Nevertheless it was also identified that, on occasions, the experience of some patients and their families was compromised due to a combination of systemic failures exacerbated by significant financial restrictions, poor service design and ineffective governance arrangements."*
Lack of Progress under Special Measures – CHC letter of 19th March 2018 to Cabinet Secretary. Also CabSec response of 13th April 2018	This letter sets out North Wales CHCs concerns about the failure of BCUHB to progress under Special Measures. Almost all of these concerns are still extant. We believe the new Chair to be performance focused and determined to resolve the internal issues. The response of the Cabinet Secretary is also attached.
Complaints and Concerns Handling – two email memos from NW CHC advocates are attached.	These emails outline the day to day experience of our Advocacy Team and the difficulties they face in getting appropriate and timely responses. BCUHB have recently made some claims about vastly improved performance in relation to the 30 day response target. We do not recognise this and believe it is being achieved primarily by sending out "holding" letters explaining why the matter will take longer than 30 days. There are further comments on BCUHB complaints handling below under the commentary to the Ockenden Report.

Ockenden Report - 2018 Full report: http://www.donnaockenden.com/downloads/news/2018/07/Donna_Ockenden_Full_Report_2018.pdf (543 Pages) Executive Summary: http://www.donnaockenden.com/downloads/news/2018/07/Tawelfan_Executive_Summary_English.pdf (53 pages)	**Complaints Handling - Page 32** "Throughout 2017 service users were still requiring considerable support from their Assembly Members (AM's) and North Wales Community Health Council (NWCHC) to resolve complaints with BCUHB and the Ockenden team has seen extensive evidence of the support provided by NWCHC and AMs respectively. (For reasons of confidentiality these documents have either been provided directly from the service user/service user representative or with the consent of the service user/service user representative for information to be shared.)" **"***Overall there was deep dissatisfaction and unhappiness amongst those attending the events about the 'concerns' and complaints system at BCUHB both overall and specific to older person's mental health care.***"** This section of the Ockenden Report shows that 3 to 4 years on from the closure of Tawel Fan, the problems of mental health care in North Wales were still not being addressed effectively. --- **16.26 North Wales Community Health Council (NWCHC) visits to Bryn Hesketh in 2016-17** There were three unannounced visits by the North Wales Community Health Council (NWCHC) to Bryn Hesketh in 2016/17. These took place on: • 18th October 2016 • 10th February 2017 • 8th May 2017 The NWCHC visits to Bryn Hesketh in October 2016 was to 'review the beds and staffing levels [and] to look at amenities and fabric of the unit.' (NWCHC 2016, page 1) The visit in February 2017 was a follow up visit to the October 2016 visit. The visit in May 2017 was described as a follow up visit to review actions undertaken following the previous visits in February 2017 and October 2016 (NWCHC 2017 page 1.)

	The latest NWCHC report in May 2017 says of Bryn Hesketh: 'The hospital staffing levels are now in a desperate state.' (NWCHC page 1.) The report states that of the six Band 5 vacancies in the unit, (a further deterioration of two since October 2016) three vacancies were described as 'filled.' These were student nurses who were not registering until September 2017, four months later. Of four Band 6 staff, only one was available for work at the time of the May 2017 NWCHC visit. The unit was staffed by a number of bank and agency staff. Not all of these staff had received appropriate training in 'Restrictive Physical Intervention.' (NWCHC page 2.) This had been raised at the NWCHC visits of October 2016 and February 2017. The report states that there is no doctor available at night in Bryn Hesketh, the unit 'depends on the duty doctor in the Ablett unit being available.' The report notes that one patient from the local area was receiving care in Bradford. (NWCHC 2017, page 2.) Out of area care and treatment was a concern from service user representatives in the 'Listening and Engagement' events held by the Ockenden review throughout the spring and summer of 2017. The report describes that Bryn Hesketh unit 'had been refurbished to a high standard' and that the open spaces were 'delightful.' The NWCHC team were 'delighted to see it being used by patients making full use of the safe area.' (NWCHC 2017, page 3.) --- **20.3 Working with the North Wales Community Health Council (NWCHC) to facilitate the events:** The Donna Ockenden governance review team worked with the North Wales Community Health Council ('NWCHC') in facilitating these events. The North Wales Community Health Council ('NWCHC') is the independent health services 'watchdog' for North Wales. Its role is to represent the interests of patients and the public who use the health services across North Wales. This role is of great importance given that every person is likely to experience the health service at some time in their lives, to varying degrees and in different ways. NWCHC also plays a role in influencing the way that health services are planned and delivered, in order to ensure the best possible health and wellbeing outcomes for the people of North Wales. The Ockenden review team considered that NWCHC's strength lay in both its statutory status

	and in its ability to represent the interest of patients and the public. In considering the best way to facilitate effective user engagement and listening events across the six counties of North Wales the Ockenden governance review team considered the NWCHC to be an effective and long established link between BCUHB (as those who plan and deliver health services) and the public Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health as end users and recipients of that health care. NWCHC has a vision statement which simply says 'NWCHC will work to develop health services which are influenced by the views and involvement of the patients and the public of North Wales' (NWCHC 2017).
HASCAS independent investigation and Ockenden governance review: progress report	This BCUHB document sets out progress against the improvement areas set out in the HASCAS and Ockenden Reports. This is a programme that they undertook to complete by May 2019. Progress to date is disappointing and seems to be limited to the creation of policy – rather than the fundamental change of culture and practice called for by the Tawel Fan reports.
Breach of PTR Procedures – On the Spot resolution	Correspondence relating to the use of "On the Spot" resolution. CHC were/are concerned that this ad hoc local procedure removes complainants rights under PTR and prevents them referring their concerns to the Public Service Ombudsman for Wales
Plaudit from Tawel Fan Families	See attached an unsolicited plaudit

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health/ Learning Disability Inspection (Unannounced)

Ysbyty Gwynedd: Hergest Unit: Betsi Cadwaladr UHB

6 - 8 January 2016

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1. Introduction

Our mental health and learning disability inspections cover both independent hospitals and mental health services provided by the National Health Service (NHS). Inspection visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services in Wales.

During our visits Healthcare Inspectorate Wales (HIW) ensures that the interests of the patients are monitored and settings fulfil their responsibilities by:

- Monitoring the compliance with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards
- Complying, as applicable, with the Welsh Government's National Minimum Standards in line with the requirements of the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The focus of HIW's mental health and learning disability inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plan
- Supported to be as independent as possible
- Allowed and encouraged to make choices
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

2. Methodology

The inspection model HIW uses to deliver the mental health and learning disability inspections includes:

- Comprehensive interviews and discussions with patients, relatives, advocates and a cross section of staff, including the responsible clinician, occupational therapists, psychologists, educationalists and nursing staff
- Interviews with senior staff including board members where possible
- Examination of care documentation including the multi–disciplinary team documentation
- Scrutiny of key policies and procedures
- Observation of the environment
- Scrutiny of the conditions of registration for the independent sector
- Examination of staff files including training records
- Scrutiny of recreational and social activities
- Scrutiny of the documentation for patients detained under the Mental Health Act 1983
- Consideration of the implementation of the Welsh Measure (2010)[1]
- Examination of restraint, complaints, concerns and Protection of Vulnerable Adults referral records
- An overview of the storage, administration, ordering and recording of drugs including controlled drugs
- Consideration of the quality of food
- Implementation of Deprivation of Liberty Safeguards (DOLS).

[1] The Measure is primary legislation made by the National Assembly for Wales; amongst other matters it makes provision in relation to assessment, care planning and coordination within secondary mental health services.

3. Context and description of service

Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Hergest Unit on the evening of 6 January and all day on the 7 and 8 January 2016. We inspected all three wards, Aneurin, Cynan and Taliesin the Psychiatric Intensive Care Unit (PICU)[2]

The Hergest Unit is a specialised mental health hospital situated within the grounds of Ysbyty Gwynedd Hospital run by Betsi Cadwaladr University Health Board (BCUHB) and provides a comprehensive range of acute mental health services including psychiatric intensive care services (PICU).

Aneurin and Cynan are both acute wards, each having 16 beds. Aneurin accommodates female patients and Cynan ward male patients. Taliesin is a six bedded PICU.

During our inspection we reviewed patient records, interviewed patients and staff, reviewed the environment of care and observed staff-patient interactions. HIW's review team comprised of one peer reviewer, one lay reviewer and two members of HIW staff.

[2] A psychiatric intensive care unit (PICU) provides care and treatment for people experiencing the most acute phase of a mental illness. A PICU is a safe, secure and low stimulus ward environment.

4. Summary

Our January 2016 visit to the Hergest Unit at Ysbyty Gwynedd was a follow-up visit, focusing primarily on the issues that HIW identified in May 2014. It was pleasing to note that considerable improvements had been made to address some of the matters we identified in our previous visit as well as other improvements. These included:

- the intensive care suite (ICS) had been modified with a separate en-suite facility which provided improved privacy and dignity for patients using this facility.
- Patient information displayed on whiteboards in the nurses' office was covered up when not in use. This improvement enabled patient information to be visually protected from visitors and other patients.
- Mandatory training for staff had improved considerably with higher compliance rates across all wards. We did however identify some areas in which improvement needed to be made and this is listed under the Training section of the report.
- A system was in place for staff to receive regular and documented supervision, with the majority of staff confirming that this takes place on an on-going basis.
- The achievement of AIMS[3] in 2015 reflects improvements made at the Unit.
- Staff morale had improved and was generally good across all wards, however, some frustrations were identified which the health board need to consider and act upon (see Governance section)

[3] AIMS - Accreditation for Inpatient Mental Health Services. AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. www.rcpsych.ac.uk/AIMS

- Advocacy services were spoken highly of by both patients and staff and the independent patient forum was a very positive initiative
- Patients and staff spoke favourably of the food served at the unit in relation to the quality, choice and portions of food served.

In addition to the improvements noted, we also identified good practices which we have continued to observe during our visits to the unit. These were specifically the receptive way staff engaged with the inspection programme and the number of positive staff and patient interactions we observed throughout our visit.

Despite the good practice identified, we also found significant scope for improvement in a number of areas. Following our visit we issued an immediate assurance letter to the health board regarding concerns that could potentially pose a risk to the safety of patients. The purpose of this letter was to seek assurance from the health board of the actions they have and will undertake to mitigate the risks. The areas we have identified for improvement are documented in Appendix A, but a summary of the main issues include:

- A considerable pressure on in-patient beds with the number of patients exceeding the 16 available beds, on both Aneurin and Cynan wards. Frequently a 17th and 18th bed are provided on the wards to accommodate additional patients. Existing patients could also be moved around the wards. This situation is very unsettling for patients and creates difficulties for staff.
- Issues regarding staffing were identified, specifically on Aneurin ward. We identified that on a number of occasions there was only one registered nurse on the ward and sometimes they were the 'bleep'[4] holder for the whole unit. A significant number of occasions were identified when staff had not been taking breaks due to the demanding workload and nature of the ward. Some staff had accumulated

[4] Bleep holder holds the bleep for communication purposes. The bleep holder will be used to contact members of the team for emergency and urgent calls and respond to Section 136 admissions.

significant time owed to them due to staff shortages and the need to work overtime.

- A number of vacancies across the unit including medical, nursing and support staff
- A ligature risk assessment had identified significant safety issues across the three wards. Numerous ligature risks were identified which included beds, door closures and bathroom pull cords. It was identified that new beds had been ordered in August 2015 and at the time of our visit had not arrived. The outstanding actions from the ligature risk assessments, which are undated need to be addressed and completed as a matter of urgency.
- The admission criteria for the Unit needs to be reviewed to ensure that patients can be cared for appropriately. A number of patients had been recently admitted with a more organic type of illness e.g. dementia and these patients require specific care for their individual needs.
- A number of sets of patient documentation were examined on Aneurin ward and some significant issues were identified in relation to the care and treatment of a patient who had recently fallen.
- Environmental issues were identified that need to be addressed and include water temperatures that were too hot in some areas and too cold in others. Windows that inappropriately screwed shut and could not be opened. In addition the nurse call systems did not meet the guidance documented and initiated by the health board on the Risk of Falls Pathway.

5. Findings

Core Standards

Ward environment

The Hergest unit is a self contained building situated in the grounds of Ysbyty Gwynedd. The unit has its own entrance and reception. The unit is single storey with three operational wards and a number of offices for staff.

On entering the reception area, doors lead to a number of areas and wards, including Taliesin ward, a psychiatric intensive care unit (PICU) and two acute wards Cynan for male patients and Aneurin for female patients.

Taliesin ward is a six bedded PICU for both male and female patients. The ward is locked with access to the ward via a key fob system for staff and an intercom system for visitors. The ward provided six single bedrooms which contained a wardrobe for patients to store personal belongings. Patients on the ward had access to shared gender specific toilet and showering facilities. The observation panels in the bedroom doors could only be operated from the outside.

Taliesin ward had a shared lounge with enough seating for the number of patients the ward can accommodate. A TV was fitted to a wall and there were some books on the window sill. There were two tables in the lounge and some pictures on the wall. Taliesin ward did not have any single gender lounges.

The dining room at the time of our visit had one table and four chairs which was not enough for all patients to eat together, however there were a number of easy chairs in the room.

It was pleasing to note that following our previous visits the intensive care suite (ICS) room had been modified and improvements made to the room that included a separate en-suite facility. A clock was also visible to allow patients to orientate themselves when in this room.

Patients had access to an outdoor area. The garden was contained and used only by patients on Taliesin. The garden had seating and areas of shrubbery which made the garden area more pleasant.

A payphone was situated in an open space which did not provide privacy for anyone using it.

Not all the call bells situated in bedrooms and other patient areas were within easy reach of patients.

The ward environment was adequate for a PICU and provided low stimulus areas that this ward requires.

Aneurin (female) and Cynan (male) wards were environmental duplicates of each other. They both were 16 bedded wards with a mixture of single and dormitory style bedrooms. Each ward had shared bathroom, showering and toilet facilities. We noted that signage on the wards required updating because bathrooms had signs stating male or female areas on them instead of being specific to the gender that the ward was accommodating.

Patients in single bedrooms on Aneurin and Cynan wards could lock their bedroom doors but this could be over ridden by staff if necessary. There were no locks on the dormitory rooms. The observational panels in bedroom doors could only be operated on the outside. Therefore patients were unable to control the observation panel for key day to day activities, such as undressing.

On Aneurin ward we noted that the bathroom had two bars of soap stored on the side of the bath, which was a potential infection control issue. In the shower room a number of products were stored on the radiator, including shampoo, shower gel and air freshener. The items were not appropriate to be left in the room due to the harm they may cause an unattended patient, especially if the bathroom door was not locked. The flooring in the shower room had burn marks from a recent incident and needs to be cleaned or replaced.

At the time of our visit the water temperature in the bath on Aneurin ward was very hot and in the bathroom on Cynan ward the water was running cold. No temperatures were being regularly recorded by staff to ensure an appropriate water temperature was available. At the time of our visit, we requested evidence that these temperatures were being recorded on a regular basis but documentation was not provided.

Throughout all the wards staff told us that some windows would flap open and bang if the weather was windy. This was due in part to the lack of closures on the windows and to overcome this on some wards that windows were screwed shut. In a dormitory on Aneurin ward all three windows were screwed shut and could not be opened to allow air to circulate. In addition, the windows that could be opened on the wards had potential ligature risks.

We identified a number of nurse call bells in rooms including bathrooms and bedrooms that were not conveniently located. In a number of bathrooms, the call bell was situated opposite the toilet. Therefore if a patient required assistance then they would have difficulty accessing the nurse call system. In addition, dormitory bays had one nurse call system for three or four patients. A review of patient access to call bells is required because it is in direct contradiction to the instruction written on the ‘Risk of Falls Pathway’

document, which clearly states call bells must be in sight and reach of patients at all times.

We identified a number of ligature risks throughout all the wards, especially beds, door closures and bathroom pull cords. This needs to be addressed in accordance with the ligature risk assessments, which are undated that was undertaken.

Aneurin and Cynan wards had pictures displayed on the walls of the corridors and both wards had notice boards displaying a good range of information and leaflets in both Welsh and English.

The lounges on both wards provided easy chairs, TVs and tables. At the time of our visit, the lounge on Aneurin ward was being utilised by a number of patients who were knitting and one patient reading. There was a puzzle on the table that had been started by a patient and there were book shelves with games and books available.

Both wards had their own garden areas which were small but landscaped.

A section 136 suite was available at the Hergest unit, which provided adequate facilities for persons using the suite.

Recommendations

Water temperatures across all wards need to be checked and regularly monitored to ensure a safe and consistent temperature is maintained. This was of particular concern in the bath on Aneurin ward.

All windows across the unit need to be reviewed, specifically windows in patient bedrooms and areas to ensure they can be operated appropriately and do not present a ligature risk.

Signage across all wards needs to be updated to ensure it is appropriate to the patient group.

Patient access to call bells needs to be reviewed because it was in direct contradiction to the Falls Pathway documentation and in one dormitory there was only one call bell for up to four patients.

A review of all the required actions from the ligature risk assessments need to be undertaken as a matter of urgency.

Safety

Discussions with patients highlighted that the majority with whom we spoke said they felt safe at the Hergest Unit. Two patients who said they didn't feel safe gave examples of other patients having the potential to be violent and concerns about who could enter the dormitory bedroom because they were unable to lock the door. The majority of staff we spoke to did not identify any safety issues, however some did mention potential ligature risks in bathrooms and with beds. Staff had mitigated these risks by locking the bathroom door so patients have to request to use it, however the door on Aneurin bathroom was not locked on the evening of our inspection.

We identified issues around staffing, specifically on Aneurin ward. There had been a number of occasions when one registered nurse was on the ward and had also been the bleep holder. Therefore if they were dealing with the bleep call their ward would have been left without a nurse or would have had to borrow another registered nurse from a different ward. We also identified a significant number of occasions when staff were not taking breaks and as a result some staff had accrued a significant amount of time owing. These areas need to be reviewed to ensure patient and staff safety.

Over occupancy of beds was clearly an issue on Aneurin and Cynan wards. Frequently additional beds were put on the wards to accommodate additional patients. At the time of our visit, Aneurin ward was over capacity. There was one patient in the general hospital receiving care and treatment for a fractured hip. Their bed had been allocated to a new admission and if the patient was to return to the ward an additional bed would be required.

In addition to the above, there had been a number of occasions when the bronze on call had told staff at the Hergest to put up additional beds for new admissions. This situation has resulted in inappropriate admissions being made, with a male patient being admitted to a female ward. Staff on call were not always aware of the service provided by the Hergest unit and this needs to be reviewed and changed to ensure on call staff have knowledge of the service and where necessary gain specific advice from nursing staff at the unit to ensure admissions were appropriate.

A number of potential ligature risks were identified throughout the wards specifically beds, door closures and pull cords in bathrooms. It was pleasing to note that new beds had been ordered in August 2015, however, at the time of our visit they had not been delivered. Staff had also put measures in place to mitigate risks in patient bathrooms. All areas need to be reviewed and actioned in accordance with the ligature risk assessments.

We noted during our night visit that not all staff were wearing personal alarms on Aneurin and Cynan wards, despite the allocation of alarms to visitors. It is

important that staff safety is reviewed and personal alarms are worn by staff at all times.

The information contained on the patient board on Aneurin ward was difficult to understand. The board at the time of our visit appeared to list 20 patients when there were not 20 patients on the ward. After some scrutiny we concluded that three patients listed were not currently on the ward. One patient was on Taliesin, one patient was an inpatient in the general hospital and other was on long term community leave. Some improvements to the notice board should be made to avoid any confusion in relation to actual patient numbers.

Concerns about the patient mix was raised by some staff, stating that some patients are being admitted that staff feel were unsuitable for the unit. Not only has this resulted in some incidents, there were concerns that facilities were not available or suitable especially for patients with dementia. Some members of staff also felt they might not have the necessary knowledge and experience to nurse dementia patients.

Recommendations

The staffing issues identified need to be addressed, specifically to ensure staff take breaks and time accrued is effectively monitored and managed. The allocation of the beep needs to be reviewed to ensure no wards are left without a registered nurse.

The over occupancy of beds must be addressed as a matter of urgency.

Staff assigned to the bronze on call system need to have improved knowledge of the Hergest unit to ensure their decisions are appropriate so that staff and patient safety is not compromised because of those decisions.

A review of usage of personal alarms is required to ensure staff are allocated and use alarms when on duty.

The multi-disciplinary team

The staff we spoke to felt their team worked in a professional and collaborative way and attended regular case reviews for their patients.

Multi disciplinary team meetings (MDT) are attended by the disciplines that have been involved with that particular patients care. Staff told us that psychology were more accessible because they were based at the unit and therefore could see patients quickly. MDT meetings take place on a regular basis, however some staff did state that community teams/key workers find it difficult to attend meetings.

Some members of staff felt that their views/opinions were not valued by some members of the clinical team. All members of staff must feel valued and professional views respected by all members of the clinical team.

The number of consultants for some wards were as many as seven which meant a lot of wards rounds and pressure on nursing staff. Staff told us that they had a ward round timetable to accommodate the number of consultants for their ward, but some consultants could turn up unannounced, again putting additional pressure on nursing staff.

Staff said they regularly attended staff meetings however at the time of our visit no minutes were available for Aneurin ward. Some minutes of meetings were presented after our feedback session. It is essential that regular team meetings take place and minutes capture the discussions and outcomes to enable all staff to be aware of them. Staff had handover meetings between each shift.

Recommendations

All members of the MDT must feel part of the team and that their opinions are valued and respected within the MDT.

Privacy and dignity

Some patients had single bedrooms and other patients were in three or four bedded dormitories. Discussions with patients and staff did confirm that everyone would prefer single occupancy bedrooms. In the dormitories curtains are used to separate individual beds, however curtains do not provide privacy for patients to discuss personal matters with staff and patients complained of being disturbed by other patients.

A lack of space on the wards was commented on by both patients and staff. Patients told us that there were limited places to meet with family and friends on the wards and staff said there was not enough space for one-to-one meetings with patients.

The majority of patients we spoke to said they were shown around the ward when admitted and 50% of patients we spoke to could confirm they had a named nurse.

The patients we spoke to told us that staff respected their privacy and dignity and would knock on bedroom doors before entering. Observation panels in bedroom doors were operational from the outside only, therefore patients could not alter the panel from inside their bedrooms in order to obtain privacy.

Patients had access to phones to maintain contact with family and friends. Some patients had their own mobile phones, while others had access to a ward payphone. At the time of our visit, there was one broken telephone on Aneurin ward. The other telephone could only receive incoming calls. The payphone on Taliesin ward was situated in the corridor and did not provide any privacy for the person using it. Staff told us that patients could use the office phone if they requested.

It was pleasing to note that following previous visits, patient information displayed in nursing offices on white boards was covered when not in use, therefore protecting patient information.

Patient therapies and activities

Displayed on wards were activity timetables offering patients a range of activities between Monday and Friday. Facilities at the Hergest unit were wide ranging and included an occupational therapy (OT) kitchen, art and craft room as well as an activity room. The activity room provided patients access to games, books, table tennis, a piano, computers without internet access and a treadmill.

Despite the facilities available, the majority of patients we spoke to told us that they didn't have enough activities to do and only a few patients said they had been asked what they like to do. One patient told us that they found the days long because of limited activities and that the facilities were not being used because patients need to be escorted by staff.

Discussions with staff confirmed that patients can only use the above facilities if staff were available. At the time of our visit, use of the facilities was limited because there were no activity co-ordinators in post.

Occupational therapy staff described their process of assessment, which starts with a referral from the ward or community mental health team. OT staff undertake a baseline assessment using various standardized and non-standardized assessments. The end result is an individual plan for the patient which is documented and saved in their care plan so all staff can follow it.

OT staff told us that they run group and individual sessions for patients which might include cooking, shopping, using transport and home visits. During term time, on two evenings a week, students facilitate activities such as art, table tennis, watching films and music. On weekends, activities which have included trips out to local attractions were arranged and organised by ward based staff.

Patients who do not have Section 17 leave are more restricted in their choice of activities. Informal patients do not have these restrictions.

During our night visit we saw a group of patients knitting and crocheting and observed a positive interaction between patients and staff.

There was dedicated psychology input for the unit, however during our visit we were unable to meet with them for specific feedback. Staff confirmed that no weight, diet or smoking cessation programmes were offered to patients.

If patients required access to other services, such as a dentist, optician and/or podiatrist this would be arranged by staff. General physical health screening was carried out by staff.

Posters were visible on the wards advertising advocacy, Citizen Advice Bureau and Hafal services, they included contact details. The majority of patients we spoke to knew how to make a complaint should they need too and also knew how to contact the advocate. All the staff we spoke to told us how good these services were and how regular they attend the unit to support patients. Having external services that can support and help patients with their concerns and are well thought of by patients and staff is noteworthy.

In addition to the above, an independent patient forum run by Unllais undertakes monthly patient meetings. Patients from each ward are invited to attend the meetings to raise any suggestions and/or concerns. Minutes from the meetings are displayed on each ward and ward managers are required to respond to the any actions arising. These independent patient forum meetings are a positive initiative and an example of transparency by the Hergest unit regarding patient care.

Recommendation

The appointment of activity co-ordinators is required to ensure the provision of OT is not negatively impacted upon.

General healthcare

We identified a number of issues regarding the Frailty Project which must be addressed. These included:

- Numbers were in excess of the planned bed availability.
- Patient access to the nurse call alarm system was not available despite the health boards 'Risk of Falls Pathway' document clearly endorsing a call bell in sight and reach of patients at all times.

- Development of a group of specialist staff is required because of the patient mix evident on the wards.
- Training needs to be improved to adequately provide for this patient group.
- Flexible admissions to be considered because some patients under the age of 65 may require the service.

Recommendations

The areas identified regarding the frailty project must be addressed, specifically bed availability provision, specialist staff, staff training and admissions for patients under the age of 65.

Food and nutrition

All the patients and staff we spoke to commented favourably on the food served at the unit. Patients were offered four meals a day, including breakfast, lunch, tea and supper.

Patients were provided with menus to choose their meals from. Their choices included a vegetarian option. In addition, snacks were also available including sandwiches and/or jacket potatoes.

All the patients we spoke to said the food portions were ample and that there was good variety offered. Staff told us that patients with specific dietary needs were catered for and access to dieticians was available.

Any patient requiring a drink or snack outside of the set mealtimes was able to obtain one. Hot and cold drinks were available as was a variety of snack options stored in the ward kitchens. Patients did have the choice to order a take away on Saturdays if they wished.

Patients were weighed regularly as part of their general physical healthcare.

Training

We reviewed 10 staff files and identified some inconsistencies with the employment information contained on file. One file had a checklist which had confirmed all the pre and post employment information had been obtained including job description, application form, two references, interview notes, contract of employment and induction. However none of this information was on file. Other files reviewed had emergency contact details and certificates of

fitness while other files did not have this information. A standard approach needs to be applied across all staff files to ensure consistent employment processes.

It was pleasing to note that systems were in place to ensure that professional registrations were up to date. Ward managers check websites to ensure compliance with registrations and the e-rostering system provides a flag up system to staff when registrations are a few months from renewal.

Following on from previous visits, a much more robust and well documented system of staff supervision was in place. Discussions with staff confirmed that the majority receive regular formal supervision which is documented. A number of informal supervision sessions also take place of which staff spoke positively.

Eight out of 10 staff files reviewed had evidence that they had received a performance appraisal and development review in the last 12 months.

A programme of mandatory training was in place for staff and a system was being used to capture, record and monitor progress for each employee. An analysis of training statistics across the three wards did highlight significant improvement in compliance rates. There were a number of areas that need improvement and these need to be monitored to improve compliance. Such areas included equality training which was under 30% compliance on Taliesin and Aneurin wards. In addition health and safety training which was under 30% on Aneurin and Cynan and 10% on Taliesin ward.

There were some vacancies across the unit that need to be filled to ensure a full complement of staff. We identified a lack of activity co-ordinators across the unit and this was having a negative impact upon OT provision because their resources were being spread thinly. The recruitment of a ward clerk is required because at the time of our visit one ward clerk was being shared between all three wards. In addition, a high number of responsible clinician (RC) vacancies were still outstanding. Locum RC's were filling vacancies on a temporary basis. A review of staffing is required to ensure a full complement of staffing can be filled for the unit.

Staff told us morale was better across the whole unit, however some staff spoke of their frustration when issues take a long time to resolve. Staff dynamics were also cited as affecting morale.

We were told by staff that there was a lack of debriefing/lessons learnt sessions for staff following patient incidents and incident reports were not available following an incident. It is essential that this area is reviewed and staff attend a debriefing/lessons learnt session to ensure good practices are continually delivered and risks mitigated as much as possible.

Since our previous visit in May 2014 the Hergest unit has promoted initiatives to develop staff. Therefore it was pleasing to note that the unit had achieved AIMS.

Recommendations

A standard approach needs to be applied to all staff files to ensure that evidence of all appointments is consistent.

A review of staffing is required and recruitment to some key posts is necessary to ensure wards are operating at full complement.

Staff morale, particularly on Taliesin ward needs improvement, with a specific focus on the time frame to resolve issues and staff dynamics.

Debriefing/lessons learnt must form part of staff communication to ensure good practices are continually re-enforced and risks mitigated as far as possible.

Governance

A high number of responsible clinician (RC) vacancies throughout Betsi Cadwaladr health board continue to be unfilled. During the feedback meeting we were assured that this issue is being addressed. A recruitment strategy is required.

The demand on in-patient beds as described in the ward environment section requires urgent attention. A bed management strategy is required to deal with the issue. In addition, better knowledge and understanding of the service requirements for those staff on bronze on call needs to be addressed to ensure admissions are appropriate.

Delays in obtaining new furniture, including new beds which had been ordered in August 2015 need to be reviewed. The time lapsed is unacceptable and impacts upon ligature issues.

Despite improvements in staff morale throughout the unit there was evidence of low morale on Taliesin. Staff dynamics were cited as key factors. A review of these issues needs to be undertaken.

Recommendation

A review of the governance/audit systems and processes need to take place to ensure the health board has robust and adequate information conveyed to them.

All the areas identified must be addressed, specifically:

- A recruitment strategy to fill the high number of RC vacancies

- A bed management strategy to manage the demand of in-patient beds
- An acceptable time frame for the delivery of new furniture needs to be established
- A review of and strategy to deal with the issues on Taliesin ward regarding staff morale

Monitoring the Mental Health Measure

We reviewed the care and treatment planning documentation for six patients at the Hergest unit and identified the following observations:

- One patient had a risk of falls identified but no care plan was in place to address the risk

- The observation records for one patient who fell were missing and could not be located

- One patients self elected use of a wheelchair was not risk assessed or care planed

- The use of the Mental Health Measure documentation needs to be improved because there was a lack of detail on the files we reviewed. As a consequence further training in the use of the Measure needs to be implemented.

Recommendation

All the areas identified must be addressed, including ensuring all risk assessments are undertaken and in place for patients, observation records are maintained and are accessible. The use of the Mental Health Measure documentation needs to be improved.

Application of the Mental Health Act

We reviewed the statutory detention documents of three of the detained patients being cared for on one of the wards. The following issues were identified:

- Section 17 leave forms were in need of updating as 'to' dates had expired and recording of leave was not easy to follow.
- Section 17 leave was not being evaluated.
- Observational recording sheets did not have dates.
- The files we reviewed had evidence that patients had been read their rights and that an independent Mental Health Advocate (IMHA) had been involved. However there was no evidence on the files or audits in place to confirm that these actions were being repeated.
- The Mental Health Act administrators were not receiving hospital manager reports in time.
- Due to the number of locum doctors, MHA administrators have to continually check that the doctor is an approved clinician and section 12 accredited.

Recommendations

All the areas identified must be addressed, specifically to ensure section 17 leave and observation forms are appropriately completed and evaluated, hospital manager reports to be completed and submitted to the MHA administrators in a timely manner. Patient rights need to be read and evidenced accordingly and systems are required to ensure checks are completed promptly for locum doctors to prove their approved clinician and section 12 status.

6. Next Steps

The health board is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit its Improvement Plan to HIW within two weeks of the publication of this report.

The health board's Improvement Plan should clearly state when and how the findings identified at the Hergest Unit will be addressed, including timescales.

The health board's Improvement Plan, once agreed, will be published on the Healthcare Inspectorate Wales website and will be evaluated as part of the on-going mental health/learning disability inspection process.

Appendix A

Mental Health/ Learning Disability: **Improvement Plan**
Health Board: **Betsi Cadwaladr University Health Board**
Hospital: **Ysbyty Gwynedd, Hergest Unit**
Date of Inspection: **6th – 8th January 2016**

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
1. Ward Environment				
1.1 Water temperatures across all wards need to be checked and regularly monitored to ensure a safe and consistent temperature is maintained. This was of particular concern in the bath on Aneurin ward.	1.1.1 All baths must be temperature checked using a thermometer before patients enter the water, based on best practice across the Health Board.	1.1.1 Confirmed at Senior Nurses Meeting 11th February 2016 that water temperatures are to be checked using a thermometer on all wards, and any issues should be raised immediately with the Estates Team. All thermostatic devices fitted to water outlets are checked every six months for correct functioning and adjusted accordingly by Operational Estates. Where fitted to a bath, a failsafe test is also carried out to ensure the hot water supply is automatically shut off if the cold water supply fails.	Locality Manager; Matron Estates Operations Manager – West	31st March 2016 31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	1.1.2 Health Board best practice to be identified and clear guidance provided to ward nurses on temperature range.	1.1.2 Locality Manager to discuss with Learning Disability Services Matron and develop guidance.	Locality Manager	31st March 2016
1.2 All windows across the unit need to be reviewed, specifically windows in patient bedrooms and areas to ensure they can be operated appropriately and do not present a ligature risk.	1.2 See 1.5.2	1.2 This matter has been logged on the Risk Register. A detailed external Audit has been commissioned through external Consultants. This work defined the high risk areas which in turn has necessitated the completion of RA for the management of specific clinical areas. This work was completed by the Clinical MH&LD teams. The Anti-Ligature Project Team have procured a BCUHB wide Contractor Framework to undertake the project work which is scheduled to commence on the 1st March 2016.	Locality Manager Head of Capital	To begin 1st March 2016; running until 31st March 2017. Commencing on 1st of March completion by June 2016
1.3 Signage across all wards needs to be updated to ensure it is appropriate to the patient group.	1.3 Signage review is not currently part of the Estates plan for Hergest in 2016-17, as a decision needs to be reached by	An Interim solution to signage will be agreed between local management and estates.	Matron/Locality Manager/Director of Estates	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	the Division regarding the appropriate patient group for the Unit, which will affect any signage used.			
1.4 Patient access to call bells needs to be reviewed because it was in direct contradiction to the Falls Pathway documentation and in one dormitory there was only one call bell for up to four patients.	1.4.1 Patients assessed as being at risk of falls are given personal alarms worn on the wrist. These are in place and being used.	1.4.1 Complete	Matron	29th February 2016
	1.4.2 A wireless nurse call system will be investigated and a proposal sent to the Divisional Leadership Team for consideration.	1.4.2 Operational Estates representatives have met with the Matron to detail areas of shortfall. Costs will be obtained from Static Systems Group to provide suitable extensions to the existing system either hard wired or wireless as appropriate.	Estates Operations Manager – West	31st March 2016
	1.4.3 Floor sensors have also been purchased and were delivered 11/02/2016, to be fitted by end February 2016.	1.4.3Purchased and delivered, to be installed.	Matron	29th February 2016
1.5 A review of all the required actions from the ligature risk assessments need to be undertaken as a matter of urgency.	1.5.1 Purchase of anti-ligature beds.	1.5.1 New anti-ligature beds have now been procured and have been delivered- COMPLETE	Locality Manager	29th February 2016
	1.5.2 Review of required work to complete Anti-Ligature Project and prioritisation of same.	1.5.2 Extensive estates work regarding ligature risks have been reviewed formally in Estates sub-group and work prioritised	Head of Capital	To begin 1st March 2016 completion by June 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
		as per Anti-Ligature Project Plan which commences on 1st March 2016.		
2. Safety				
2.1 The staffing issues identified need to be addressed, specifically to ensure staff take breaks and time accrued is effectively monitored and managed. The allocation of the beep needs to be reviewed to ensure no wards are left without a registered nurse.	2.1.1 Implement a National Mental Health (Inpatient) Ward Acuity Process, and present the results of this to the Divisional Leadership Team to guide decision-making for the Unit.	2.1.1 This commenced in February 2016. Results are expected to be presented to Divisional Leadership Team in March 2016.	Locality Manager; Matron	31st March 2016
	2.1.2 Division to commence a review of the skill mix within the Unit based on results of 2.1.1, with particular regard to numbers of RMNs available in the Unit over the 24hr period.	2.1.2To commence once 2.1.1 complete.	Director of Nursing; Divisional General Manager	30th June 2016
	2.1.3 The Divisional Managers to have a system for closely monitoring e-rostering against the required staffing template. To ensure that e-rostering is fully utilised as a planner and management tool to ensure reliability and cross-cover within the Unit.	2.1.3E-roster use is currently being reviewed by Divisional Leadership Team.	Interim CRES Programme Manager	31st August 2016
	2.1.4 The Senior Nurse / Bleep Holder role to be in addition to establishment ward staffing, not part of it.	2.1.4This is already in place and occurs only in exceptional circumstances where mitigation to manage the situation is put in place.	Locality Manager; Matron	completed

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	2.1.5 Accumulation and use of TOIL to be managed under the current Health Board policy – audits to be undertaken followed by managerial intervention where required.	2.1.5 Matron to provide monthly position statement on TOIL to Divisional General Manager as of April 2016.	Matron; Divisional General Manager	1st April 2016
	2.1.6 Division to review how shifts are managed in practice, and introduce shift workplans across all wards. Effectiveness of shift workplans to be monitored through daily escalation tool and monthly quality audit.	2.1.6 Confirmed at Senior Nurses Meeting 11th February 2016 that shift workplans are to be in use on all wards, and any changes to the workplan due to challenges or pressures should be escalated to the Matron through the Daily Escalation Tool.	Matron	1st April 2016
2.2 The over occupancy of beds must be addressed as a matter of urgency.	2.2.1 The immediate use of the daily escalation support tool will be utilised for any bed which is being required.	In use across all wards; to be reiterated and included in all Senior Nurses Meetings. It was agreed by the Divisional Leadership Team on 15 February 2016 that to ensure the safest environment with appropriate staffing levels in the current accommodation, Hergest will operate 2 x 16 bed wards (plus PICU).	Locality Manager; Matron	1st April 2016 Completed
	2.2.2 Divisional Leadership Team	2.2.2 See above	Divisional	Completed

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	has provided definitive operational guidance regarding the management of finite bed numbers in the Hergest Unit (see above).		Leadership Team	
	2.2.3 The guidance document will set out bed management guidelines to staff and managers with regard to bed pressures and escalation when required.	The Hergest Operational Policy will be reviewed and revised to ensure clarity for admissions, including bed management.	Matron/Locality Manager	31st March 2016
	2.2.4 To manage capacity the Division will develop and maintain region-wide Bed Status Dashboard, accessible to Duty Nurses, Home Treatment Teams, Matrons and On-Call Managers.	2.2.4 Bed Management and Patient Flow is currently being reviewed by Divisional Leadership Team. An existing patient flow system used in acute physical health care will be considered and adapted for use in mental health care.	Interim Programme Consultant	31st August 2016
	2.2.5 Division to prescribe whole system "patient flow" protocols and apply to service, including Continuing Health Care, Delayed Transfer of Care, discharge planning milestones.	See 2.2.4	Interim Programme Consultant	31st August 2016
2.3 Staff assigned to the bronze on call system need to have improved knowledge of the Hergest unit to ensure their decisions are appropriate so that staff and patient safety is not compromised because of those	2.3 Divisional Leadership Team has provided definitive operational guidance regarding the management of finite bed numbers in the Hergest Unit.	See 2.2.2 above.	Matron/Locality Manager/ Divisional General Manager	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
decisions.	The revised Operational Policy document will set out bed management guidelines to staff and managers with regard to bed pressures and escalation when required.			
2.4 A review of usage of personal alarms is required to ensure staff are allocated and use alarms when on duty.	2.4 Personal alarms are available in sufficient numbers for staff and should be in use on wards.	2.4 In use across all wards; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager; Matron	Complete
3. The Multi-Disciplinary Team				
3.1 All members of the MDT must feel part of the team and that their opinions are valued and respected within the MDT.	3.1 Staff engagement exercise to be completed for West Locality to understand specific issues and challenges to good MDT working across all specialities. Implement the use of the NHS Engagement Diagnostic Tool and the NHS Wales staff engagement resource for all leadership roles in West Locality.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016
4. Patient Therapies and Activities				
4.1 The appointment of activity co-ordinators is required to ensure the provision of OT is not negatively impacted upon.	4.1 Two activity co-ordinators have been appointed and are pending employment checks. Expected to start work by April 2016.	4.1 Complete	Matron	1st April 2016
5. General Healthcare				
5.1 The areas identified regarding the frailty project must be addressed, specifically bed availability provision, specialist staff, staff training and	5.1.1 Division to consider development of complex / frail health care either within the existing ward environments or	Linked to 2.2.2 Divisional Leadership Team to explore alternative inpatient	Director of Nursing	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
admissions for patients under the age of 65.	whether a separate ward environment would be more appropriate.	environments able to provide safe, age appropriate care for complex, frail patients.		
	5.1.2 The Division to re-establish use of the falls pathway already introducedto clinical areas. The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.Confirmed at Senior Nurses Meeting 11th February 2016 that falls pathway will be in use across all wards; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager, Matron	Completed
	5.1.3 Division to investigate and procure as appropriate assistive technologies and supplementary equipment with regards to falls prevention, i.e. call systems that are ligature safe and bed sensors / alarms.	See 1.4	Matron	29th February 2016
	5.1.4 Division to commence active monitoring of the levels and complexity of patients currently under its care. To provide assurance that appropriate risk mitigations are in place.	See 2.1.1 Acuity review to be undertaken.	Locality Manager; Matron	31st March 2016
	5.1.5 A review of specialist skills required to support and meet all physical and mental health needs	See 2.1.1 To be based on results of acuity review.	Director of Nursing	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	must be undertaken across all inpatient areas of the Division.			
	5.1.6 Compliance against mandatory training to be reported in Locality Governance Meeting.	5.1.6 Report is sent to Locality Governance Meeting bi-monthly.	Divisional Training and Development Co-ordinator	29th February 2016
	5.1.7 Specialist training needs analysis to be undertaken as highlighted above.	See 5.1.5	Director of Nursing	31st August 2016
	5.1.8 Training in complex / frail health care issues to be delivered and ward "champions" identified to lead of care issues.	Training – see 5.1.5. Champion - The Locality OPMH Matron has been asked to be a visible presence on the Hergest Unit to support staff and to act as champion.	Matron; OPMH Matron	31st March 2016
6. Training				
6.1 A standard approach needs to be applied to all staff files to ensure that evidence of all appointments is consistent.	6.1 Staff file audit to be undertaken against standard guidelines of what information should be held in paper copy and what information should be on ESR.	6.1 to begin in May 2016	Locality Manager	31st May 2016
6.2 A review of staffing is required and recruitment to some key posts is necessary to ensure wards are operating at full complement.	6.2 Ward clerk has been appointed and pending employment checks. Expected to start work by April 2016.	6.2 Complete	Matron	1stApril 2016
6.3 Staff morale, particularly on Taliesin ward needs improvement, with a specific focus on the time frame to resolve issues and staff dynamics.	See 3.1 Staff engagement exercise.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
6.4 Debriefing/lessons learnt must form part of staff communication to ensure good practices are continually re-enforced and risks mitigated as far as possible. There are processes in place to ensure that lessons learnt are presented to the West Governance Meeting and the Divisional Leadership Team, however cascade processes are needed to ensure information is shared with all staff in the team.	6.1 Locality Scorecard is being developed which will capture this information and provide a route for cascading through the teams.	6.2 Locality Scorecard is being developed.	Interim CRES Programme Manager	30th June 2016
7. Governance				
7.1 A review of the governance/audit systems and processes need to take place to ensure the health board has robust and adequate information conveyed to them.	7.1 Governance processes across the Division are currently being reviewed. The Division will have a formal Quality, Safety and Experience Committee to act as central hub for all governance and audit information and ensure the appropriate flow of this information up and down through the organisation.	7.1 New governance structures and processes are being developed and will be introduced over the year as processes are finalised.	Director of Nursing; Associate Director Governance	30th June 2016
7.2 All the areas identified must be addressed, specifically: 7.2.1 A recruitment strategy to fill the high number of RC vacancies	7.2.1 A recruitment plan was put to the Medical Director and Director of Workforce and Development in July 2015. The Divisional Clinical Director will continue to seek support for this plan at a Health Board level.	7.2.1 The Divisional Clinical Director will continue to seek support for this plan at Health Board level.	Divisional Clinical Director	31st December 2016
7.2.2 A bed management strategy to manage the demand of in-patient beds	7.2.2 See 2.2.4	See 2.2.4	Interim Programme Consultant	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
7.2.3 An acceptable time frame for the delivery of new furniture needs to be established	7.2.3 See 1.5.1; furniture is being delivered in February 2016.	7.2.3 New non-ligature beds have now been procured and are to be delivered on 17th February 2016.	Locality Manager	17th February 2016
7.2.4 A review of and strategy to deal with the issues on Taliesin ward regarding staff morale	7.2.4 See 3.1; staff engagement exercise.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016
8. Monitoring the Mental Health Measure				
8.1 The review found that CTPs were not being appropriately updated to reflect inpatient care planning, including risk assessment, observations and Mental Health Measure documentation. There needs to be a consistent approach to management of CTPs from community and inpatient across the Division.	8.1.1 Locality Manager to discuss with colleagues in Central and East to understand how this issue is managed elsewhere.	8.1.1 Locality Manager to discuss in March.	Locality Manager	31st March 2016
	8.1.2 Results of that region-wide review to be discussed with Head of Nursing.	8.1.2 Locality Manager to present finding to Director of Nursing for consideration.	Director of Nursing	30 April 2016
	8.1.3 The Division will continue to monitor valid CTPs asa a percentage of team caseload: the standard set is 90%	8.1.3 On the 27th January 2016, the Division had achieved 85% compliance against this standard	Mental Health Measure lead: General Manager	30th June 2016
9. Application of the Mental Health Act				
9.1 Section 17 leave forms to be appropriately managed in line with the Mental Health Act.	9.1Reminder to all nursing staff regarding their responsibilities for ensuring forms are appropriately updated. Monitor appropriate updating of Section 17 leave forms through use of the monthly	The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	Locality Manager, Matron	1st April 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	Quality Audit.			
9.2 Observational records should be signed and dated and filed in the patient's notes.	9.2Reminder to all nursing staff regarding their responsibilities for ensuring observational records and signed, dated and filed. Monitor quality of observational records through use of the monthly Quality Audit.	9.2 Confirmed at Senior Nurses Meeting 11th February 2016 that observational records should be signed and dated and filed in the patient's notes; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager, Matron	Completed
9.3 Patients should be read their rights and offered the services of an IMHA, and this should be evident from the file. Processes already exist to ensure that this occurs at the time of a change to the patient's status; however there are currently no systems to ensure that patients are reminded of their rights or their access to an IMHA at relevant stages of their care.	9.3.1 Reminder to all nursing staff regarding their responsibilities for reminding patients of their rights and IMHA services, particularly at times when the patient's capacity is noted to have improved.	9.3.1 The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	Locality Manager, Matron	1st April 2016
	9.3.2 Adapt checklist in order to provide prompts to nursing staff on reaffirming to patients their rights under s132 MHA and IMHA access at periodic intervals. This will need to apply cross-region.	9.3.2 Locality Manager to discuss with Mental Health Act Manager and Co-ordinator.	Locality Manager; Mental Health Act Manager	31 March 2016
9.4 Hospital Managers reports should be received in a timely manner.	9.4 Mental Health Act Co-ordinators to escalate any delays with Hospital Managers reports through the Daily Escalation Support Tool, to the Locality Manager or Divisional Clinical Director for action.	9.4 Mental Health Act Manager will issue reminder to all staff who prepare Hospital Managers reports that any delays will be escalated as a matter of urgency from now on.	Locality Manager; Mental Health Act Manager.	29thFebruary 2016
9.5 Robust systems should be in place	9.5.1 The Mental Health ActCo-	9.5.1 The Clinical	Mental Health	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
to ensure that locum doctors are checked for Approved Clinician and Section 12.2 status.	ordinator must be notified immediately, via the Clinical Services Co-ordinator, of any/all changes to the senior medical workforce, including the full name of the proposed locum, and geographical area of employment to be covered.	Services Co-ordinator is integrating an alert for the Mental Health Act Co-ordinators into existing processes.	Act Manager; Business Manager	
	9.5.2 Divisional Clinical Director to write to Office of the Medical Director to request priority is given to responding to requests for approval.	9.5.2 Divisional Clinical Director to write to Office of the Medical Director	Divisional Clinical Director	29th February 2016

Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report

Executive Summary

This report was commissioned by
Betsi Cadwaladr University Health Board

May 2018

Report Author:
Dr Androulla Johnstone:
Chief Executive Health and
Social Care Advisory Service Consultancy Limited
and Independent Investigation Chair

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Contents

1 Preface

1.1 The Independent Investigation into the care and treatment provided on Tawel Fan ward was commissioned formally by Betsi Cadwaladr University Health Board (BCUHB/the Health Board) in August 2015 pursuant to the Welsh Government (Version 3 – November 2013) *Putting Things Right: Guidance on Dealing with Concerns about the NHS from 1 April 2013*. The Investigation was commissioned initially to examine specific concerns raised by some 23 families about the care and treatment received by their loved ones between January 2007 and December 2013. At this time the 23 families were held on the BCUHB open concerns register. In order to identify any other patients whose care and treatment might have fallen below an acceptable standard the Investigation was also asked to examine the archives developed during the following prior processes:

1. The Ockenden external investigation (conducted in 2014 and published in May 2015).
2. The North Wales Police investigation (2014-2015).
3. The Betsi Cadwaladr Mortality Review (2015).

1.2 Consequently additional patients were added to the Investigation Cohort which rose to 108 in number. Separate confidential reports have been prepared detailing the findings in relation to each case.

1.3 The Investigation was also commissioned to provide human resource management reports for any person employed by the Health Board identified with either conduct or competency issues in relation to any established untoward events or substandard practice on Tawel Fan ward.

1.4 The care pathways followed, and care and treatment received, by the patients in the Investigation Cohort have been examined closely in order to identify the lessons for learning. It is a matter of public interest to understand exactly what occurred on Tawel Fan ward, how expressed concerns were escalated and managed, and to establish the lessons for learning relevant to both local and national service provision.

1.5 Investigations of this kind should aim to increase public confidence in statutory health service providers and to promote organisational competence. It is the duty of any Independent Investigation Panel to conduct its work in an impartial and objective manner. This Investigation has endeavoured to maintain an independent and evidence-based stance throughout the course of its work with the aim of providing as accurate account of events as the available evidence allows.

2 Acknowledgements

Patients, Families and Friends

2.1 The Investigation Panel would like to extend its sincere thanks to the patients, families and friends who have contributed to this work. For some individuals the process has been a demanding one whereby challenging and difficult experiences have had to be relived.

2.2 The Investigation Panel has heard, and taken into account, a wide variety of views and concerns. There has been no unified set of experiences put forward; family accounts differ greatly. For example: some families stated that in their view Tawel Fan ward was an abusive environment where their loved ones were mistreated, neglected and came to harm. Other families offered the view that the care and treatment their loved ones received was of a very good standard with staff showing kindness and compassion throughout their relative's entire episode of care.

2.3 The Investigation Panel acknowledges the lived experience of every person who has come forward and has endeavoured to provide a fair and balanced view based on an independent analysis of events.

2.4 It should be recognised that each individual who came forward to the Investigation, either in writing or in person, gave a significant amount of their time to the process. We are grateful to them for this.

Witnesses

2.5 Independent Investigations commissioned via NHS frameworks do not have the statutory powers to compel witnesses to take part in proceedings. Whilst individuals who were either employed by the NHS (or who were still active on a professional register) had a requirement to take part in the Investigation, those to whom these conditions did not apply could not be compelled to take part against their wishes. The Investigation would therefore like to thank all of those participating individuals who are currently retired or who no longer work in health related activities for coming forward voluntarily to assist with the inquiry process.

2.6 Those current NHS employees who were called to give evidence were asked to provide information about clinical and managerial practice. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Health Board's senior management team who have granted access to facilities and individuals throughout this process.

Support

2.7 Investigations of this kind can cause a significant degree of distress and trauma to all involved (families, patients and staff witnesses alike). Prior to the commencement of the investigation process there was a requirement to ensure expert and timely support was in place. BCUHB provided access to timely, easily accessible psychological triage and commissioned an independent counselling and trauma therapy service. The Investigation Panel would like to extend its thanks for the level of support that was provided and continues to be provided.

Multi-Agency Partners and External Stakeholders

2.8 The Investigation Panel acknowledges with gratitude the inputs received from Betsi Cadwaladr University Health Board's multi-agency partners together with the Nursing and Midwifery Council and General Medical Council for their assistance and cooperation throughout. We thank them for their patience and the professional courtesies they extended throughout the course of the Investigation.

3 Investigation Terms of Reference

3.1 The original Terms of Reference (ToR) for the Investigation were agreed by BCUHB at the Board meeting held on 8 September 2015. Minor amendments were made in July 2016.

Terms of Reference

"Betsi Cadwaladr University Health Board has commissioned HASCAS Consultancy Limited to provide the lead independent investigator role in relation to the complaints, concerns and disciplinary matters arising from the investigation into the failings of care on Tawel Fan Ward in the Ablett Unit at Ysbyty Glan Clwyd.

Remit

To provide independent and comprehensive investigation management and triangulation of all previous investigation material and evidence which will include:

- *Police investigation statements and written evidence.*
- *External investigation undertaken by Mrs Donna Ockenden and written evidence collated and sent through to the Police and published report.*
- *Complaint files and correspondence.*
- *Internal investigations commenced and suspended when Police investigations commenced.*
- *Mortality review and report.*
- *Any internal audit or external report/review or other information held by the Health Board which is deemed relevant.*
- *Provide family point of contact where additional information to support concerns has and is being provided, meeting with families who have made contact and collate their evidence.*

Purpose

With the evidence available, triangulate all sources of information which will enable the evidence to be collated into a comprehensive public facing document (redacted) and an internal document (un-redacted) and additionally provided into two streams of evidence for the purposes of:

(1) Complaints Management

- *Collated into patient specific evidence so that a comprehensive summary can be made in response to each formal complaint that will stand up to external scrutiny and enable each family to be confident that all information has been used in the response. Where health care issues have been identified or harm caused, the Putting Things Right (PTR) regulations are considered with regard to Regulation 24, 26 and 33 (Harm and Causation).*

(2) Professional Regulation and Employment policies and procedures

- *Collated into staff specific evidence, so that the information which needs to be considered where omissions in professional practice and breaches in clinical standards are evidenced are individualised into summary evidence which can be used as Statements of Case if appropriate for consideration under BCUHB employment policies and where necessary onward referral to the relevant regulatory bodies for example the General Medical Council (GMC) and Nursing & Midwifery Council (NMC). In addition consideration must be given to the notification and or referral to Disclosure and Barring Service (DBS)/Independent Safeguarding Authority (ISA).*

Escalation

If at any time new information is identified the appropriate action must be taken to ensure escalation in line with the relevant policies and procedures.

Timescales

The Investigation will complete the work program which has been set out in 5 stages.
First Stage: August/September 2015
Second Stage: September/October 2015
Third Stage: October/November 2015
Fourth Stage: December/January 2016
Fifth Stage: January/February 2016

Reporting

In keeping with other large and complex NHS investigations a formal governance assurance process has been established for the Tawel Fan HASCAS Investigation.

Team and Resources

The Executive Director of Workforce and Organisational Development will be the Lead Executive Director on behalf of the Board overseeing these arrangements. This role will be supported by a team of senior managers who will provide the required Input and the professional expertise to contribute to the work of HASCAS who will lead the Investigation".

3.2 It should be noted that the Investigation underwent significant time slippage and the dates for the completion of each stage were not met. This was due principally to the Investigation Panel not being able to access key documentation in a timely manner.

4 Summary of General Findings and Key Lessons for Learning

Investigation Context

4.1 There always have been, and probably always will be, occasions when NHS services fail to deliver against the standards that it strives to achieve. The pressures that NHS services face are reported frequently in the media together with the recognition that patient care is sometimes compromised. It is important to recognise that this state of affairs, whilst regrettable, occurs for a number of reasons as part of the ebb and flow of daily service provision within the NHS.

4.2 The Investigation Panel does not seek to be an apologist for the NHS in general, or for BCUHB or Tawel Fan ward in particular, however it would be both unrealistic and unreasonable to visit harsher tests than those deemed to be acceptable for any other NHS service currently delivering patient care under the normal day-to-day pressures that are encountered throughout the United Kingdom. It has therefore been essential for the Investigation Panel to work in a manner proportionate to the circumstances and the available evidence base.

4.3 The Investigation Panel concludes that the care and treatment provided on Tawel Fan ward was of a good overall general standard even though there were key areas identified where clinical practice and process required development and modernisation.

4.4 Nevertheless it was also identified that, on occasions, the experience of some patients and their families was compromised due to a combination of systemic failures exacerbated by significant financial restrictions, poor service design and ineffective governance arrangements. However it should be understood that these issues were not as a result of any failings in relation to Tawel Fan ward *per se* but were encountered by patients and their families across a wide range of services on the care pathway that they travelled.

4.5 These issues encompassed problems from the point of first diagnosis through to (and often past) the point of discharge from Tawel Fan ward and/or the eventual death of a patient. These issues also included the lack of dementia friendly Accident and Emergency Department inputs and the difficulties patients and families encountered on medical wards and with other BCUHB services.

4.6 Tawel Fan was the common denominator in that of the 108 patients in the Investigation Cohort 105 were admitted onto the ward for a period of time. However it is evident that many of the concerns and complaints raised by families did not relate to the ward and that a significant number of families had nothing but praise for the care and treatment their loved ones received on Tawel Fan and for the kind and compassionate care provided by members of the treating team.

4.7 This view was not shared by all of the families in the Investigation Cohort; the Investigation Panel encountered significant dissonance between the accounts provided by family members. It has been a key responsibility of the Investigation Panel to ensure that no single view or family stance took precedence over any other and that all findings and conclusions were made after extensive examination and triangulation of the evidence available. It was also the responsibility of the Investigation Panel to ensure that the focus remained upon lessons for learning rather than calls for punishment and retribution which were entirely disproportionate to the actual findings and conclusions of the multidisciplinary expert Investigation Panel.

4.8 Whilst the Investigation Panel found the care and treatment provided on Tawel Fan ward to be of a good overall general standard, there were nine key factors that served on occasions to compromise the quality of the patient and family experience during the period of time under investigation. These factors are set out below and apply to the experience of the older adult (and their families) across the whole care pathway encountered including Accident and Emergency Departments, medical wards, old age psychiatry and community-based care.

Summary of General Findings

Factors Impacting upon Patient Care

4.9 **Governance.** During the period of time under investigation governance processes (both corporate and clinical) were weak across the whole of the BCUHB provision; this served to disrupt strategy development and implementation. This also served to prevent a robust approach from being taken in relation to patient safety in that evidenced-based practice and organisational learning were under-developed and could not always be relied upon to provide the levels of protection that were required.

4.10 Clinical governance provides the means to ensure patient safety and quality improvement; its effectiveness (or lack of it) has a direct impact on service delivery. In the most basic of terms the care and treatment delivered by BCUHB services was often compromised by:

- poor quality clinical policies and guidelines that did not always provide an appropriate and evidence-based set of standards for practice (particularly in relation to the older adult);
- limited training and education opportunities for staff;
- an ineffective approach to patient safety alerts such as those raised by complaints, incidents and safeguarding referrals;
- inadequate levels of capacity and capability in relation to the workforce in general and medical and nurse staffing in particular;
- ineffective clinical information systems which compromised access to individual patient information in a timely manner.

4.11 **The Care Pathway.** Most of the patients in the Investigation Cohort experienced problems with the care pathway that they encountered. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as

those for medicine and psychiatry, often served to create significant barriers which had a negative impact upon patients and the timely access to the care and treatment that they required. As a result patients often experienced:

- delays and restrictions when accessing the most appropriate clinical service (for example: inpatient medical care and hospice beds);
- distress and loss of dignity (caused by prolonged delays in A&E departments and medical assessment units);
- compromised care and treatment that was sometimes provided in clinical environments that were suboptimal;
- hospital acquired infections and injuries (exacerbated by delayed transfers of care);
- compromised levels of health, safety and wellbeing;
- multiple moves driven by service rather than clinical need with a subsequent loss of patient trust and confidence.

4.12 **Financial Pressures and the Consequences for Patient Care.** The financial pressures that BCUHB faced from the point of its inception (and including the period of time under investigation) made a significant contribution to both bed shortages and restrictions to service access (across the system as a whole). The organisation had to fund service developments from a 'zero funding base'. This meant that one service had to close before another could be developed. The interim period often caused pressures within the system (for example: when older adult psychiatric inpatient beds had to be closed during 2012 in order to develop community services) until the new service redesign benefits could work through the system; this had the effect of raising inpatient acuity levels.

4.13 Financial restrictions also placed pressures on staff recruitment practice which meant that clinical services could not recruit to staff vacancies in a timely manner. As inpatient acuity levels rose as a consequence of overlapping service redesign initiatives, the ability to access a workforce with the required capacity and capability reduced. Consequently competing financial pressures served to restrict access to services, increased patient acuity causing 'bottle necks' and delayed transfers of care, and reduced access to a workforce that could provide the levels of skilled care and treatment required.

4.14 **The Clinical Environment.** The clinical environment on Tawel Fan ward was not optimal for the patient cohort receiving their care and treatment there. The ward design did not lend itself to the safe management of the confused elderly person and the ward layout could not be adapted to provide single-sex accommodation.

4.15 In addition, over the years, the fittings and fixtures of the ward had deteriorated and constituted both a risk to health (for example: worn carpets which were trip hazards) and a decline in the quality of the patient experience (for example: the inability of the Ablett Unit boiler to provide a consistent supply of hot water).

4.16 **Care and Treatment.** The levels of care and treatment provided on Tawel Fan ward were of a good overall general standard. From the evidence available it is evident that good nursing care was provided and that the Fundamentals of Care

were maintained well. However on occasions care and treatment did not comply in full with national policy expectation and this meant a consistent and evidence-based approach was not always taken. Of particular note were issues in relation to:

- the management of falls;
- medications management;
- access to therapies (such as occupational therapy, speech and language therapy and psychological services);
- the formal recording of clinical risk assessment.

4.17 Nevertheless a key finding of this Investigation is that the care and treatment on Tawel Fan ward was in general safe and effective as evidenced by the contemporaneous clinical records, internal and external reviews and inspections, patient outcomes, and the evidence provided by a significant number of families who provided information to this Investigation.

4.18 **Safeguarding.** Systems and structures within BCUHB were not always robust enough to support the protection of adults at risk. This was exacerbated by a general lack of consistency on the part of Local Authority partners as to what constituted abuse and how this should be managed. Safeguarding referrals took a long time to process and did not meet the timescales prerequisite in policy guidance. This meant that Tawel Fan ward staff had to manage risks in the interim period without the level of external scrutiny and support required. There was an inability of the system to aggregate safeguarding trends (such as increasing patient acuity and rising levels of patient-on-patient assault) in order to formulate management strategies and workforce responses.

4.19 Despite problems with the system there is no evidence to suggest that Tawel Fan ward was an environment where abusive practice took place either as a result of uncaring staff who acted wilfully in an inappropriate manner, or due to a system that failed to protect. There is no evidence to support findings of abuse from a perspective of cruel or inhumane treatment and neither is there any evidence to support the notion of institutional abuse or neglect.

4.20 **Legislative Frameworks.** The Investigation Panel found that when patients were detained on Tawel Fan ward under the Mental Health Act (1983) processes were managed appropriately and in accordance with the legislation and Code of Practice.

4.21 However it was evident that on occasions patients who had been admitted informally should have been assessed under the Act with a view to formal detention. This is because those patients met the threshold for assessment and it was not always clear under which legal framework they were being kept in hospital and provided with care and treatment. In addition, apparent acquiescence was often taken to indicate that a patient did not need to have an assessment under the Act; however as they did not have the capacity to consent to admission and treatment they were in fact detained but without the legal protections afforded to patients sectioned under the legislation.

4.22 **Carer and Family Support.** During the period under investigation the levels of advice, supportive coordination, counselling and education provided to patients and their families were of an inconsistent standard at the point of first diagnosis. For many patients and their families this served to create confusion throughout the dementia journey that they embarked upon.

4.23 Consequently patients and their families were not always able to plan for the future in an informed manner and on occasions this compromised the levels of trust and confidence they had in NHS services and also compromised their ability to make decisions and be effective co-partners in care and treatment planning.

4.24 **The Clinical Record and Professional Communication.** During the period of time under investigation BCUHB operated (and operates still) a hard-copy clinical records system. Recording templates were inconsistent and were not subject to audit. This meant that the quality of the clinical records varied enormously.

4.25 Of particular concern was the archiving and retrieval system which meant that clinical records could not always be accessed with ease by members of treating teams. This created problems with continuity and, at times, compromised the efficacy of patient care.

Key Lessons for Learning

Patient and Family Support

1 **Counselling.** There is a need for a more comprehensive and specialist range of pre and post diagnostic counselling opportunities for patients and their families. Regardless of how well members of the treating team try to communicate diagnostic information they are to some extent boundaried by their primary clinical roles and functions. It is naïve to expect individual clinicians, no matter how caring and compassionate they are, to be able to provide a consultation in a memory clinic, or a ward-based family meeting context, in *lieu* of formal counselling.

2 **Dementia Coordination and Signposting.** There is a need for the better coordination of patients and their families from the point of first diagnosis; this is in keeping with Welsh Government strategy. Continuity of care and relationship building are essential factors when working with patients and their families over a long period of time, especially as the dementia process is both challenging and progressive.

If BCUHB is to meet the Welsh Government challenge to increase dementia diagnostic rates at increasingly early stages of the condition, an additional resource in relation to support will be required. This will need to be addressed as part of the current BCUHB Mental Health Strategy as increased success in one area will inevitably lead to service pressures in another.

3 **Clarification at the Point of Admission.** When admissions take place during times of crisis it is difficult for families to understand what is happening and what they are being asked to agree to. It is important to clarify events and revisit the decisions made and the subsequent consequences once the admission is complete and the patient has been made safe. It is not good practice for misunderstandings to arise; however on occasions these will be inevitable. To minimise the likelihood of this it is important that families are provided with a clear account of events as soon as is possible and that plans for the immediate future are discussed with them moving forward.

4 **Operational Policy Synchronisation.** In order to provide a streamlined service that can meet expectations it is necessary for there to be a consistent set of criteria in place to guide the care pathway. Operational policies should be developed from an 'integrated' service perspective so that patients and their families can be signposted correctly and reliably.

5 **Living Well with Dementia.** Over recent years a more positive and community-based approach to living with Dementia has grown. Clinical services need to ensure that they are in step with this ethos and assessment and care and treatment planning needs to focus on holistic need with the aim of providing meaningful person-centred care which does not focus on disease processes alone.

6 **Education, Information and Support to Patients and their Families.** People need access to education, information and support throughout their journey with dementia. 'Frontloaded' inputs at the point of diagnosis are not enough, and neither are meetings and consultations with members of treating teams once a person has reached a point of crisis. Consideration needs to be given as to how information can be provided and tailored to each stage of the journey, particularly at key points of transition such as admission to acute inpatient wards or eventual placement in care homes. It should also be understood that family support needs will be ongoing and they should be re-assessed and provided for in a dynamic manner.

7 **Communication Practice across all NHS Services.** Patient and family communication issues were identified in relation to Accident and Emergency, medical and surgical services. There is an obvious need for all NHS services to communicate well; however a key lesson for learning is that all services should (in addition) be dementia aware and appreciate the fact that family members often have to give consent for their loved ones who are no longer able to do this for themselves.

8 **Placing the Patient at the Centre of Decision Making.** The best interests of the patient should always be at the centre of any decisions made. When there are ongoing disputes between families and treating teams these disputes should be recorded and independent advice sought. It is essential that delays to important decisions are avoided (such as admission or discharge) as these can have a negative impact on the safety and welfare of the patient.

9 **Co-production of Care and Treatment Plans.** If adequate education, information and support is provided then people with dementia and their families will be empowered to co-produce care and treatment plans. The co-production of care and treatment plans should be about *"how do you want to live your life"* from the outset of the dementia journey.[1] The process of ascertaining preferred options in relation to treatment (and gaining knowledge about the person) should begin from the first point of contact.

Clinical Governance

10 **Documentation and Clinical Recording.** Where hard copy documentation systems exist clinicians have to work harder when both accessing information and recording it. This can present additional workforce challenges within often highly pressured services.

The hard copy clinical record system as it operated in BCUHB (and operates still) was not always reliable and caused significant problems in relation to both the transmission and transcription of clinical information. It is essential that standardised procedures are established so that records can be traced and accessed in a reliable and timely manner. Standardisation is also essential in relation to clinical documentation so that hard copy records capture all of the essentials of baseline assessment.

11 **Policy Guidance.** Clinical governance systems should provide as a minimum a clear set of policy guidance together with a set of organisational expectations about professional standards. National guidance provides clear best practice guidance for clinicians (regardless of discipline). It is the responsibility of each individual to ensure they are up-to-date and that they work within this guidance. However it is the corporate responsibility to highlight this guidance and to ensure that adherence is monitored and the quality of clinical care and treatment assured.

12 **The Management of Complaints and Concerns.** It is essential that families and their loved ones are informed about how to raise complaints and/or concerns and how these will be managed; where appropriate patients and their families should have access to advocacy services. Clear guidance should also be provided in relation to the management of investigation outcomes. Families should be advised that if they are not happy with investigation outcomes, and if their issues have not been addressed to their satisfaction by the NHS PTR process, then they should contact the Ombudsman. Health services should not endeavour to resolve complaints and concerns beyond the point advised in the All Wales Putting Things Right guidance. This can undermine the process and create a confrontational and intractable situation which is counterproductive and where neither side can move forward.

13 **Professional Standardisation.** Evidence-based clinical guidance and practice adherence is a key tenet of clinical governance. Without systems to ensure access, implementation, monitoring and review the quality of the

1 NHS Wales (2013) *Tools for Improvement 8 1000 Lives Co-Producing Services – Co-Creating Health*

patient experience can be compromised and suboptimal practice and/or unsafe practice provided.

14 **Policy Development.** Policy guidance should be tailor made to the needs of the older adult. It is poor practice to subsume them into policies produced for adults of working age whereby the evidence-base in relation to older adults is ignored and care and treatment guidance compromised as a result.

15 **Professional Leadership and Escalation.** When wards are under pressure it is essential that managers and senior clinical practitioners are available to provide advice, leadership and support. During 2013 when Tawel Fan ward was under its most significant period of pressure it was evident that the ward team were able to rely increasingly upon the Modern Matron, the Dementia Nurse Consultant and senior CPG managers. This ensured that (whilst care and treatment and service management issues arose) overarching safety was maintained whenever possible.

Legislative Frameworks

16 **Mental Capacity, Best Interests and Advocacy.** Legislative frameworks must be deployed for patients deemed to have a loss of capacity when making specific treatment decisions. This is of particular importance for those patients who are not detained under the Mental Health Act (1983). The use of independent advocates should be an integral part of any service provided.

17 **Patient-Centred Care.** It is important that care giving is flexible and sensitive enough to ensure dignity, health, wellbeing and safety whilst at the same time allowing the patient sufficient autonomy wherever possible. This applies to all patients, but is particularly relevant for those deemed to no longer have the capacity to make decisions on their own behalf. There should be no 'one size fits all approach' and care plans should take into account the needs and preferences of each individual patient which always take preference over those of families and services alike whenever appropriate to do so.

18 **Family Communications, Engagement and Support.** Legal frameworks are complicated to understand and often associated with preconceptions and stigma. It is important to ensure that each family member is acknowledged in accordance with their particular roles (Lasting Power of Attorney, nearest relative and/or next of kin) and their rights are both explained to them and supported. Strategies need to be agreed and put in place so that communication is effective (and bears in mind the needs of large families) without contravening due process in relation to decision making and confidentiality.

19 **The Need for Clarity Regarding Legal Frameworks.** NHS organisations must provide clear guidance to services about the use of the Mental Health Act (1983) and the Mental Capacity Act (2005); the guidance should clarify how they must work together and which takes precedence over the other and in what circumstances. These guidelines should be kept under review and audited where necessary on a patient-by-patient basis.

20 **The Protections that Legal Frameworks Afford to the Patient.** The Mental Health Act (1983) should not be seen as a punitive and restrictive option for the older adult with advanced dementia. Instead it should be seen as the framework under which individuals are protected and their rights upheld.

21 **The Importance of the Independent Mental Capacity Advocate (IMCA).** Under the Mental Capacity Act (2005) all patients have the right to access an IMCA. This is important when complex and difficult decisions have to be made in the patient's best interests as an independent advocate should always be accessed to ensure they are maintained and protected. When there are disputes between family members and the treating team the input from an IMCA is essential to ensure the patient's needs are paramount and that they are addressed in the best manner possible.

22 **The use of Legislative Frameworks.** Even if families are engaged in full, when difficult decisions have to be made in relation to care and treatment risk versus benefit analyses, Do Not Attempt Resuscitation (DNAR), end of life care and any planned changes to a clinical placement an Independent Mental Capacity Advocate should be involved where the patient is deemed not to have the capacity to make decisions on their own behalf.

23 **Accident and Emergency Departments and Medical Wards.** When elderly confused people are admitted to these kinds of NHS facilities the requirements of the MHA (1983) and MCA (2005) cannot be 'suspended'. They apply equally to all care and treatment environments where a patient meets the threshold for assessment and intervention under the Acts. All treatment decisions need to be recorded clearly and any issues in relation to capacity, consent and DoLS should be made explicit and managed in keeping with Acts. The failure to do so could result in illegal detention and the potential for improper care and treatment interventions.

Medication and Treatment

24 **Psychotropic Medications – Documentation and Standardised Evaluation Processes.** Psychotropic medications carry an inherent degree of risk. It is always good practice to adhere to National Institute for Health and Care Excellence (NICE) guidance and to ensure that documentation is completed in a systematic manner. This will ensure a comprehensive record is made of all decisions taken and will assist with a logical and evidence-based evaluation process. Where there are no pre-set organisational standards or clear levels of expectation clinical practice is determined by individual practitioners and might not always be optimal.

25 **Risk Assessment.** Risk assessment is a key cornerstone of clinical practice. As such it should be prioritised and conducted as a core multidisciplinary function. All aspects of clinical risk should be recorded and subsequent care plans documented clearly so that explicit rationales for clinical decision taking are set out and patients are protected.

Efficacy of the Care Pathway

26 **Resourcing.** Patients who are acutely unwell and in crisis require the highest levels of expertise and resource. It is poor practice for financial pressures to remove essential services from wards like Tawel Fan (such as occupational therapy and routine physiotherapy). The quality of the patient experience is reduced, the quality of the care and treatment compromised and the length of stay potentially lengthened. This kind of cost saving is both counter productive and ineffective. Care and treatment approaches should be multidisciplinary in nature. The older adult suffering from dementia often has a range of comorbidities and needs. It is naïve to assume these can be met by a 'traditional' doctor and nurse treating team.

27 **Transitions between Secondary and Primary Care.** The transition point between secondary care and primary care ought to be examined. Arrangements need to be agreed in relation to specialist assessment, monitoring and review once a person has been discharged back to the care of their General Practitioner. This is to ensure that antipsychotic medication is not used as a 'maintenance medication' and that all benefits and risk are kept under regular review.

28 **Access to Medical Assessment.** Psychiatric inpatients should not experience lower levels of medical assessment access than those to be expected in a community setting.

29 **Management of the Elderly Confused Patient in Acute Secondary Care.** Accident and Emergency Departments and Medical Wards must ensure that the care and treatment provided to elderly confused patients is person-centred, dignified and safe. It is not acceptable for them to be left for hours without food and drink, nursed in corridors, or left unsupervised encountering numerous falls that could be prevented with better assessment and management plans.

30 **Strategic Planning and Multiple Moves.** Service provision should be as integrated and person-centred as possible so that patients can experience smooth transitions of care which ensure optimal clinical outcomes and inspire trust and confidence. It is not acceptable for patient care to be compromised by rigid boundaries between services. It has long been recognised that multiple inpatient moves have been associated with raised rates of morbidity and mortality. It is never acceptable for multiple moves to be conducted to meet the needs of the service as opposed to the needs of the patient.

31 **Risk Assessment and Service Modernisation.** Service improvement and modernisation requires financial and service re-modelling. Improvements that require the concurrent running down of one service whilst another is built up carries inherent risks over the period required to enact the change; wards like Tawel Fan can be expected to absorb the pressures. The risks to the system and its ability to manage extant patient services should be understood and compensated for, particularly when specific groups of patients can be readily identified to be placed at additional risk during change management processes.

Safeguarding

32 **Connectivity between Multi-agency Partners.** Safeguarding frameworks require a consistent and unified approach. Despite the challenges posed by geographies (such as county and statutory agency boundaries) systems and processes have to be robust enough to provide person-centred safety measures. The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (first version 2010 and second version 2013) required small Unitary and Local Authorities to work together to ensure consistency and safety across geographical areas; it also required full cooperation between the NHS and Social Services. It is an essential lesson for learning that safeguarding systems and processes have to be managed across boundaries if they are to achieve their primary goal to safeguard adults at risk.

33 **Prioritisation and Adequate Resourcing.** Safeguarding adults at risk cannot be compromised by an organisation's perceived inability to adequately resource the systems and processes required. All NHS and Local Authority bodies are required to conduct themselves in accordance with policy guidance and any capacity and/or capability shortfalls should be addressed and managed so that their statutory duties can be fulfilled.

5 Overview of Conclusions and Recommendations

Overview of Conclusions

General Conclusions

5.1 The findings and conclusions in relation to BCUHB governance and systems failures have been identified previously by multiple review processes which have already been placed in the public domain. If an organisation operates with inadequate governance arrangements then the likelihood of poor service provision is heightened together with an increased inability to identify and remedy failings and patient safety problems. The findings and conclusions of this particular Investigation concur with those previous findings but also makes a separate and distinct contribution in relation to the following:

- the patient care pathway and service design;
- patient acuity and restrictions to service provision;
- evidence-based practice and the care and treatment of the older adult.

5.2 Any investigation process that undertakes an examination of care and treatment that took place a number of years ago has to differentiate between findings and conclusions that are 'historic' in nature and where practice has moved on and improved, and those where practice remains of a suboptimal nature and where urgent remedial action is required in the here and now.

5.3 The three points listed above have been identified by the Investigation Panel as being the basic underlying factors that made a distinct contribution to suboptimal care and treatment provision in the past and which the available evidence suggests are either still unresolved or in a relatively embryonic stage of service improvement and implementation.

The Patient Care Pathway and Service Design

5.4 One of the most significant findings of this Investigation is in relation to the fragmented care pathway followed by the majority of the patients in the Investigation Cohort; most of the patients in the Investigation Cohort experienced problems with the care pathway that they were placed on. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as those for medicine and psychiatry, often served to create significant boundaries which had a negative impact upon patients and the timely access to the care and treatment that they required.

5.5 Older adults are placed at significant risk when care pathways are not managed well. Disruptions to care pathways are known to increase the likelihood of hospital acquired infections and injuries and, on occasions, death. The poor management of the older person's care pathway across north Wales is a key finding of this Investigation. The lack of strategic direction and oversight,

combined with significant financial restrictions, meant that each separate CPG within BCUHB was allowed to develop levels of service provision without any interconnectivity in play. This led to a set of systems that functioned independently of each other and which could not address the day-to-day challenges posed by patients moving between services to the detriment of their health, safety and wellbeing.

5.6 There has been insufficient evidence provided to the Investigation Panel to suggest that in practical terms the experience of a patient would be significantly different today in comparison to that of patients from the Investigation Cohort. This is an area that requires priority and urgent action.

Patient Acuity and Restrictions to Service Provision

5.7 The Investigation Panel established that patient acuity rose on Tawel Fan in the years prior to its closure due to:

- the reduction of care home beds;
- a relatively embryonic community-based Home Treatment Team that could not manage patients in their own homes once they had reached crisis;
- reductions to the numbers of older adult inpatient beds across the Mental Health and Learning Disability CPG.

5.8 This situation was exacerbated by additional pressures placed on mental health services by Emergency Departments, inadequate Out of Hours provision and restricted access to medical and hospice services.

5.9 It is recognised widely in Wales that the number of people with dementia is rising steadily and will continue to rise. Pressures on nursing home beds remain and there is evidence to suggest that community-based services remain under-developed and that older people with dementia still experience compromises in relation to the kinds of service they can be offered in community, primary and secondary care settings.

5.10 The challenges for BCUHB and its multi-agency partners in 2018 is to provide a range of services that do not discriminate against those individuals with dementia and to ensure that a diagnosis of dementia is not one of exclusion or compromise.

Evidence-Based Practice and the Care and Treatment of the Older Adult

5.11 During the period of time under investigation BCUHB did not provide evidence-based clinical policies that pertained to the particular needs of the older adult with dementia and/or mental health problems. The needs of the older adult were subsumed into those for adults of working age which was entirely inappropriate. This lack of evidence-based guidance exacerbated fractures in service provision and led to a high degree of confusion on the part of the treating teams responsible for providing care and treatment.

5.12 Of particular concern was the fact that clinical practice was not subject to audit in the manner prescribed within the United Kingdom for the past twenty years. This meant that clinicians were left largely to 'their own devices' and that there were no structured clinical governance structures in place to ensure patient safety.

5.13 The Investigation Panel heard evidence from many senior clinicians during the course of its work. From the testimonies provided by those witnesses it would appear that the custom and practice around the development and auditing of clinical practice guidance within BCUHB is still in a somewhat embryonic stage. Witnesses described the work as 'being part of a journey', or 'not yet having reached its destination'. This is not acceptable for a modern NHS service and will require urgent and priority actions to take place.

5.14 Part of the challenge that BCUHB needs to face is the underlying culture of resistance to clinical policy uniformity and regulation. The Investigation Panel established that a key barrier to progress being made is predominantly one of custom and practice and that there are views still retained by some senior clinicians within the organisation that the clinical decision-making process should not be overseen by formal governance and management structures. This is exacerbated by a lack of organisational confidence and ethos in relation to formal oversight and performance management as a legacy of the highly devolved and medically-led service model that prevailed for many years within BCUHB.

The Issue of Wilful and Institutional Abuse and Neglect

5.15 The nature and scale of any failures in relation to patient care on Tawel Fan ward cannot be compared to those of the Stafford Public Inquiry or the Trusted to Care Independent Investigation (conducted in Wales), on either a macro (system) or micro (individual patient) level.

5.16 Neither of those robust and universally accepted reports set their findings within the context of institutional abuse or concluded that care and treatment deficits occurred within the context of an abusive system (even though care and treatment fell well below those standards commonly accepted by the general public and statutory services alike). The Investigation Panel concludes that this approach has to be maintained in relation to the circumstances encountered by patients and their families on Tawel Fan ward, especially as the standards of care on the ward have been found to be of a good overall general standard, even though on occasions care and treatment practice across the pathway was compromised.

5.17 The Investigation Panel could not replicate the specific findings of abuse from any of the earlier investigations and reviews that did. This does not mean that the Investigation Panel can categorically state that abuse on an individual patient basis *never* took place on Tawel Fan ward; no investigation of this kind could ever make such a bold statement. However the Investigation Panel can, and does, conclude that the evidence relied upon previously was:

- incomplete; and/or
- misinterpreted; and/or
- taken out of context; and/or
- based on inaccurate (and at times misleading) information; and/or
- misunderstood with thresholds being applied incorrectly.

5.18 The Investigation Panel therefore concludes that there is no evidence to support prior allegations that patients suffered from deliberate abuse or wilful neglect or that the system failed to deliver care and treatment in a manner that could be determined to meet the thresholds for institutional abuse.

5.19 It is essential that this conclusion is made in the clearest and most unambiguous of terms in order to restore public confidence and to ensure natural justice is served.

Safeguarding

5.20 Adult safeguarding frameworks exist purely to provide protection for adults at risk of abuse and neglect; they work at two levels. First: at a multi-agency Local Authorities are the lead agencies and are tasked to bring statutory and other agencies together to co-ordinate the development of effective policies and procedures to protect those at risk. Second: at a single agency level, each organisation must develop its own set of procedures that meet the requirements of the multi-agency framework and legislation, and deliver adult safeguarding services to protect adults at risk of abuse or neglect.

5.21 This Investigation found that the systems and processes in place during the period under investigation were not operating in an optimal manner and the expectations and requirements of the multi-agency policy documentation of the time were not met in full. At a multi-agency level, whilst the six Local Authorities endeavoured to bring agencies together around adult safeguarding for their areas, there is no doubt that the formation of the large Health Board in 2009 disrupted the pre-existing relationships that had developed over the years between local health and social care agencies.

5.22 Each of the Local Authorities developed their own approach to adult safeguarding under the umbrella of the *Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (2010 and 2013)*. Each developed their own safeguarding referral paperwork and it was reported to the Investigation Panel that there were differing referral thresholds in place. Systems and processes did not allow easy tracking of safeguarding information. Referrals were made by name and home address and did not monitor the place of abuse thereby making it difficult for Local Authority safeguarding staff to spot trends from particular clinical areas. In addition, individuals at this time were moving across both agency and geographic boundaries due to closures of care beds. It appears that safeguarding information did not readily follow individuals at risk across geographical boundaries and this built risk into the system.

5.23 These arrangements made it very difficult for clinical staff in the ward areas to navigate the adult safeguarding system easily. There were delays in the process of safeguarding, which often moved outside of the timescales in the policy, and ward staff who were responsible for the protection of the individual whilst they were in their care, often did not receive feedback in terms of what had been decided within the safeguarding meetings rendering ongoing protection and decisions regarding discharge, difficult.

5.24 During the period of time under Investigation there were poor safeguarding record storage and retrieval processes. This resulted in staff being unclear about what protection processes they were supposed to be putting in place and how to best deal with relatives when they were considered to be a risk to the individual in their care. As a result, information to individuals, families and carers was not conveyed clearly which led to confused expectations and understanding of what was happening.

5.25 In relation to BCUHB processes, the Investigation Panel found that adult safeguarding had not been well resourced and each CPG had been allowed to develop its own processes and structures. In addition, Board oversight was not strong and the Executive and Independent Members were not advised clearly of the problems relating to adult safeguarding in either the multi-agency partnership or specific clinical areas. Audit systems during this period of time were rudimentary, so opportunities for BCUHB to triangulate data about safeguarding referrals were lost.

5.26 At the time of writing this report there was evidence to suggest that good foundation work is taking place in relation to the restructuring and resourcing of the internal BCUHB safeguarding frameworks and processes. However a substantial amount of service development is still required in order to ensure safeguarding works to protect adults at risk across north Wales as many of the issues identified by the Investigation Panel are still a problem within current service provision. The Investigation Panel concludes that this constitutes essential and priority work for the organisation and those responsible for its performance management moving forward.

Summary of General Conclusions Specific to Clinical Care and Treatment

5.27 Many of the findings and conclusions made specifically in relation to Tawel Fan are to a large extent redundant as the ward is now closed. However there are key issues that have been identified in relation to clinical practice that need to be highlighted as they are relevant to the care and treatment of the older adult and/or those with dementia regardless of clinical setting.

5.28 Many of the findings of the 2014 *Trusted to Care* report dovetail into those of this Investigation. Basically the needs of the older adult and those with dementia require specialist nursing and medical care and treatment. Older adult services should not be seen as 'Cinderella' services but should be recognised as priority services that require clinical staff with expert skills and access to specialist

training. Resources should be ring-fenced to ensure that neither old age nor dementia exclude any individual from accessing appropriate and timely care and treatment.

5.29 During the period under investigation older adult and dementia services were neither planned nor coordinated with the degree of organisational strategic oversight that was required. This not only made an impact upon the quality of the care pathway patients and their families encountered, but also made a direct impact upon the effectiveness of the care and treatment that they received.

5.30 It is of significance that during the period of time under investigation there were no older adult or mental health clinical specialists at Board level or within the senior corporate team. Inspections, strategy and assurance processes were overseen by those with limited expertise and a limited understanding of what evidence-based service provision and care and treatment should look like.

5.31 At the present time significant work has taken place to make services more aware of the needs of the older adult and those with dementia. However the approach taken remains rather *ad hoc* with separate clinical divisions approaching these issues differently. The work currently being undertaken is primarily being led by the mental health division and BCUHB needs to move away from the stance that dementia is primarily the concern of mental health services and embrace a different ethos where the Health Board accepts the care and treatment challenges of old age and of dementia embrace all health and social care provision in all care and treatment settings. However one very positive step has been the decision to appoint a dedicated dementia specialist into the corporate nursing team to ensure that in future a more integrated approach is taken; in this manner resources are beginning to be aligned to support pace and consistency.

5.32 Moving forward BCUHB needs to ensure all aspects of clinical governance come together to ensure the particular needs of the older adult and those with dementia are met. This needs to include workforce capacity and capability, education and training, clinical audit and evidence-based practice guidance, patient safety and safeguarding. Alongside this costed and timed strategic plans need to be developed spanning the entire of breadth of service provision to ensure the needs of the older adult and those with dementia are inbuilt into every service and care and treatment context. The work that needs to be undertaken *must* be built across all executive teams and clinical divisions to ensure full integration and a unified strategic ethos.

Recommendations

Overview

5.33 The setting of recommendations is a primary task for any investigation process. In the case of BCUHB the situation is complex in that the organisation is currently subject to action plans stemming from various other investigation, review and performance management processes; it should also be taken into account that at the time of writing this report the organisation was still subject to

Special Measures. Not all of these issues are related directly to Tawel Fan ward or older peoples' mental health services, but many share a degree of interconnectivity.

5.34 The Investigation Panel has not been privy to all of the outstanding issues or the levels of progress made by BCUHB to-date. To this end the recommendations fall into two distinct categories – the first requiring a concerted degree of oversight (and possible further development) from Welsh Government in relation to ongoing high-level performance issues, and the second requiring practical, operational service change within BCUHB requiring a less intensive level of oversight from external bodies.

5.35 In addition BCUHB will soon be in receipt of the Ockenden Governance Review. This review will provide a significant number of recommendations in relation to governance systems, structures and processes. Consequently this Investigation has limited the setting of its recommendations to strategic and specific clinical practice issues. Following the publication of the Ockenden Governance Review further work will need to be undertaken to provide synergy in relation to action planning and the recommendations from both of the separate investigative and review processes.

5.36 On reviewing the progress made by BCUHB in relation to many of the current recommendations it is working to, it is evident that moving forward *all* future recommendations need to be overseen with the support of a structured action plan that sets:

- clear milestones, aims and objectives;
- clear performance targets and indicators;
- clear methods of audit and evidence collection, progress review and assurance;
- clear costings and resource implications;
- clear indications of where multi-agency inputs are required;
- clear timeframes and completion dates;
- clear methods of accountability and oversight.

5.37 With this in mind the Investigation Panel has reviewed the progress made by BCUHB in relation to the findings and conclusions of this Investigation. The recommendations have been set with the intention of supporting the work that BCUHB has already embarked upon and to also ensure that future strategic planning incorporates inputs from Welsh Government particularly where multi-agency partners also need to make significant contributions to planning, process and service provision.

5.38 The Investigation Panel has identified that during the period of time under investigation, and into the present day, many BCUHB initiatives have either been confounded or rendered ineffective by a lack of integrated, strategic thinking and planning. The recommendations set out below place emphasis on the importance of joined-up thinking and integrated service planning. The expectation is that all recommendations will be completed within 12 months of the publication of this report.

Category One: High-Level Recommendations Requiring External Oversight and Further Development

The Dementia Care Pathway and Service Design

Progress Made

5.39 BCUHB has developed a series of initiatives to improve the quality of the patient and family experience when accessing services for the older adult with dementia. There is a newly developed 'Care Pathway for Patients Developed with Dementia on Medical Wards'. There is also a 'Carer's Passport' initiative which improves the access and practical support available to carers when visiting their loved ones in clinical settings. This is all good practice.

Progress Required

5.40 It is not the intention of the Investigation Panel to detract from the work that is currently taking place within BCUHB. However the newly developed Care Pathway document focuses solely upon very basic patient and carer support and nursing care standards. The care pathway work and service redesign work that is still required is more complex and strategic in nature.

Recommendation One: Care Pathway and Service Design

- An integrated service review is required to map the needs of the older adult and those with dementia across north Wales. This review needs to involve all stakeholders (from the statutory, independent and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those confined to mental health and older adult services) in order to ensure that all interventions are integrated and that patients, service users and their families do not encounter service barriers that prevent them from receiving access to the care, treatment and support that they need.

- The review outcomes and options should underpin all current and future health and social care strategies across north Wales and be overseen by the appropriate performance management and inspection bodies.

Implementation of the National Wales Dementia Strategy

Progress Made

5.41 BCUHB has made significant progress in relation to many key areas detailed within the Wales Dementia Strategy:

1 The Health Board has a designated Consultant Nurse in Dementia care who provides input at a strategic and clinical level into services.

2 There are currently a wide range of opportunities for patients and families to obtain support through memory services and the third sector (such as the Alzheimer's Society). In addition BCUHB dementia training is now open for

families and carers to participate in. This training has been developed alongside families and carers who have provided evaluation. Across the Health Board there are an increasing number of Nurse Specialists with enhanced skill sets to provide ongoing support to patients with dementia and their families/carers.

3 There is a Delirium and Dementia Specialist Nurse available to provide expertise to individuals and services. There has also been a strong focus on the recruitment of Dementia Support Workers who are working across the organisation together with ten Dementia Activity Workers who are further supporting patients when accessing mental health services.

4 The Flynn and Eley Review highlighted the importance of support for those affected by or living with dementia at or around the point of diagnosis. They recommended that BCUHB develop a standard offer of post diagnostic support for people living with dementia and their families as part of a wider network of support.

Significant progress has been made in respect of this recommendation. Memory services have been redeveloped and mapped to local need so that supportive interventions can be offered in each locality in the language of choice supported by dementia support workers and third sector organisations. In the first year of operating over 700 new patients accepted the offer of meeting with a Dementia Support Worker and from that cohort 54 percent have gone on to receive further input.

5 BCUHB has produced a Dementia Handbook in conjunction with the Alzheimer's Society which is given to patients and their families at the point of diagnosis.

Progress Required

5.42 The Investigation Panel acknowledges the steady progress that BCUHB has made in relation to patient and carer support. However a great deal of work still needs to be done. At present the Dementia Strategy is a high-level document that will require further detailed action planning if it is to be implemented in a consistent and sustainable manner. The progress already made (as listed above), together with the progress still needing to be made, should be subsumed into a distinct strategy implementation programme which is supported by a costed and timed action plan.

Recommendation Two: Dementia Strategy

- BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with Recommendation One. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the Mental Health Directorate) in all care and treatment settings (community, primary and secondary care).

- The action plan should take into account all of the clinical and practice deficits that have been highlighted by this Investigation and will require independent clinical input and oversight.

- Access to therapy and non-medical interventions and treatments should be an integral part of any costed Dementia Strategy plan which takes into account NICE (and all other) best practice guidance in this regard. The capacity and capability of the workforce should be reviewed to ensure that fit for purpose services can be provided. Implementation should be managed and audited in tandem with Recommendation Ten (see below) as the reduction of the use of antipsychotic medication will to a large extent be predicated upon alternative therapeutic interventions being made available.

- Formal audit and performance management arrangements should be agreed and built into the action plan.

Care Home Provision in North Wales

Progress Made

5.43 BCUHB has been working proactively to support the care home sector. The initiatives that have been put in place include:

1 **Practice Development Team**. This team is responsible for ensuring the delivery of quality, evidence-based and personalised care within the homes. They undertake annual quality monitoring audits utilising an electronic tool that scores the delivery of care associated with Healthcare Standards and the Fundamentals of Care. The team facilitates and delivers training in-house and can arrange for specialist nurse support to provide clinical leadership.

2 **Quality Assurance Framework**. This has been developed to describe and set out quality assurance processes to ensure safe care. This includes holding a monthly clinical management group to proactively discuss each care home with all relevant stakeholders. This helps to gain and collate key intelligence and provides a robust and proactive response in order to support homes as required.

3 **Contracts and Fees**. The Health Board has employed a contracts team. This team works to explicit performance indicators and can work with the Practice Development Team to raise quality and provide practical support directly into any care home experiencing difficulties.

Work is ongoing to ensure the sustainability of the market in conjunction with the need for quality and safe care provision. This work is currently being undertaken with the North Wales Care Home Market Group which incorporates health and Local Authority inputs to sustain access to the market. Membership from this group also works with the National Commissioning Board care home agenda.

4 **Home First**. The Home First Initiative was launched in response to the National Care Home census data undertaken by the National Commissioning Board which identified that BCUHB had a higher percentage of patients in care homes with increased average lengths of stay in comparison to other Health Boards in Wales. This project will reduce the pressure on the care home sector by reducing the demand and thus increasing the bed capacity and availability for those who need such placements.

Progress Required

5.44 The Investigation Panel acknowledges the progress that is being made in this area. Moving forward this progress needs to be audited and any ongoing work programmes need to form part of an integrated process that brings together the BCUHB Mental Health Strategy, the Dementia Strategy and all ongoing service re-design initiatives; particularly those changes and improvements to community support provision.

5.45 A fragile care-home market can impact greatly upon NHS community, primary and secondary care services. Care home provision and quality monitoring needs to be unified into wider strategic action planning as part of an integrated approach to providing timely access to appropriate and good quality services.

Recommendation Three: Care Homes and Service Integration

- The current Care Home work streams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB Mental Health and Dementia Strategies.

Safeguarding

Progress Made

5.46 The BCUHB safeguarding service has been realigned, to incorporate strengthened safeguarding governance, with a focus on prevention and protection. New roles, where team members work across clinical areas in a proactive manner, are being implemented whilst maintaining specialisms. The realigned service incorporates the previously stand-alone services of DoLS, Safeguarding Adults and Children, and Tissue Viability, along with specialised individuals including a Safeguarding Dementia lead.

Progress Required

5.47 At the time of writing this report there were significant areas that still required improvement. However the Investigation Panel acknowledges the fact that BCUHB is aware of the areas that require improvement and is reassured by the levels of increased insight and understanding of its safeguarding responsibilities. BCUHB have identified ongoing issues:

- the current safeguarding training programme is not fit for purpose and requires updating;
- staff are not attending safeguarding training in the numbers required;

- the current database is immature and lacks the ability to triangulate data from IT and reporting databases throughout the organisation;
- the problems with the storage and retrieval of hard copy safeguarding information remains in keeping with the findings of this Investigation;
- there have been difficulties in resourcing the new safeguarding structures in a timely manner;
- governance processes require review in relation to safeguarding policy and process.

Recommendation Four: Safeguarding Training

- BCUHB will revise its safeguarding training programme to ensure it is up-to-date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance.

- BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation.

- BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.

Recommendation Five: Safeguarding Informatics and Documentation

- BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 are implemented – namely:

  - the use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;
  - process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;
  - team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.

- In addition BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided. This to include specific guidance on:

  - the content of protection plans;
  - the recording of strategy meetings and all decisions taken (guidance should require a standardised approach across all BCUHB clinical divisions);
  - formal monitoring and review templates should be developed and audited to ensure safeguarding timescales are met and those with key responsibilities in this regard held to account.

- BCUHB will repeat the audit within 12 months of the publication of this report to ensure that all clinical areas are compliant.

Recommendation Six: Safeguarding Policy and Procedure

- The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This Investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are:

  - *"to identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners;*
  - *agree a priority list and activity timeframe to review documents within the parameters of Corporate Safeguarding;*
  - *provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy and legislative safeguarding frameworks;*
  - *agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;*
  - *update and maintain the Safeguarding Policy webpage;*
  - *continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards".*

Recommendation Seven: The Tracking of Adults at Risk across North Wales

- BCUHB will work with multi-agency partners, through the North Wales Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.

Recommendation Eight: Evaluation of Revised BCUHB Safeguarding Structures

- BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.

Category Two: Recommendations Concerning Localised Operational Service Change

Informatics and Clinical Records

Progress Made

5.48 The Investigation Panel is aware of the initiatives currently in train to introduce an electronic clinical records system within BCUHB. This work is to be encouraged for the future.

Progress Required

5.49 The issues in relation to the extant hard-copy clinical records and the systems currently in place to store and retrieve them remain a problem that requires priority action in the here and now. The Investigation Panel noted that around 50 percent of the clinical records that it had access to were commingled one patient with another. The Investigation Panel also noted that BCUHB found it difficult to compile complete sets of clinical records; whilst the majority of the patients in the Investigation were deceased, approximately 30 percent of the patients were still living at the beginning of the investigative process. It is of concern that BCUHB could not access complete sets of clinical information for a cohort of living patients and calls into question BCUHB's ability to ensure clinical information is accessible when needed in the interests of continuity of care and patient safety.

Recommendation Nine: Clinical Records

- BCUHB needs to undertake a detailed check of the clinical records in the investigation cohort to evaluate and re-order all commingled casenotes.
- BCUHB needs to ensure that none of the commingling involving living patients could have led to any inappropriate acts or omissions on the part of clinical treatment teams during any episode of care (past and present).
- BCUHB needs to restructure and redesign its hard copy clinical records archiving and retrieval systems. This redesign needs to provide assurance in relation to the tracking of individual casenotes across north Wales together with a set of service level agreements pinpointing the timeframes required for clinical record retrieval and access.

Medications Management and the Use and Monitoring of Antipsychotic Medications

Progress Made

5.50 Internal BCUHB audits concur with the general findings and conclusions of this Investigation in relation to the use of antipsychotic medication in community and primary care settings. BCUHB provided the following information:

"A pilot project was carried out in 2012 where consultants and GPs shared a 3 monthly review of antipsychotic treatment which led to an improvement in the rate of review and reduction in prescribing. However this was not sustainable and it was concluded that this review was better carried out by nursing or pharmacy staff. An aide memoire was developed and the study presented at numerous collaborative events in 2012 and 2013 and to Care Forum Wales.

Prescribing guidance was agreed within the MHLD Division in 2015 and Aide Memoire sent round to GPs as well as several visits to increase awareness.

The baseline audit from GPs across BCUHB was carried out during 2017 in order to establish the extent of prescribing. The results showed about 10% people with dementia prescribed an antipsychotic in Central, 11% in the west and 18% in the East.

The audit recorded whether a medication review had been carried out in the last 6 months. The majority of the people with dementia had a general medication review documented as part of the care home enhanced service or dementia review. Any patients who required further clarification on the need for antipsychotic could be referred to the MH specialist team.

An audit of antipsychotic prescribing in 2015 and again in 2017 in secondary care demonstrated that although prescribing was deemed appropriate in many cases based on target symptoms, there was lack of documented risk assessment and discussion with the carer / patient or ongoing management plans.

As a result the 2015 guideline has been updated and a proforma developed to aid documentation of antipsychotic prescribing and review. Prescribers were asked to pilot this proforma in 2017 and work is ongoing to raise awareness of the importance of including a clear indication and duration for antipsychotic treatment in older people and the need for ongoing monitoring. A training needs analysis and implementation plan will be incorporated into the guidance.

Current Situation

The updated guidance is currently in consultation and reflects the need for greater collaboration and communication across care settings to ensure that patients are reviewed after being discharged to the GP. The review should be undertaken in collaboration with the carer(s). If the GP/practice staff are unable to review or have concerns then the patient should be referred to the community mental health team for advice and support.

A Patient Safety Notice has been drafted to highlight the issue of inappropriate continuation of antipsychotics as the issue extends beyond mental health and into the general hospital where people may be started on antipsychotics for delirium. It is therefore felt that the Patient Safety group should oversee the process of ensuring that people with dementia prescribed an antipsychotic have a documented risk assessment, indication and review date.

Work has been ongoing to raise awareness of this issue and this year a baseline was obtained in primary care which has helped highlight outlying practices who may require support to review their patients. This support has been provided by a limited resource of mental health pharmacists, as well as the mental health community teams.

Ongoing audits in primary and secondary care, and education will be carried out until the process of prescribing review is embedded in practice across primary and secondary care.

Clinicians in both primary and secondary care will be continually reminded to ensure that they follow national and local recommendations to review and reduce antipsychotics medication where appropriate. There may be situations where ongoing use is justified and this must be clearly documented.

Given that antipsychotic medication is used in those who may have lost a care home placement on account of challenging behaviours, there is still considerable work to be done to train carers in managing challenging behaviours without using medication in order to allow the gradual reduction and stop without the fear of re-escalation of behaviours and subsequent failure of placement".

Progress Required

5.51 The Investigation Panel supports in full the very comprehensive work that BCUHB has conducted in relation to the prescribing and monitoring of antipsychotic medication. It is evident that work is ongoing and the following recommendation is set in order to support further the remaining actions that require completion.

Recommendation Ten: The Prescribing and Monitoring of Antipsychotic Medication

- The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.

- BCUHB will continue to work with care homes across north Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of antipsychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit detailed in the bullet point directly above.

Evidence-Based Practice and Clinical Guidelines

Progress Made and Still Required

5.52 BCUHB has not been able to provide any progress update in relation to governance processes regarding evidence-based practice and clinical guidelines. It is evident from the information provided to the Investigation Panel that the processes underpinning the development and monitoring of clinical policies and procedures within BCUHB is inconsistent and on occasions clinical staff do not have access to the most up-to-date best practice guidance. The amount of work that needs to be undertaken is significant and will require a detailed risk assessment and focused and timed action plan.

Recommendation Eleven: Evidence-Based Practice

- BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet. As part of this work:
  - A risk assessment should be conducted to prioritise the work that needs to be undertaken and to establish whether there are any urgent policy revisions and alerts required to ensure patient safety is maintained.
  - Work should be undertaken to review the extant clinical policies across the three BCUHB geographical regions to determine corporate ratification and fitness for purpose.
  - All clinical policies should be reviewed with the specific needs of the older adult in mind. Policies should either be re-written to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified in detail, or separate clinical policies and procedures should be developed for this particular patient cohort. This work should be conducted with expert multidisciplinary inputs.

Legislative Frameworks: Deprivation of Liberty Safeguards (DoLS)

Progress Made

5.53 The 'BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018' sets out a robust overview of current practice together with the work that BCUHB is still required to achieve.

Progress Required

5.54 The BCUHB Annual Report sets out a work plan which at the time of writing this report was close to completion. The work plan includes:

- *"Review DoLS Policy, Procedures and Guidance in consultation with other partners in Wales i.e.; Health Boards, Local Authorities, Healthcare Inspectorate Wales and Welsh Government to identify priority changes, plans and actions.*
- *Consult with the Professional Advisory Group implementation of a recently devised draft "Gold Standard" DoLS Application Form to improve quality and practice within all clinical areas.*
- *Reporting DoLS and MCA issues and activity across Corporate Safeguarding Areas to raise awareness and implications for practice.*
- *To review the role, responsibilities and functions of the signatories within the Supervisory Body to ensure it is fully compliant to governance expectations and continues to be fit for purpose.*
- *To review the current arrangements for recording DoLS data so it is more streamlined and fit for purpose in monitoring and reporting annually to HIW.*
- *A barrier to full integration of this provision within clinical areas is the lack of office accommodation on acute and community sites".*

Recommendation Twelve: DoLS

- BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018 – 2019.

The Management of Aggression in the Elderly

Progress Made

5.55 The BCUHB 'Assurance Report – Older Peoples' Mental Health Service December 2017' states that:

"In May 2015, the National Institute for Health and Care Excellence published 'NG10', their latest guidelines relating to the management of aggression and violence in health care settings. Until this release, the vast majority of health providers in the UK were implementing reactive strategies to manage incidence of violence and as a consequence there has been a national drive to move away from the reactive paradigm towards a proactive approach which is emphasised in the guidelines".

5.56 Since this time BCUHB has stressed the need for providing the least restrictive procedures possible when managing patients who are exhibiting aggressive behaviours. BCUHB has taken part in a benchmarking exercise with other services in Wales. The Mental Health Division has:

"In response to the changing needs of OPMH [Older Peoples' Mental Health] services, the division has reviewed Restrictive Physical Intervention (RPI) training to ensure that practices taught are commensurate with the needs of our older population. All OPMH clinical personnel undergo a comprehensive five day training package and are assessed for competency prior to certification. Training meets the requirements of the current 'All Wales Passport Scheme' and compliance rates are monitored and reported through governance structures".

Progress Required

5.57 The Investigation Panel acknowledges the progress made by BCUHB in relation to reducing restrictive practices in older peoples' mental health services. The evidence provided suggests that safe and current best practice guidance is being implemented. However there needs to be an assurance that all care and treatment settings within BCUHB (Emergency Departments, medical wards etc.) are working to the same policies and procedures and that all staff involved with restrictive practice incidents are trained to the appropriate standard and that all incidents are recorded and form part of the BCUHB organisational learning cycle.

Recommendation Thirteen: Restrictive Practice Guidance

- BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision. BCUHB will also ensure that the *Royal College of Psychiatrists' Centre for Quality Improvement (March 2007) National Audit for Violence: Standards for In-patient Mental Health Services* guidance is embedded in all training and policy documentation in relation to 'taking dementia patients to the floor' during restrictive interventions.

End of Life Care

Progress Made

5.58 The BCUHB 'Assurance Report – Older Peoples' Mental Health (OPMH) Service December 2017' states that:

- *"Through 2018 Memory Service staff will have the skills and knowledge to hold accurate and sensitive conversations about End of Life preferences.*
- *OPMH link staff supported by specialist hospice nurses and palliative care nurses will assure dignified End of Life care on in-patient wards".*

5.59 The Assurance Report states that *"innovations involving all memory services and OPMH in-patient wards. Memory services are opening the conversation about advance directives with people newly diagnosed with dementia. Such is the sensitivity of this that staff are still undergoing training from specialist hospice nurses".*

Progress Required

5.60 Dementia is a life-limiting condition. Of some concern is the prevailing BCUHB stance that end of life care can be provided appropriately on Older Peoples' Mental Health wards. The rationale provided by BCUHB is that this is to prevent any unnecessary distress caused by a transfer to another care setting.

5.61 The Investigation Panel acknowledges that many families and their loved ones experienced a good standard of end of life care on Tawel Fan ward (and many continue to do so in other similar environments). However not all families report positive experiences. It remains a fact that acute psychiatric admission wards are not optimal places for end of life care to take place due to the conflicting needs of the patient cohort. Of concern would be the retention of patients on acute psychiatric admission wards due to difficulties in finding suitable alternative placements (such as a medical or hospice bed) and/or a lack of timely and suitable transportation. The environment for end of life care has to provide dignified, safe and clinically appropriate care. Regardless of the levels of expert input into care planning from hospice and palliative care staff there will always be circumstances where robust care inputs cannot mitigate against an inappropriate care and treatment setting.

Recommendation Fourteen: Care Advance Directives and Support to Patients and Families

- BCUHB has made significant progress in providing support to patients and families when holding end of life conversations and developing advance directives. This is good practice. BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care.

Recommendation Fifteen: End of Life Care Environments

- All older adults and people with dementia have the right to the same access to quality end of life care as any other individual (of any age) with any other condition. If a person is to receive end of life care on an older person's mental health ward (and in particular an acute admission ward) the following should always be undertaken:

  - a clinical risk assessment to determine the appropriateness of end of life care being provided in an older people's mental health facility – the risk assessment should take into account the levels of patient acuity and any potential conflicts that could be present;
  - an assurance that out of hours medical cover can be provided if the patient's physical condition requires it;
  - an assurance that equipment can be resourced with the minimum of delay and that patients are never nursed on mattresses on the floor due to a shortage of hi/low beds;
  - an assurance that patients can be supervised appropriately and not left unattended due to other challenges that ward might face;
  - an assessment to confirm patients can be nursed in quiet and peaceful environments and that the ward layout can accommodate this;
  - an incident form should be completed if a patient receives end of life care due to a lack of appropriate alternative placements and difficulties with transport;
  - consultation with relatives who should be able to request the transfer of their loved one to a different clinical setting if they feel a mental health facility is in any way unsafe or inappropriate;
  - the training of all registered nursing staff (including night staff) in end of life and palliative care.

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North Wales Community Health Council.
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19th March 2018

Vaughan Gething
Cabinet Secretary for Health & Social Services
BY EMAIL ONLY

[redacted]

Dear Cabinet Secretary,

Betsi Cadwaladr UHB – Lack of Progress under Special Measures

I write on behalf of the members of North Wales Community Health Council to express their growing concern about the failure of Betsi Cadwaladr University Health Board to emerge from its period in Special Measures. North Wales CHC members have had a growing concern about this situation and it is at their request that I drafted a letter setting down those concerns. We have had two meetings with members of the BCUHB Board to discuss the content of this letter and they recognise our concerns. We have amended the letter in the light of comments we received during those meetings.

Following the 100 day Plan, there was an initial improvement and further improvements occured with the appointment of the current Chief Executive in early 2016. North Wales CHC were keen to provide support and encouragement for the reconstituted Board and, in consequence, North Wales CHC was positive about the steps being made to address the five key improvements areas that your predecessor listed as requiring urgent attention;

- governance, leadership and oversight;
- mental health services;
- maternity services at Ysbyty Glan Clwyd;
- GP and primary care services, including out of hours services;
- reconnecting with the public and regaining the public's confidence.

Specifically, we have been pleased to see improvements in the following areas:

- improvements in the working relationships between senior leaders
- responsibility for Putting Things Right transferred to the Executive Director of Nursing and Midwifery
- we regard the Board's use of social media for communication with patients and the public as an exemplar
- GP out of hours service – there has been a marked improvement in rota fill rates
- The new strategy for mental health services, Together for Mental Health, was developed with extensive input from service users and other stakeholders.
- The Health Board diverted an additional £5 million from elsewhere in the system in order to provide an increased level of support to the Mental Health Division and its services.
- We note that the WAO Structured Assessment highlighted that BCUHB's corporate arrangements for savings planning and delivery are becoming stronger and that significant financial savings have been delivered.

Nevertheless, we are now almost three years into Special Measures and the pace of improvement has slowed. There is a belief amongst CHC members that Special Measures is now the "*new normal*" for the Betsi Cadwaladr Board and appears to have lost its impact. We are not the only people who believe this. Our members' extensive contact with the public during our widespread public engagement sessions this summer confirmed that there is lack of public confidence in the current "*Betsi*" Board being able to deliver the healthcare that the public in North Wales expects.

Additionally, examination of Board minutes over the previous three years will support our view that, despite some improvement, there is still insufficient challenge from Independent Members and an absence of

any debate or concerns from those members about failures in the delivery of service, many of which are reported in the press and media on a regular basis.

You will know that the recent Deloittes Report, although heavily redacted for the public, has this to say;

- *"In our view, executive level leadership capability and capacity needs to be enhanced. It will also require a "strengthening of financial and strategic capability amongst independent members".*
- *"Financial and Strategic Planning at the Health Board is simplistic with budgets generally rolled forward into next year."*
- *"There is a distinct lack of secondary questioning from Board members to facilitate detailed debate and discussion across the key areas of risk".*
- *"The Finance and Performance Committee is spread too thinly, its role is poorly defined and misunderstood by Board members".*

The report makes other worrying statements;

- *"It is acknowledged by interviewees that the HB has not explicitly focussed on strategy development in recent years due to high levels of turnover in Executive Directors and a focus on shorter term operational issues".*
- *"In our view change management arrangements at the HB are not fit for purpose and remain a significant obstacle towards delivering sustainable change. Plans are underway to consolidate the various activities but we have concerns over whether the capability exists to successfully drive this agenda".*

The Deloittes Report shows that areas highlighted for improvement in the June 2017 Joint WAO/HIW Report have failed to progress sufficiently. We know that you share our concerns about the lack of progress and said recently;

> *"It has been disheartening and unacceptable that during 2017/18 issues have escalated in Betsi Cadwaladr UHB in relation to the financial position and some key areas of*

performance. This has resulted in the Welsh Government increasing its oversight, including my personal chairing of monthly accountability meetings since July".

In relation to the Board's strategic planning capabilities, the Deloittes Report says that the BCUHB flagship strategic initiative "Living Healthier, Staying Well" consists of a "*very high level of strategic objectives but provides limited guidance regarding the specifics behind the plan*". It is the CHCs experience that this echoes much of the Board's planning – a great deal of time and effort is expended on creating strategic plans which are then never acted upon.

A consistent criticism of BCUHB over many years has been that the creation of a plan that can be kept on the shelf and referred to periodically is seen as the end of the process, with no one taking responsibility for delivery and change management. Worryingly, Deloittes say that "*we are concerned that the Integrated Medium Term Plan is being used inappropriately as a primary driver of strategy*" and that "*Living Healthier, Staying Well" is being used to populate the Medium Term Plan without developing the detail behind the plan*".

In relation to the five areas of concern originally highlighted by Special Measures, we feel we must especially express our worries about the provision of Mental Health Care. You will be aware that Conwy Council expressed concern about the safety of community based mental health care provided jointly with BCUHB. A report to Conwy Council said;

"cultural, managerial and leadership" issues at BCUHB had been impeding satisfactory progress" in community mental health services.

Initially Conwy Council had suggested that they might withdraw from joint provision if things did not but at a recent Council meeting the Council's Service Manager for Vulnerable People, said that weekly meetings were now in place and BCUHB had experienced a "*reality check*". We understand that this situation has now been resolved but we believe that it should never have arisen.

Suicide rates have been a particular concern in recent years and on 14th February 2018 the North Wales Coroner, John Gittins, delivered a highly critical report about the suicide of a young person in Wrexham. He said

there had been lengthy delays in transferring the patient's care from Flintshire to Wrexham community mental health service and that this led to "*missed opportunities*" to improve the patient's mental health. Mr Gittins said there was a "*risk future deaths will occur*" unless changes were made.

Criticisms about the provision of current and future mental health care as identified in recent HIW reports and coroner's inquests do nothing to raise public confidence in the quality of mental health care in North Wales. All six of our Local Committees have included monitoring of mental health care in their Annual Plans for the coming year. CHC visiting teams have been making regular unannounced visits to mental health wards and in some key areas their findings have shown a persistent lack of progress.

The fifth key improvement area was reconnecting with the public and regaining public confidence. Our experience is that waiting times are an important factor in public confidence. Whilst BCUHB might have marginally better performance in some specialities that other LHBs, the facts are that, at the end of 2017, 10,469 patients had been waiting more than 36 weeks for treatment, despite your clear instruction in October 2016 that the "*people in Wales must have timely access to services based on clinical need*". You said that 95% of all ages should be treated within 26 weeks and no-one should wait beyond 36 weeks. At the end of 2017 10,469 patients were waiting longer than this.

Your October 2016 instruction also stated that ailments must be diagnosed early and that no-one should wait for diagnostic tests beyond 8 weeks. Despite this clear instruction, at the end of 2017, 1,135 patients experienced waits over 8 weeks for their diagnostic tests.

You also instructed Local Health Boards that 95% of A&E attendees should be helped within 4 hours and that no-one should spend over 12 hours in A&E. In North Wales at the end of December 2017, only 72.5% of those seeking help received it within 4 hours. A quarter of those attending A&E were let down. 1,470 patients were kept in A&E for more than 12 hours. A major factor in this may have been an inadequate number of beds in acute and community hospitals because of permanent and temporary closures. *We informed you about our recent report that suggested that, on any given day, nearly 20% of the*

published bed numbers in North Wales are temporarily closed for a variety of reasons.

160 patients were referred to Betsi Cadwaladr with Urgent Suspected Cancers. Your October 2016 instruction stated that at least 152 of them should have been treated within 62 days. Only 140 patients were treated, 12 short of the target and leaving 20 urgent suspected cancer patients, largely those needing endoscopies or radiology, with treatment delays contrary to your instructions. Despite this the new endoscopy system planned for Ysbyty Gwynedd has been delayed until March.

BCUHB is struggling with serious GP recruitment issues in North Wales. The CHC is seeing a stream of practices closures where the partners retire together and it becomes necessary for the Board to step in and directly manage the practice. Over the past 3 years we have seen a tenfold increase in the number of directly managed practices. This rate of increase is not something that can be sustained and BCUHB is in need of Welsh Government support to cope with this situation.

The Board's performance on complaints and concerns has not been adequate and seems to have concentrated on higher level management reorganisation rather than addressing the root causes of delay and dissatisfaction. The same issues and concerns are raised repeatedly but this seems to make no impact on everyday practice. In fairness, this is the case for many other NHS organisations across but most have them have not been in Special Measures for nearly three years.

When your predecessor placed the Betsi Cadwaladr Board into Special Measures in June 2015 it was not because of one major issue but rather a variety of failings across the range of its activities. This signalled that this was a Board in crisis without the capability or capacity to address the issues it faced and in need of significant levels of help.

North Wales CHC believes that we are again at that point and this is despite almost three years in Special Measures. We note that you have brought in David Jenkins but, in reality, this is simply replacing the previous post-holder (*a highly competent retired NHS Executive with a great deal of experience*) who held virtually the same role since the start of Special Measures. We note also that there are appointments to be made into new posts including a Turnaround Director and hope that the

Board is able to recruit people with the necessary skill sets to fill these posts.

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North Wales CHC members, who have sought to be constructive and supportive in response to Betsi Cadwaladr UHB's improvement initiatives, believe that the recovery task is now beyond the oversight of a few key individuals and that it is time to consider escalating current support; taking whatever action you consider necessary to achieve a first class health service for the people of North Wales in a timely manner. In this context, support does not mean simply pointing out the areas where the Board is failing. In preparing this letter, we met with the Chair, Chief Executive and other key Board members to discuss this letter. It is clear to us that the Board is well aware of the challenges it faces and the areas that need improvement.

The difficulty is that some of these problems are beyond their control and need a partnership approach between the Board and Welsh Government with both taking responsibility for service improvement. For example, GP and Consultant recruitment and retention is a complex area that needs action at a national level as well as local; the financial challenges facing BCUHB can only be resolved in the long term – 10 years rather than 3 and it could be argued that the funding formula is not appropriate to the needs of North Wales.

We strongly urge joined-up working between Betsi Cadwaladr University Health Board and Welsh Government, with both taking responsibility for improvement, if we are ever to address the lack of confidence in the NHS in North Wales.

Yours sincerely

Jackie Allen
Chair – North Wales CHC

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref VG/00970/18

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North Wales Community Health Council
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LL13 9AE

Geoff.Ryall-Harvey@waleschc.org.uk

13 April 2018

Dear Jackie,

Thank you for your letter of 19 March raising the North Wales Community Health Council concerns on lack of progress under special measures at Betsi Cadwaladr University Health Board (BCUHB).

I note from your letter that you had discussed the content of the letter with members of the BCUHB Board.

In your letter you referred to initial progress under special measures and that the Welsh Government, Wales Audit Office and HealthCare Inspectorate Wales had also reported on evidence of green shoots of recovery in the first two years. You outlined in your letter some of the areas in which you have been pleased to see improvements.

I would also note the significant improvements made in maternity services, including a reduced reliance on locum/agency staff (rate to 11% from 50%); compliance with Birthrate Plus; the re-introduction of pre-registration midwifery students to Ysbyty Glan Clwyd so that all three sites in North Wales are now being fully utilised for training purposes; appointment of a Consultant Midwife to lead improvements in midwife led care; and progress on the development of the SuRNICC. Given the good progress and stability demonstrated, I announced in February that this no longer represented a special measures concern and was therefore de-escalated as an issue.

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Correspondence.Vaughan.Gething@gov.wales

I am disappointed to hear the view of your members that special measures is the 'new norm' for the Health Board and the lack of confidence in the Board to deliver the healthcare the public in North Wales expects. My focus is on ensuring the improvements expected are delivered by the Health Board in order that we can de-escalate the organisation. That is why I have been holding accountability meetings with the Chair and Chief Executive on a monthly basis. I have also set out additional support, actions and key milestones that I expect the Health Board to have achieved or progressed by April 2018, including responding fully to the recommendations set out in the Deloitte report. Key priorities are enhancing the capacity and capability of the executive and non-executive members of the Board and strengthening strategic and service planning expertise to develop an IMTP in partnership that is focussed on delivery.

On mental health services, I recognised in my statement in February that the absence of the Director of Mental Health and the Mental Health Nurse Director on extended sick leave had meant the improvements in this area had lost momentum in recent months. I was clear on the urgent need to embed and build on the new mental health leadership structure and speed up the pace of quality improvement to urgently rebuild confidence in the safety and sustainability of the existing mental health services, alongside beginning the longer- term transformational change set out in the new strategy. This will now be set out in a thematic quality improvement and governance plan for mental health services that I expect to be discussed at the May Board meeting.

You rightly noted that waiting times are an important factor in public confidence and performance on planned and unscheduled care is included under the special measures arrangements. Betsi Cadwaladr University Health Board was allocated the highest level of funding from the performance fund available for 2017-18 to improve referral to treatment waiting times and diagnostic waits.

On unscheduled care, the current performance is not acceptable and I have agreed additional funding of £1.5 million over two years for an unscheduled care programme to drive forward immediate and longer term sustainable improvements. We are continually working with the Health Board to further identify areas of support to drive progress in all the areas of concern.

I also note your concerns on urgent suspected cancer and GP recruitment. These challenges are similar across the NHS in Wales, and indeed the rest of the UK. The Welsh Government is working with health boards across Wales and continuing to invest in the estate and the NHS workforce to increase capacity. The new endoscopy system at Ysbyty Gwynedd and the two day surgery / endoscopy modular theatres at Wrexham Maelor Hospital will help ensure patients are treated within the timelines agreed and increase the attractiveness of north Wales to potential new staff. We exceeded our GP training target for this year, due in part to the success of our international recruitment campaign to encourage more medical professionals to choose Wales as a place to train, work and live. The Welsh Government has also received proposals from Bangor, Cardiff and Swansea Universities, working together, aimed at increasing opportunities for medical education and training in north Wales. These are currently being considered.

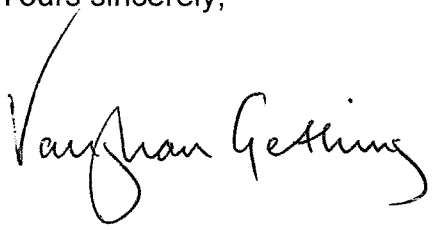
On the financial challenges facing the Health Board, it is evident that the organisation needs to develop and implement improved financial, service and workforce plans to recover and realise the opportunities available, and to also deliver on the transformational change required to move to a more sustainable position. I will be putting in additional support to build capacity and capability in its financial planning for the short, medium and long term.

I am unsure what is meant by your comment that the current funding formula is inappropriate to the needs of North Wales as assessment, shared with Health Board officers, indicates that its actual allocation under existing arrangements is higher than it would be under a needs based formula.

I fully recognise the need to ensure the Health Board has the capacity and capability to drive forward the improvements needed. My officials are working jointly with the Health Board to recruit people to key roles and to put in place advisory support in specific areas, including David Jenkins on leadership and governance and Emrys Elias on mental health services. The appointment of a new Chair will also be completed in the next month.

I keep the position under constant review and Welsh Government will continue to work in partnership with the Health Board and its staff to secure improvements. I will provide the necessary scrutiny, intervention and support to do what is right for the people of North Wales and ensure they receive the health services they deserve.

Yours sincerely,



Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Sutton, Elin (Staff Comisiwn y Cynulliad | Assembly Commission Staff)

From: Bethan Perkins <Bethan.Perkins@waleschc.org.uk>
Sent: 23 January 2019 14:38
To: Geoff Ryall-Harvey (CHC - NWCHC); Carol Williams (CHC - NWCHC)
Subject: Palliative Care during ward inspections

Hi Geoff and Carol,

I met with a complainant who was complaining about the palliative care her own mother received at Wrexham Maelor (MAU). The complainant is herself a palliative care nurse and she believes that most wards should be checked whether they have certain practices in place to help support these patients. I was wondering if something along the lines of these following questions are asked and if not, could be included in CHC ward inspections or could/should be passed on to the HB Ward Accreditation Team and included on their inspections?

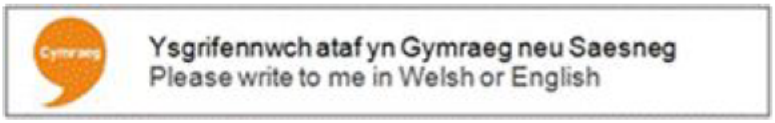
- Do you have an End of Life Care box on the ward or an area where patient End of Life information is kept?
- Are there EOL information leaflets readily available for families i.e. what to expect when patients are dying, what facilities are available to them etc?
- Where is the EOL plan of care (Care decisions for the last days of life pathway) kept? Would expect the document to be held somewhere central.
- Is there an EOLC Facilitator or Dementia Nurse and can you provide their name?
- What do you have on the wards that recognises that patients are at EOL?
- Are systems in place to identify dementia patients (blue butterfly on the board above the bed)? Is there a similar system in place for EOL patients?
- Do you use a This is Me Document?

I would say that probably a quarter of my cases involve EOL concerns, that these patients and their families did not have a “good” EOL experience.

Secondly, I was at a meeting where a senior clinician on the above unit and he stated that they had the scan equipment but were having difficulties getting a sonographer up there(instead of patients having to go to a busy ultrasound department and wait with expectant mothers). The complainant offered to write a letter championing their cause, which he welcomed. We received no response from the letter. An email was sent to Gill Harris with the issue and she responded “The ultrasound scanner that is located on the Early Pregnancy Assessment Unit/Emergency Gynaecological Unit is used by medical staff to scan in emergency situations. All non-emergency scans will continue to be undertaken in the ultrasound department.” Which was rather a non-response to the reported issue of not being able to get it staffed. Do you ever do inspections of the Early Pregnancy Assessment Unit, if so are members in a position to check if and how often the ultrasound equipment is used there?

Thanks,
Bethan

BETHAN PERKINS
EIRIOLYDD CWYNION/COMPLAINTS ADVOCATE
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council.
Unedau 1B & 1D Parc Busnes Wilkinson, Ffordd De Clywedog, Ystad Ddiwydiannol Wrecsam, Wrecsam. LL13 9AE / Units 1B & 1D Wilkinson Business Park, Clywedog Road South, Wrexham Industrial Estate, Wrexham. LL13 9AE. Ffôn / Tel : 01978 356178 est/ext 2



Os ydych angen yr wybodaeth yma ar ffurf wahanol cysylltwch â 01978 346873 est 106 neu bethan.perkins@waleschc.org.uk
If you need this information in an alternative format please contact 01978 346873 ext 106 or bethan.perkins@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

Sutton, Elin (Staff Comisiwn y Cynulliad | Assembly Commission Staff)

From: Debra Jones <Debra.Jones@waleschc.org.uk>
Sent: 10 January 2019 15:31
To: Carol Williams (CHC - NWCHC); Geoff Ryall-Harvey (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Cc: Debbie Postle (CHC - NWCHC); Allison Hughes (CHC - NWCHC); Lucy Barker; Bev Davies (CHC - NWCHC)
Subject: RE: Public Accounts Committee Inquiry - Tawel Fan

Hi Carol

These are some of the general themes that we feel are on-going and that we are aware of:

- Problems with support in the community- there appears to be a lack of care coordinators and those that are in post, don`t seem to be retained for long.
- Lack of continuity of care (some of it prob due to the above)
- Care plans not followed or not in place at all
- Appears to be no permanent psychiatrist in NYG
- Appears to be mainly locums in Hergest – once these move on patients left in limbo, new locums start with back log and OPDs pushed back with some patients waiting months to be seen
- Cancelled appointments
- Problems when trying to self-refer
- Community MH units seem to be a law unto themselves – don`t feel that anyone takes over arching responsibility. Management structure should be more visible, clearer and accountable.

Also, a recent complaint seemed to indicate that Bryn Y Neuadd was having difficulty with provisions – things not being replaced and delivery not reliable (i.e. butter, sugar, squash and soap powder).

Regards

Debra, Audrey and Emily

DEBRA JONES
EIRIOLYDD CWYNION / COMPLAINTS ADVOCATE
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11 Llys Castan/Chestnut Court, Ffordd y Parc, Parc Menai, Bangor, Gwynedd, LL57 4FH
Ffôn/Tel 01248 679 284 est/ext 2

Rydym yn croesawu gohebiaeth trwy gyfrwng y Gymraeg a'r Saesneg. Os byddwch yn ysgrifennu atom yn Gymraeg byddwn yn ateb yn Gymraeg, ni fydd hyn yn arwain at oedi wrth ymateb i'ch gohebiaeth
We welcome correspondence through the medium of both Welsh and English. If you write to us in Welsh we will answer in Welsh, this will not lead to a delay in responding to your correspondence

Os ydych angen yr wybodaeth yma ar ffurf wahanol cysylltwch â 01248 679284 est 2 neu debra.jones@waleschc.org.uk

If you need this information in an alternative format please contact 01248 679284 ext 2 or debra.jones@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

From: Carol Williams (CHC - NWCHC)
Sent: 09 January 2019 15:59
To: Debra Jones; Geoff Ryall-Harvey (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Cc: Debbie Postle (CHC - NWCHC); Allison Hughes (CHC - NWCHC); Lucy Barker; Bev Davies (CHC - NWCHC)
Subject: RE: Public Accounts Committee Inquiry - Tawel Fan

Great stuff – many thanks all

C

CAROL WILLIAMS
DIRPRWY BRIF SWYDDOG / DEPUTY CHIEF OFFICER
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council
11 Llys Castan/Chestnut Court, Ffordd y Parc, Parc Menai, Bangor, Gwynedd, LL57 4FH
Ffôn/Tel 01248 679 284 est/ext 3

Ysgrifennwch ataf yn Gymraeg neu Saesneg
Please write to me in Welsh or English

Rydym yn croesawu gohebiaeth trwy gyfrwng y Cymraeg a'r Saesneg. Os byddwch yn ysgrifennu atom yn Gymraeg, byddwn yn ateb yn Gymraeg. Ni fydd hyn yn arwain at oedi wrth ymateb i'ch gohebiaeth.
We welcome correspondence through the medium of both Welsh and English. If you write to us in Welsh, we will answer in Welsh. This will not lead to a delay in responding to your correspondence.

Os ydych angen yr wybodaeth yma ar ffurf wahanol cysylltwch â 01248 679284 est 3 neu carol.williams@waleschc.org.uk
If you need this information in an alternative format please contact 01248 679284 ext 3 or carol.williams@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

From: Debra Jones
Sent: 09 January 2019 15:56

To: Carol Williams (CHC - NWCHC); Geoff Ryall-Harvey (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Cc: Debbie Postle (CHC - NWCHC); Allison Hughes (CHC - NWCHC); Lucy Barker; Bev Davies (CHC - NWCHC)
Subject: RE: Public Accounts Committee Inquiry - Tawel Fan

Hi Carol

We do seem to have some general themes, so we`ll pull something together tomorrow and get back to you.

regards

DEBRA JONES
EIRIOLYDD CWYNION / COMPLAINTS ADVOCATE
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council
11 Llys Castan/Chestnut Court, Ffordd y Parc, Parc Menai, Bangor, Gwynedd, LL57 4FH
Ffôn/Tel 01248 679 284 est/ext 2

From: Carol Williams (CHC - NWCHC)
Sent: 09 January 2019 14:22
To: Geoff Ryall-Harvey (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Debra Jones; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Subject: RE: Public Accounts Committee Inquiry - Tawel Fan

Hi all

Further to Geoff's e-mail, we are particularly interested to hear about failings in BCUHB Mental Health Services since May 2018.

Should you have any examples, please can you provide us with the details.

Thanks

Carol

CAROL WILLIAMS
DIRPRWY BRIF SWYDDOG / DEPUTY CHIEF OFFICER
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council
11 Llys Castan/Chestnut Court, Ffordd y Parc, Parc Menai, Bangor, Gwynedd, LL57 4FH
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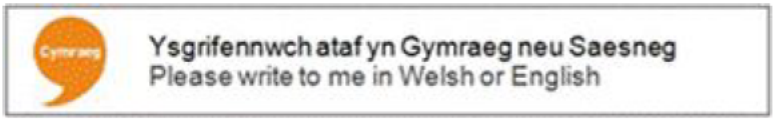

Rydym yn croesawu gohebiaeth trwy gyfrwng y Cymraeg a'r Saesneg. Os byddwch yn ysgrifennu atom yn Gymraeg, byddwn yn ateb yn Gymraeg. Ni fydd hyn yn arwain at oedi wrth ymateb i'ch gohebiaeth.
We welcome correspondence through the medium of both Welsh and English. If you write to us in Welsh, we will answer in Welsh. This will not lead to a delay in responding to your correspondence.

Os ydych angen yr wybodaeth yma ar ffurf wahanol cysylltwch â 01248 679284 est 3 neu carol.williams@waleschc.org.uk
If you need this information in an alternative format please contact 01248 679284 ext 3 or carol.williams@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

From: Geoff Ryall-Harvey (CHC - NWCHC)
Sent: 09 January 2019 14:12
To: Carol Williams (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Debra Jones; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Subject: Public Accounts Committee Inquiry - Tawel Fan

Dear All

I have been invited to give evidence to the Public Accounts Committee on 4th February. I am allowed to be accompanied by two CHC colleagues. Let me know if you would wish (*and be able*) to attend.

Regards

GEOFF RYALL-HARVEY
PRIF SWYDDOG / CHIEF OFFICER
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council.

Unedau 1B & 1D Parc Busnes Wilkinson, Ffordd De Clywedog, Ystad Ddiwydiannol Wrecsam, Wrecsam. LL13 9AE / Units 1B & 1D Wilkinson Business Park, Clywedog Road South, Wrexham Industrial Estate, Wrexham. LL13 9AE.

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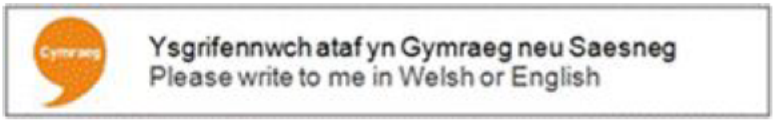
07970 194777



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Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

Quality Safety & Experience Committee **22.1.19**	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	HASCAS independent investigation and Ockenden governance review: progress report
Report Author:	Mrs Deborah Carter, Associate Director Quality Assurance
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The paper provides the progress updates as at the end of Q3 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	The Improvement Group and Stakeholder Group meetings review, monitor and scrutinise the work and progress of the recommendations
Governance issues / risks:	Work is underway to identify any additional resources required to progress the work identified to deliver improvements and address the recommendations.
Financial Implications:	A paper will be submitted to Executive Team setting out the additional resources and any related costings, including any additional workforce requirements, for their approval.
Recommendation:	To note the progress of the HASCAS & Ockenden recommendations

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Mental Health Leadership and Governance			
Equality Impact Assessment			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

HASCAS Investigation and Ockenden Governance Review Progress Report as at January 2019

Background

In the autumn and winter of 2013 a series of events occurred which brought issues of concern regarding care on Tawel Fan Ward to the attention of senior staff within the Health Board. This led to the ward being closed in December 2013.

In January 2014, Donna Ockenden was commissioned by the Health Board to conduct an external investigation into the concerns raised and her report was published in May 2015.
http://www.wales.nhs.uk/sitesplus/documents/861/tawel_fan_ward_ockenden_internet.pdf

In August 2015 the Health Board commissioned an Independent Investigation to be undertaken by HASCAS Consultancy Limited into the care and treatment which had been provided on Tawel Fan Ward. The outcome of the Independent Investigation was the provision of three separate outputs which included:

- A thematic "Lessons for Learning" report
- Detailed Individual Patient reports to support the Putting Things Right process
- Individual Staff reports to support employment processes

The conclusions and findings of the thematic lessons for learning report were published in the '*Independent Investigation into the Care and Treatment provided on Tawel Fan Ward: A Lessons for Learning Report* 'on the 3rd May 2018 and included 15 recommendations. The full report and executive summary can be found via the following links:-

http://www.wales.nhs.uk/sitesplus/861/page/75258/
http://www.wales.nhs.uk/sitesplus/861/page/94107

Alongside the HASCAS investigation, a governance review was commissioned by the Health Board which was undertaken by Donna Ockenden. This review focussed on the governance arrangements relating to the care of patients on Tawel Fan Ward prior to its closure and current governance arrangements in older people's mental health services within the Health Board. The findings of the Ockenden Governance Review were received at the public Board meeting on 12th July 2018.
http://www.wales.nhs.uk/sitesplus/861/page/75258

On the 12th July at its public Board meeting, the Health Board considered a paper which contained the initial response to the HASCAS report and approved the governance and reporting arrangements which would oversee the implementation of the recommendations from the HASCAS report and the Ockenden Governance review. At this meeting the Health Board also approved the establishment and terms of reference for an Improvement Group to respond to the recommendations arising from both HASCAS and Ockenden reports as well as a Stakeholder Group to strengthen and guide the work of the Improvement Group.

Both the Improvement Group and the Stakeholder Group have now been established with membership agreed and confirmed in line with the respective terms of reference for both groups (attached at Appendix 1).

The inaugural meeting of the Improvement Group was held on 16th August 2018, and chaired by the Executive Director of Nursing & Midwifery, where the Group received status and progress updates from each of the operational leads who had been given delegated responsibility for specific recommendations. This included developing metrics and achieving milestones where these had been set in the reports as well as agreeing ones for where they had not. The leads also described progress towards achieving the outcomes of the recommendations. The second meeting of the Improvement Group was held on 23rd October and meetings are scheduled bimonthly throughout 2019 where progress reports are presented by each operational lead as well as monthly highlight reports submitted to the Executive Director of Nursing & Midwifery and an internal tracker tool developed for performance monitoring purposes.

The Stakeholder Group, which is a subgroup of the Improvement Group, has confirmed membership from representatives of the Community Health Council, Bangor University, St Kentigern Hospice, North Wales Police, North Wales Local Authorities, Community Voluntary Councils, North Wales Adult Safeguarding Board and Care Forum Wales as well as 6 Tawel Fan family members. The first meeting of the stakeholder group was held on Monday 8th October and was conducted in the form of a workshop, facilitated by the Associate Director of Quality Assurance and the Director of Partnerships for Mental Health & Learning Disabilities. The workshop aimed to engage with the members to:

- Establish Group Values
- Agree required outcomes
- Consider a 12 month forward view in the form of a work programme
- Establish individual areas of interest and intent to support

The group also reviewed the terms of reference for the group in order to consider their role in respect of scrutiny, advice, support, challenge and endorsement of the work being undertaken to deliver the required improvements. Members of the psychology service were also in attendance at the meeting to offer support to members if required.

The Stakeholder Group is required to meet quarterly, however, at the request of the members at the first meeting, an additional meeting was scheduled within 6 weeks, due to discussions around the amount of work and pace of progress, within a schedule of meetings being held on a quarterly basis. This second meeting was subsequently held on 19th November and enabled discussion and review of a proposed cycle of business for the work of each recommendation. Stakeholder Group members have also put themselves forward as members of any task and finish groups that have been established for specific recommendations, where they hold a particular interest and wish to contribute and support ensuring the views of stakeholders are incorporated into this important programme of work. Meeting dates have been scheduled quarterly throughout 2019.

On 1st November 2018, the Health Board received a paper providing an update against the recommendations of both the HASCAS and Ockenden recommendations as well

as confirmation of the establishment of both the Improvement Group and Stakeholder Group. The update presented by the Executive Director of Nursing & Midwifery reported positive progress following establishment of both the Improvement Group and Stakeholder Group. A piece of work was now being undertaken to review overall costs and required resources with the support of workforce and finance teams for consideration by the Executive Team.

Early positive feedback had been received from third sector representatives who had attended the first Stakeholder Group event and assurance was provided that the Health Board has been reviewing and strengthening its approach to partnership working and relationships with local authorities were also being maintained. In particular, the membership of the Regional Partnership Board has been strengthened and an event was held in January 2019 to share strategic issues and identify principles for improved collaboration. Further work is also underway to build further on relationships with the sector, with discussions taking place with third sector leaders and through the Health Board's Stakeholder Reference Group. This work is taking place alongside the development of the Health Board's three year plan and identification of priorities for 2019 onwards.

All recommendations from both the HASCAS and the Ockenden reports have been mapped together to ensure the necessary actions identified are embedded across the organisation and are not dealt with in isolation.

Table 1 below summarises the recommendations from both reports and sets out the blended governance and oversight arrangements.

This report provides updates against the recommendations as at the end of quarter 3, December 2018 and further progress updates will be reported to future board meetings no less than quarterly.

Table 1

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
1. Care Pathway and Service Redesign	**1**.Review and redesign service model for older people and those with Dementia **12.** Older Persons Strategy	Executive Director of Strategy	Deputy Director of Nursing	Older Persons Group / Regional Partnership Board.
2. Dementia Strategy	**8.** Dementia Strategy	Executive Director of Nursing & Midwifery	Area Director for Clinical Services (West)	Dementia Clinical Network Group
3. Care Homes and Service Integration		Executive Director of Nursing & Midwifery	Deputy Director of Nursing	Older Persons Group / Regional Partnership Board
4. Safeguarding Training		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
5. Safeguarding Informatics and Documentation		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
6. Safeguarding Policies and Procedures		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
7. Tracking of Adults at Risk across North Wales		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
8. Evaluation of Revised Safeguarding Structures	**6**. Safeguarding structures	Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
9. Clinical Records		Executive Medical Director	Chief Information Officer	Health Records Group
10. Prescribing and Monitoring of Anti-Psychotic Medication		Executive Medical Director	Chief Pharmacist	Safer Medication Group
11. Evidence Based Practice	**2a.** Quality impact assessment **2b.** Integrated reporting **3**. Policy review **10.** Reviewing external reviews **14.** Board development	Executive Director of Nursing & Midwifery	Deputy Board Secretary	Quality and Safety Group
12. Deprivation of Liberties	**9.** Deprivation of Liberties	Executive Director of Nursing & Midwifery	Assistant Director, Safeguarding	Corporate Safeguarding Group
13. Restrictive Practice Guidance		Executive Director of Workforce & OD	Director of Nursing (Mental Health)	Quality and Safety Group (Corporate)
14. Care Advance Directives		Executive Medical Director	Senior Associate Medical Director	Palliative Care Group

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
15. End of Life Care Environments		Executive Medical Director	Senior Associate Medical Director	Palliative Care Group
	2c. Workforce development **4a.** Staff engagement **4b. & 4c.** Staff surveys **4d.** Clinical engagement **13.** Culture change	Executive Director Workforce and Organisational Development	Head of Organisational and Employee Development	Workforce Senior Leadership Team / Staff Engagement Group
	2d. Consultant Nurse in Dementia	Executive Director of Nursing & Midwifery	Director of Nursing Mental Health	N/A
	5. Partnership working	Director Mental Health and Learning Disability	Director of Partnership Mental Health and Learning Disability	Together for Mental Health Partnership Board
	7. Concerns management	Executive Director of Nursing & Midwifery	Associate Director Quality Assurance	Quality and Safety Group
	11. Estates Older Persons Mental Health (OPMH)	Executive Director of Finance	Director of Estates and Facilities	Task Group

Recommendations updates

The following updates are provided against each of the recommendations in order of the sequence of the mapping described in Table 1:

HASCAS 1: Care Pathway & Service Redesign
HASCAS 3: Care Homes and Service Integration
Ockenden 1: Review & Redesign service model for older people and those with dementia [progress update required by end of Sept]
Ockenden 12: Older Persons Strategy

Three emerging themes have been identified for the above recommendations:
i) Organisational culture; including corporate & clinical governance and stakeholder relationships
ii) Strategy & planning; care pathways, service redesign for Older Persons Mental Health (OPMH) and care homes & service integration
iii) Organisational learning; including knowledge & skills, training & development and information management

Work has progressed to identify the interdependencies of the older person strategy alongside recommendations 2, 3 and 5 and a programme and scoping exercise has now been completed that includes the identification of all existing strategies currently in place. This initial scoping exercise has helped inform the Health Board's HASCAS & Ockenden delivery plan, the objective of which is to support the overarching integrated pathways for older persons and those with dementia. This will ensure that there is a focus on clinical redesign and integration, education and the integration with the care home sector.

An exercise has also been completed to scope out all interlinking Older Persons forums and groups to ensure consultation and engagement take place across the organisation. The Quality Safety Group meeting in January received an update on the end of life care pathway for Older Persons Mental Health and approved the draft Standard Operating Procedures presented to the group 'End of Life Care for the Person with Dementia under the care of In-patient Mental Health Services', ('*One chance to get it right'*).

Extensive work has been undertaken within BCUHB and the North Wales Regional Partnership Board in relation to care services across North Wales for the older person. In February 2019, a partnership event will be held, which will identify and review the significant work underway in both health and social care services, in addition to the care provider sector. This work will inform a gap analysis to aid the future delivery plan.

Joint working has also commenced with the Older Persons Commissioner for Wales' office and support gained to help advise on future delivery plans.

A North Wales training programme for 'Care of the Older Person and those with Dementia' has been developed in specific relation to knowledge and skills around the care of the elderly. This involves a basic module to be made mandatory to be accessible to all health and social care staff, care providers and families and will

ensure consistent delivery of training material for all services that deliver care to the older person. Furthermore, an advanced programme will be developed with Glyndwr and Bangor universities, for postgraduates.

A North Wales wide joint clinical event for BCUHB and Care Home staff will be held in the beginning of Quarter 4, for ward staff and care home managers, to capture shared experiences and learning; encourage team building; and most importantly improve relationships and communication across all acute, community and care home settings. Furthermore, this will help identify the work needed to improve clinical pathways for integration and the future development of a long term clinical strategy.

A 'Pledge of Principles' has been developed by a small partnership working group to raise awareness around the good practice principles of cross-sector working, which aim to refresh and raise awareness about the care philosophy that underpins staff culture and effective ways of working in true collaboration.

A delivery plan on the Health Boards support into North Wales Care Homes has been developed following the HIW report and a meeting is scheduled for January 2019 to discuss the implementation and outcomes to help inform the future delivery plan and long term clinical strategy.

Risks and Issues

- A joint and clear action plan with milestones and timelines is in place to mitigate risk to delivery of outcomes, particularly given the review of a broad range of services across the Health Board within required timescale.
- An agreed partnership approach will be taken when reviewing services to ensure validation of data between NHS reporting and local authorities.
- Joint responsibility will be undertaken in ensuring translation of strategy into action in response to workforce capacity and resource for transformation to avoid duplication and conflicting agendas.
- An agreed set of principles will be developed in partnership together with quality and safety standards to inform the model of care and strategy to ensure sustainability and differing standards of quality & safety of services across multiagency providers and commissioners of care.

HASCAS 2 & Ockenden 2: Dementia Strategy

The Health Board's Dementia strategy was co-launched in February 2018 by the Executive Director of Nursing & Midwifery and the Regional Director for Alzheimer's Cymru. The strategy emphasises the importance of how best to support individuals within their environments, whether this be at home or within a healthcare setting. A draft high level action plan has been developed and is being reviewed including the financial details required around some of the delivery areas. The Health Board will be working within the framework of working towards becoming a dementia friendly organisation in line with the Alzheimer Society's dementia friendly communities programme. The three District General Hospitals, Emergency Departments, main Out-Patient Departments, Older Person's Mental Health services and Learning Disability services have project leads and action plans in place for this work. In December 2018 Ysbyty Gwynedd become the first acute hospital site in Wales to achieve Dementia Friendly status.

A task and finish group responding to Recommendation 2 has been established and terms of reference agreed. The remit of this group is to support the development of the action plan and monitor the delivery of the priorities and objectives defined within the HASCAS report. The first two meetings have taken place in November and December 2018, with project support identified to progress the action plan.

HASCAS 13: Restrictive Practice Guidance

Relevant guidance has been reviewed by the operational lead and the Improvement Group have acknowledged that there was more recent and up to date NICE guidance (NG10, 2015) than that referred to in part 2 of Recommendation 13 (RCP, March 2007). This has been considered alongside the updated Mental Health Code of Practice and quality standards on how to support and assess people with dementia and how to manage behaviours which challenge.

The Task & Finish Group for Recommendation 13 has been very well represented from all areas of the Health Board and output from the group has enabled us to deliver a number of complex issues at pace. Terms of Reference for Recommendation 13 Task & Finish Group have been refreshed and revisited to ensure focus on the HASCAS recommendation and provide assurance, that all older adults and those with dementia, receive lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within BCUHB.

The Health Board Area Directors and Secondary Care Nurse Directors have undertaken a scoping exercise for restraint training and reviewed the scoping of restraint reporting. The Health Board's Restrictive Physical Intervention (RPI) policy has been ratified at the Policy Approval Group and Quality, Safety & Executive committee.

A benchmarking exercise has been undertaken across all areas against the policy implementation and the outcomes of this will be presented to Quality & Safety Group in January 2019.

A Proactive Reduction & Therapeutic Management of Behaviours which Challenge Policy has also been developed to support the delivery of Recommendation 13 and monitoring actions are in place to ensure it is achieved.

The requirement for a project management post has been submitted to lead on education, training and embedding positive management of behaviours to support the current programme of all Wales training passport modules A-C.

Identified processes are in place for patients within acute physical healthcare settings and who are distressed, due to a deterioration in mental health issues / symptomology, who will be assessed by liaison psychiatry and supported by MH&LD violence & aggression team.

Reporting of restraint incidents is being uniformed across the organisation utilising Datix as the reporting mechanism, training is being delivered to compliment a consistent approach of reporting, across the Health Board.

Ockenden 2d: Consultant Nurse in Dementia

The additional Consultant Nurse with a special interest in Dementia post has been advertised and interviews are scheduled for the 15th January 2019. The aim is to have a representative of the Stakeholder Group as part of the panel. Recruitment to this post is an essential step in response to the recommendations.

The Health Board are also working with Bangor University to review other roles including Advanced Nurse Practitioners to support people in their own homes.

HASCAS 4: Safeguarding Training
HASCAS 5: Safeguarding Informatics and Documentation
HASCAS 6: Safeguarding Policies & Procedures
HASCAS 7: Tracking of Adults at Risk across North Wales
HASCAS 8: Evaluation of Revised Safeguarding Structures
Ockenden 6: Safeguarding Structures
HASCAS 12 & Ockenden 9: Deprivation of Liberties

Following a scoping exercise across the whole of the safeguarding portfolio over the last 2 years, a thematic report and action plan including benchmarking are now in place. A further review has been undertaken of the Safeguarding Governance & Performance Group including membership to ensure the Terms of Reference enable the delivery and accountability of the HASCAS and Ockenden recommendations. A safeguarding dashboard has been developed and implemented and safeguarding has been included within the ward dashboards. Going forward a safeguarding communication strategy will be developed.

A scoping exercise has been undertaken of safeguarding policies and procedures and a matrix has been developed for monitoring, updating and implementation.

A Standard Operating Procedure (SOP) has been developed for adults at risk documentation, to support engagement, decision making and internal reporting and escalation. A revised and improved adult at risk reporting tool and database has been implemented.

Appointments have been made to several posts including Safeguarding Practice Development Lead, Safeguarding Data Analyst and a Business Manager.

All training packages have been reviewed and updated in line with legislation. A scoping exercise has been completed on training activity which has identified key areas of focus and the implementation of revised training packages and training methods.

A review has commenced of the Deprivation of Liberty (DoLs) service to identify and address the gaps in the service and ensure effective and efficient service delivery. Following the review, a position paper regarding the DoLs service and proposed requirements for the DoLs service and team will be presented at the Quality and Safety Group March 2019. A training package and governance framework has been developed for DoLs signatories this is to provide a monitoring framework of support, guidance and governance and to address the low numbers of signatories, relevant

staff are being identified for training, with a target of a minimum of 6 staff to be trained each month.

A new safeguarding web page has been developed with an implementation date of 21st January 2019 following which an external internet page will be developed for the public.

HASCAS 5: Safeguarding Informatics & Documentation
HASCAS 9: Clinical Records

Work has commenced in respect of training and communication in the use of safeguarding dividers within the clinical record and identified the need for a Standard Operating Procedure to be developed that will provide guidelines on filing and storing of safeguarding information to ensure consistency across all specialities. GRK training will be revised to include a section on filing of safeguarding information and uptake will be monitored by the Electronic Staff Record (ESR).

Significant work has commenced on the transfer of management of the Mental Health patient records within the same portfolio as acute patient records, under the Health Records service. The scope of this work has been expanded by the Executive Team of the Health Board in response to this and other regulatory recommendations (e.g. ICO Audit) to review the management arrangement for ensuring good record keeping across all patient record types including *Mental Health (inc. CAHMS, Drug and Alcohol services); Radiology, Audiology, Posture & Mobility Service (formerly ALAC), Sexual Health, Speech and Language Therapy, Community Hospitals, Child Health, Podiatry, Emergency Department, Physiotherapy, Occupational Health, Acute Records, Oncology, Midwifery, Genetics, Diabetics, Primary Prisoner Clinical Record*, all of which are now under the portfolio of the Executive Medical Director.

The 'Patient Records Transformation Programme' is being established with the Executive Medical Director as the Executive Lead and SRO, and will focus on 4 key areas of work; *ATHR under GDPR*, *Infected Blood Inquiry*, *Retention of Oncology Information within the Acute Record*, and the Project for this piece of work *'Management of BCU Patient Records'*

Phase 1 of this specific project will initially aim to deliver the following objectives of the overall programme to ensure:

- Objective 4: A baseline is in place that maps out the storage, processes, management arrangements and standards compliance, for all types of patient records, by (date).
- Objective 5: To present the recommendations and funding requirements to work towards PAN-BCUHB compliance with legislation and standards in patient records management across all case note types.

In order to progress this project which will meet the recommendations in both the HASCAS and Ockenden reports, and to ensure sustainability in mitigating against future risks, resource requirements to deliver this Programme have been identified and will be submitted for executive approval. Recognising that there will be many demands on limited resources; the Chief Information Officer is seeking to prioritise areas of

informatics funding to secure the senior 8b post required, however, funding for the Band 7 Project Manager will require additional funding.

HASCAS 10: Prescribing & Monitoring of Anti-Psychotic medication

The Health Board has recently updated guidance on prescribing antipsychotic medication in the presence of a dementia diagnosis (MM17) which will be subject following implementation, to a full audit within 12 months of the HASCAS report publication.

A medicines reconciliation audit was undertaken in Wrexham on the completion of an accurate drug history, within 24 hours of admission. This demonstrated that 24 hour targets are not consistently being met due to lack of pharmacy staffing on the OPMH wards, this can result in errors and omissions and the potential for patient harm. An improvement plan has therefore been developed which for the use of anti-psychotic medication, will mean that patients with a diagnosis of dementia will have 3 monthly reviews of any antipsychotic medication in use upon discharge.

A CAIR (checklist for antipsychotic initiation and review) chart has been prepared and distributed to all OPMH and CMHT teams across the MHLD Division (October 2018). Work is ongoing to continue to implement the use of the CAIR antipsychotic form and highlight best practice, particularly in care homes. The CAIR form and a letter has also been circulated to GPs and practice pharmacists for information.

Key to this work is the consistent availability of pharmacists or technicians on the wards and in CMHTs or memory clinics to support and embed change. This is being scoped and will be presented through the improvement group.

<u>Monitoring</u>

At present the pharmacy department is reviewing the capacity to support OPMH and care homes to deliver medicines optimisation in line with national recommendations and will report this back through the Improvement Group.

Care homes are not currently reporting on the use of anti-psychotics and length of treatment. In order to address this, a care home proforma is in development and will be progressed through the care home subgroup of the primary care pharmacists group. This will enable care homes which need support to be identified and targeted for intervention. In addition an all wales audit is being carried out in 2019 – 20 to identify the number of people with dementia who are prescribed antipsychotics.

The MHLD lead pharmacist for the Health Board will work with the Nurse Consultant in Dementia to ensure that training includes relevant information around psychotropic medication for frontline staff. A business case is being prepared to support a MDT project initiative. The anti-psychotic initiation and review (CAIR) chart will be used for people within the division and then rolled out across secondary care and community settings.

Also in line with the WG recommendations on antipsychotic prescribing, a project is being set up to trial the use of an ADRe (Adverse Drug Reaction profile) for use within

care homes / OPMH wards. This will aim to improve the documentation of care, side effects and monitoring, relevant to the use of all psychotropic drug usage. This has been implemented in Swansea where there was a notable reduction in falls as a result of the project.

Audit

Information is published annually in relation to the use of antipsychotics in care homes, benchmarked against NICE guidance and Welsh targets for patients with a diagnosis of dementia and this data was collected in primary care in 2017. The WG national audit of antipsychotic use in primary care is under consultation and is expected to deliver this recommendation once the audit implemented.

A community pharmacy care homes National Enhanced Services (NES) is in place to monitor antipsychotic use in care homes, to which only 5 pharmacies are currently signed up. Further work is ongoing to ensure all pharmacies that supply BCUHB care homes are signed up to the NES.

An audit of 'antipsychotics prescribing' including non-drug measures used to prevent behaviours that challenge is being planned jointly with the Consultant dementia nurse for February 2019 in line with HASCAS recommendations, and the National primary care audit on prescribing of antipsychotics in dementia is being planned for 2018-19 .

Implementation

A business case has is being prepared to fully support implementation and recommendations to increase pharmacy support to MHLD in order to support the full HASCAS recommendations including Recommendation 10.

HASCAS 11: Evidence Based Practice
Ockenden 2a: Quality Impact assessment
Ockenden 2b: Integrated reporting
Ockenden 3: Policy review
Ockenden 10: Reviewing external reviews
Ockenden 14: Board Development

The Board in September 2018 adopted revised arrangements for Board and Committee meeting arrangements to respond to the findings and recommendations of the Deloitte report into financial governance, the Wales Audit Office Structured Assessment for 2017, and the advice of the Specialist Adviser to the Board.

http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20Board%20Public%206.9.18%20V2.0.pdf

The revised arrangements are intended to further improve and strengthen the effectiveness of the Governance Arrangements of the Board and its Committees, ensuring greater oversight and challenge in key areas by Independent Members and the ability for Executives to have an increased focus on turnaround and operational productivity. The revised arrangements seek to ensure appropriate time between meetings for follow up actions to be taken forward, whilst maintaining the ability to provide timely financial and performance reports to the Board and its Committees.

Failings in the health and social care systems in the past have highlighted the on-going need for greater focus on the impact on quality when considering cost improvement or efficiency related changes. A system is in place for Quality Impact Assessment (QIA) of savings schemes and progress will be measured from samples of completed QIAs and a record of outcomes and as part of the internal audit programme 2019/20. No changes, schemes, or indeed overall financial plans, will be approved without first having received appropriate assurances that the impact of the proposed changes on quality have been appropriately assessed and are, in the worst case neutral but at best are aiming for an improvement in quality. With an increased focus on cost containment and improving efficiency managers have been tasked with ensuring that any projects or schemes to help achieve this aim have due regard for the impact on service provision.

The Board has also sought to strengthen its decision making with a clear focus on quality and affordability and had revised its coversheet template to expressly include a requirement to document financial implications of any proposals. In addition, the Terms of Reference of the Finance and Performance Committee of the Board have been modified in this respect.

Following changes in the Executive portfolios and weaknesses identified in the effectiveness of the performance and accountability framework, the arrangements in place have been subject to detailed review. A revised framework has been considered by the Executive Management Team and was subsequently discussed at a Board Workshop in autumn 2018. The key principles set out in the revised framework include supporting the organization in delivering:

a) The strategy set out by the Board through the IMTP or Operational plan
b) Operational ownership of the key organizational priorities across services and at each level in the organization
c) Clarity of expectations as to level of performance expected within resources allocated to services
d) Decision-making based on visible performance information triangulated across key indicators
e) Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
f) Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
g) Challenge to accountable officers through a holding to account mechanism for areas where performance falls below expectations.
h) Clarity as to outcomes and consequences of poor performance through clear escalation process

Revised arrangements have been agreed in principle and are being tested over the next six months to ensure that they provide a more robust and effective accountability mechanism.

Work has been underway for some months to review the Health Board's arrangements for managing BCU wide policies, procedures and other written control documents

(WCDs). Part of this has involved the review of the Policy on Policies together with a new intranet page. The revised policy and intranet page were launched in September 2018.

Numerous sessions have been held between October and December to ensure Directorate Governance Leads are fully conversant with the new policy and the transfer arrangements to the new intranet location. In order to avoid any confusion or risk, staff, particularly clinical staff not being able to access documents quickly (from their former locations) transition arrangements are in place. One to one meetings with the Leads have been taking place to confirm which documents can move across to the new site and from what date and to agree dedicated communication plans for various cohorts of policies in terms of the key target audience. Access to the documents from the old location will remain active for an initial period but these links will be withdrawn over time and substituted with redirection notices. Staff feedback on the new arrangements has been encouraged (agreement in terms of the timeline for transition leading to final arrangements will be agreed by the end of April 2019).

The new Policy on Policies appends a new template which also includes a table showing the approval route for various types of document. Staff have been reminded that all clinical policies should be developed using a person centred approach. Existing Policies are being reviewed to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified and if necessary separate clinical policies and procedures will be developed with input from experts. Authors of Policies, Procedures and other WCDs have also been reminded of the need to undertake an Equality Impact Assessment on all Health Board wide Policies and Procedures to ensure that decisions do not discriminate against people based on any protected characteristic. Environmental Impact Assessments also need to be undertaken where appropriate.

In relation of BCU wide clinical policies the Corporate Nursing Team have undertaken a clinical policies mapping exercise to determine the location and current status of all clinical policies. These clinical policies have been risk assessed in terms of prioritising those that require urgent review under the direction of the Executive Clinical Directors. In line with the existing policy on policies the Quality, Safety and Experience Committee of the Board must approve clinical policies. From August 2018 an additional step has been added to the ratification and approval process with all new or refreshed clinical polices being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based. In addition to this a BCU wide mapping exercise has been undertaken to assist Leads in identifying all linkages to existing intranet documentation supported by the Compliance Officer.

Reviewing External Reviews – Work has been undertaken to strengthen assurances around external reports produced in respect of the Health Board. The Corporate Nursing Team have undertaken a review of all HIW inspections from July 2017 to July 2018 to identify findings, recommendations and actions which were applicable to older people and specifically the care of older people with mental health concerns. All open/outstanding actions arising from these inspection reports continue to be monitored/managed on a monthly basis by the Quality and Safety Group. In addition to the review as detailed above, it should be noted that a BCUHB/HIW Management plan was ratified at the June 2018 Quality and Safety Group and has been circulated

to all Leads. This Management Plan has introduced the following additional assurance processes:

- Members of the Corporate Nursing Team complete regular post HIW inspection walkabouts (approximately six months post inspection) to review both closed and open/outstanding actions to identify areas of good practice, if actions/recommendations have been sustained and to offer support where required for open/outstanding actions;
- The Corporate Nursing Team hold regular meetings with Governance/Local Leads to progress action plans and review both open and outstanding actions to provide support where required, share learning and celebrate success.
- The Corporate Nursing Team to work with Governance Local Leads post inspection to ensure SMART action plans are developed in response to HIW inspection findings/recommendations.
- Pan BCUHB level actions (identified during local HIW inspections) are taken to the Quality and Safety Group for review and to identify/allocate a Lead.
- Thematic Analysis of HIW findings from 2015 to date has been undertaken by the Informatics Team to inform future improvement plans/learning.

The actions as outlined continue to be implemented in accordance with the agreed HIW Management Plan which can be accessed via the following link.
http://howis.wales.nhs.uk/sitesplus/861/page/74145

In addition to this the Office of the Board Secretary has established a database to capture all externally commissioned/produced reports such as the Delivery Unit, Royal Colleges, Commissioners etc. to ensure such reports are centrally logged and a lead officer identified. Further work is being undertaken to improve the system for recording external reports to ensure logging, cascade and follow up are automated as far as possible. Discussions have taken place with the All Wales Board Secretaries Group to share best practice. Resources in this area have also been strengthened with the assignment of a Compliance and Assurance Manager. These improvements will ensure that the system logging those reports is robust. This system has recently been expanded to capture applicable recommendations originating from National Assembly Wales (NAW) Committee Business. The relevant Committees are as follows:

- Children, Young People and Education Committee
- Climate Change, Environment and Rural Affairs Committee
- Committee for the Scrutiny of the First Minister
- Constitutional and Legislative Affairs Committee
- Culture, Welsh Language and Communications Committee
- Economy, Infrastructure and Skills Committee
- Equality, Local Government and Communities Committee
- External Affairs and Additional Legislation Committee
- Finance Committee
- Health Social Care and Sport Committee
- Petitions Committee
- Public Accounts Committee

NAW Committee business (agendas and minutes) is monitored by the Compliance and Assurance Manager. Items of note (Inquiries, Petitions, Reports, Recommendations, and Consultations) are logged and reviewed by the Office of the Board Secretary Senior Management Team. Where applicable, items are added to the TeamMate electronic monitoring system and reported via the Audit Committee.

In relation to Board Development, the Executive Director of Nursing and Midwifery has given consideration to Ockenden Recommendation 14 and has determined that this ambition will best be met by the full Board undertaking dementia training which will be delivered on 10.1.19 to be led by the Consultant Nurse (Dementia) and a Service User National Champion.

HASCAS 14: Care Advance Directives
HASCAS 15: End of Life Care Environments

Work is underway to embed and roll out Advanced Care Planning. Clarification has been sought with HASCAS that the ongoing work is for planning, not directives, as cited in the report.

In relation to Treatment Escalation Plans (TEPs) and DNACPR, significant progress has been made with increasing numbers of end of life conversations taking place within community and hospital settings. Communication with families is being encouraged to share decision making and identify common goals. Learning from the initial pilot of TEPs implementation in the community will inform further roll out.

The National Audit for Care at the End of Life (NACEL) The National Audit for Care at the End of Life (NACEL) was carried out nationally in 2018, and in BCUHB was led by the Performance Directorate. The North Wales Department for Specialist Palliative Care contributed to the data collection and the full audit of organisational data for end of life care in hospital settings, was submitted by the Performance Directorate; results awaited early 2019. The National Audit of Dementia (NAD), both audits have been added to the National Clinical Audit & Outcome Review Plan (NCAORP) Welsh Government programme of mandatory projects for 2018/19.is currently underway being led by Dr Andrew Shuler (Consultant in Palliative Medicine) and the National Audit of Dementia (NAD), both audits have been added to the National Clinical Audit & Outcome Review Plan (NCAORP) Welsh Government programme of mandatory projects for 2018/19.

In respect of End of Life Care environments, a task and finish group has been established and has met to determine the actions required. These have been developed further into a SOP to support delivery of high quality end of life care on Older Person's Mental Health Wards (OPMH) and training has commenced for Older Persons Mental Health (OPMH) nurses in respect of this guidance and SOP to improve the end of life care environment on OPMH wards. In addition a process is in place to monitor paperwork for inpatient deaths for patients receiving palliative & end of life care. This has been developed by the North Wales Department for Specialist Palliative Care to ensure a full complement of nursing staff are trained in this area and know how to access additional support from palliative care services. Staff training commenced in early December 2018 and a further six study days are being held

monthly (January – June 2019), in addition to staff from OPMH wards being able to access further training on a regular basis.

A dementia care pathway has been developed with the Alzheimer's Society.

Ockenden 2c: Workforce Development
Ockenden 4a: Staff engagement
Ockenden 4b & 4c Staff surveys
Ockenden 4d: Clinical engagement
Ockenden 13: Culture change

A draft Workforce Strategy is in place which details workforce improvements aligned to organisational priorities. Work has progressed in the following areas:

- The Team Survey element of the Go Engage tool which has been rebranded for the organisation as 'ByddwchYnFalch / BeProud' is being deployed to support the Older People care Pathway as a priority. Teams will commence training in engagement improvement work in March 2019, each team will produce a team level 6 month improvement plan supported by the Organisational Development Team.
- NHS Wales Staff Survey intelligence is being used to drill down into priority areas in order to develop meaningful team/department level improvement plans to support improved engagement, staff workplace experience and culture.

Ockenden 5: Partnership working

The Health Board recognise the importance of working effectively at a strategic level with the voluntary sector and wide range of multi-agency partners and is set out within the mental health strategy. Different ways of partnership working are being considered to develop, provide and sustain services to older people and those older people with mental health needs and dementia and a strategy implementation structure is in place. Local implementation teams are established with the third sector and including wider partner representation Engagement sessions have been held with third sector providers to develop themes and reports to ensure clear alignment to achievement of outcomes and objectives.

All mental health third sector contracts / grants for 2016/17 will be reviewed to inform strategy development in line with the dementia plan and the Health Board's *living healthy, staying well strategy* in relation to older people and older people with mental health needs. This will ensure a more diverse range of delivery models and fully implemented effective contract management arrangements.

A commissioning framework will be completed via the mental health commissioning group with a commissioning plan developed setting out clear intentions. A commissioning lead will be appointed within the agreed mental health structure.

Ockenden 7: Concerns Management

Work is progressing to improve the thematic analysis for management of concerns and the timescales for responses. Progress has been made with a 50% reduction in the total number of open complaints achieved with many legacy complaints now dealt

with, and improved responses, in real time. Reductions are also reported in the number of major and catastrophic incidents and the number of complaints that are open beyond 3 months.

Improvement plans have been developed for all elements of the service and task and finish groups have been established to drive improvement work. These will focus on:

- Staff training (including roles and responsibilities)
- Putting Things Right Management including Redress
- Data Analysis to include lessons learned and sharing
- Communication with and about patients including timeliness of responses, depth of investigations and letter writing
- Review of all policies and guidance to support the principles of good complaint and incident management

Work is ongoing to rollout the PASS (Patient Advocacy and Support Service) which has been piloted at Ysbyty Glan Clwyd to support increased local resolution of complaints in near or real time.

The roll out of an electronic form to support complainants to register and submit concerns has been commenced in January 2019.

A review of the Patient Experience real time data feedback is underway the results of which will be used to shape the way the service is offered.

Dashboards are in development to be used at a ward and department level which will include a broad range of patient experience measures including real time feedback, complaints and harms reported from incidents.

A revised process for claims has been completed and ratified at Quality & Safety Group. This process will be audited in March.

Ockenden 11: Estates – Older Persons Mental Health

A multi-directorate / professional task and finish group has been established with agreed terms of reference and membership which includes Operational Estates, Estate Development and Mental Health and Learning Disabilities to deliver the following work streams for initially Older Persons Mental Health Facilities and thereafter all ward areas within inpatient facilities.

Scoping exercise has been competed for work stream 1 to develop a site by site schedule (Inventory) of outstanding repairs and actions required from recent and previous external HIW and CHC audits and inspections relating to MH&LD OPMH facilities. Work is progressing to reduce the number of outstanding repairs required.

Work Stream 2 will develop the Kings Fund *Enhancing the Healing Environment* (EHE) assessment across all wards within MH&LD OPMH facilities to determine the scope of work and resources required at each facility.

Work Stream 3 will develop the Kings Fund *Enhancing the Healing Environment* (EHE) assessment across all remaining wards to determine the level of resources required. Scoping work has commenced on identifying outstanding repairs from within operational estates work management systems. Work has also commenced on identifying outstanding works and actions contained within previous and current HIW and CHC audits and inspections and a detailed schedule of work is being developed.

Project management capacity and availability of revenue and capital requirements are identified as required resources to support the delivery of the three work streams.

Appendix 1

Improvement Group (HASCAS and Ockenden)

Terms of Reference

1.1 The Health Board will establish under the direction of the Executive Director of Nursing and Midwifery an Improvement Group to oversee the implementation of the recommendations arising from the HASCAS Thematic Report a Lessons for Learning Report and the Ockenden Governance Review to be published July 2018.

1.2 The Improvement Group are responsible for ensuring that there is a clear plan to address the recommendations and will provide leadership, governance and scrutiny of the implementation of the recommendations adopting an improvement methodology to sustain change.

1.3 The Improvement Group will, on behalf of the Health Board, maintain a robust grip and oversight of the improvement work required. The Improvement Group will take decisions and make arrangements which need to be effected to respond to the recommendations and the Executive Director of Nursing and Midwifery will report on progress directly to the Quality, Safety & Experience Committee of the Health Board to provide assurance on progress, no less than 3 times a year.

1.4 It remains the responsibility of the Health Board to scrutinise the findings and recommendations of the HASCAS Lessons for Learning Report and the Ockenden Governance Review. When the recommendations have been implemented and improvements have been made to the satisfaction of the Quality, Safety, Experience Committee, the Improvement Group will be stood down.

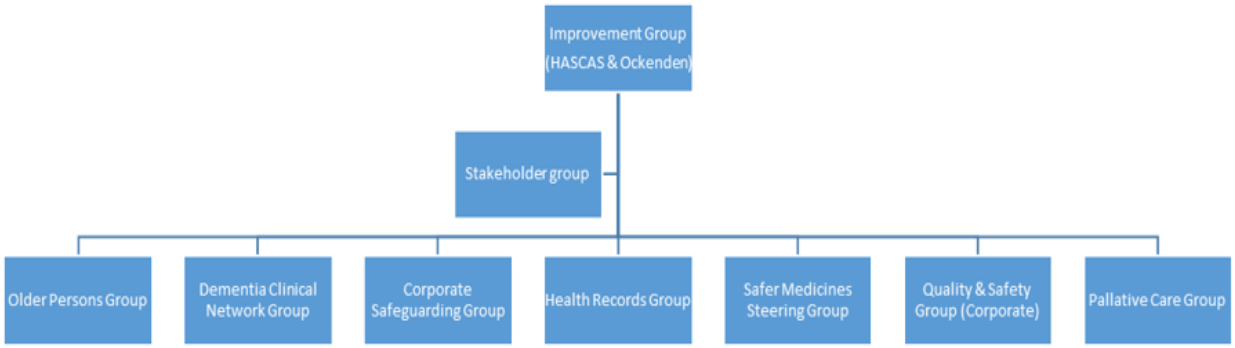
Remit

1.7 The Improvement Group in respect of its actions, provision of advice and assurance is authorised by the Board to;

- Ensure there is a clear plan to address the recommendations
- Scrutinise, challenge and seek assurance on the actions identified to effectively deliver the recommendations;
- Hold programme leads to account for the successful implementation of actions in response to the recommendations;
- Agree and monitor metrics in order to identify improvements and track progress against these;
- Agree direct actions to address any under-performance including the mitigation of risk;
- Provide assurance to the Board via Quality, Safety and Experience Committee of the progress being made, escalating as appropriate.

Improvement Group Structure

1.8 The Improvement Group governance and reporting structure is set out below:



Membership

Membership of the Improvement Group shall comprise of the following;

Executive Director of Nursing & Midwifery (Chair)
Executive Medical Director (Vice Chair)
Associate Director of Quality Assurance (Chair of Stakeholders Group)
Associate Board Member (Director of Social Services)
Executive Director of Workforce and Organisational development
Nurse Director Mental Health & Learning Disability
Medical Lead Older Persons
Named Doctor Adult Safeguarding

In attendance:
Welsh Government Advisor
Operational Leads for addressing the recommendations.

The Chair will have the discretion to invite additional members to the meeting if it becomes apparent that this is appropriate and necessary to fulfil the purpose of the group e.g. finance

Nominated deputies will be permitted

Meetings

Quorum

1.9 At least four members including one executive director must be present to ensure the quorum of the Improvement Group.

Frequency of meetings

1.10 Meetings shall be held no less than bi monthly or otherwise as the Chair of the Group deems necessary.

Agendas and Papers

1.11 The Improvement Group will be supported administratively by the office of the Executive Director of Nursing and Midwifery, whose duties in this respect will include;

- Chairing
- Dedicated secretariat
- Programme Manager
- Producing and collating assurance reports to the Quality, Safety and Experience Committee
- Maintaining oversight and monitoring progress on the implementation of the recommendations and work progress of the sub groups
- Arrangement of meetings

Reporting and Assurance Arrangements

1.12 The Improvement Group is accountable to the Quality, Safety & Experience Committee for its performance in exercising the functions as set out in these Terms of Reference.

1.13 The Improvement Group shall recognise the interdependencies of wider improvement work within the organisation, especially as it relates to dementia care and older person services.

1.14 The Improvement Group will:

- Provide an assurance report after each meeting normally bi monthly, outlining progress to date, a summary of the business discussed, key assurances provided, key risks identified including mitigating actions and milestones, matters which require escalating to the Quality, Safety & Experience Committee and planned business for the next meeting.

- Ensure appropriate escalation arrangements are in place to alert the Quality, Safety & Experience Committee to any urgent / critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

- Embed the Health Board's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

1.15 The Improvement Group has delegated authority from the Board and Quality, Safety & Experience Committee to exercise its functions as set out within these Terms of Reference.

Date Terms of Reference Approved:…….

Review date: August 2019

Stakeholders Group

Terms of Reference

The Health Board recognises the importance of Stakeholder engagement and wishes to establish a Stakeholder Group to strengthen and guide the work of the Improvement Group (HASCAS and Ockenden).

Remit

The group will provide scrutiny, advice, support, challenge and endorsement of the work being undertaken to deliver the necessary improvements across all areas affected by the recommendations from the HASCAS Thematic Review and the Ockenden Governance Review when published in July 2018.

The Stakeholder Group will provide a forum to facilitate full engagement and activate debate amongst stakeholders from across the communities served by the Health Board. Their aim will be to reach and present, wherever possible, a cohesive and balanced stakeholder perspective to inform the Improvement Group's decision-making in relation to implementing the recommendations arising from the HASCAS Thematic Review and the Ockenden Governance Review.

Membership

Membership of the Stakeholder Group shall comprise of the following;

Associate Director of Quality Assurance (Chair)
Director of Mental Health and Learning Disabilities (Vice Chair)
Representative of North Wales Local Authorities
Representative of Community Health Council
Representative of Bangor University
Representative of the Community Voluntary Councils
Representative of North Wales Police
Representative of Tawel Fan families (x5)
Representative of service user families and carers
Representative of Care Forum Wales.

The Chair will have the discretion to invite additional members to the meeting if it becomes apparent that this is appropriate and necessary to fulfil the purpose of the group.

Meetings

Quorum

1.16 At least one Health Board management member and three stakeholder members must be present to ensure the quorum of the Stakeholder Group.

Frequency of meetings

1.17 Meetings shall be held no less than quarterly and otherwise as the Chair of the stakeholder Group deems necessary.

Agendas and Papers

1.18 The Stakeholder Group will be supported administratively by the office of the Executive Director of Nursing and Midwifery, through the Associate Director for Quality Assurance whose duties in this respect will include;

- Chairing
- Dedicated secretariat
- Arrangement of meetings
- Ensure strong links to communities
- Facilitate effective reporting to the Improvement Group thereby enabling the Quality, Safety and Experience Committee to gain assurance that the business of the Stakeholder Group accords with the governance and operating framework set.

Reporting and Assurance Arrangements

1.19 The Stakeholder Group is accountable to the Improvement Group (HASCAS and Ockenden) for its performance in exercising the functions as set out in these Terms of Reference.

1.20 The Stakeholder Group shall recognise the interdependencies of wider improvement work within the organisation especially in older person and dementia services.

1.21 The Stakeholder Group will:

- Report formally after each meeting on the activities of the Group outlining progress to date and key recommendations and advice made to the Improvement Group.

- Embed the Health Board's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

The Stakeholder Group has delegated authority from the Improvement Group to exercise its functions as set out within these Terms of Reference. Through its Chair and members it shall work closely with the Improvement Group to co-ordinate the sharing of information and good governance ensuring that its outputs are aligned with the Health Board's strategic goals.

Date Terms of Reference Approved:…….

Review date: August 2019

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
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1st August 2018

Gill Harris
Director of Nursing
Betsi Cadwaladr UHB
BY EMAIL ONLY

Dear Gill

PTR PROCEDURES

Recent discussions with my Advocacy Team have left me concerned about a developing practice within your Concerns Team. This is that complainants are invited to a meeting with key staff to discuss their concerns and at the close of the meeting are informed they will be sent a recording of the meeting and a written summary. Complainants are usually not told that the matter is being dealt with outside of PTR. ***The meeting is presented as the full and final response of BCUHB, the case is closed at that point because it has been downgraded to an "on the spot" matter.***

When this process has been followed the complainant suffers a number of disadvantages;

- Complainants are told the case is closed and if there are any further issues they must be raised as new and separate complaints;
- The report of the meeting and any action is no longer subject to Executive scrutiny because it is signed off by Patient Experience leads;
- Complainants are not told of their right to go to the PSOW or the time limits set by the PSOW;

- Issues of breach of duty, qualifying liability and harm is not referred to in the meeting summary;
- Complainants may be inappropriately denied access to PTR and Redress if they are unaware of NHS Concerns Procedures (*this applies particularly to individuals who are not supported by the CHC*);
- It is our experience that complainants are asked if they are satisfied and given little or no explanation of other options that might be available to them;
- It is claimed that complainants are being told that their concern is being dealt with outside the PTR procedures but this is not our experience. Often complainants do not know or understand what the various components of the complaints procedures are not able to give informed consent to the route they are being taken down and do not understand the disadvantages;
- We are informed that if Concerns Team members feel that there has been no breach of duty, qualifying liability or harm then they can decide to downgrade the matter to an "*on the spot*", informal status.

We do not wish to unnecessarily delay resolution and would generally regard any steps to deal with complaints more speedily as a good thing. However, this cannot be at the cost of disadvantaging complainants or losing the value of complaints in monitoring standards and ensuring best practice.

I wonder whether it would be possible for us to meet to discuss the issues that these new practices present and ensure that the correct balance between speed and accountability is maintained.

Regards

Geoff Ryall-Harvey
Chief Officer

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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E-bost / Email: gill.harris@wales.nhs.uk
Dyddiad / Date: 9 August 2018

Dear Geoff

Thank you for your recent letter dated 1st August 2018 regarding PTR procedures, it is always helpful to receive feedback to enable us to review our practices and where we can make improvements.

In considering your comments I have reviewed with the team our overall approach to complaints handling and it is clear that the Health Board has indeed been increasingly offering meetings to complainants in an effort to offer more timely resolution to their concerns. This approach is only applied for complaints where there is no allegation of harm. Such complaints are logged as an 'on the spot' (OTS) and are passed to the relevant division for local resolution. The divisional staff contact the complainant within 2 days of receiving the complaint and attempt to resolve the issues to the complainant's satisfaction. Should this be successful the complaint will be closed as an OTS. Should the complainant remain dissatisfied or request the complaint be managed formally, the complaint will be managed under PTR and appropriately investigated.

These cases are managed within the agreed timescale of 'ideally the next working day'. Should this not be deliverable the complaint will be made formal and responded to under PTR. However, in some cases particularly where a meeting is planned within the agreed timescale but cannot happen due to availability of relevant people (to include the complainant), with the complainants agreement the OTS may be open longer than the recommended timescale. This approach does not preclude a written response confirming the actions taken.

This approach is in keeping with the PTR regulations for managing OTS. I understand that Barbara Jackson met with your advocacy team early in the early days of this approach to discuss the benefits and any potential concerns. There was broad agreement with this approach as being better for the complainants.
In terms of your specific issues raised:

- Complainants are told the case is closed and if there are any further issues they must be raised as new and separate complaints;

The OTS should not be closed unless the complainant is satisfied with the outcome. If they have further issues to raise after the closure has been agreed these would indeed be a new complaint as would be the case had it been dealt with as a formal complaint.

- The report of the meeting and any action is no longer subject to Executive scrutiny because it is signed off by Patient Experience leads;

Only cases where there is no allegation of harm would be dealt with as an OTS. These are managed by the relevant division and the relevant senior managers in that service are sighted on these. There is regular reporting of the themes and trends for cases dealt with as OTS at Board level.

- Complainants are not told of their right to go to the PSOW or the time limits set by the PSOW;

The management of OTS cases is laid out in the regulation for PTR and allows for these type of complaints to be managed outside of PTR. No OTS would be closed unless the complainant was satisfied with the outcome. Should they become dissatisfied on reflection we would advise them that we would make their complaint formal and investigate under PTR. Their right to approach the Ombudsman would then be advised in the PTR response. The PSOW will not routinely investigate until the PTR process has been exhausted.

- Issues of breach of duty, qualifying liability and harm is not referred to in the meeting summary;

A complaint where there was an allegation of harm would not be dealt with as an OTS. Should there be an indication during the management of the OTS that harm may have been caused, this would become a formal complaint and be managed under PTR.

- Complainants may be inappropriately denied access to PTR and Redress if they are unaware of NHS Concerns Procedures (*this applies particularly to individuals who are not supported by the CHC*);

This approach is only used for complaints where there is no allegation of harm.

- It is our experience that complainants are asked if they are satisfied and given little or no explanation of other options that might be available to them;

We are clear that OTS should not be closed until the complainant is satisfied with the outcome. If you have cases where this has not happened I would be very grateful if you could share examples of these so that I can review them.

- It is claimed that complainants are being told that their concern is being dealt with outside the PTR procedures but this is not our experience. Often complainants do not know or understand what the various components of the complaints procedures are not able to give informed consent to the route they are being taken down and do not understand the disadvantages;

Again if you could make me aware of these cases I would welcome the opportunity to review them.

- We are informed that if Concerns Team members feel that there has been no breach of duty, qualifying liability or harm then they can decide to downgrade the matter to an "*on the spot*", informal status.

If there is no allegation of harm, and there can be a quick response for the complainant that they are satisfied with, then it is possible to resolve the case for the complainant as an OTS.

I would like to assure you that we aim at all times to ensure that the processes operating within the Health Board are in line with the PTR guidance and regulations, and are designed to ensure that complaints are dealt with in an appropriate and timely manner. However, if there are examples where this is not the case then I would welcome the opportunity to review them. The view of the complainant is always respected and should the complainant request a complaint be managed formally this will always be dealt with under PTR regardless of the content of the complaint.

I welcome your feedback and am happy to work with you to ensure that we deliver our responsibilities under PTR effectively and in line with the regulations at all times.

Yours sincerely

Gill Harris
Executive Director of Nursing and Midwifery

During the last five years our family have had to endure the mistreatment and subsequent avoidable death of our loved one, The CHC have worked for my family and other Tawel Fan families quietly and diligently.

In the days before the CHC became involved we had to try and navigate a very complex and technical complaints system completely alone, we often felt that we had no voice and no one to listen or to turn too.

The CHC have become indispensable to my family, not just in navigating the complex systems and processes of the NHS but much more than that.

The Chief Officer and support staff have stood shoulder to shoulder with my family at very difficult meetings, stood up for our rights when others would try to disregard them or worse still try to take them away from us. They have been a confidante, an unofficial support system or a clear head in the face of overwhelming emotions or muddled thoughts but most of all they have given our family and others a voice when we often would have had none.

Our journey would have been far more difficult without the CHC maybe even impossible, we would have possibly given up as it can be a lonely place dealing with complex and emotional matters alone and as a family we will always be grateful for the help they have given us.

John & Ann Stewart