Safety Review of Betsi Cadwaladr University Health Board Mental Health & Learning Disabilities Inpatient Units

Final Report

June 2023

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Introduction

This report provides the findings of a joint safety assurance review of the Betsi Cadwaladr University Health Board mental health and learning disabilities inpatient services by the National Collaborative Commissioning Unit and the NHS Wales Executive Performance and Assurance team.

The review was commissioned by the Welsh Government, and terms of reference agreed with the Health Board and Welsh Government prior to commencement.

Background

On the 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of Betsi Cadwaladr University Health Board to special measures.

There had also been a number of high profile inquests and incidents relating to the Mental Health service in the health board. Following these incidents, the coroner raised a number of concerns. These included:

- Concerns that it has taken the Health Board a considerable amount of time to update and provide an Action Plan in relation to the death of a patient with the most recent version still containing outstanding actions although the patient died over 2 years ago.

- Concerns that learning and actions arising therefrom were not more quickly addressed with added concerns that if the learning, actions and changes are taking so long then there is a risk that deaths will continue in the interim.

- That there is an evident lack of overall strategic direction to investigations and learning.

In response to these concerns, The Welsh Government as part of the Special Measures intervention commissioned the National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division to undertake a quality and safety review and inspection on all 24 inpatient Mental Health & Learning Disability units provided by the health board.

The full terms of reference are attached in appendix 1 of this report.

Approach and Methodology

The findings of this review are informed by four approaches:

- Approach 1: Desk top review of information provided by the Health Board
- Approach 2:In depth observations of ward environments using the Quality Assurance Improvement Service's (QAIS) environmental audit tool
- Approach 3:Semi-structured interviews held with senior managers and leaders from the Mental Health & LD Division and locality areas.
- Approach 4:Attendance at a Divisional learning event.

Date of Review

Desktop information was requested on 20th April with additional information provided during the course of the review. Observations of the ward environments took place between the 25th of April and 4th of May and the semi-structured interviews held between the 2nd of May and the 5th of May. A Divisional Learning event was held on the 4th of May and attended by a member of the review team.

Initial verbal feedback was provided to representatives of the Health Board and Welsh Government on the 15th of May.

Key Messages

- The review found that a number of actions had been undertaken to improve the safety of inpatient services and across the locality areas. There were processes of escalation in place such as putting things right meetings that were consistently described and replicated across service areas and the Division.
- There was evidence that the Division had made efforts to improve communication and relationships with partners such as estates and health and safety leads. These were described positively and enabled better understanding and support of actions to reduce identified risks. However, the review also noted that much of this was described in recent terms with some actions remaining outstanding.
- There was evidence that ligature risk assessment were being completed. However, the review team observed a number of potential ligature risks in ward environments, some of which had been raised by staff and were awaiting action, however the review team were also able to identify potential ligature risks that had not been previously identified.

- There were a number of policies that had recently been, or were in the process of being developed and implemented, however there are some current policies that have passed their review date. The review team also observed some procedures being used within ward environments that were not the most current.

- There are a high number of staff vacancies across the inpatient services, with temporary (bank and agency) staff used regularly. There were examples given where temporary staff were unfamiliar with some of the health board policies and procedures or did not have suitable training to manage patient care such as safehold techniques.

- Staff training includes safeguarding, clinical risk assessment (WARRN) and emergency physical health response. However, the Division is not fully compliant with staff attendance across the suite of training.

- The Mental Health and Learning Disabilities Division sits alongside the IHC structure. The operating model was described as developing and needing further clarification. Further, the workforce model for therapies, psychology and pharmacy was described as blurred.

- There is an audit programme in place across the Division, however some staff commented that there are many audits currently undertaken but not all were felt to be specific or applicable to Mental Health.

- Processes for gathering service user feedback was described consistently across the areas alongside Divisional forums for service user engagement. However, staff also recognise that this could be strengthened.

- Staff support is provided through formal supervision and wellbeing support. An induction programme and additional support for new staff was being developed.

- Processes are in place to ensure that any escalation in physical health issues are identified quickly. However, there is evidence to suggest that these processes are not always followed correctly.

- There was evidence that care and treatment plans were not always updated to reflect the patient’s admission or demonstrated a collaborative approach to goal setting between the patient and the MDT.

- A lack of electronic record system was the most common issue reported by the service representatives.

Recommendations

- Recommendation 1: The Health Board must ensure that all relevant staff are appropriately trained to undertake ligature risk assessment with consideration to this being a peer review process across the Division. The Health Board and the Division must also ensure that all identified risks are mitigated, as soon as possible.

- Recommendation 2: The Division must ensure that processes are in place to confirm that all physical health monitoring documentation is completed, as prescribed, by staff who are appropriately trained to do so. The Division must also ensure that any escalation of physical health issues of patients are considered, within an appropriate timescale, by the MDT.

- Recommendation 3: The Health Board and Division should continue to strengthen the escalation and governance arrangements from the Ward to the Board, ensuring there is clear communication and tracking of actions to completion.

- Recommendation 4: The Division must ensure that all staff are aware of and follow the most current operational policies and procedures, and that staff are maintaining vigilance in enacting them.

- Recommendation 5: The Division should ensure that all inpatient staff, including temporary staff, are suitably trained to meet the needs of the patients, that all staff are aware of any potential areas of risk and the actions to be taken if a hazard or risk is discovered.

- Recommendation 6: The Division must ensure that care and treatment plans reflect the current needs and intended outcomes of patients admitted to inpatient services, including how risk and safety is managed during the admission.

- Recommendation 7: The Division should continue to strengthen the opportunities to receive feedback from service users, family and carers.

- Recommendation 8: The Welsh Government and then Health Board should consider a follow up review to ensure that improvements have been sustained and outstanding actions have been completed or are progressing towards completion.

Main Findings

1.Operational Arrangements

Within BCUHB the Mental Health and LD Division sits alongside the three Integrated Health Communities (IHC). Children and Young People's Mental Health services do not sit within the Division and are managed through each IHC.

The senior divisional leadership team is made up of the Mental and Learning Disabilities Director and the supporting triumvirate namely the Medical Director, Director of Nursing and the Director of Operations. Wider members of the senior divisional leadership team comprise of the Chief Financial Officer, Head of Psychology and Psychological Services, Head of Governance and the Head of Workforce.

The Division is made up of five distinct services, the East, West, Central, and Regional Specialist Services, which includes Learning Disability Services and Substance Misuse Services and Specialist Commissioning Care Services which include Forensic, Rehabilitation and Continuing Healthcare along with Specialist Services that includes forensic, substance misuse services and learning disabilities. Each service has its own senior leadership team that include a head of operations, head of nursing and clinical director. The area and specialist services SLT's report to the Divisional leadership Team.

Executive accountability is held by the Executive Director for Public Health; however, the Executive Director of Nursing will also hold accountability for the nursing workforce and other patient care issues within the Division. There are formal interface meetings between the executive and Board team and the Division.

Both the Executive Director for Mental Health and the Executive Director for Nursing were described by representatives of the Division as approachable, present and involved, with frequent interface meetings occurring. However, members of the Division also commented that the relationship with other executive members and the board was more distant.

In terms of integration with the IHCs and BCUHB as whole it was felt by some members of the Divisional SLT that there was little integration beyond that which Mental Health offers e.g., psychiatric liaison to general sites and that this was not always replicated from the input of physical health are to Mental Health. The operating model was described as developing and needing clarification.

There were positive examples described of multi-disciplinary working with pharmacy and other allied health professionals, however it was also reported that there are some challenges in providing psychology and psychological therapies due to these services being managed outside of the Division. The workforce model for allied health professionals was described as blurred.

2. Assessment of Environmental Safety of Inpatient Units

2.1 Staffing – Skills, numbers and recruitment challenges

Safe staffing is important within Mental Health units and adequate staffing levels are essential for ensuring patient safety and quality of care. Research has consistently shown that understaffing can lead to a variety of negative outcomes, including medication errors, patient falls and increased rates of restrictive practice. Understaffing can also lead to staff burn out, job dissatisfaction and high turnover which can further exacerbate staffing shortages and reduce the quality of care provided to patients.

Discussions with staff from the Senior Management Team and with staff on the wards highlighted significant recruitment issues across the Division. There is a reliance on agency staff on many of the units. However, this is not an issue unique to this Health Board. There are well documented issues with recruitment (and retention) of staff across the NHS and the independent sector in the UK. The rise in the number of agencies across the UK has accelerated the staffing crisis across the sector. The Division have tried to reduce the significance of this by using agency staff that regularly work on their units wherever possible and there is a Divisional procedure in place for staffing escalation.

Even when mitigation is taken into consideration, there remains evidence that the use of temporary staff (agency and bank) has affected the quality and sometimes the safety of the service provided within Mental Health and Learning Disability inpatient services in BCUHB. Examples of this include temporary staff being unable to support the safehold of patients when required due to them having different training than that provided to Health Board staff, and agency staff being unfamiliar with some of the Health Board policies and processes.

Staff also discussed the perception, that many posts across the Division, from the wards to senior management, were still interim. However, some of the personnel in those posts had been employed for a number of years.

The Division confirmed that it has invested in a 12 month recruitment and marketing campaign which commenced in September 2022. This is aligned to four main staff groups – Nursing, Health Care Support Workers, Admin and Clerical and Medical. There has also been a recruitment drive to appoint a substantive Director, however at the time of this review substantive recruitment to this post this had not been successful.

There was evidence of training in place in relation to risk assessment and management (WARRN) although only 63% of relevant staff were trained at the time of the review. The Division confirmed that there are plans in place to increase compliance with WARRN training, with twice weekly sessions held. Monthly training progress reports are presented to the Divisional Quality Delivery Group (QDG) with the aim of achieving 85% compliance by July 2023.

2.1 Staffing – Skills, numbers and recruitment challenges

There was evidence that training in relation to the new Therapeutic Observation Policy and process was due to be rolled out very soon following final sign off of the policy. However, there was also evidence of some confusion of staff in relation to which policy and documentation was currently in use. Some staff were not fully aware of the new policy and one ward was still using old versions of the enhanced observation document.

There were gaps observed in some of the observation records and on some occasions, there was no evidence of therapeutic engagement in the records (e.g., records had statements such as: watching television, sitting in lounge etc.).

There were concerns raised at all levels across the Division in relation to a lack of opportunities to provide appropriate psychological supervision and interventions for inpatients due to limited capacity of staff.

2.2 Review of staff training, staff resourcing and capability

Assessing and understanding the capability of any particular workforce is a complex and lengthy process. Due to the short timescale of this review, the review team were not able to gain a full understanding of the capability of the workforce within the Mental Health and Learning Disabilities division.

The review team did examine the procedures in place to ensure that staff are in receipt of appropriate training and resources to enable maximum capability and skills relevant to their particular areas of expertise. The review team found areas of good practice where training has been arranged and/or delivered in relation to the recent concerns raised. For example:

- A learning event for staff took place on the 21st of November 2021 and a second event on the 4th of May, which was attended by one of the review team. These events were for all Mental Health and Learning Disabilities staff to attend. The theme of the training event on the 4th of May was assessment and management of risk including clinical risk and environmental risk. Participants and presenters included staff from the Ligature Risk Reduction Group, WARRN trainers, Estates and Health and Safety department. The Division intend for a learning event to be held every 3 months.

- The Division reported that toolbox training events have also commenced and were being rolled out across the Division.

- There was evidence of recent training sessions for staff in relation to clinical risk assessment (Wales Applied Risk Research Network or WARRN).

- Therapeutic Engagement and Observation. Further training has been provided to key staff in relation to the Health and Safety Executive (HSE) Notification of Contravention (NoC).

Overall, the Division reported mandatory training compliance rates as 91.9% for Level 1 modules and 84.1% for level 2 modules. This was reported as being high in comparison to other BCUHB areas. However, the training statistics up to March 2023 provided by the Health Board continues to show low training percentages in some particularly pertinent areas, such as, WARRN (63% of relevant staff) and Moving and Handling (52%). The Level 1 Adult Basic Life Support statistics provided showed 94% compliance, however Level 2 Adult Basic Life Support statistics only show 54% compliance.

The Division has recently undertaken a safe staffing review which makes 18 recommendations, at the time of review this had not yet been signed off by the BCUHB executive team. The Division have also undertaken an options appraisal for a Senior Leadership Development Programme.

A BCUHB staff wellbeing support service is in place alongside which, a Wellness, Work and Us project and team has been established as an additional support mechanism for Mental Health and Learning Disabilities staff. This includes emotional support, counselling and coaching. The service has been evaluated with positive feedback received included from senior leadership teams and those who have used the service.

2.3 Assessment of training undertaken in the recognition and escalation of the unwell patient

The acute care operating framework states that all people admitted to an inpatient facility will have a baseline physical health assessment at the point of admission completed by a nurse and a routine physical examination by a doctor within 12 hours. It also advises that other allied health professional should be included to support a physical review.

The review team were asked to assess training undertaken in the recognition and escalation of the unwell patient. As described above, only 54% of relevant staff across the whole Division had received training in Level 2 adult basic life support. There was also concern raised during the review that not all relevant documentation relating to monitoring physical health was completed appropriately. For example, in some cases, NEWS charts were not completed within the timescales prescribed.

2.4 Ligature anchor point assessments, ligature mapping and environmental safety

Ligatures and ligature anchor points both high and low, present risk to patient safety in Mental Health units. Therefore, it is imperative that units undertake regular assessments of their environments to ensure that each potential risk is identified and that actions are put in place in order to mitigate those risks.

The Mental Health & Learning Disabilities Practitioners within the NCCU visited each of the Mental Health, Learning Disabilities and CAMHS unit provided by BCUHB as part of this review. The emphasis of the review focused on services being provided in safe environments. Each of the practitioners assessed the units for any actual or potential risks in the environments and the plans in place to mitigate those risks.

The reviewers were satisfied that ligature risk assessments are undertaken by staff on a regular basis. Reviewers were able to view risk assessments and discuss mitigations for identified risks with some of the staff on the units. Mitigating actions included changing or removing risks within the environment, increasing observations by staff in certain areas of higher risk and making some areas staff only supervised areas. Due to time constraints, it was not possible to view all ligature risk assessments and match them against each reviewer's observations. There was also a Division action plan in place for identified ligature risks that needed to be rectified by the Health Board estates department.

There were some areas of concern identified by the reviewing team. These included:

- Some areas where ligatures had not been identified in risk assessments that had been undertaken. For example, one unit there were fire exit signs which could be used as a ligature anchor point, command hooks used throughout the [redacted] Garden hose in the garden area of the [redacted] along with plant feed.

- Some areas where remedial works had not been completed by the estates department for a number of years. These actions had been identified in the works action plan but had not been initiated. Staff on the units were unsure as to why they had still not been actioned.

- Some areas where remedial works had commenced but remained incomplete. For example, a contractor had come to some units to ensure various screws were changed to anti-tamper type screws. The contractor didn't bring enough screws and had not changed all of the screws or returned to complete the job.

- Some areas where ligature risk assessments were identical to previous assessments on a unit, but remedial actions had since been completed. The ligature risk assessment did not indicate this.

- Some areas where remedial actions were inappropriate. For example, one of the anti-ligature doors on the [redacted] which had an ant-ligature sensor on the top edge had broken. Estates department came to the unit and turned the door over, leaving the ant-ligature sensor along the bottom of the door with a gap along the top of the door, which increased the ligature risk.

- Some areas where remedial actions were not initiated appropriately. For example, one of the [redacted] had areas on the unit which were not ligature minimised. Those areas were identified as areas that patients could only use whilst supervised by staff. However, staff on the ward stated that the areas were in fact used by patients, at times, without staff supervision.

- Contraband items- some units had items which, due to high risk levels, were not allowed on units. For example, cigarette lighters and which reviewers observed that on times patients were in possession of.

The Health Board has commissioned an environmental risk review from an external company. This initially focused on one unit of the Mental Health units but was then extended to other units. However, at the time of this review the report for the external environmental risk review was overdue.

2.5 Mixed cohorting of patients

Male & female patient cohorting

Many of the units had male and female patients on the same unit. However, reviewers observed that on some of those units, areas did not have facilities appropriate to the mixed cohort. This included males and females in rooms next door to each other, some of these rooms were in blind spots so difficult to observe, some were not en-suite therefore, males and females shared bathrooms. Not all units had female only lounges which is not in line with best practice and guidelines.

Acute & Rehabilitation cohorting

Staff on rehabilitation units stated that although not common practice, there are times when rehabilitation units admit acute patients due to bed availability issues. The review team had concerns in relation to this practice due to the increased environmental risks (more ligature anchor points) in relation to acutely unwell patients.

No issues were raised in relation to mixed cohorting of Mental Health and Learning disability patients or adults and children and young people.

2.6 Risk management / care and treatment plan review

Appropriate and up to date care and risk management planning is essential within inpatient Mental Health settings. They are used to provide patient centred care based on up to date assessment of risk. Care plans should be used as a collaborative way of setting goals whilst managing identified risks. Collaborative care planning can be used to empower patients, this in turn will lead to increased success in reaching those set goals.

The review team observed a sample of care and risk management plans across all inpatient services. All patients had a care plan however, there were variations in the care planning template in use across the Division. It was also observed that some units only used the community care and treatment plan (CTP) that accompanied the patient on admission. These care and treatment plans did not appear to be updated to reflect inpatient care other than some handwritten sentences. There did not appear to be a collaboration between the MDT and the patient in setting goals for inpatient care.

The majority of staff across the Division that spoke with members of the review team, all felt that the introduction of an electronic patient record is essential to improving the continuity and safety of patients. The review team heard anecdotal evidence of staff not being able to access historical clinical information which limited decision making and having to drive to different sites to collect paper records.

Summary

Staff training compliance records show that generally, training compliance is high in terms of percentage of staff trained. However, there are concerns relating to some areas of training where percentages of staff trained are low, which could in turn affect the safety of patients. Examples where training levels are low are, WARRN training, Level 2 Adult Basic Life Support and Moving and Handling.

Patient records that were examined showed that all patients had a care plan in situ. However, there was variance in the quality of those care plans with some just being community CTP's which had very few additions relating to inpatient care. Also, there were instances where MDT collaboration with the patient in relation to care planning, could not be verified.

The mixed cohorting of patients was generally widespread across most units in the Division with male and female cohorting being the most prevalent. Concerns raised were in relation to male and female cohorting, where in some cases there were no separate toilet and washing facilities, no separate lounge areas for female and patients of mixed sex in adjacent rooms which were difficult to observe. There did not appear to be large numbers of acute patients being nursed on rehabilitation units, however staff stated that this does occur on occasions. The review team were concerned that acute patients could be cared for in areas that have large amounts of ligature anchor points.

Ligature risk assessments are undertaken by staff on a regular basis. Many ligature risks had been identified via these assessments and had either been mitigated or action plans were in place to mitigate the risk. However, there were occasions where the review team had identified ligature risks, but the ward staff had not, and estates work to mitigate risk was incomplete or inappropriate. There were also concerns raised in relation to patients being in possession of contraband items, in particular, ignition sources such as lighters.

3. Assessment of Policies and Procedures

The review considered a number of policies that are related to patient safety within inpatient services.

3.1 Acute Care Operating Framework

The Acute Care Operating Framework applies to all staff who work in the Mental Health and Learning Disabilities Division and patients who require acute care. The purpose of the policy is to set out a framework for the delivery of safe and recovery focused patient centred Acute Mental Health care. The framework has been in place since 2013 with periodic reviews of the document. The latest version was drafted and implemented in May 2023.

The framework describes the pathways for access and admission to Acute Mental Health inpatient care and how the patient journey will be supported in the first 7 days of admission utilising a seven day risk reduction pathway.

The framework is underpinned by a range of supporting polices and operating procedures across the Division and Health Board.

The framework is in place to account for a range of operating procedures such as the Acute Care Meeting, safety huddle and handover processes.

The Acute Care Meeting (ACM) is attended by a range of professional disciplines including consultant psychiatrist and other medics, ward managers, nursing staff, occupational therapist and pharmacists. The ACM is also attended by the home treatment team. Each meeting follows a standardised agenda that focuses on actions required daily around patient flow and progress made.

In addition to the ACM, a daily safety huddle takes place, these were observed by members of the review on a number of acute and forensic wards. The purpose of the safety huddle is to monitor system risk that present that day including staffing issues, patient flow and any incidents that have occurred. Each area described a daily safety huddle that occurs at least twice a day in the acute inpatient wards, the process was described as being purposeful and helpful for ensuring timely response to issues that arise.

3.2 Clinical Risk Assessment

The Health Board has a current clinical risk management policy in place. The policy references the use and training of the WARRN risk assessment process. Reference is made to each profession's roles and responsibility to clinical risk management of patients in their care. The policy also describes the process where initial risk assessments are undertaken on admission, a further clinical assessment over the next 7 days and then longer term formulation of risk.

This policy references regular review of risk assessment along with risk management plans which should be developed in collaboration with the patient. The more general risk management procedure that was provided references identification and reporting of risks, however this policy was due for review in December 2020.

The risk management strategy provided by the Division references the procedure for reporting identified risks and the proactive management and reduction of those identified risks.

3.3 Observation and Engagement

The Health Board have recently ratified a new Therapeutic Observation Policy which will be used across all MH&LD inpatient services. However, not all staff on units were aware of the new policy. Some were working to the new policy, and some were still using the old policy. Observation records on some wards were recorded on the old documentation and some were on new documentation.

The policy itself was generally comprehensive but some parts appeared quite confusing for example:

- High level Intermittent observation- States that the patient will be observed at a minimum 2 or 4 times an hour and a maximum of 6 times an hour. This could be confusing to staff. The policy should just state a minimum and maximum for an hour i.e., 2-6 times an hour.

- The policy also refers to differing levels of observation of a patient if awake or asleep. This could put the safety of patients at risk as staff will not always be present when the patient wakes up. The only exception to this would be if a patient is on a higher level of observation when asleep, perhaps due to physical health issues such as sleep apnoea.

- The highest level of observation refers to multi professional observation. This again is confusing as it appears to reference different professionals being involved in the observation when it actually means multiple people undertaking the observations, e.g., 2-1, 3-1 etc.

3.4 Safeguarding Policy

The BCUHB Adults at Risk (Handling Individual Cases) is described as the safeguarding policy. This was activated as live in November 2022 and covers all areas of BCUHB including Mental Health and Learning Disabilities. A useful flow chart is included in the policy, however there is no specific reference or instruction for Mental Health or Learning Disabilities inpatient services.

Training compliance against the different levels of Mental Capacity Act and safeguarding training were provided. There was evidence of overall good compliance across the Division, including high compliance in rehabilitation and the majority of inpatient services. However, there were some outstanding training of staff noted in Older Persons Mental Health in the West area and acute forensic services.

3.5 Restricted Items Policy

The Restricted Items Policy has been in operation since 2019 and last updated in 2022. The policy provides definitions and a list of restricted items across the Division.

Whilst recognising it is not exhaustive the listed restricted items include ignition sources such as lighter, matches and lighter fluid and chords such as those from a dressing gown.

The policy states that a comprehensive risk assessment will be undertaken at point of admission which will pay particular attention to risk of self-harm and risk to others. This will also be updated following any event related to the restricted item and discussed at the next MDT meeting.

3.6 Searching Patients and their Property Policy

The Health Board has a policy to enable staff to undertake searches on the person and their property in Mental Health and Learning Disability inpatient units. The policy recognises that all patients have right to be cared for in a safe environment and a right to privacy and dignity. This policy applies to patients who are detained under the Mental Health Act and those who are informal. It may also apply to visitors and in some circumstances staff, where staff suspect harmful items may have been brought into the environment.

Whilst staff will endeavor to be vigilant within policy standards both for restricted items and the search of patients and property, there have been recent reported incidents and observations where patients have had restricted items on their person, such as lighters or dressing gown chords during admission, which has led to harm.

3.7 Supervision Policy

There is a Divisional procedure in place for supervision that aims to set the minimum standards for management supervision of all staff. The policy also recognises informal staff supervision and states that all staff should have access to daily 'ad hoc' supervision for urgent and routine work.

Supervision of staff was described by senior staff as being provided through team meetings and PADRs as well as formal supervision on a monthly basis. At the time of the review the overall compliance for PADR across the Division was reported as 84.8%.

However, the review team noted variation across the division in relation receipt of clinical and managerial supervision. Some staff reported regular supervision, but others reported sporadic supervision being undertaken at irregular intervals.

There have been previous staff engagement events, with the results of staff surveys being developed into a 'you said, we did' document which was then shared with staff. The Division are considering other ways to strengthen opportunities to engage with and listen to staff on a more regular basis including progressing with 'Stay Conversations' as part of the Wellness, Work and Us project. There is an induction programme for all staff and additional support for new starters.

Summary

There are a number of polices and operating procedures in place that aim to provide patient safety and reduce risk. Many of these are specific to acute services within the Division, while others, such as the policy relating to adult safeguarding, are BCUHB wide and therefore less explicit in their reference to Mental Health and Learning Disability environments.

The acute care operating framework is a Divisional document that describes the pathways and processes across the inpatient services, there was evidence that the acute care meetings and safety huddles were being adhered to.

There is evidence of policies being actively reviewed and updated, although there are some which had passed their review date. However, it was observed that whilst policies and operating procedures had been updated not all staff or ward areas were using the most current versions. It was also noted that even with policies in place to restrict harmful items there were still occasions where patients were accessing such items.

4.Review of Incident Reporting, Investigations and Learning

The review team met with various members of the senior management team across the division. These meetings were held with individuals across a three day period in the second week of the review. The aim of these discussions was to form an understanding of the ward to board governance arrangements across the Division in relation to the reporting and understanding of incidents and issues raised.

Staff described the reporting of incidents through Datix to weekly meetings such as the Putting Things Right (PTR) meeting to the Divisional PTR and Quality Delivery Group (QDG) meetings. Other regular governance meetings in place are the Senior Leadership Team (SLT) meeting, Operational Accountability Meeting (OAM), Heads of Nursing Forums, and Health and Safety meeting.

The information is shared to the board via forums such as the monthly summit with the Executive Team and the Health Board Leadership Team meetings. There were also consistent descriptions of how learning is shared across the Division and back to ward staff. All staff reference the 7 minute briefing process as a good way of sharing information quickly.

The review team were also informed about newer initiatives across the Division such as the Learning from Incidents Group.

The review team noted that the processes for reporting and learning from incidents and issues, was described consistently in the same way across the Division and service areas.

The Mental Health and Learning Disabilities Quality and Safety Team report to the Health Board wide team and provide support to the Division. The team also provides support to the NoC action plan. The team support and attend both local and Divisional PTR meetings as well as daily incidents calls with the corporate team. This is a recent arrangement, but staff reported it has been positive to close the gap between the Division and corporate teams and has improved corporate oversight. Staff also told the review team that the relationship between the Division and corporate governance team has improved.

The implementation of new governance process were reported as being very live and there are close working relationships between the quality and safety leads and the Divisional Directors to ensure the governance process is in place. Staff reported that there is more clarity of governance from idea to approval within the Division.

Summary

Governance process in are place in order for the whole division to be able to share information and learn from incidents. Some of these processes have been in place for quite a while and may not have always been as robust as they should have been. However, there are a number of new initiatives now in situ that have been instigated in order to enhance the current governance processes. These new processes are recent and will take time to embed. Once embedded, the review team feel that the governance process will be stronger across the division.

5.Assurance of systems for developing action plans, discharging these actions, and gathering evidence to demonstrate actions have been completed

The Division has reviewed governance reporting arrangements with a view to strengthen these. From January 2023 there are additional subgroups reporting to the Mental Health and Learning Disabilities service Quality Delivery group (QDG), which replaces the previous Quality Safety and Effectiveness group (QSE). Subgroups now reporting to the QDG include risk management, positive steps (to scrutinise restrictive practice), ligature risk group and HSE NoC to address themes and actions from the HSE notice of contravention. In total there are 17 sub-groups reporting to the QDG.

The Division held an initial Mental Health and Learning Disability summit in order to discuss Reg 28 and Schedule 5 notifications from the coroner's office. Subsequently the Divisional Quality and Delivery Group meet on a monthly basis to discuss the progress of 4 action plans that have been developed in relation to the Regulation 28 and schedule 5 notifications.

There is now a tracking log set up for all external requests for information to ensure requests are not missed. Also, a Learning from Incidents group has been set up so that learning from incidents and inspections/reviews is used to improve services.

An action plan and tracker was provided to the review team that shows evidence and actions in situ to provide assurance to the coroner that concerns are being addressed.

5.1 Action taken following the receipt of the reports produced on the assessment of the MHLD inpatient estate for ligature risk

BCUHB initially commissioned a ligature risk review for the Hergest unit in 2022. This review was undertaken via an external agency. Following that review a Division wide review was commissioned via the same agency. Whilst the initial report for the Hergest unit was received, the Division wide report is currently overdue. The Health Board have made numerous attempts to expedite the publishing of the report but have been advised that there is likely to be a long delay before the final report is ready.

Staff on BCUHB inpatient units also undertake Ligature risk assessments for each environment. Any estates work required from the outcome of these assessments are added to the estate action plan. This action plan and progress against the action plan is discussed at various Divisional and board meetings.

There have been other reports produced in the past which have referenced the identification and risk of Ligature anchor points, such as the annual NCCU reviews of Ty Llewellyn and NWAS which are undertaken on behalf of WHSSC.

Although there appears to be a process in place for assessing the ligature risks on units, the process for actioning mitigating estates work is sporadic and variable across the Division. Although there is an action plan in place for identified ligature risks, it is evident that some works have been completed, some partially completed, and some have not been commenced.

During this review, the review team attended the BCUHB MH/LD learning event. In that event the estates department indicated that there was an awareness that works had not been completed as swiftly as they should have been in the past but had initiated new processes for ensuring that the action plan for the Division is actioned as early as possible.

5.2 How well is the Health Board prepared for the HSE prosecution?

A HSE Notice of Contravention Delivery Implementation Group has been set up and replaces the original HSE NoC group. The Delivery and Implementation Group was described as focusing on the delivery and implementation of actions in response to the NoC. An action tracker is in place that provides narrative on progress and evidence documents such as staff training compliance, audit and policy positions.

Summary

There have been actions implemented to put assurance mechanisms in place through the Division, including establishing subgroups of the Divisional QDG to focus on specific areas such as ligature reduction, restive practice and response to the NoC. However, much of this was described as being established recently e.g., January 2023.There are tracking logs in place to evidence progress against actions including those relating to the NoC.

There is a process in place for identifying and escalating ligatures but there has been variability evidenced in the process of actioning work to mitigate the risks. However, there is now a closer and more collaborative working relationship between the Division, wards and estates services.

6. Conclusions

The review found evidence of actions being undertaken by the Health Board and the Division to improve the quality and safety of Mental Health and Learning Disability inpatient environments.

Evidence of these improvements were found in changes to policies and operating procedures, improved audit and monitoring processes and closer working relationships between different departments that have a role in risk reduction. Further, the processes and forums where patient safety incidents are escalated and actioned were reported consistently across the Division and described positively by those who attend, although these were also deemed to be more recent in their implementation.

The Division are aware of, and attempting to, embed principles of risk management that are based upon environmental, procedural and relational security with this being a focus of the most recent learning event. The Divisional Management Team are also considering and implementing further opportunities to develop and support staff at all levels across the service areas.

There were a number of environmental risks and hazards observed by the review team, these were raised and actioned by the ward staff and Divisional Management Team, however it was noted that there were some ligature risks that had been escalated but were unresolved at the time of the review.

Staff who met with the review team were committed to improving the quality and safety of inpatient care and often conveyed frustration towards some of the challenges that constrain this, such as limited staff capacity and vacancies, the ability to provide patients with psychological therapies or a lack of an electronic record system across the acute service. It was also noted that a number of senior staff were either recent to their posts or continue to be interim.

The review team would like to thank the Health Board, the Division and all staff who accommodated the review and contributed to the findings.

Appendix 1

Mental Health Inpatient Sites Quality and Safety Inspection and Review Terms of Reference

Introduction

On the 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of Betsi Cadwaladr University Health Board to special measures with immediate effect. This significant decision followed the tripartite group of Healthcare Inspectorate Wales, Audit Wales and Welsh Government officials' meetings in November 2022 and January 2023 to specifically discuss concerns about the service delivery, quality and safety of care and organisational effectiveness at Betsi Cadwaladr University Health Board. This decision reflects serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership and financial management.

Mental health services had been in Targeted Intervention since the de-escalation from special measures in 2020.

Background

Over recent weeks there have been a number of high profile inquests and incidents relating to the mental health service in the health board. (See annex A for further details).

The matters of concern raised by the coroner were as follows:

- The Health Board undertook an investigation following Ben's death. The investigation contains an Action Plan arising as a result of the learning. It has taken the Health Board a considerable amount of time to update and provide the Action Plan, the most recent version still containing outstanding actions and yet Ben died over 2 years ago.

- It is particularly concerning that learning and actions arising therefrom are not more quickly addressed. If the learning, actions and changes are taking so long then there is a risk that deaths will continue in the interim.

Overall, there is an evident lack of overall strategic direction to investigations and learning.

As a consequence:

- An interim **Regulation 28** Prevention of Future Deaths was issued following a pre-inquest hearing into the death of Ben Harrison, who died in the Ablett Unit, Glan Clwyd Hospital, on December 15, 2020. The Health Board was given 56 days to respond to the order.

- MHLD director of nursing [redacted] was issued with a **Schedule 5** order to produce documents and information relevant to the inquest within 28 days.

More recently the health board have been notified of a pending prosecution from the HSE following the death of an inpatient. The HSE commenced an investigation after which they issued a Notice of Contravention (NOC) (09 May 2022) identifying breaches of legislation. The NOC identified three issues in the case of DO:

1.Risk assessment and care and treatment plan (specifically not being updated with current risk and management plans/mitigations)

2.Bed safety (specifically the use of a standard hospital bed rather than an anti-ligature bed)

3.Removal of ligatures (specifically providing the dressing gown belt)

Discussions with the health board on their preparedness for the inquests and upcoming prosecution have not given the Welsh Government full assurance in relation to ligature risk training and ligature risk assessments. In response to our concerns the health board undertook site visits (Hergest and Ablett) w/c 20 March and reported that these visits provided significantly more assurance than was reported and that staff awareness, training records and assessments were all in place. However the health board indicated that an external review of management of ligature risks, particularly in areas of highest historic concern, but also in lower risk units would be helpful.

Aim of the intervention

Welsh Government as part of the Special Measures intervention has commissioned the National Collaborative Commissioning Unit (NCCU) supported by the mental health team within the NHS Executive to undertake a quality and safety review and inspection on all impatient mental health sites managed by the health board, this will include a review of all 24 wards

Objectives

1.To assess whether the main inpatient sites are safe. Assessment to include:

- Staffing – Skills, numbers (recruitment issues)
- Ligature anchor point assessments, Ligature mapping
- Mixed cohorting of patients (Male/female, MH/LD, Acute/Rehab, Adult/CAMHSetc)
- Therapeutic Enhanced Supportive Observations of patients

2.Assessment of policies and procedures including but not limited to:

- Clinical Risk assessment
- Observation and engagement
- Management and reduction of ligature risk
- Handover
- Leave
- Admission / Discharge arrangements

3.Review of incident reporting, investigations and learning

4.Assessment of patient experience

5.Interfaces with physical health services

6.Leadership and culture assessment

7.Review of staff training, staff resourcing and capability

8.Assessment of training undertaken in the recognition and escalation of the unwell patient

9.Risk management/care plan review

10. How assured are we that the health board has a solid and robust system in developing action plans, discharging these actions, and gathering evidence to demonstrate that they have been completed.

11. Responding to inquests and coroners request to include:

- Why were the health board unable to satisfy the coroner's request?
- What work has been undertaken in response to the Reg 28?
- What processes are in place to plan, prepare and respond to HM Coroner
- What learning is in place following an inquest

12. How well prepared the health board is for the HSE prosecution

13. Action taken following the receipt of the reports produced on the assessment of the MHLD inpatient estate for ligature risk

Timing

- The quality and safety review and inspection will commence on the 25 April 2023 and will take place over 2 weeks.

- Initial observations will be fed back on 28 April 2023 and 5 May 2023

Full report to Welsh Government and the health board by 26 May 2023

Key Personnel

The review will be led by:

- ██████████ Clinical Director and Deputy Managing Director, National Collaborative Commissioning Unit

- ████████████████████████████ Mental Health and Learning Disabilities, Performance & Assurance, NHS Wales Executive

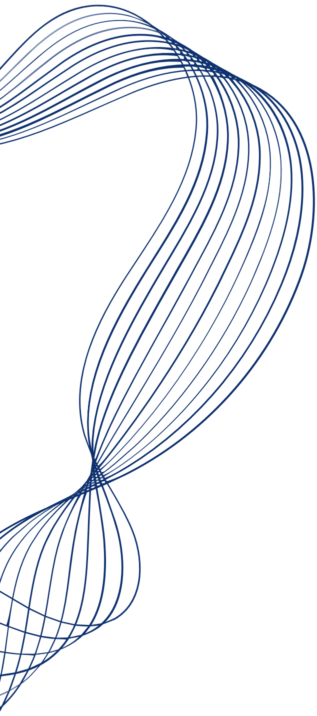
- The nominated health board contact for this review will be ████████████████ Director of Operations

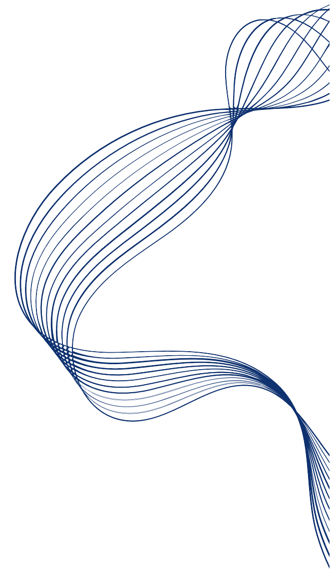
The Welsh Government SRO will be ████████████ – Deputy Director, Performance and Escalation

Escalation of Issues

A meeting will be held on Friday 28 April to review the findings and recommendations from the first week

All safety and governance issues or concerns, should be escalated as they emerge, to the Board of BCUHB and WG. The review team do not have a responsibility to determine potential breaching of professional regulatory standards or performance issues. If any information is to arise which might lead to such concern, this will be escalated via the Welsh Government Escalation team through agreed pathways and a feedback process developed to ensure that the concern has been properly assessed and a decision on the actions required has been made. Consideration in the pathways should be given to external notification where a statutory requirement, in extreme circumstances, may be required.





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