

# **Review of the Governance Arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 20th December 2013 and governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB) from December 2013 to the current time**

This report was commissioned by  
Betsi Cadwaladr University Health Board

Report Author: Donna Ockenden  
Director, Donna Ockenden Limited

June 2018



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**Review of the Governance Arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013 and current governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB) from December 2013 to the current time.**

# 1 Executive Summary

## 1.1 What will this Executive summary do?

**This Executive summary will:**

- Provide a definition of 'governance' and explain why 'governance' is important in healthcare;
- Describe the Terms of Reference for the Ockenden 'governance review' at BCUHB and explain how the Ockenden team have met those requirements;
- Explain what the remit of the Ockenden review of governance is and what falls outside that remit;
- Describe Tawel Fan ward and the closure of Tawel Fan ward in 2013;
- Assess the effectiveness of the systems, structures and processes of governance underpinning staffing, equipment and estates and a number of other factors relating to Tawel Fan ward from 2009 to the current day;
- Describe the formation of BCUHB, its Clinical Programme Group, (or CPG) structure and the way the CPGs related to the BCUHB Board from 2009 onwards;
- Discuss the range of external reviews undertaken at BCUHB from its formation in 2009 until the current day and assess the actions undertaken by the BCUHB Board as a result of these external reviews;
- Review any evidence of organisational learning at BCUHB from these external reviews and other key national inquiries e.g. The Francis Inquiry and Report (2013);
- Outline the importance of 'Healthcare in North Wales is Changing' to Older Peoples Mental Health (OPMH) services from 2012 to the current day;
- Discuss what we know from a review of a range of HIW and other external inspection visits to mental health facilities at BCUHB caring for older people from 2009 to 2017;
- Describe how current and recent service users and service user representatives experience the current systems, structures and processes of governance underpinning older people's mental health (OPMH) at BCUHB;
- Describe how former and current staff have described their experience of the current systems, structures and processes of governance underpinning older people's mental health at BCUHB;

- How useful is an understanding of the Hergest unit as a barometer of the state of the systems, structures and processes of governance across OPMH at BCUHB 2009 to 2017?

## 1.2 What is 'governance' and why is governance important in healthcare?

Healthcare governance is a general term for the overall framework through which NHS organisations are accountable for continually improving clinical, corporate, staff and financial performance. Governance therefore, is a word used to describe the ways that NHS organisations ensure they run themselves effectively and efficiently. Good governance in the NHS is about creating a framework within which an NHS organisation:

- Provides patients with good quality and safe health care services;
- Is transparent in the way they are responsible and accountable for their work;
- Ensures it continually improves the way it works.

Good governance is maintained by the systems, structures and processes an organisation puts in place to ensure appropriate management of its work. Good governance is about how an organisation scrutinises its performance and deals with poor practice and other problems. It is about how an organisation identifies and manages risk, whether in terms of patient care, to its staff or to the organisation as a whole.

Throughout the Ockenden review, the full report and this executive summary report the definition of governance used is that adopted by the NHS in Wales. For the NHS in Wales, governance is defined as:

*"A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives."*

In simple terms, governance refers to the way in which NHS bodies ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector. The effectiveness of governance arrangements within an organisation such as BCUHB has a significant impact on how well that organisation will meet their aims and objectives.

## 1.3 What are the Terms of Reference for the Ockenden 'governance review' at BCUHB and how have the Ockenden team ensured they have met those requirements?

The Terms of Reference for the Ockenden review of governance were presented and discussed at the BCUHB Board on the 10th November 2015. The Terms of Reference for the Ockenden governance review also outline in some detail the

work of the HASCAS review, which was previously discussed at the BCUHB Board on the 8th September 2015.

#### 1.4 The Terms of Reference for the governance review led by Donna Ockenden were required to:

- Review the systems, structures and processes in place prior to the closure of Tawel Fan ward, in the Ablett unit at Ysbyty Glan Clwyd on 20th December 2013;
- Identify any failings in governance arrangements which may have contributed to the failings of care on Tawel Fan ward;
- Review current governance arrangements in older peoples mental health (OPMH) at BCUHB.

The Terms of Reference for the Ockenden review describe the need for an 'independent review into the wider 'ward to Board' governance arrangements in place at the time to identify any matters which may have had a bearing on events in Tawel Fan ward.' The Terms of Reference required the Ockenden team to 'review the systems, structures and processes [of governance] in place prior to the closure of Tawel Fan ward on 19th December 2013. The Ockenden team were then required to identify any failings in systems, structures and processes which contributed to the events/may have contributed to the failings of care on Tawel Fan ward, and identify lessons for learning and actions to be taken within a timely and specified timeframe (BCUHB 2015, page 2.) Lastly, the Ockenden review of governance was also required to consider current governance arrangements in place for mental health services for older people at BCUHB.

#### 1.5 What is within the remit of the Ockenden review and what falls outside its remit?

The Terms of Reference for the Ockenden review make explicit the areas of focus for the Ockenden governance review and the areas of focus and anticipated outputs from the HASCAS review. They state that the HASCAS review has the role of focusing 'on the concerns raised in respect of individual patients, and to their care and treatment on Tawel Fan ward.' It is not therefore the role or remit of the Ockenden governance review to consider for example 'the treatment of individual patients and the actions of individual members of staff....'

*“It is not therefore the role or remit of the Ockenden governance review to consider for example ‘the treatment of individual patients and the actions of individual members of staff....’”*

#### 1.6 How has the Ockenden team ensured that the Ockenden governance review was independent as required by the terms of reference?

The Ockenden team visited North Wales as often as was required in order to meet current and former BCUHB staff, current service user representatives and attend as required meetings associated with the Ockenden governance review. Other than this the Ockenden team have worked at a geographically distant location to North Wales. In addition all administration of the governance review



including transcription of interviews and written and telephone/email contact with all interviewees including all staff and service user representatives has been carried out by the Donna Ockenden team at our offices. All interviewees and those participating in the governance review in any way have been able to make direct contact with the Donna Ockenden team at our offices at any time throughout the time the review has been underway.

## 1.7 What was Tawel Fan ward and how and why did Tawel Fan ward close?

Tawel Fan ward was a seventeen bed ward in the Ablett Unit at Ysbyty Glan Clwyd. The site is commonly known locally as YGC. The Ablett unit was made up of four wards and is a separate building from the main hospital campus on the Glan Clwyd Hospital site. The other wards found within the Ablett unit are Tegid ward, (10 beds), Dinas ward, (twenty beds) and Cynnydd ward, (eight beds.) Documentation provided to the Ockenden review describes Tawel Fan as a ward that provided assessment and treatment for dementia patients.

## 1.8 Closure of Tawel Fan ward

Evidence has been provided to the Ockenden review team that Tawel Fan ward closed in two stages, first being closed to admissions on the 13th December 2013. Secondly Tawel Fan ward was temporarily closed (and patients transferred to either Bryn Hesketh unit in Colwyn Bay, approximately 10.5 miles away with a fifteen minute car journey time or to Cefni Hospital on Anglesey if that was closer to home) on Friday the 20th December 2013. The Ockenden review has been advised by some participants in the governance review that some patients were also admitted to EMI/care homes or discharged home but this 'patient level' detail has not been seen by the Ockenden review team, as consideration of patient level detail was not part of the Ockenden governance review.

No evidence has been provided to the Ockenden review that the closure of Tawel Fan ward was formally discussed at a BCUHB Board meeting prior to closure as would be expected and usual practice. The Ockenden review team was provided with five documents dated between the 13th December 2013 and the 14th January 2015 that are relevant to an understanding of the events leading up to and after the closure.

### **These comprise, in date order:**

- a) An SBAR (Situation, Background, Assessment, Recommendation) paper for the Executive Director of Nursing and Midwifery, written by the then ACOS Nursing (dated 13th December 2013);
- b) An 'In Committee' Board paper described as 'Briefing for the Health Board' dated 19th December 2013 and titled 'Mental Health Services.' The majority of the paper is devoted to issues within the Hergest Unit and Tawel Fan ward is mentioned only briefly on page 2. The section around Tawel Fan ward refers to the completion of an SBAR document



and the escalation of this document to Executive level. The information within this paragraph around Tawel Fan ward is presented as suggesting that decisions to a) stop admissions to Tawel Fan ward and b) 'planned discharge/transfers of existing patients' had already occurred prior to this Board meeting;

- c) A further briefing for the Executive Director of Nursing and Midwifery with authorship as above and dated 21<sup>st</sup> January 2014;
- d) A briefing paper for Healthcare Inspectorate Wales (HIW) from BCUHB, (authorship unknown) in March 2014;
- e) An informal briefing paper for the Chairman of BCUHB dated 14th January 2015 by the then Executive Director of Nursing and Midwifery.

Of note within the SBAR paper is that five other services across Mental Health are described as 'in escalation' in addition to Tawel Fan ward. The paper states these are:

- Hergest unit (Ysbyty Gwynedd);
- North Powys;
- Cemlyn ward, Cefni Hospital;
- Hafan Day unit, Bryn Beryl Hospital;
- Heddfan unit, Older Persons Mental Health Unit, Wrexham.

The extent of the mental health services at BCUHB 'in escalation' as of December 2013 suggests a fragile mental health service approaching, if not already at crisis point. In the documents seen by the Ockenden team Tawel Fan ward is described as 'undoubtedly a ward in difficulty' and closure is recommended because of significant staffing issues made up of a number of facets including:

- Short and long term sickness absence;
- Vacancies;
- A growing number of staff who have been redeployed to non-patient duties with the potential of further redeployments.

In addition the Ockenden review team has seen evidence advising the BCUHB Board that 'The CPG is currently not assured that Tawel Fan is able to provide an environment of care 24/7 which is consistent to safe standards of compassionate care to the most vulnerable patients suffering from advanced dementia in the present setting of Tawel Fan ward.'

The rapidly approaching Christmas and New Year holidays were an important part of the context at the time. (Tawel Fan ward closed on Friday the 20th December 2013, Christmas Eve was the following Tuesday. It is likely that Monday, the 23rd December 2013 would have been the last full 'working' or 'office' day for many senior and Board level staff until the 2nd of January 2014, 10 days later. In addition, Tuesday 24th December, (Christmas Eve) is likely to have been a

*“Five other services across Mental Health are described as ‘in escalation’ in addition to Tawel Fan ward.”*

*“The extent of the mental health services at BCUHB ‘in escalation’ as of December 2013 suggests a fragile mental health service approaching, if not already at crisis point.”*

*“Tawel Fan ward is described as ‘undoubtedly a ward in difficulty’”*

*“The CPG is currently not assured that Tawel Fan is able to provide an environment of care 24/7 which is consistent to safe standards of compassionate care to the most vulnerable patients suffering from advanced dementia in the present setting of Tawel Fan ward.”*

'half' working day for administrative, senior and Board staff so the time of year and timing was clearly a significant issue in the urgency of the ward closure.

## 1.9 Conclusion reached by the Ockenden team on the closure of Tawel Fan ward

It is agreed by the Ockenden review team that it would be usual practice to have briefed a full BCUHB Board prior to the decision to close a ward and the decision to transfer patients to a neighbouring unit. This is especially the case as both Bryn Hesketh and Cefni Hospital – which is where the Ockenden review team have been told that patients were largely transferred to are 'standalone' units without 24 hour medical cover. Therefore the patients from Tawel Fan ward were transferring to very different kinds of care settings from one co-located on a main hospital site. The timing and the context of the closure set out, as above so close to Christmas 2013, with only one full working day remaining prior to the Christmas break means that the Ockenden team is less critical of the BCUHB Board at this time.

Usual practice would be that a formal 'In Committee' Board session should have been called, which could have been called at the Board Development day. It is also not clear to the Ockenden team if notice of the advice to close Tawel Fan ward and the fact that this decision was being discussed was conveyed to attendees prior to the Board Development session and whether this would have led to potentially increased attendance. Had a formal Board session been called at the Board Development day, then a report could have been 'tabled,' (presented at the meeting) minutes kept of the discussion and the recording of the discussion of the decision to close the ward and what were (if any) risks to patients in transfer to Bryn Hesketh and Cefni and the risk to patients in not transferring. The Ockenden review has not seen details of such a Board discussion.

## 1.10 Assessment of the effectiveness of the governance underpinning staffing, equipment and estates and a number of other factors relating to Tawel Fan ward from 2009 to the current day

### 1.11 Staffing

Difficulties with staffing in Older Persons Mental Health (OPMH) from 2009 to 2013 were clearly not just associated with Tawel Fan ward. Evidence has been seen by the Ockenden review team of wards needing to repeatedly merge together in the Heddfan unit (due to poor staffing) and the BCUHB staffing bank, (which was discussed as a concern by a number of interviewees throughout this review) being unable to provide staff.

Due to shortage of beds, (caused by the merging or joining together of wards, which had first been necessary as a result of poor staffing) evidence was also seen by the Ockenden team of ward staff needing to consider admitting new patients to beds already allocated to those patients on home leave. Ward staff

*“Evidence was also seen by the Ockenden team of ward staff needing to consider admitting new patients to beds already allocated to those patients on home leave.”*

were described as reluctant to do that as the patients on leave were on their first weekend home and there was an increased risk of the patients needing to return to the ward early if difficulties arose at home. Staffing on Tawel Fan ward at the same time was described as 'dire.' In some wards staff describe patients discharged 'before they were ready' and difficulties in admitting patients when they required admission. As a result of poor staffing across OPMH extensive evidence has been seen by the Ockenden team of poor rates of compliance with annual appraisals and mandatory training. The Ockenden review has been informed by multiple interviewees that staff were not able to leave clinical duties to attend mandatory training over a prolonged period of time.

In 2014, after the closure of Tawel Fan ward management team minutes record a lack of systems, structures and processes with the appointment of temporary medical staff with minutes stating that an 'agency locum staff grade doctor who is not on our establishment' was looking after patients at Bryn Hesketh. This shows a lack of appropriate human resources processes for the recruitment of temporary staff within OPMH after the closure of Tawel Fan ward.

Poor staffing appeared to be impacting on patient care on a number of fronts including a stated lack of meaningful activity for inpatients described on the wards. This had also been clearly described in the HIW visit to Tawel Fan ward in July 2013 and the Dementia Care Mapping<sup>1</sup> exercise undertaken on Tawel Fan in October 2013. These are both discussed in detail in the full report.

## 1.12 The management structure within the Mental Health and Learning Disabilities, (MHL D) CPG from 2009 onwards

Many of the key leadership and management roles within the MHL D CPG were part time. This includes the Chief of Staff who was responsible for the leadership and management of the CPG from October 2009 onwards and the Associate Chief of Staff (or ACOS Nursing) from August 2010 to the summer of 2012. There was no one appointed to the role of ACOS Nursing from October 2009 to August 2010.

There was a significant stripping out of management posts following the merger creating BCUHB which left the MHL D CPG with a wholly insufficient management structure to deliver mental health services across the six counties of North Wales. This was recognised by two interim Directors of Mental Health from 2014 onwards with one post-holder describing the gaps in the management structure as a 'chasm.' The incoming substantive BCUHB Director of Mental Health in summer 2016 introduced a new 'holding management structure' which was made substantive at the end of 2017. This now ensures a fit for purpose management structure within the MHL D Division going forward. This had taken BCUHB four years after the closure of Tawel Fan ward to achieve.

*“In some wards staff describe patients discharged ‘before they were ready’”*

*“Management team minutes record a lack of systems, structures and processes with the appointment of temporary medical staff with minutes stating that an ‘agency locum staff grade doctor who is not on our establishment’ was looking after patients at Bryn Hesketh.”*

*“There was a significant stripping out of management posts following the merger creating BCUHB which left the MHL D CPG with a wholly insufficient management structure to deliver mental health services across the six counties of North Wales.”*

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<sup>1</sup> See glossary

### 1.13 What was the 'Vacancy Control Panel'<sup>2</sup> and how did this impact on staffing in OPMH?

The 'Vacancy Control Panel.' has been described throughout this governance review by many interviewees as a process when vacancies that were approved as essential by the then CPG had to go through a process of further Executive scrutiny prior to approval for recruitment. The Ockenden review team has been told that each CPG had to have a vacancy control panel which scrutinised and agreed every vacancy. There was then a further process where each CPG agreed vacancy would then get agreed (or not) via the Executive team of the Health Board. A number of staff have told the Ockenden governance review team that every vacancy had to be scrutinised by the Executive team, even those the CPG had the budget for. Many staff have explained to the Ockenden team that when a post went through the Executive led vacancy control process it would often be returned to the CPG as 'more information needed' or with an instruction to be resubmitted three months or six months later. This included clinically essential posts. The Executive led 'vacancy control' process frequently added a significant delay in the recruitment of clinically essential posts.

*"Each CPG had to have a vacancy control panel which scrutinised and agreed every vacancy."*

*"There was then a further process where each CPG agreed vacancy would then get agreed (or not) via the Executive team of the Health Board."*

### 1.14 What is the situation around staffing to the current day in OPMH?

Medical and nurse staffing continues to be a concern within OPMH at BCUHB to the current day. Clinically based nurses across OPMH in BCUHB described to the Ockenden review staffing in 2017 as 'very difficult' and as 'constantly firefighting.' Nurses also described staffing as 'worse now' and state the OPMH service is using 'a lot of agency staff.' This has also been noted in recent reports by the North Wales Community Health Council (NWCHC) and Healthcare Inspectorate Wales (HIW) and raised as a concern by service users and service user representatives in the 'Listening and Engagement' events across the six counties of North Wales in the spring and summer of 2017. As an example NWCHC undertook three unannounced visits to Bryn Hesketh in 2016-17 and on the last of these visits in May 2017 said: 'the hospital staffing issues are now in a desperate state....' (NWCHC 2017, page 1.)

*"Clinically based nurses across OPMH in BCUHB described to the Ockenden review staffing in 2017 as 'very difficult' and as 'constantly firefighting.' Nurses also described staffing as 'worse now' and state the OPMH service is using 'a lot of agency staff.'"*

Medical staff raised concerns with the Ockenden review team regarding the number of locum medical staff in post as of summer 2017. As of the summer of 2017 the Ockenden review was advised that BCUHB did not have in place an induction programme for locum medical staff. Service users and their representatives reported a loss of continuity of care and having to repeat case histories and problems repeatedly over a number of appointments due to the high number of medical locums particularly in the 'West.' Service user representatives described in the spring/summer of 2017 how care plans agreed with one locum doctor were then not put in place when that doctor left BCUHB and having to 'chase' for follow up appointments. Staffing remains an area of considerable challenge for the MHLD Division as of the end of 2017 and is impacting significantly on quality of care for service users and their families and on BCUHB staff morale.

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<sup>2</sup> See glossary

### 1.15 Experience of low staffing levels in an inpatient mental health unit in BCUHB as of October 2017

A letter was sent to the Ockenden review team containing an article from the Daily Post newspaper dated 10 October 2017. The letter was from a front-line clinical nurse who has contributed to the governance review. The nurse said 'I am sending you a copy of an article that was in last weeks 'Daily Post'. I don't know who the member of staff is, but I do know that the staff I work with (and myself) would agree with every word. It just demonstrates that nothing has changed for the better'

The Daily Post newspaper headline reads: 'We feel more like prison guards than nurses' ... life on the front line at North Wales' stretched mental health units'.

In summary, in the article a North Wales mental health nurse professional spoke of how she and her colleagues felt 'exhausted, depleted and unheard' in what she called a 'dangerous environment' because of the strain the BCUHB mental health service was said to be under as of October 2017.

The nurse went on to say "how would I feel about being a nurse? Vulnerable, unsafe, unsupported by senior management, as they are ignorant to the fact it happens – despite all the incident reporting. Why? Because they don't go onto the wards anymore. They stay in their offices telling the heads of the trust we don't have any issues, when clearly if they talked to the staff on the floor we no longer feel safe'

The nurse also describes patients as 'not safe as there are not enough staff' and 'patients remaining without medication due to no doctors on wards' She added 'money comes before staff and patient safety. I feel I am no longer a nurse but a prison guard trying to keep the wards and patients safe'

BCUHB were reported as saying that it couldn't comment on the claims but said patient and staff wellbeing was of 'paramount importance'.

*“Service users and their representatives reported a loss of continuity of care and having to repeat case histories and problems repeatedly over a number of appointments due to the high number of medical locums particularly in the ‘West.’”*

### 1.16 The Ockenden review findings on equipment and estates and other factors relating to OPMH from 2009 to the current day

There are a number of references to long term estates problems across older people's mental health at BCUHB that did not seem to be resolved. These included ligature risks that were a concern expressed in multiple HIW inspections over many years. Across Tawel Fan ward until closure and other wards caring for older people over many years and until the current time the following have been raised:

- Changes required to bathroom equipment to make bathroom facilities accessible for older people;
- Carpets and beds that needing replacing;



- Cluttered areas with old furniture that needed removal;
- Decoration that needed attention.

Current and former staff raised a chronic lack of basic equipment as an issue continually from 2009 to 2015. It was not raised with the Ockenden team as an issue in the current day. Dementia support workers however did describe coming into role in the last year, being provided with no or minimal equipment to fulfil that role and having to 'fund raise' in order to buy basic equipment – despite having no previous experience of fundraising. Service user representatives in summer 2017 described equipment used for speech and language therapy as not being fit for purpose – with Americanised vocabulary cards being used such as 'popsicle' (ice lolly), 'trunk' (car boot) and 'candy' (sweets.) One daughter told the Ockenden governance team 'How on earth was dad to be expected to understand these? The tools to help speech therapy are not available in English let alone in Welsh!'

### 1.17 Are problems with Estates across Older Persons Mental Health, (OPMH) still a significant governance risk as of the end of 2017?

#### Yes

From the perspective of a review of current governance arrangements across OPMH in BCUHB lack of beds and the poor quality of the estate has been (and remains) a key governance concern. This is raised as a concern in a number of HIW reports over a prolonged period of time until late 2017. There is a continuing lack of action and very slow progress made by BCUHB to resolve estates concerns when raised as a governance, quality and patient safety concern by HIW and others over many years and to the current time.

Following a visit to the Ablett unit in November 2017 HIW said of two wards Cynnydd and Dinas: 'we found that the environment of the two wards we visited were not fit for purpose. Cumulatively, we believe that a number of the issues we identified during our inspection represent a risk to patient safety....' (HIW 2018, page 3.) Although Dinas was not a designated ward for care of the older person with mental health problems service users and advocates told the Ockenden team that it was often used to provide care and treatment for elderly people when Tegid ward in the Ablett unit was full.

On a positive note there has been extensive refurbishment of Bryn Hesketh unit in Colwyn Bay which was described positively by the NWCHC in their unannounced visit of May 2017 and improvements to Ysbyty Cefni, also described positively by NWCHC in June 2017.

*“Service user representatives in summer 2017 described equipment used for speech and language therapy as not being fit for purpose – with Americanised vocabulary cards being used such as ‘popsicle’ (ice lolly), ‘trunk’ (car boot) and ‘candy’ (sweets.) One daughter told the Ockenden governance team ‘How on earth was dad to be expected to understand these? The tools to help speech therapy are not available in English let alone in Welsh!’”*

*“We found that the environment of the two wards we visited were not fit for purpose. Cumulatively, we believe that a number of the issues we identified during our inspection represent a risk to patient safety....”*  
(HIW 2018, page 3.)

## 1.18 Was there sufficient Welsh Government policy and guidance around the systems, structures and processes of governance available to BCUHB leading up to and following the merger creating BCUHB in 2009?

**In responding to the Terms of Reference the Ockenden review team considered:**

- The rationale and preparation for merger and the creation of BCUHB in 2009;
- The historical position across the NHS in Wales prior to the creation of BCUHB in October 2009.

To understand the creation of the systems, structures and processes of governance across BCUHB, the Mental Health and Learning Disabilities CPG and OPMH the Ockenden review team needed to understand the context in which BCUHB and its systems, structures and processes of governance was formed in 2009. A range of documents were considered by the Ockenden team and these are discussed in more detail in the main report. The Welsh Assembly document 'One Wales' – A progressive agenda for the Government of Wales' – 2007 had identified that a redesign of NHS structures was required to deliver effective health care in and across Wales.

As a result of this the NHS in Wales underwent a major reorganisation in 2009. The outcome was that the existing 22 Local Health Boards (LHBs) and 7 NHS Trusts being replaced with 7 integrated Local Health Boards, responsible for all health care services across Wales.

There were a number of social, health and financial challenges facing Wales at the time of the merger creating BCUHB including:

- An increasing ageing population;
- More people living with chronic conditions;
- Challenges regarding health provision in rural locations;
- Increasing obesity rates and low levels of physical activity.

## 1.19 Outcome of the 2009 NHS Wales reorganisation:

The NHS reorganisation came into being across Wales on 1st October 2009 creating single health organisations that were responsible for the entirety of health delivery across a designated geographical area. This replaced the NHS Trusts and local health systems that previously existed.

7 integrated Local Health Boards replaced the existing 22 Local Health Boards and 7 NHS Trusts:

- Aneurin Bevan Health Board;
- Abertawe Bro Morgannwg University Health Board;
- Cardiff and Vale University Health Board;

- Hywel Dda Health Board;
- Cwm Taf Health Board;
- **Betsi Cadwaladr University Health Board;**
- Powys Teaching Health Board.

## 1.20 What is Betsi Cadwaladr University Health Board (BCUHB)?

Betsi Cadwaladr University Health Board was the largest of the nominated Health Boards at its establishment on the 1st of October 2009. It provided a full range of primary, community, mental health and acute services across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham) as well as some parts of Mid Wales, Cheshire and Shropshire. The Health Board came into being following the merger 9 months earlier of 2 former Trusts and 6 Local Health Boards in 2009:

- North Wales NHS Trust (formed from the previous Conwy and Denbighshire NHS Trust and North East Wales Trust;)
- North West Wales NHS Trust;
- Anglesey LHB;
- Conwy LHB;
- Denbighshire LHB;
- Flintshire LHB;
- Gwynedd LHB;
- Wrexham LHB.

BCUHB currently serves a population of circa 670,000 people across the six counties of North Wales.

As one of 11 CPGs at the time of merger, it could be said that the MHLDP CPG, Mental Health and specifically Older Persons Mental Health was a relatively small part of the BCUHB Board's responsibilities. However older peoples mental health is a very significant issue in that it is acknowledged that people aged over sixty are the greatest users of the NHS and according to the Older Peoples Commissioner for Wales account for around 47%<sup>3,4</sup> of acute inpatients; of these around 60% are expected to have a degree of cognitive impairment. Within a general hospital setting older persons mental health needs including depression and dementia can go undetected which can lead to longer inpatient stays, loss of independence and a reduction in the chances of the older person returning home to a pre hospital environment. All this can significantly increase care costs.<sup>5</sup>

*“Older peoples mental health is a very significant issue in that it is acknowledged that people aged over sixty are the greatest users of the NHS and according to the Older Peoples Commissioner for Wales account for around 47% of acute inpatients; of these around 60% are expected to have a degree of cognitive impairment.”*

<sup>3</sup> [http://www.olderpeoplewales.com/Libraries/OPCW\\_Publications/Dignified\\_Care\\_Full\\_Report.sflb.ashx](http://www.olderpeoplewales.com/Libraries/OPCW_Publications/Dignified_Care_Full_Report.sflb.ashx)

<sup>4</sup> <https://www.jcpmh.info/wp-content/uploads/jcpmh-olderpeople-guide.pdf>

<sup>5</sup> [https://www.rcpsych.ac.uk/pdf/jcpmh-publicmentalhealth-guide\[1\].pdf](https://www.rcpsych.ac.uk/pdf/jcpmh-publicmentalhealth-guide[1].pdf)



## 1.21 Was there sufficient guidance available from Welsh Government and other agencies in the setting up of Local Health Boards and the setting up of BCUHB specifically?

Yes

The Ockenden review team has scrutinised a large amount of documentation from across the NHS in the UK, (much of which is referred to in NHS Wales own documents) and documents published by Welsh Government, HIW and WAO and The Older Peoples Commissioner for Wales. It is very evident that there was sufficient guidance containing sufficient clarity around the requirements and expectations of Local Health Boards including BCUHB from 2009 onwards.

## 1.22 The merger creating BCUHB

Interviews with current and former Board members have described the arrangements put in place for the creation of BCUHB. It has been explained to the Ockenden review team that the merger was overseen by a project board chaired by the Chief Executive elect, with Chief Executives of the various contributing organisations leading on particular work-streams. Progress on the restructuring that ultimately led to the creation of BCUHB was described as being reported to the Boards of the organisations that would go on to form BCUHB and to Welsh Government.

Despite the precise arrangements outlined above by Board members; communication with staff working throughout the merger that formed BCUHB was often experienced as poor. A number of members of staff who worked within the Mental Health and Learning Disabilities CPG, (MHLDP) within the 'new' BCUHB from merger described the confusion for (and lack of communication with) staff at that time. This is discussed in greater detail within the main report. Other members of staff described the lack of effort made by the BCUHB Board to 'merge cultures' post the merger which created BCUHB and told the Ockenden team this 'was a disaster waiting to happen....' Multiple members of staff have described taking on huge pan North Wales roles following the creation of BCUHB with many interviewees saying of their individual role in the 'new' BCUHB 'It was three separate jobs.'

*“Members of staff described the lack of effort made by the BCUHB Board to ‘merge cultures’ post the merger which created BCUHB and told the Ockenden team this ‘was a disaster waiting to happen....’”*

## 1.23 The BCUHB Board structure from 2009 to the end of 2013 – what do we know?

It is widely acknowledged that BCUHB had significant churn and organisational turmoil in Board membership from its inception in 2009 until late in 2016. The churn and turmoil has been made up of four key issues:

- Change in Board members, (leavers, joiners, and interim positions);
- Significant periods where both Board members and interim Board members suffered ill health and other long absences;

- 'Acting up arrangements' to cover the leavers, joiners and those absent for illness and other reasons;
- Insufficient management capacity and long standing recruitment issues.

### 1.24 How successful was the adoption of a 'clinically led organisation' at BCUHB?

It could have been, but it was not.

In the 'new' BCUHB from October 2009 operational delivery was based around clinically led 'Clinical Programme Groups' (CPGs) across North Wales. The structure had created a number of challenges. The progress to address the challenges was slow. Any review of the CPG structure needed to ensure clear connectivity, line accountability and geographical site management was realised, along with sufficient time and resource for clinical staff appointed to senior leadership roles to be able to perform in their roles. Evidence seen by the Ockenden review team suggests that this did not happen.

### 1.25 Relationships between the CPGs, the Chiefs of Staff, the Chief Executive and the Board of Directors

Multiple interviewees including Board members at the time and Chiefs of Staff have commented on the very strong relationship, individually and collectively between the Chiefs of Staff and the first Chief Executive of BCUHB. Former Chiefs of Staff contributing to the Ockenden review have explained that they held weekly meetings and on a more often than not basis the then CEO would join them. These meetings were not joint with others, for example the Executive Directors.

A number of current and former Executive Directors have reflected on the role of Executive Directors in being given Executive responsibility for 'oversight' of a number of CPGs. One Board member at the time explained that all the CPGs 'fed through' an Executive Director. BCUHB had eleven CPGs and it was described that four Executive Directors had circa 3 CPGs each. This appeared to be an arrangement that again had not been thought through by the Board in how effective it could be.

It has been explained to the Ockenden review team that to have the additional responsibility of three or four CPGs to support, sponsor and oversee in a newly merged organisation covering the breadth and depth of North Wales was clearly not a workable solution and not one that an Executive Director could hope to give more than cursory attention to.

### 1.26 Key points in understanding the relationship between CPGs and the BCUHB Board:

- There was a strong relationship between BCUHBs first CEO and the Chiefs of Staff which effectively disempowered the then Executive Directors;

- Long term concerns regarding the CPGs from the Independent members were not acted upon;
- The role of Executive oversight of the CPGs, by some Directors (not all) has been described by a number of Executive Directors as one that could be given only nominal or cursory attention. It was ineffective as a method of Board scrutiny. This was a 'sticking plaster' approach to the equivalent of a major haemorrhage and did not contribute to the likelihood of success at BCUHB going forward.

## 1.27 BCUHB and its development of its governance structure post-merger in 2009

Many external reviews (and all of the staff interviews for the Ockenden governance review) describe that the development of governance structures in the new BCUHB 'was left to them' (the CPGs). This meant that each individual CPG had autonomy and accountability for the implementation of governance and reporting arrangements. This autonomy is described as having a significant impact on the implementation of a number of governance processes across BCUHB 'including those associated with safeguarding', and management of the 'concerns' process.

Multiple interviewees participating in the Ockenden governance review have noted that there was no specific governance framework or objectives for CPGs to follow. There was also agreement from interviewees, (and the documentary evidence seen) that CPGs and the CPG leadership teams were generally more confident in the management of operational issues, performance and finance, but generally had significantly less experience in governance including quality and safety.

Evidence has been provided to the Ockenden review that the Mental Health and Learning Disabilities CPG delivered their first report to the BCUHB Quality and Safety Committee (or Q and S) in October 2010, a year after the formation of BCUHB. The next appearance to the Q and S Committee was well over a year later (not until March 2012.) From evidence seen it would appear that from 2009 until the closure of Tawel Fan ward the CPGs presented to the Q and S Committee, as a committee of the BCUHB Board only annually. This was insufficient.

## 1.28 What were the reports and feedback around the systems structures and processes of governance from the external scrutiny, external reports and reviews into BCUHB from 2012 onwards?

The Ockenden review team have considered a range of external reviews into BCUHB from 2012 onwards. These are considered in detail in the main report. Also considered by the Ockenden review team is the Francis Report (2013) and BCUHBs response and actions following publication of the Francis report.

The year 2012 saw the beginning of a long continuum of external reviews into BCUHB that continue to the present day. Some of these external reviews are

*“There was a strong relationship between BCUHBs first CEO and the Chiefs of Staff which effectively disempowered the then Executive Directors”*

*“Long term concerns regarding the CPGs from the Independent members were not acted upon”*

*“This was a 'sticking plaster' approach to the equivalent of a major haemorrhage”*

*“The development of governance structures in the new BCUHB 'was left to them' (the CPGs).”*

seen to commence very shortly after the completion of the preceding review. There is little if any evidence of the BCUHB Board 'learning' from these external reviews and in some cases the external reviews do little more than 'commend' the recommendations from previous reviews and go on to recommend that the BCUHB Board implement previously known about recommendations. Despite an extensive review of more than three thousand two hundred documents by the Ockenden team there is little evidence of BCUHB wide organisational learning from these multiple external reviews for a number of years after the closure of Tawel Fan ward. The most recent joint review by HIW/WAO published in June 2017 describes progress in a number of arenas but concludes 'several of the most pressing challenges that we identified in 2013 continue to remain evident, some four years after our original report..' (HIW 2017, page 4.)

With specific reference to the BCUHB Board many of the external reviews focused on concerns around Board behaviours, effectiveness and relationships with again a number of the external reviews repeating the recommendations and requirements of previous reviews. Concerns were also expressed regarding the way information was presented to the Board. There were significant concerns around performance management and accountability arrangements over a prolonged period of time. Many of the reviews gave the BCUHB Board the same messages including that within BCUHB there were/was:

- Inconsistencies in incident reporting
- Inconsistencies in receiving information
- Inadequate systems, structures and processes of governance
- Inadequate Board scrutiny
- A failure to ensure an effective 'line of sight' from 'Board to Ward'
- A failure to ensure the adoption of essential BCUHB wide systems, structures, processes and policies with 'legacy policies' and 'workarounds' in use for many years after the birth of BCUHB
- A failure to ensure adequate resourcing of key posts essential to keeping patients safe

From 2009 until at least mid-2015 the BCUHB Board was not analysing or scrutinising with sufficient rigour the gap between the Board and the ward(s) across the six counties of North Wales. There were fundamental issues relating to the inability of the Board in holding the CPG(s) to account and the mechanisms for escalating concerns from the individual CPGs to the Quality and Safety Committee to the BCUHB Board needed to be reviewed and strengthened. The systems, structures and processes of governance underpinning clinical care across BCUHB were clearly contributing to continuing and significant risks to patient safety. The BCUHB Board from 2009 onwards were far too slow to recognise this.

There was an urgent and ongoing need to ensure effective lines of communication and accountability between the CPG(s) and the hospital management teams and

then the Board in order that concerns which impacted on the quality and safety of patient care were identified and addressed. A key component of these concerns and found within many of the external reviews was a lack of Board action on estates that were not fit for purpose over a prolonged period of time. This was despite the creation of multiple action plans seen by the Ockenden team describing how these matters were intending to be 'put right.'

## 1.29 Findings on the complaints process within the CPG and BCUHB at the time of the first Ockenden report and progress made to date

Feedback from the relatives who spoke to Donna Ockenden in spring 2014 as a part of the first Tawel Fan review were in line with the criticisms found of the BCUHB 'Concerns' and 'Putting Things Right' process found within two external reviews commissioned in 2013. The NHS Wales Shared Services Partnership (NHSWSSP) review of 2013 focused on BCUHB's management of complaints and its ability to learn lessons from them, finding limited assurance overall. The NHS Wales Delivery Unit 'Review of Management of Concerns' report dated December 2013 found that it was 'not possible to obtain assurance that [BCUHB] has adequate mechanisms in place for managing concerns and learning lessons.'

Concerns from Tawel Fan families interviewed for the first Ockenden review included:

- The length of time taken to investigate concerns;
- The lack of an accurate written response or minutes of meetings when requested.

These concerns have also been repeated in the extensive service user and service representative engagement by Donna Ockenden across the six counties of North Wales that took place in the spring/summer of 2017. Reluctance to use the current 'PTR' and 'concerns' process and either fear of raising or reluctance to raise concerns regarding poor care was also a repeated theme during the 2017 engagement events. This is discussed further in the main report and the reader is recommended to consider in full the feedback from service users and service user representatives found in the appendices of the main report.

Executive 'ownership' of the 'concerns' process at BCUHB is known to have changed four times since 2009. It is recognised that extensive work has been undertaken by a number of Executive leads since 2013 to reduce the backlog of 'legacy' (or out of date) complaint responses and information has been seen by the Ockenden team who acknowledge that this work is continuing to the current time with determination. However the experience of service users and service user representatives when making a complaint remains poor, particularly when dealing with a complaint of a 'historic' nature. A number of the case studies in the main report deal with this matter specifically and the Ockenden team have seen first-hand the distress caused to families at the ongoing failure of BCUHB to

*“The NHS Wales Delivery Unit 'Review of Management of Concerns' report dated December 2013 found that it was 'not possible to obtain assurance that (BCUHB) has adequate mechanisms in place for managing concerns and learning lessons.'”*

*“Reluctance to use the current 'PTR' and 'concerns' process and either fear of raising or reluctance to raise concerns regarding poor care was also a repeated theme during the 2017 engagement events.”*



deal in an appropriately timely way with complaints perceived as very serious by families.

### 1.30 What are the key points from consideration of the evidence around the systems, structures and processes of governance at BCUHB from 2009 to 2015?

A comprehensive range of external reviews by a number of different organisations until 2015, (with the imposition of 'Special Measures' in June 2015), shows that the Board of BCUHB had completely failed in the first six years of the organisation to put in place a system for effectively investigating serious incidents, 'Never Events' and patient and family complaints. In the absence of investigating these issues appropriately BCUHB was unable to learn from them. External reviews in 2013 found evidence of repeated 'Never Events' where BCUHB had failed to investigate effectively and therefore failed to learn. There was also a significant backlog of 'open' serious incidents and where serious incidents had been closed, a significant number needed to be reopened and reinvestigated.

From a governance and patient safety perspective 2012 saw the start of a lengthy series of external reviews telling the BCUHB Board very clearly that there were significant flaws in their ability to understand the real nature of the risks facing their organisation. The Clostridium Difficile outbreak in Ysbyty Glan Clwyd from January to May 2013 culminating in 96 known and reported cases from January to May 2013 was of the most catastrophic nature. This is discussed in greater detail in the main report.

### 1.31 Summary

**The Clostridium Difficile Outbreak at YGC in 2013 – What went wrong with the systems, structures and processes of governance underpinning infection prevention and control and to what extent, (if any) did these failures mirror events leading to the closure of Tawel Fan ward and beyond?**

The key failures of the systems, structures and processes of governance in the management of the C. Difficile outbreak at YGC was that a higher than comparable incidence of healthcare acquired infection was not recognised. The BCUHB Board failed to recognise itself as an outlier. (Duerden 2013).

This resonated with the lack of action BCUHB took following the Healthcare Inspectorate Wales (HIW) Mental Health Act visit to Tawel Fan ward in July 2013. Those receiving the feedback from the visit on the day failed to realise the seriousness of the issues raised. A member of the Board was not present for feedback, there has been no evidence seen by the Ockenden review that the feedback was shared with either the CPG Chief of Staff or the Executive team. Finally, there was a significant failing in the systems, structures and processes within HIW at the time in that communication from HIW to the then interim CEO at BCUHB was also significantly delayed from July 2013 to October 2013. When Dementia Care Mapping raised equally serious concerns on Tawel Fan ward

*“The ongoing failure of BCUHB to deal in an appropriately timely way with complaints perceived as very serious by families.”*

*“External reviews in 2013 found evidence of repeated ‘Never Events’ where BCUHB had failed to investigate effectively and therefore failed to learn.”*

three months after the HIW visit there was again little (if any) evidence of prompt or effective action by BCUHB.

### 1.32 Key points: Where do concerns within the Duerden Report (2013) resonate with concerns found within OPMH?

- As with both the Mental Health and Learning Disabilities CPG, and specifically OPMH, safeguarding and Deprivation of Liberty Standards, (or DoLS) Duerden (2013) found a grossly insufficient infection prevention and control (IP&C) management structure at BCUHB leading to a lack of leadership and action on key issues over a prolonged period of time.
- As with OPMH there was a lack of adequate training provided for ward staff in key areas of practice.
- As with OPMH there were considerable estates issues (and a failure to respond to concerns around estates provision) for both IP&C and OPMH for many years until the current time- the end of 2017.
- As with OPMH the way in which healthcare acquired infection issues were reported to (or understood by) the Board led to false assurance and complacency. For OPMH this can be seen in the two Board presentations by the OPMH team around 'Healthcare in North Wales is Changing' (July 2012 and January 2013) and the two visits by the MHLD CPG team to the BCUHB Quality and Safety Committee in October 2010 and then not until March 2012. All four of these meetings on critical issues affecting Older Persons Mental Health care provided the Board and its Quality and Safety Committee with untested and unchallenged assurances.
- As advised by multiple staff members representative of nursing, consultant medical colleagues and 'support functions' to OPMH mental health in general and most specifically safeguarding adults and older persons mental health at the time appeared to have had a low priority at Executive level and in the clinical management system through the CPGs. This was the same situation faced by infection prevention and control at the time according to Duerden (2013).

*“There were considerable estates issues (and a failure to respond to concerns around estates provision for both IP&C and OPMH for many years until the current time) – the end of 2017.”*

*“Mental health in general and most specifically safeguarding adults and older persons mental health at the time appeared to have had a low priority at Executive level and in the clinical management system through the CPGs.”*

### 1.33 What did the first joint HIW/WAO review of governance tell the BCUHB Board in 2013?

The first joint HIW/WAO review of governance arrangements at BCUHB took place in June 2013. This again highlighted very significant failings in the way the Board operated at BCUHB and can be seen as a continuum in the very serious nature of failings already highlighted to the Board by HIW, Public Health Wales and Professor Duerden. In the midst of this came further external reviews regarding the management of 'concerns' at BCUHB throughout 2013 from the NHS Wales Shared Services Partnership, Audit and Assurance service and the NHS Delivery Unit. These external reviews and their subsequent reports, (all of which are discussed in greater detail within the main report), highlighted a lack of assurance around the recording, investigating and learning from complaints

and serious incidents in BCUHB with significant concerns around BCUHBs timeliness and systems, structures and processes in investigating and 'closing' complaints and serious incident reviews.

### 1.34 The Francis Report<sup>6</sup> (2013)

The Ockenden review team considered and discussed twelve papers presented at the BCUHB Board and various BCUHB committees and meetings throughout 2013 concerning the Francis Report published in February 2013. For further details on the report of the Francis Inquiry see the link below.

The purpose of the Ockenden review team considering the papers arising from multiple BCUHB discussions regarding the Francis report was to assess the action taken by BCUHB following the publication of the Francis report in 2013.

### 1.35 What was the significance of the Francis report to care of older people with mental health problems in BCUHB in 2013?

It was hugely significant.

The publication of the Francis Report (2013) was some ten months before the closure of Tawel Fan ward in December 2013 and thrust the care of vulnerable elderly people into a national (UK wide and Wales wide) spotlight. It would have been reasonably expected that:

- All NHS bodies would have undergone a thorough review of their systems, structures and processes of governance to ensure that the systems they had in place, specifically around the care of vulnerable older people were robust enough to have accurately captured concerns from staff, patients and families in a timely manner.
- Secondly, and with reference to the Francis Report (2013), that all NHS bodies were able to provide evidence of organisation wide learning.

### 1.36 Key point: How much progress had the BCUHB Board made with responding to Francis by November 2013?

Very limited, the Quality and Safety Committee paper of the 7th November 2013 refers and is discussed in greater detail in the main report. The paper provided an almost identical overview of information previously discussed on multiple occasions in various forums. At this point in November 2013, eight months have passed since the publication of the Francis Report. The language still focuses on 'analysis' in the future tense i.e. the Director 'will need' rather than a plan focused on current action and measurement of progress. This is against a history of two previous reports to the Quality and Safety Committee and many months following the publication of the Francis Inquiry.

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<sup>6</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/13\\_046.4%20francis%20report\\_findings%20of%20public%20enquiry%20mid%20staffs%20nhs%20foundation%20trust%20final.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/13_046.4%20francis%20report_findings%20of%20public%20enquiry%20mid%20staffs%20nhs%20foundation%20trust%20final.pdf) (accessed on 28th January 2018)



The previous reports were consistent with the presentation of this one with a complete absence of robust and measureable data.

### 1.37 What conclusion does the Ockenden team draw from the way in which BCUHB responded to the 2013 Francis report?

In its response to the Francis report BCUHB showed itself to have an overall lack of systems, structures and processes of governance with which to drive forward, in a timely manner the Francis recommendations. This was further evidenced within the three reviews into maternity services in YGC in 2012 and 2013, the Public Health Wales Report, (2013) the Duerden report, (2013), the external reviews of the 'concerns' process throughout 2013, the Good Governance Institute review (2014), the Ann Lloyd Report<sup>7</sup> (2014) and both the first (2013) and second Joint HIW/WAO review (2014). All of these reports had significant relevance to the delivery of Mental Health care and specifically Older Peoples Mental Health care as provided by BCUHB.

### 1.38 What do we know from a review of a range of HIW and other visits to mental health facilities at BCUHB caring for older people from 2009 to 2017?

HIW reviews and inspections happen in a large number of BCUHB services associated with the care of vulnerable elderly people over a period of time in excess of seven years. There are some clear examples of good practice over the period of these reviews. BCUHB staff are frequently commented on in a positive way. The good practice seen is often despite (rather than because of) any specific interventions by either the CPG management team or the BCUHB Board over the timescale, particularly from 2009 to 2016. Throughout these reports and over this prolonged period of time there are a long catalogue of issues that are similar across many of the HIW inspection reports. These are repeated across multiple units with very little assurance that the situation is improving. These include:

- Estates that are neither fit for purpose, maintained adequately or addressing risks to patients – e.g. ligature risks left in place for several years following on from HIW raising concerns about them in multiple visits.
- 'Too many patients with too few beds' and a lack of availability of alternative models of care to inpatient care.
- Inadequate numbers of staff and staff not engaged in the appropriate work for their skillset.
- Long term concerns over medical staff numbers and ways of working.
- Lack of staff training (both mandatory and developmental.)

*“In its response to the Francis report BCUHB showed itself to have an overall lack of systems, structures and processes of governance with which to drive forward, in a timely manner the Francis recommendations.”*

*“BCUHB staff are frequently commented on in a positive way.”*

<sup>7</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Ann%20Lloyd%20Report.pdf>

- Concerns regarding record keeping and formats – These concerns are found at all levels from Mental Health Act documentation to risk assessment, care planning and documentation of physical care provision.
- Lack of psychology, occupational therapy interventions and meaningful activities for patients.
- Poor standards of cleanliness.
- Staff who demonstrate a lack of understanding of concepts of consent and capacity.

Action plans following on from HIW visits over the period of seven years have varied from the perfunctory to the more recent detailed action plans from 2017 that start to link to the wider governance systems within the Division and BCUHB.

There is frequently no description of how the interventions are to be monitored nor do the local management systems within the CPG or the Division give any convincing evidence that the reports are given much time, consideration or review. Response to HIW visits, reports and action plans appear to be largely thought of and treated as a necessary task to be completed after one visit. Action plans from 2009 to 2016 seem to be developed in isolation. There is no evidence to the current time that lessons learnt from an HIW inspection visit in one unit are transferred to other units or care settings although many problems found by HIW are repeated across many units e.g. training, documentation, estates, lack of patient activities and medical and nursing staffing.

Opportunities were lost to highlight problems with the HIW Mental Health Act visit to Tawel Fan ward on the 17th July 2013 and the subsequent delay by HIW in writing to BCUHB, following that visit on the 10th October 2013. However, even on receipt of the letter the very basic action plan developed by the then CPG team showed a lack of understanding of the very serious issues identified by the July 2013 visit. In addition, verbal feedback had been given on the day to relatively senior members of the CPG team and the review has not found any evidence that this was fed up through any CPG governance structures to the Chief of Staff and onwards to the Executive team/Board. HIW (2017) noted that significant changes have been made to HIW processes that will mitigate this issue in the future. (Letter HIW to Ockenden D, February 2017)

In conclusion, all of the wards visited by HIW across BCUHB providing care to vulnerable elderly people have experienced very significant problems in the period of time reviewed (from 2009 to the current day.) There was little evidence found by the Ockenden team of any significant 'lessons learned' from events on Tawel Fan ward. Had lessons been learnt across the provision of elderly mental health care in the CPG as these visits and their subsequent action plans occurred many of the ongoing and recurring problems seen are likely to have been preventable. The role of HIW in ensuring that basic processes are in place to keep vulnerable elderly people safe has been strengthened to a degree over time but the resource implications and level of attention still required of HIW in

*“Estates that are neither fit for purpose, maintained adequately or addressing risks to patients – e.g. ligature risks left in place for several years following on from HIW raising concerns about them in multiple visits”*

*“‘Too many patients with too few beds’ and a lack of availability of alternative models of care to inpatient care.”*

*“Lack of psychology, occupational therapy interventions and activities for patients.”*

monitoring the older persons mental health services at BCUHB at the level which still appears to be necessary in late 2017 are significant.

### 1.39 Summary and conclusions of the Ockenden team around the systems, structures and processes of governance in the Hergest Unit to the current day:

The reports of Healthcare Inspectorate Wales (HIW) from 2009 to 2017 and other independent reviews including the Royal College of Psychiatrists (2013), the Holden review (2014) and a partially complete external review at the end of 2012 reveal a unit with significant problems over the period from late 2009 to 2016 when it appears that improvements are starting to be made. A number of continuing themes and concerns run throughout this period including staffing issues, both medical and nursing, poor compliance with training, significant problems with estates, clinical records, Mental Health Act administration, bed usage, lack of support services such as occupational therapy, and poor relationships with the senior management team. Many of these issues start being noted by HIW in September 2009. Not surprisingly there are long term problems noted with staff morale with staff being described as under significant pressure and the wards within the Hergest unit running on 'staff goodwill' for many of those years. Throughout these years, many of the recommendations made by HIW were repeated over and over again, with limited success by BCUHB in resolving the issues. Multiple action plans, often repetitive have been considered by the Ockenden review team covering the period of time 2010 to the current time.

There were attempts throughout 2013 using the Hergest Improvement Plan, (also known as the HIP,) to make improvements in the Hergest unit for the benefit of patient care and staff wellbeing. This initiative is noted positively by the Holden investigation. However, the delivery of the multiple work streams, concurrently, at pace and with limited ward staff engagement proved ineffective according to Holden.

Some information regarding the Hergest unit and its long term issues is fed upwards through the then Health Board governance structures. This does not appear to have had a positive impact upon the process to support the Hergest unit. The reports presented to the Health Board governance structure, both Committees and the Board outline the work done in a very bland way but do not accurately represent any of the significant difficulties experienced in making the changes required over many years. One BCUHB Board member told the Ockenden review team at interview 'I think to caricature it, you know, that actually we were doing alright in the West until we became part of this organisation...' Whilst this was not entirely true, in that some issues of concern were identified at the Hergest unit by HIW as early as September 2009 it is correct that review of extensive HIW and other external reports showed the failure of the BCUHB Board to support the Hergest unit in meeting multiple (and repeating) recommendations, as was clearly required over many years from 2009 to 2016.

*“There is no evidence to the current time that lessons learnt from an HIW inspection visit in one unit are transferred to other units or care settings although many problems found by HIW are repeated across many units e.g. training, documentation, estates, lack of patient activities and medical and nursing staffing.”*

*“Not surprisingly there are long term problems noted with staff morale with staff being described as under significant pressure and the wards within the Hergest unit running on 'staff goodwill' for many of those years.”*

The multiple HIW reports also appear to have little impact within the Clinical Programme Group to judge by the minimal details around the Hergest unit found within minutes of the senior management team meetings, the Operational Group or the later Senior Leadership Group, from 2010 to 2016. Comments on the repeated HIW visits are minimal sometimes just acknowledging the reports, and that responses had been made. Whilst many of the recommendations are of central importance to themes that run throughout these meetings including training, staffing levels, estates, clinical notes, psychology and activities, the recommendations and action plans do not appear to have been scrutinised in any detail by these groups and there is no structured follow up to ensure that actions have been completed. The shortcomings in progress are clearly recognised in the Quality, Safety & Experience Sub Committee by February 2015 but there is little evidence over the coming year that this has any impact on local management. In discussing whether a response would be received to concerns raised within the CPG staff members have confirmed these were escalated to the then senior leadership team in the CPG. In responding to whether a response would be received one member of staff told the Ockenden team 'Occasionally, sometimes the response was a bit unclear, you'd get a response but it wasn't always clear what it meant....'

It is of concern that HIW continually raised these issues with the Health Board often in a timely manner and always in a very clear manner. HIW subsequently received multiple action plans from BCUHB but changes did not happen. The period of time covered by these reports was one in which the HIW was under scrutiny from the Welsh Government which recognised some of these concerns and significant changes to the organisation have been made (see National Assembly for Wales Health and Social Services Committee Inquiry into the work of HIW (2013) and Marks (2014) An Independent review of the work of Healthcare Inspectorate Wales; The way ahead to become an Inspection and Improvement Body<sup>8</sup>.

#### 1.40 A Summary of Progress – Joint review<sup>9</sup> undertaken by Healthcare Inspectorate Wales and the Wales Audit Office' with recommendations that had significant relevance to a review of the current systems, structures and processes of governance at BCUHB. (June 2017)

#### 1.41 What progress had the BCUHB Board made in developing effective governance arrangements by the summer of 2017?

This was the third joint report into governance arrangements at BCUHB by HIW and WAO, and was published in June 2017 (previous reports were in 2013 and 2014 and are covered in greater depth in the main report.) The 2013 and then 2014 report followed the original concerns raised regarding BCUHB in 2012. The 2014 joint review by HIW/WAO considering progress made by BCUHB since the

<sup>8</sup> [http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board\\_Item\\_5.1a\\_Independent%20Review%20of%20HIW\\_Appendix%201\\_EXECUTIVE%20SUMMARY.pdf](http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board_Item_5.1a_Independent%20Review%20of%20HIW_Appendix%201_EXECUTIVE%20SUMMARY.pdf)

<sup>9</sup> <https://www.wao.gov.uk/system/files/publications/An%20Overview%20of%20Governance%20Arrangements%20-%20Eng.pdf>

original 2013 report acknowledged that there had been significant improvements made by the BCUHB Board between 2013 and 2014.

However in considering progress made since the 2014 joint HIW/WAO review many of the proposals identified as necessary in 2014 had not been implemented and the pace of change had not been maintained. HIW said 'Several of the most pressing challenges that we identified in 2013 continue to remain evident, some four years after our original report.' (HIW/WAO 2017, page 4.)

The financial challenges faced by BCUHB combined with the lack of strategic plans for the development of clinical services across North Wales, (HIW 2017 page 4.) and the continuing concerns regarding leadership, governance and progress in BCUHB resulted in the Minister for Health and Social Services placing the Health Board in 'Special Measures' in June 2015. This is covered in greater detail in the main report.

As part of the special measures programme announced in June 2015 five key improvement areas were required of BCUHB:

1. Governance leadership and oversight,
2. Mental health Services,
3. Maternity services at Ysbyty Glan Clwyd,
4. GP and primary care services including 'out of hours' services,
5. Reconnecting with the public and regaining public confidence.

(HIW/WAO 2017, page 5.)

*“HIW said  
'Several of the  
most pressing  
challenges that  
we identified in  
2013 continue to  
remain evident,  
some four years  
after our original  
report.'”*

*(HIW/WAO 2017,  
page 4.)*

The report was clearly stated not to be a review or assessment against Welsh Government's special measures assessment framework. The report followed the previous format of consideration of the 4 original themes from the 2013 and 2014 joint HIW/WAO reviews:

1. Effectiveness of the Board and its committees,
2. Strategic planning and development of sustainable services,
3. Management and organisational structures,
4. Quality and safety arrangements.

#### 1.42 Effectiveness of the BCUHB Board and its Committees – what was the position as of summer 2017?

HIW and WAO recognised the 'visible improvements' in the effectiveness of the Board and its Committees that had taken place since the 2014 review. (HIW/WAO 2017, page 8.) The concerns relating to Board behaviour and Board cohesion were no longer apparent. The Executive were providing a stronger collective lead that was assisting BCUHB to progress a resolution of ongoing concerns:

- Communication with the whole Board had improved with the addition of the daily briefing circulated to the Independent Members;



- Board development sessions were described as well attended and they had been used constructively as part of individual development;
- Both Board administration and discipline had improved in line with timeliness, Board behaviour and etiquette and the content of Board papers;
- There were positive improvements with regard to Committee working however further work was still required to ensure that sufficient detail was provided without stepping into operational management function.

In interview one Board member told the Ockenden governance review team 'It now feels like a much more active team of Independent Members, it's a much more balanced skillset.....we have very open transparent conversations....and there's much more sharing of information and peer mentoring....so it is a lot healthier state than when I first came in...' In interview (April 2017), another Board member, noted the improvement in Board papers 'they are a lot better, because the message has got through about what we want..' The Board member continued and discussed the current discipline around Board papers that still requires improvement 'You'll find that some people are saying oh, it's not ready today, we'll have to take it,.....so it's still getting people.... into that discipline.'

### 1.43 What was the situation around performance management at BCUHB in summer 2017?

Performance management was found to be improving. (HIW 2017, page 8.) As BCUHB further developed its strategy this would need to be an area requiring ongoing review and development. A Board member said of the progress made to date 'I think there is a discernible difference. I think it is still work in progress and it's something the Board needs to be very mindful of over the next couple of years in terms of moving things forward, but I think there are some positive things there...' Asked at interview where BCUHB would score out of a possible ten the Board member replied 'Where would I put the organisation? Probably in the six or seven domain....'

Reflecting on the progress made at BCUHB as of April 2017 another Board member stated at interview with the Ockenden review team that 'on every indicator we're in a better place but we're nowhere near where we should be but there's been no deterioration in some of the performances, the staff survey results were all improved in terms of scores on the staff survey, across the board, but again not where they should be.....a Board that had in the past got used to mediocrity and its baseline was a bad baseline.....this (April 2017) is where we should have been then and it's not where we should be, but at least we're not getting worse....the Board has got itself now where it is a bit more confident, a bit more prepared for real change...the firefighting isn't as prevalent now....so we've got the platform....now is the era of real progress and change...'

In summarising the position within BCUHB in June 2017 a member of staff working at Board level was asked if the views of some colleagues describing BCUHB's progress as 'green shoots' was accurate. The staff member responded

*“HIW and WAO recognised the ‘visible improvements’ in the effectiveness of the Board and its Committees that had taken place since the 2014 review.”*

(HIW/WAO 2017, page 8.)

*“A Board member said of the progress made to date ‘I think there is a discernible difference. I think it is still work in progress and it's something the Board needs to be very mindful of over the next couple of years in terms of moving things forward, but I think there are some positive things there...’”*

to the Ockenden team 'I think it would be naïve and arrogant to think there is not significant further work to be done despite early 'green shoots.' We still have major challenges in relation to our financial position and do not yet have an approved 3 year plan. There is much to be done to rebuild the confidence of the public and our partners and all of that has an impact on the quality, safety and experience of care provided....'

A further current Board member reflected on the composition of the Board in April 2017 and their ability to be able to move BCUHB forwards at appropriate pace and with appropriate rigour. 'The same people were around the table when I came into my role as had been there, certainly in the previous year and it creates an amount of difficulty. I think it's ... just not around governance, there's an issue of capacity and capability in other key roles around the Board table, even today...'

#### 1.44 What did HIW/WAO (2017) find on strategic planning and the development of sustainable services at BCUHB in June 2017?

The Health Board was required as part of the NHS Wales Finance Act to prepare an Integrated Medium Term Plan. (IMTP) This was a statutory requirement. However, for a range of reasons (which are described in more detail in the main report) BCUHB had not been able to approve an IMTP. In line with the special measures improvement framework, the Board had agreement from the Welsh Government that it could continue to operate on the Annual Operating Plan arrangements.

The 2017 joint HIW/WAO review found that positive steps had been taken as regards improving risk management at BCUHB. However there remained a requirement for continued focus on the balance of detail and content and ensuring the correct risks are identified, described, acted upon and escalated.

The WAO had noted that the Board in the absence of the IMTP have developed a Corporate Risk and Assurance Framework (CRAF). Whilst this was a pragmatic, 'workaround' solution, the lack of clarity around BCUHB's objectives could be a barrier to the development of a robust Board Assurance Framework. The review found that strategic development had not progressed in the short term. This needed to be an area for continuing future development.

One Board member told the Ockenden review at interview 'it's a frustration that the organisation can't move forward more quickly.....because it doesn't have a plan...' This Board member continued at interview: 'The organisation's come from a place where it never had a clear strategic direction. It had 'Healthcare in North Wales is Changing' but that was almost like a picking bits of services rather than taking that overview'

The Board's overarching strategic approach had been set out in 'Living Healthier, Staying Well'<sup>10</sup>.

*"A Board that had in the past got used to mediocrity and its baseline was a bad baseline..... this (April 2017) is where we should have been then and it's not where we should be, but at least we're not getting worse...."*

*"The same people were around the table when I came into my role as had been there, certainly in the previous year and it creates an amount of difficulty. I think it's ... just not around governance, there's an issue of capacity and capability in other key roles around the Board table, even today..."*

<sup>10</sup> <http://wames.org.uk/cms-english/2017/12/north-wales-living-healthier-staying-well-consultation/>



There had been opportunities for the local population to become involved in the future direction of BCUHB via this initiative. The 2017 joint HIW/WAO review cited a positive change in BCUHB's level of public engagement process and the current progress was found by the joint review<sup>11</sup> to be both comprehensive and continuing to develop.

HIW/WAO (2017) stated that they did not have clarity that BCUHB had 'the capacity and capability to deliver the complex change agenda that is needed.' (HIW/WAO 2017, page 20.) The original 2013 joint HIW/WAO joint review cited medical recruitment and financial sustainability of current services as an issue of considerable concern. There was little evidence of long term solutions identified in these two critical areas and without clear direction potential financial instability would impact on the ability of BCUHB to deliver the requirement of an IMTP.

The delivery of this was critical to allow BCUHB to return to sustainable financial balance. A Board member told the Ockenden review team in interview in April 2017: 'On every indicator we're in a better place but we're nowhere near where we should be.....'

Overall the financial position in BCUHB in 2017 was found to be unacceptable and untenable. The Board had led a pan BCUHB benchmarking exercise to identify examples of inefficiency. Whilst the understanding of the issues were becoming clearer, how this would be translated into the IMTP still lacked clarity. However the 2017 joint HIW/WAO review found the Board was beginning to address some key longstanding clinical issues. A Board member agreed with the findings of the joint HIW/WAO review and stated at interview with the Ockenden team in April 2017 'We're overspending and underperforming, so that's not good....And the frustration, what keeps me awake is the fact that we've got enough money, we just don't spend it terribly well, we're inefficient, we've got variations in outcomes clinically still..'

#### 1.45 What did HIW and WAO (2017) say on BCUHBs management and organisational structures as of June 2017?

HIW/WAO acknowledged that there had been significant work undertaken regarding the new BCUHB organisational structure which had been reviewed positively. The structure provided clear lines of accountability and allowed for increased capacity. The previous Clinical Programme Group (CPG) structure had been replaced with a new 'Divisional structure'.

#### 1.46 What did HIW and WAO (2017) say on Mental Health services at BCUHB as of June 2017?

HIW noted that there were concerns regarding failure to escalate concerns about Community Mental Health teams. When progress was not achieved escalation did not happen (HIW 2017, page 23) but strengthened arrangements between

*“It's a frustration that the organisation can't move forward more quickly..... because it doesn't have a plan...”*

*“We're overspending and underperforming, so that's not good....And the frustration, what keeps me awake is the fact that we've got enough money, we just don't spend it terribly well, we're inefficient, we've got variations in outcomes clinically still..”*

<sup>11</sup> See example in link <https://www.bcugetinvolved.wales/lhsw>

BCUHB and the Local Authority had since been put in place. HIW noted that 'issues relating to quality and safety are now identified and reacted to more quickly than might have been the case previously.' HIW stated that 'the mental health service is at the start of a long journey and a sustained effort will be required to ensure that a culture exists which encourages issues to be acted upon quickly and effectively....'

It is stated by the 2017 joint HIW/WAO review that mental health services at BCUHB were beginning to emerge from a period of concern but the need for wider cultural change would not be rectified in the short term. There needed to be a continued emphasis on the early escalation of issues to ensure they were acted upon quickly and effectively. There would also be the need for BCUHB to respond effectively to the HASCAS and Ockenden reviews into mental health services once published.

HIW (2017) notes that 'There has been a concerted effort by the Health Board over the past 12 months to strengthen quality assurance arrangements in regards to mental health services. It is clear that some of the key appointments within this Division have had a positive impact.' (HIW 2017, page 23.) One staff member described the governance structure within the MHLD Division at interview with the Ockenden team in the spring of 2017 'It's still very nascent and it's still quite new, some of the meetings are quite new, so some things will need to shake down...some things are being a bit overlapped.....'

*"HIW stated that 'the mental health service is at the start of a long journey and a sustained effort will be required to ensure that a culture exists which encourages issues to be acted upon quickly and effectively....'"*

#### 1.47 What did HIW and WAO (2017) say on quality and safety arrangements at BCUHB as of June 2017?

HIW/WAO noted that since 2014 significant revisions of quality and safety arrangements had taken place across BCUHB. In 2017 the Executive Director of Nursing and Midwifery became the chair of the Quality and Safety Group (QSG) with the Executive Medical Director as the vice chair. The purpose of the QSG was to oversee the quality improvement strategy and to monitor clinical risks and seek assurance from its sub groups.

The HIW/WAO 2017 review observed that whilst the QSG was in its infancy it had a well-structured agenda with appropriate attendance and was focused on the correct issues. Areas for ongoing improvement included a stronger integration of risk management which would allow greater focus on clinical governance across BCUHB. Each Division now had its own QSG group. However the 2017 HIW/WAO review found that the introduction of the Quality Assurance Groups across the Divisions had been slow and there was variability in the effectiveness of the groups. The effectiveness of the QSG would be highly dependent upon the quality of information it received. Therefore there was limited assurance that correct issues were always being discussed and escalated appropriately. The review noted the BCUHB Board could still do more to engage with the medical workforce. A number of consultant colleagues interviewed by the Ockenden

*"There has been a concerted effort by the Health Board over the past 12 months to strengthen quality assurance arrangements in regards to mental health services. It is clear that some of the key appointment within this Division have had a positive impact."*

(HIW 2017, page 23.)

team agreed with the HIW/WAO view on medical staff engagement. These consultant colleagues fed back on a range of issues around the Board saying:

- They did not know the name of key post holders, (for example the BCUHB Executive Medical Director)
- They did not know the names of any of the Independent Members (IMs)
- They did not see any members of the Board coming into their workplace, all of the consultants acknowledged there were emails, but most emails went unread because of pressure of work
- Communication between clinical staff and the Board was still often poor with the BBC and the local newspapers acknowledged as the place most clinical staff found out about what was happening at BCUHB
- Some of the consultants were unsure about the names of the members of the MHLD Divisional senior team, with the exception of the Divisional Medical Director who was known by all of the consultants interviewed. One consultant, who worked in a full time role described seeing the Director for Mental Health at BCUHB once from June 2016 to January 2017

*“The review noted the BCUHB Board could still do more to engage with the medical workforce.”*

#### 1.48 What did the 2017 joint HIW/WAO review find on complaints in June 2017?

Both the 2013 and 2014 HIW/WAO joint reviews identified concerns regarding the reporting, escalation, resolution and BCUHB organisational learning from complaints, concerns and incidents. This 2017 review noted an improvement in response time however there remained inconsistencies across the Divisions in complaint, concern and incident responses. There was still varied clinical input and a lack of co-ordination regarding organisational learning. This was said to have been exacerbated by staff shortages across the Divisions. Overall the 2017 joint HIW/WAO review found that there remained concerns that BCUHB did not have consistent processes to ensure an effective response to complainant claims and incidents and found the lack of a process to ensure robust organisational learning across BCUHB.

*“They did not know the name of key post holders, (for example the BCUHB Executive Medical Director)”*

One Board member reflected on the management of complaints in BCUHB in early 2017 and said at interview with the Ockenden team ‘I’m still unhappy about many of the things I see and read in concerns raised by people, what people want is a solution not a .....long drawn out twenty page response.....’

*“Communication between clinical staff and the Board was still often poor with the BBC and the local newspapers acknowledged as the place most clinical staff found out about what was happening at BCUHB.”*

In order to address the fragmented management of complaints, concerns and incidents, highlighted in the 2017 joint HIW/WAO review the Board responsibility for ‘concerns’ would be managed by the Executive Director of Nursing and Midwifery. This would be the fourth change in Executive leadership since the creation of BCUHB in 2009. Asked about the frequency with which the complaints and concerns portfolio at BCUHB had changed Executive leadership since 2009 one senior member of BCUHB staff stated at interview ‘That is a risk but it’s a greater risk to have left them where they were at those individual times.... Different Chief Execs have different views on how organisations should be

Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health

run.....it's clear that the preferred portfolio holder is the Executive Director of Nursing and Midwifery, at an All Wales level.'

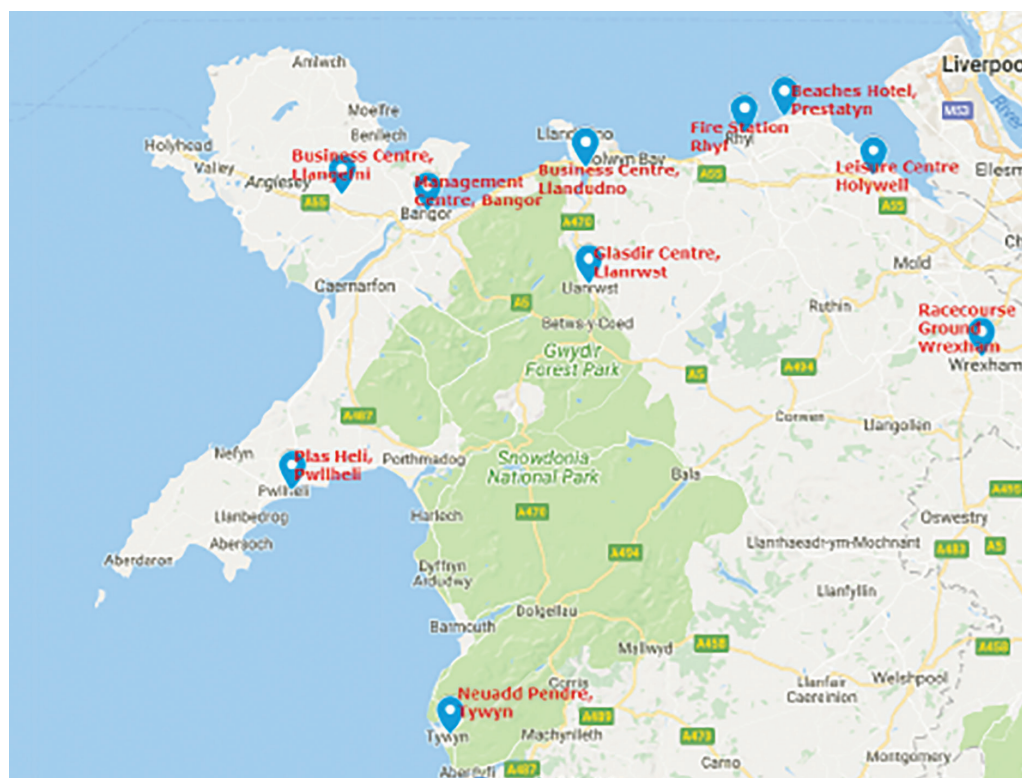
BCUHB subsequently described to Donna Ockenden in 2018 a 'root and branch' review of the whole complaints process that commenced in September 2017 under the leadership of the Executive Director of Nursing and Midwifery. As part of this BCUHB have reported a significant reduction in the number of open complaints between August 2017 (when there were 450 complaints open) and April 2018 when there were 250 complaints open.

The concerns in the 2013 joint HIW/WAO review regarding quality, safety and governance arrangements at BCUHB were central to the report. The 2014 joint review had identified that more work was required. The 2017 joint HIW/WAO report indicated that the processes at BCUHB were evolving and still maturing. The main challenge remaining for BCUHB was to sustain the improvement to further strengthen accountability and authority. It was key that vacant posts were recruited to swiftly and that Area Directors were supported with appropriate management capacity. The quality and safety governance arrangements demonstrated effectiveness and evolving improvements. There needed to be a sustained focus to ensure consistency across BCUHB.

*“I'm still unhappy about many of the things I see and read in concerns raised by people, what people want is a solution not a .....long drawn out twenty page response.....”*

#### 1.49 What did service users and service user representatives tell the Ockenden governance review about the BCUHB management of compliments, concerns and complaints, in spring and summer 2017?

'Listening and Engagement' events took place at Llanrwst, Llandudno, Llangefni, Bangor, Tywyn, Pwllheli, Rhyl, Wrexham, Holywell and Prestatyn. (See map below)



*“‘Listening and Engagement’ events took place at Llanrwst, Llandudno, Llangefni, Bangor, Tywyn, Pwllheli, Rhyl, Wrexham, Holywell and Prestatyn.”*



In addition a number of individual follow up conversations and interviews took place after the 'Listening and Engagement' events where this was requested by service users or their representatives. 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. Individual staff members were frequently singled out for positive comments within older person's mental health. However there was recognition of insufficient clinical staff numbers – (both nursing and medical) in hospital and community and it was said by service user representatives that they frequently felt that BCUHB staff and the services they provided across mental health were at 'breaking point' in the spring and summer of 2017. BCUHB staff in older people's mental health were often described as 'trying their best, often in very difficult circumstances' by carers and service user representatives.

Delays on the part of BCUHB in responding to complaints was discussed as a concern as was the poor quality of responses once received. Others felt that the complaints process at BCUHB was not clear and transparent and that BCUHB had an air of 'arrogance' when dealing with any complaints. Many service user representatives talked about the reluctance to complain, because of the fear of 'reprisals' as a result of making a complaint and a complaint affecting negatively the subsequent care provided to an elderly relative. This 'fear' was discussed at Bangor, Tywyn, Prestatyn, Holywell and Llangefni. In Wrexham in July 2017 some service user representatives described BCUHB as having a culture of 'bullying' where complaints were concerned.

Some service user representatives said that they didn't know how to go making a complaint using the BCUHB complaints process and that they didn't know how to contact personnel at BCUHB within the complaints system, (Bangor, Holywell). They described constant reorganisation and a high workload within the complaints team as an excuse for a poor service. The complaints service provided by BCUHB was described as 'shambolic' (Holywell, Prestatyn and Pwllheli). Complainants said they were made to feel like a 'nuisance' for complaining in Pwllheli and Wrexham and that elderly patients were turning to BCUHB for help at crisis point because there was no help until a crisis was reached, (Wrexham and Prestatyn). Service users across the six counties described complaint responses from BCUHB and being given assurances in those complaint responses that actions would be taken, but with no follow up.

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.”*

### 1.50 What did service users and service user representatives tell the Ockenden governance review about the systems, structures and processes of governance underpinning care planning, care delivery, communication and engagement at BCUHB in the spring and summer of 2017?

#### 1.51 Care Planning:

There was considerable concern expressed by service users and their representatives about the delays in diagnosing dementia across North Wales. Once dementia was diagnosed service users and their representatives described an absence of advice and information for carers and families. There was particular concern around lack of support for those with younger onset dementia. Further concerns were expressed around care plans with care plans described as standardised with no room for individuality and with little or nothing perceived as being done to ensure that the individual was at the heart of any care planned or delivered.

#### 1.52 Care Provision/Care Delivery:

Carers described to the Ockenden team a lack of carer assessments and lack of carer support (as of autumn 2017.) Discussion also took place about staff shortages across both nursing and medical staff in the care of older people with mental health problems across the BCUHB catchment area. Carers described long waiting lists and how these then caused delays in the care process. Lack of any therapies and activities for older persons for dementia was described. In particular, attendees questioned when such activities were provided, whether they are tailored around the patients' needs. Many families and patients themselves described BCUHB as frequently resorting to providing 'colouring in pictures' as the only available activity on a repeated basis. Many families described that their relatives would refuse to attend activities sessions as they found this unsuitable, uninteresting and did not want to participate. There was a lack of consistency of activities provision described to the Ockenden team with some very sad stories told of planned activities stopped with no notice due to a shortage of community staff. One family in Dolgellau told the Ockenden team 'the support workers didn't turn up for 2 weeks and Dad was standing there at the window with his coat on waiting for them and he said to me 'have I been a naughty boy because they don't want me anymore?'. There's been no thought, no planning, no what are we going to do with X if we don't take him out on a Monday'.

Attendees raised concerns regarding lack of care provision for patients with learning difficulties or younger people with dementia were catered for. The experience described by attendees was that both these groups of people were 'forgotten' by the BCUHB system. The issue of travelling times across North Wales in order to access care led to concerns about whether there were enough staff employed by BCUHB to deliver the care required. Delayed transfers of care,

*"It was said by service user representatives that they frequently felt that BCUHB staff and the services they provided were at 'breaking point' in the spring and summer of 2017."*

*"Many service user representatives talked about the reluctance to complain, because of the fear of 'reprisals' as a result of making a complaint and a complaint affecting negatively the subsequent care provided to an elderly relative."*

*"The complaints service provided was described as 'shambolic' "*  
(Holywell, Prestatyn and Pwllheli)

*"Elderly patients were turning to BCUHB for help at crisis point because there was no help until a crisis was reached"*  
(Wrexham and Prestatyn).

out of area transfers to geographically distant areas and the lack of BCUHB inpatient beds and EMI residential homes were also discussed as concerns.

### 1.53 What did current service users tell the Ockenden team about communication with OPMH at BCUHB?

An increase in independent mental health advocacy support was said to be urgently needed by attendees at the Listening and Engagement events across all six counties. The language barrier for elderly Welsh speaking patients was also seen as being problematic in accessing care provided by many BCUHB staff.

Some questioned why BCUHB was still not appearing to be visibly involved in speaking with and listening to service users and service user representatives. Discussion took place about the BCUHB system for engagement and its current and long term lack of visibility across many parts of Gwynedd and Anglesey. The role of Independent Members of the Health Board in engagement with service users and their representatives was queried. Attendees felt that there were too many organisations in North Wales dealing with the same issues – and as such there were too many structures and job titles which were difficult to understand and navigate. Some described difficulties in communicating with the Health Board and others talked about a lack of understanding about the services that are delivered in the many hospitals across the region. Poor communication between the BCUHB and the third sector<sup>12</sup> overall was described.

A current Board member at interview with the Ockenden team in April 2017 stated 'Governance is about behaviours, it's not just about systems and structures.....I feel this organisation and the health service and people in North Wales deserve this to work properly.'

### 1.54 What did the Ockenden review team find about BCUHB staff morale generally throughout the governance review?

The Ockenden team found a recurring theme of lack of staff support and poor staff morale in BCUHB for those staff working within and outside mental health services at BCUHB from 2009 to the present day.

Whilst this was not a specific part of the Ockenden review Terms of Reference a large number of former and current BCUHB staff interviewees from outside and inside mental health have explained to the Ockenden team that at critical times BCUHB was not felt to be a supportive employer. Staff described that situations were often handled very badly by senior managers and Executives. A phrase repeatedly used was that BCUHB as an employer acted with a 'knee jerk' reaction at a time when staff most needed considered and carefully thought through support. The numbers of staff relaying these concerns to the Ockenden review team throughout 2016 and 2017 were significant and therefore it is important that these findings are informed to BCUHB.

*“Many families and patients themselves described BCUHB as frequently resorting to providing ‘colouring in pictures’ as the only available activity on a repeated basis.”*

*“One family in Dolgellau told the Ockenden team ‘the support workers didn’t turn up for 2 weeks and Dad was standing there at the window with his coat on waiting for them and he said to me ‘have I been a naughty boy because they don’t want me anymore?’.”*

<sup>12</sup> See glossary, main report



It is important to note that this feedback was separate to and different to the actions taken around the closure of Tawel Fan ward, which have not been considered in this review of governance. This perceived lack of support from BCUHB as an organisation, (not specifically referring to the former Mental Health and Learning Disabilities CPG or current MHL Division) was not associated with any particular legacy area, e.g. East, West or Central but was felt across the organisation and at all levels of the organisation and was described by staff as being present over a very long period of time – since the formation of BCUHB and existing to the current day.

One staff member described to the Ockenden review team at interview their last day in employment in the NHS which was in BCUHB and told the Ockenden review team 'The most hurtful thing of all was I spent 30 years in the NHS..... and my last ever day was in Wrexham in North Wales, my last day ever and not a single Director or senior manager came and said goodbye to me.'

Many staff in their interviews discussed that the use of the grievance process was utilised widely across BCUHB with the example of a staff member making a complaint or taking out a grievance against another staff member. Both the person complained about and the complainant (both examples were found in staff contacting the Ockenden review team) described that frequently investigations that should have occurred did not occur at all and that in some situations an investigation would be started, then halted or passed to several different 'investigation managers.' This meant that a 'complainant' and the person complained about would need to recount events to a number of different people, sometimes over a prolonged period of time. Some staff told the Ockenden review team that such processes were frequently left open and unresolved, sometimes for many years. This made working relationships across many services very difficult to navigate over a prolonged period of time.

One staff member summarised the situation as BCUHB needing a whole new mind set around staff support and told the Ockenden team that BCUHB should be making the organisation a positive place to work so that staff members didn't need to be resilient, and that there had been a 'man up' and 'ooh, still off with stress..' attitude expressed by some senior managers towards clinically based colleagues. BCUHB employees outside and inside mental health referred to feeling ashamed of the 'tatty' buildings they worked in, the lack of equipment they were given to do their job, insufficient staffing levels and poor mandatory and developmental training opportunities.

With specific reference to the Mental Health and Learning Disabilities Division the last eighteen months since the formation of the Division had started to be seen more positively by some staff. One colleague told the Ockenden review team 'I do feel that there is some movement and there's some action and some things have changed that needed changing....' Acknowledging the significant length of the journey ahead for Mental Health as of April 2017 this staff member said 'I'd say we're probably about a third of the way there, we're not even halfway yet. ...' Communication within and outside mental health and the wider

*“Governance is about behaviours, it's not just about systems and structures..... I feel this organisation and the health service and people in North Wales deserve this to work properly.”*

*“The most hurtful thing of all was I spent 30 years in the NHS..... and my last ever day was in Wrexham in North Wales, my last day ever and not a single Director or senior manager came and said goodbye to me.”*

*“Many staff in their interviews discussed that the use of the grievance process was utilised widely across BCUHB with the example of a staff member making a complaint or taking out a grievance against another staff member.”*

organisation of BCUHB and between the BCUHB Board and 'front line' staff continued to be problematic with many interviewees not knowing the name of Executive Directors as of mid-2017 and many clinical staff interviewees not able to name any independent members of the Board, other than the Chairman.

### 1.55 In conclusion:

BCUHB is now approaching its ninth birthday and those years has seen significant intervention and external input, review and advice from a number of bodies and external consultancies. These bodies have included Welsh Government, HIW and WAO, the NHS Delivery Unit and a number of Royal Colleges. These include three joint reviews of governance by HIW/WAO in 2013, 2014 and 2017; support around the development of systems and structures of governance from the Good Governance Institute in 2014, targeted intervention in 2014/15 and the imposition of special measures in 2015. Many of the external reviews have followed one another and have commended and repeated the recommendations from one review to another. There has often seemed to be some progress as in between the joint HIW/WAO reviews of 2013 and 2014 but follow up reports, sometimes after a number of years as with the 2017 joint HIW/WAO review showed significant work still to be done.

The Ockenden team had the privilege of engaging with 105 service users, their carers and service user representatives over the six counties of North Wales from April to December 2017. In addition the Ockenden team has had contact with 135 members of current and former BCUHB staff, working at all levels within BCUHB from 'ward to Board.' Those staff working clinically were more likely to share the viewpoints of service users and their representatives currently receiving care. Both service users and frontline Clinical staff described an older people's mental health services that was stretched beyond capacity and unable to respond to the needs of service users and carers.

Senior managers and service leaders were able to describe clearly the systems, structures and processes of governance and strategies either being put in place or already in place in the 'new' BCUHB post implementation of special measures. However, BCUHB service user representatives and carers were yet to feel the benefit of receiving care within this new system. As an example carers and service user representatives described a BCUHB concerns system that was still described as 'shambolic' and 'broken,' care planning that lacked any individuality and a lack of support for carers of older people with mental health difficulties.

It is clear that as BCUHB approaches its ninth birthday that it is still 'on a journey' but for the majority of service users, service user representatives and many clinically based staff the destination as of late 2017 remained uncertain and unclear. Communication between the 'ward' (i.e. clinically based staff and the service users and their representatives and carers) and the 'Board' (the Executive team, Independent members and senior managers) remained critically weak and many staff and service users lacked confidence in the ability of the BCUHB Board to navigate the long and difficult road ahead. Whilst some progress has

*“Some staff told the Ockenden review team that such processes were frequently left open and unresolved, sometimes for many years. This made working relationships across many services very difficult to navigate.”*

*“BCUHB should be making the organisation a positive place to work so that staff members didn't need to be resilient, and that there had been a 'man up' and 'ooh, still off with stress..' attitude expressed by some senior managers towards clinically based colleagues.”*

undoubtedly been made (as is set out in a number of external reviews, particularly those carried out jointly by HIW/WAO in 2014 and 2017 and Healthcare Inspectorate Wales in late 2017) much more remains to be done.

In conclusion, progress to date has been too slow, change where it has occurred is embryonic with little evidence seen by the Ockenden team that any positive changes made are yet on a sustainable footing. In summary from 2009 to the present day the Ockenden review has seen significant evidence that on many occasions since 2009 the BCUHB Board have demonstrated a lack of strategic planning and a lack of integration of corporate, clinical and financial governance. This focus on integrated governance accompanied by a visible commitment to partnership and multi-agency working and effective and meaningful staff and service user engagement needs to be the **each and every day** modus operandi of the BCUHB Board moving forward.

*“Both service users and staff described an older people’s mental health services that was stretched beyond capacity and unable to respond to the needs of service users and carers.”*

*“Progress to date has been too slow, change where it has occurred is embryonic with little evidence seen by the Ockenden team that any positive changes made are yet on a sustainable footing.”*

## 2 The Main Report – Part 1

### 2.1 Acknowledgements and thanks:

### 2.2 Service users, service user representatives and carers

The Ockenden review team wishes to extend its sincere thanks to the 105 service users, service user representatives and carers who have participated in this governance review. It is recognised that for many attendees participation in the Ockenden governance review took place against many competing priorities including employment and caring responsibilities. The fact that many service user representatives chose to prioritise engagement with the Ockenden review against a backdrop of often complex and very full lives is very gratefully noted by the Ockenden review team.

The 'Listening and Engagement' events with service users, carers and service user representatives occurred across the six counties of North Wales. Many participants followed up attendance at the events by sharing of documentation with the Ockenden governance review. All of this has been extremely helpful to the Ockenden review team in providing BCUHB with extensive feedback from current and recent service users, service user representatives and carers.

One service user wrote to Donna Ockenden after attending an event and said: 'The quieter voices remain seldom heard. That is why your work is so important and why I am sure that many are very appreciative that you have listened and enabled their voices and stories to be heard....' (Service user representative 51, October 2017.)

*"The quieter voices remain seldom heard. That is why your work is so important and why I am sure that many are very appreciative that you have listened and enabled their voices and stories to be heard...."*

(Service user representative 51, October 2017.)

### 2.3 Former and current BCUHB staff members

The Ockenden review team has engaged with 135 former and current BCUHB staff members throughout this governance review. Our sincere thanks are extended to all those who have participated in this governance review. Thanks should also be extended to those professional colleagues who attended with staff throughout interviews. A number of staff agreed to attend two interviews where this was necessary, (because of the larger volume of material to be considered.) Many staff prepared large amounts of documentation before and after interview. A number of BCUHB staff also participated in the factual accuracy checking of the final Ockenden report, ensuring that the final report was indeed accurate. It is recognised that for the many BCUHB staff participating in the Ockenden governance review a great deal of time was taken. All of this is greatly appreciated.

## 2.4 How many interviews were undertaken as part of the Ockenden governance review?

In total 200 interviews and conversations were conducted as part of the Ockenden governance review, the majority were face to face and held locally in North Wales.

*“In total 200 interviews and conversations were conducted as part of the Ockenden governance review, the majority were face to face and held locally in North Wales..”*

## 2.5 Betsi Cadwaladr University Health Board

The Ockenden team would like to express their gratitude to the many staff working for BCUHB who helped with the conduct of the Ockenden 'governance review.' These include the external investigations team, based at BCUHB who helped source and send securely over 3200 individual documents to the Ockenden team and made practical arrangements over an extended period of time for meetings and other arrangements associated with meetings to be held in North Wales.

## 2.6 The North Wales Community Health Council (NWCHC)

The significant work undertaken by the NWCHC throughout the spring and summer of 2017 cannot be underestimated and the efforts made by NWCHC to facilitate the successful user events across the six counties of North Wales is hugely appreciated. Although Donna Ockenden was herself responsible for the conduct of each of the 'Listening and Engagement' events the facilitation and organisation 'behind the scenes' was all carried out by NWCHC. This included the sourcing and booking of suitable community venues across North Wales, the advertising and promotion of the events and the presence of NWCHC staff 'on the day' at all the events to ensure the smooth running of 'housekeeping' arrangements at the events. The extensive support from NWCHC all allowed Donna Ockenden to concentrate solely on interaction with attendees which played a large part in the success of the events.

*“The efforts made by NWCHC to facilitate the successful user events across the six counties of North Wales is hugely appreciated.”*

In conclusion, the success of the 'Listening and Engagement' events is due in a large part to the support and facilitation of the NWCHC for which the Ockenden team would like to express its heartfelt thanks. Individual thanks are due to Chief Officer Mr Geoff Ryall Harvey and Deputy Chief Officer Mrs Carol Williams and her team.

*“The success of the 'Listening and Engagement' events is due in a large part to the support and facilitation of the NWCHC for which the Ockenden team would like to express its heartfelt thanks.”*

## 2.7 Healthcare Inspectorate Wales, (HIW)

Healthcare Inspectorate Wales provided very significant assistance to the Ockenden governance review team by providing copies of information and communication arising from every HIW visit to both mental health and older people's inpatient care from 2009 to the current day. This has been a very significant amount of material for HIW staff to source and provide and has contributed greatly to the Ockenden team's understanding of the systems, structures and processes of governance underpinning mental health care and

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older people's care at BCUHB. My sincere thanks to Dr Kate Chamberlain and her team for their assistance which is very much appreciated.

## 2.8 The Independent Oversight Panel (or IOP)

The Ockenden team would wish to convey it's sincere thanks to the three Independent Oversight Panel members who have supported the Ockenden governance review team since coming into role in January 2017 following appointment by the Cabinet Secretary. Over the last eighteen months of the review the Ockenden team has very much appreciated the important role played by the IOP, with particular thanks to the chair of the IOP, Mr Jack Straw.



## 3 Members of the governance review team

### 3.1 Team Structure

The Ockenden governance review team and review itself was led personally by Donna Ockenden, an experienced independent reviewer who worked with a small expert team specifically selected for this governance review.

The Ockenden governance review team members had extensive experience including Board and Divisional level leadership and extensive experience of psychiatry and specifically Older Person's Mental Health (OPMH) including dementia. Confidential office, administration and transcription support was also an important part of the independent governance review. Contact details were provided for Donna Ockenden to all participants of the Ockenden governance review, (both staff and service users.)

### 3.2 Team members

**Ms Donna Ockenden** – MA (ed), BA Hons, RN, RM (Donna Ockenden Limited)

Report author and independent reviewer, lead for the governance review and first point of contact for BCUHB and all participants regarding all aspects of the review.

Donna Ockenden was assisted and supported by the following team members (in alphabetical order):

**Dr Christopher Ball** – MB MS MRC Psych, (Governance review team member August 2015 onwards)

**Professor Sube Banerjee:** MBE, MB BS, MSc, MBA, MD, FRC Psych. (Governance review team member from August 2015 until June 2016)

**Ms Gillian Gould** – RN MSc, (Governance review team member spring/summer 2017)

**Dr Elzbieta Sawicka:** MA, MD, MB BChir, FRCP, (Governance review team member from August 2015 until June 2016)

**Mr Graeme Zaki** – BDS, MBDS, FDS (Eng,) FRCS (Ed), FRCS (Eng), MD Healthcare Management. (Governance review team member from August 2015 onwards)

**Ms Zoe Bolt** – Administration lead for the governance review and office manager at Donna Ockenden Limited.

Legal advice was provided by **Nicholas Cunningham** of Gowling WLG.



## 4 Independent Oversight and Quality Assurance of the 'Ockenden' governance review

### 4.1 The 'original' oversight panel

The original 'Oversight' panel met the Ockenden governance review team for the first time in March 2016. The purpose of the 'Oversight' panel was set out in the original 'Terms of Reference' for the Ockenden governance review and can be summarised as follows:

- To report to and assure the BCUHB Board on all aspects of progress, process and costs;
- To work with the Ockenden team to ensure all governance matters underpinning and supporting the governance review were discussed and resolved;
- To advise on any necessary changes to the original Terms of Reference, (none were required.)
- To discuss the setting of recommendations at the end of the governance review, with the governance review team holding editorial control of the final report and recommendations.

#### **The original Oversight Panel members were:**

Mr Martin Jones, (Chair) Executive Director of Workforce and Organisational Development, BCUHB.

Mr Trevor Jones, Health Board Committee Advisor, (Lay member)

A Director of External Investigations was appointed by BCUHB in July 2016, Ms Tina Long.

### 4.2 The Independent Oversight Panel

As the governance review progressed it was evident that the size and scope of the Ockenden governance review had grown significantly. Along with the Chair of the HASCAS investigation, Donna Ockenden expressed concerns to the Chair and CEO of BCUHB regarding the need to strengthen the 'oversight' function. This was necessary to ensure a robust framework moving forward to completion of the governance review, (and HASCAS investigation.)

The first meeting of the Independent Oversight Panel was held in February 2017 in North Wales. The purpose was stated as 'To provide oversight and governance to ensure the process for the completion and publication of the reports resulting from the HASCAS investigation and Ockenden review are concluded in a timely way and protected from any inappropriate influence from those currently and previously employed by the LHB and other stakeholders.'

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### 4.3 Membership of the Independent Oversight Panel

Mr Jack Straw, (Chair)

Ms Helen Bennett

Mr Philip Hodgson

Meetings were held in North Wales, usually at Llandudno Junction at Welsh Government offices.

## 5 Introduction to the 'Ockenden governance review'

### 5.1 What definition of governance will the Ockenden review use?

Healthcare governance is a general term for the overall framework through which NHS organisations are accountable for continually improving clinical, corporate, staff and financial performance. Governance therefore is a word used to describe the ways that NHS organisations ensure they run themselves effectively and efficiently. Good governance in the NHS is about creating a framework within which an NHS organisation:

- Provides patients with good quality and safe health care services;
- Is transparent in the way they are responsible and accountable for their work;
- Ensures it continually improves the way it works.

Good governance is maintained by the systems, structures and processes an organisation puts in place to ensure appropriate management of its work. Good governance is about how an organisation scrutinises its performance and deals with poor practice and other problems. It is about how an organisation identifies and manages risk, whether in terms of patient care, to its staff or to the organisation as a whole.

Throughout the Ockenden governance review and this report the definition of governance used is that adopted by the NHS in Wales. For the NHS in Wales, governance is defined as:

*"A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives."* In simple terms, governance refers to the way in which NHS bodies ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector. The effectiveness of governance arrangements within an organisation such as BCUHB has a significant impact on how well that organisation will meet their aims and objectives. More information on governance in the NHS in Wales can be found using the link<sup>13</sup> below.

The definition of governance for the NHS in Wales above was agreed to be the definition of governance that would underpin this review and the subsequent report at the outset of this review.

*"A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives."*

*"Governance refers to the way in which NHS bodies ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector."*

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<sup>13</sup> <http://www.wales.nhs.uk/governance-emanual/what-is-governance>.  
(Link accessed March 2nd 2018).

## 5.2 Why does the NHS need governance?

The NHS across the four countries of the UK, including Wales have used definitions of governance for more than twenty years. The Audit Commission in 2002 in one of the earlier definitions of governance defined governance within the NHS as: "The systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives and by which they relate to their partners and wider community."

The Department of Health (2006) defined integrated governance as: "Systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organizational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations."

Governance therefore is at the heart of everything that an NHS organisation does. NHS bodies should have a number of systems, structures and processes for ensuring good governance. These include:

- Standing Orders<sup>14</sup>, Standing Financial Instructions<sup>15</sup>, Reservation of Powers to the Board and Scheme of Delegation.<sup>16</sup> (Explanations are provided in the footnotes below.)
- Requirement for a statutory Board, and requirements on the committees that support the Board
- Business planning
- Procedural guidance for staff
- A risk register<sup>17</sup> and assurance framework<sup>18</sup>
- Effective internal audit
- Scrutiny by a range of external assessors

*"Governance therefore is at the heart of everything that an NHS organisation does."*

## 5.3 What were the Terms of Reference for the Ockenden review?

The Terms of Reference for this review (described as Appendix A) were presented and discussed at the BCUHB Board on the 10th November 2015.

<sup>14</sup> <http://www.wales.nhs.uk/sitesplus/documents/1064/LHB%20Model%20Standing%20Orders%20Reservation%20and%20Delegation%20of%20Powers%20%28March%202014%29>.

<sup>15</sup> <http://www.wales.nhs.uk/sitesplus/documents/1064/LHB%20Model%20Standing%20Financial%20Instructions%20%28March%202014%29.pdf>

<sup>16</sup> See Glossary

<sup>17</sup> See Glossary

<sup>18</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/15%5f225%20hascas.pdf>.

The Terms of Reference for the Ockenden Governance review<sup>19</sup> outline in some detail the work of the HASCAS<sup>20</sup> review, which were previously discussed at the BCUHB Board on the 8th September 2015.

The Terms of Reference for the Governance review led by Donna Ockenden were required to:

- Review the systems, structures and processes in place prior to the closure of Tawel Fan ward on 19th December 2013;
- Identify any failings in governance arrangements which may have contributed to the failings of care on Tawel Fan ward;
- Review current governance arrangements in Older Peoples Mental Health at BCUHB.

(BCUHB Board paper 10th November 2015 item 15/285.)

## 5.4 How will this report address the two key issues as set out in the Terms of Reference?

- Review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013 and:
- Current governance arrangements in Older Peoples Mental Health at BCUHB

The Terms of Reference for the Ockenden review titled 'Review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013 and current governance arrangements in Older People's Mental Health at BCUHB' describe/are broken down into the following elements, all of which will be considered in this report:

**Firstly**, the Terms of Reference state the need for '**an independent review into the wider 'Ward to Board' governance arrangements** in place at the time to identify any matters which **may have had a bearing** on events in Tawel Fan ward.' (BCUHB 2015, page 2).

**Secondly**, the Terms of Reference are required to 'review **the systems, structures and processes** (of governance) in place **prior** to the closure of Tawel Fan ward on 19th December 2013. (BCUHB, 2015, page 2)

**Thirdly**, the Terms of Reference then identify 'the broad purpose of the Governance review is to **identify any failings in systems, structures and processes** which contributed to the events/may have contributed to the failings of care on Tawel Fan ward, and identify lessons for learning and actions to be taken within a timely and specified timeframe (BCUHB 2015, page 2.)

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<sup>19</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/15%5f285%20tawel%20fan%5freview%20of%20governance%20arrangements.pdf> (Link accessed 12 March 2018).

<sup>20</sup> See glossary

**Lastly**, the review of governance will also consider **current governance arrangements** in place for mental health services for older people.' (BCUHB 2015, page 2, ref 15/285)

The Terms of Reference set out the conduct of oversight of the Ockenden review, as it was envisaged at the time of the commencement of the review and the establishment of the Oversight Panel as was envisaged at the time. The responsibilities of the Oversight Panel are outlined within the Terms of Reference. (BCUHB 2015, page 4.) Oversight arrangements were amended significantly in February 2017 with the appointment of the Independent Oversight Panel reporting to Welsh Government.

As per the Terms of Reference what will the Ockenden governance review and its subsequent report consider leading up to the closure of Tawel Fan ward? In understanding the governance arrangements in place from 'Ward to Board' leading up to the closure of Tawel Fan in December 2013 the review will consider three things. It will:

**Consider** the systems, structures and processes of governance put in place at the creation of BCUHB some four years earlier in October 2009.

**Consider** any requirements or advice around the development of the systems, structures and processes of governance provided to BCUHB by Welsh Government in 2009 and beyond. This is an important consideration because until it is understood what was **available** for BCUHB (both as a source of advice and a requirement to act upon) it is not possible to ascertain whether there are **'any matters'** (or not), having **a bearing** (or not) on events in Tawel Fan ward.

**Consider** the progress made by the BCUHB Board in establishing 'Ward to Board' systems, structures and processes of governance from the creation of BCUHB in October 2009 until the closure of Tawel Fan ward in December 2013.

The consideration of governance from 'Ward to Board' will be examined through a wide range of documentary sources, both internal to BCUHB, (for example BCUHB policies and guidance, minutes of relevant meetings at Board, Board Committee and CPG/Divisional level) and those external to BCUHB, (for example Welsh Government policy and guidance and external reviews at key points in the time from 2009 to the end of 2013.)

The Ockenden review will include the experience of current and former BCUHB staff working within those 'Ward to Board' systems, structures and processes of governance at BCUHB from 2009 to December 2013 as described at interview and in documentation submitted to the review. The current and former staff contributing to the review have worked at all levels of BCUHB as an organisation – from 'Ward' to 'Board.'



The Terms of Reference for the Ockenden review, (BCUHB 2015) make explicit the areas of focus for the Ockenden review and the areas of focus and anticipated outputs from the HASCAS investigation. They state that the HASCAS investigation has the role of focusing 'on the concerns raised in respect of individual patients, and to their care and treatment on Tawel Fan ward.' It will not therefore be the role or remit of the Ockenden governance review to consider for example 'the treatment of individual patients and the actions of individual members of staff...' (BCUHB 2015, page 2)

In understanding the governance arrangements in place from 'Ward to Board' the Ockenden review will explore and consider the external scrutiny:

First of BCUHB as an organisation;

Second any available scrutiny of the Mental Health and Learning Disabilities Clinical Programme Group, (or MHLD CPG);

Thirdly any available scrutiny of the Older People's Mental Health service within that CPG.

External scrutiny has occurred by a range of organisations from 2009 onwards including but not limited to Healthcare Inspectorate Wales, (HIW), and the Welsh Audit Office, (WAO), the NHS Delivery Unit, and others. The review will consider:

- What these external reviews told the Board at BCUHB about the systems, structures and processes of governance in place at BCUHB from 'Board to Ward' from October 2009 to December 2013;
- What the BCUHB Board did in response to these external reviews;
- What was the impact of the scrutiny, the recommendations and the BCUHB response;
- Whether there is any evidence of organisational learning across BCUHB as a result of the external scrutiny that occurred.

In understanding the governance arrangements in place from 'Ward to Board' the Ockenden review will consider:

**Firstly**, the setting up of the management and clinical leadership structures within BCUHB via the CPGs and how the CPG structure related to and reported to the Board;

**Secondly**, how effective the clinical leadership structures were in ensuring that there was appropriate oversight at BCUHB of the systems, structures and processes of governance from Board to Ward;

**Thirdly**, the Ockenden review will consider the management and clinical leadership structures across BCUHB the Mental Health and Learning Disabilities (MHLD) CPG and finally the Older People's Mental Health service within the CPG all from October 2009 to December 2013.

In understanding the effectiveness of 'Ward to Board' governance arrangements and systems, structures and processes of governance in place prior to the closure of Tawel Fan ward the Ockenden review team will examine the resourcing of the clinical leadership structures within BCUHB from October 2009 to December 2013.

Resourcing, (both in terms of capability and capacity) will influence the effectiveness of the leadership and management structures put in place. The Ockenden review will also consider the context that these leadership and management structures worked within from the 'Board to the Ward' from October 2009 to December 2013. (This will include consideration of key issues such as the consultation into and implementation of 'Healthcare in North Wales is Changing'<sup>21</sup> from 2012 onwards, the Clostridium Difficile<sup>22</sup> outbreak in Ysbyty Glan Clwyd in 2013 and events within a number of mental health services across North Wales including the Hergest unit)

Multiple external reviews clearly articulated concerns regarding the systems, structures and processes of governance at BCUHB and these concerns were clearly informed to the Board. The Ockenden review will consider to what extent (if any) these concerns mirrored concerns in the systems, structures and processes of governance underpinning the Mental Health and Learning Disabilities (MHLDD) CPG and the systems, structures and processes of governance operating in the Older People's Mental Health service from 2009 to 2013.

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<sup>21</sup> See Glossary <http://www.wales.nhs.uk/sitesplus/861/news/25624>

<sup>22</sup> See Glossary <http://www.wales.nhs.uk/sitesplus/documents/861/BCUHB%20Prof%20Duerden%20Report%20Final%20version%2011th%20August%202013.pdf>

## 6 Introduction to Part 2: How will the Ockenden review 'consider current governance arrangements in place for mental health services for older people?'

The Ockenden review will consider the period of time for the consideration of the 'current' governance arrangements in older people's mental health to have commenced after the closure of Tawel Fan ward in December 2013 and will consider 'current' governance arrangements in place for mental health services for older people until December 2017. (A period of four years)

The Ockenden review will:

**Consider** the systems, structures and processes of governance in place in BCUHB at the beginning of 2014 and review any developments in those systems, structures and processes of governance from then to December 2017;

**Consider** any relevant requirements, scrutiny or advice around the development of the systems, structures and processes of governance provided to BCUHB, the MHLD and Older Peoples Mental Health (OPMH) by Welsh Government and other bodies in between January 2014 and December 2017;

**Consider** to what extent BCUHB the MHLD and OPMH utilised and followed any advice/requirements from Welsh Government and other bodies between January 2014 and December 2017;

**Consider** the progress made by the BCUHB Board, the MHLD and Older Peoples Mental Health (OPMH) in ensuring effective and robust 'Ward to Board' systems, structures and processes of governance from 2014 to 2017;

**Consider** the management and clinical leadership structures and processes of governance across BCUHB and then specifically the Mental Health and Learning Disabilities (MHLD) Division, and Older People's Mental Health service within the Division from January 2014 to December 2017;

**Consider** how the management and clinical leadership structures within the Mental Health and Learning Disabilities (MHLD) Division and in the Older People's Mental Health service related to and reported to the Board from 2014 to 2017.

The consideration of 'current governance arrangements in place for mental health services for older people' will be examined through:

- Documentary sources;
- The experience of the 135 current and former BCUHB staff who the Ockenden review team have engaged with;

- The experience and views of the 105 service users and service user representatives who have engaged with the Ockenden governance review team.

The methodology used to gather service user and service user experience of the systems, structures and processes of governance is described more fully later in the report. Donna Ockenden travelled across the six counties<sup>23</sup> of North Wales from April to July 2017 meeting 104 recent and current service users, carers and current service user representatives. In addition Donna Ockenden undertook a number of supplementary follow up conversations as requested and received supplementary documentation from service users, carers and their representatives throughout the autumn of 2017.

1. Stakeholder engagement and listening events have been formalised in response to the terms of reference of the Ockenden review.
2. The North Wales Community Health Council (NWCHC) facilitated all stakeholder engagement ensuring that events took place in suitable community venues across the six counties of North Wales.
3. The broad principles of good practice underpinning stakeholder and engagement were utilised making provision for a range of listening events, written feedback and individual interviews as required.
4. Stakeholders were able to submit any relevant documentation for the review, before and after interview or the engagement event they attended.
5. Information gained from stakeholder engagement was compared/ evidenced and triangulated against all other sources of information presented as part of the documentation review and staff interviews.
6. Preparation was made to provide support to individuals if the sharing of information caused distress. This was not required but was available if required.
7. NWCHC made available trained advocates at all of the stakeholder engagement and listening events to ensure that any concerns that required direct feedback to BCUHB could be facilitated.
8. Each stakeholder engagement and listening event across the six counties of North Wales was delivered according to the same methodology inviting participants to provide feedback on the 7C's<sup>24</sup>. (See below)
9. At the end of each event every participant was given contact details for Donna Ockenden Limited so that they were able to submit further information to the governance review if they wished to.

*“How assured could the BCUHB Board be that its organisation was engaging effectively with service users and service user representatives.”*

The key question to be asked was how assured could the BCUHB Board be that its organisation was engaging effectively with service users and service user

<sup>23</sup> Anglesey (Ynys Mon), Gwynedd, Conwy, Denbighshire, Flintshire, Wrexham,

<sup>24</sup> The '7 C's' used to underpin discussion at the engagement and listening events and listening events for the review were Compliments, Comments, Concerns, Complaints, Communication and Engagement, Care Planning and Care Delivery.

representatives. As part of the governance review, the Ockenden review team also visited a number of clinical sites and community venues across the six counties of North Wales in 2016 and 2017 to understand fully the implications for care delivery at the time of the concerns. This included gaining an understanding of the journey times to access care across North Wales and the journey times required for the staff, managers and leaders working within the mental health services provided by BCUHB.

## 6.1 Commissioning of the 'second' Ockenden review into Older Persons Mental Health in BCUHB

The first Ockenden report was presented to the BCUHB Board on the 9th June 2015, after external publication by BCUHB had already occurred in May 2015. At the meeting held on the 9th June 2015 the Chairman advised that 'Mrs Ockenden would be commencing a Board to Ward review with immediate effect.' (See minute<sup>25</sup> 15/148.5 for further information).

There followed extensive discussion between Donna Ockenden Limited and BCUHB throughout the summer of 2015 and until the end of November 2015. The Ockenden team was in place from August 2015. Whilst preparatory work for the Ockenden governance review was underway in November 2015 work on the governance review properly commenced in January 2016.

Updates to the BCUHB Board regarding the commissioning of the Ockenden governance review were provided in July 2015<sup>26</sup>, (Board minute 15/165.2) and September 2015<sup>27</sup>, (Board minute 15/225.4). The Terms of Reference for the Ockenden review of governance was approved on the 10th November 2015 (see Board minute 15/285.1).

Both the HASCAS and Donna Ockenden Terms of reference<sup>28</sup> are discussed in this document with HASCAS commissioned to 'undertake a full investigation into the concerns raised by the families of patients on Tawel Fan ward. (See Board minutes item 15/285, in the link below for the full discussion.)

The original Terms of Reference for the Ockenden review stressed that 'it is essential that a clear distinction is maintained between both the HASCAS investigation and the Governance review.' Subsequently that decision was reviewed by BCUHB leading to a discussion at the March 2016 BCUHB led Oversight meeting around potential 'convergence' between the Ockenden review team and the HASCAS investigation. Agreement was reached at that Oversight panel, (the first Oversight panel for the Ockenden governance review) that the same methodology around staff interview preparation and information should be adopted across both the Ockenden governance review and the HASCAS investigation. This would allow the HASCAS and the Ockenden teams to share

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<sup>25</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20Board%209.6.15%20Public%20v1.0%20Approved.pdf>.

<sup>26</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20Board%208.9.15%20Public%20v1.0%20Approved.pdf>

<sup>27</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20Board%208.9.15%20Public%20v1.0%20Approved.pdf>

<sup>28</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20Board%2010.11.15%20Public%20v1.0%20approved.pdf>

information where appropriate, to minimise duplication and to rely upon each other's information where appropriate and if required.

In practice, whilst there was a short delay during April 2016 whilst the Ockenden review team adapted their processes to 'shadow' the HASCAS processes separate interview schedules for the Ockenden review and the HASCAS investigation went ahead and information sharing across the review and the investigation was minimal. Throughout the spring and summer of 2016 once the Ockenden review of governance adopted the same principles for undertaking staff interviews as the HASCAS investigation there were some temporary issues with staff uncertainty regarding the Ockenden interview process. This meant that staff interviews, took much longer than anticipated to complete. As a consequence, although it was planned to arrange to interview the 'Ward' to the 'Board' in a set and orderly fashion from Ward to Board in reality interviews have been completed as and when they could be. This has not, in the end affected the overall number of staff interviews. Staff interviews and engagement with the Ockenden governance review continued positively throughout Summer 2016 and 2017 with a number of staff being interviewed twice and some staff interviewees preparing extensive statements and collections of supplementary documentation for the governance review.

By the end of December 2017 there remained some gaps in the staff interviewed meaning that some essential information and context is not available to the Ockenden review team. Of note is that two former BCUHB Executive Directors have declined to participate in the governance review and the staff drop in sessions were poorly attended, other than BCUHB staff who contacted the Ockenden review team via the North Wales Community Health Council<sup>29</sup> (NWCHC) Aside from that, every effort has been made by the Ockenden team to engage with as wide a range of colleagues in post from the 'Board to Ward' from 2009 onwards. The purpose of staff interviews the drop in sessions offered was to capture as much information as possible around the merger creating BCUHB and the actual experience of staff working within the systems, structures and processes of governance within BCUHB from 2009 until the current time.

In order to ensure independence of the processes underpinning the governance review all necessary communication, (written, email and telephone) between current and former BCUHB staff and service users and their representatives occurred from the Donna Ockenden Limited offices. All appointments made for staff, service users and their representatives were similarly arranged directly between the Donna Ockenden team and staff/service users directly.

The overarching principle underpinning staff interviews has been to determine staff experience and knowledge of working within the existing governance structures leading up to the closure of Tawel Fan ward and those currently in place across Older Persons Mental Health (OPMH) within BCUHB. Staff interviews have operated in line with Scott<sup>30</sup> and Salmon methodology<sup>31</sup> principles:

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<sup>29</sup> See glossary

<sup>30</sup> See glossary for references 31, 32, 33

<sup>31</sup>



**Each interviewee received a letter of invite to interview in advance of attending for interview from Donna Ockenden Limited informing the current/former staff member:**

1. Of the Terms of Reference and the procedures adopted by the governance review, and;
2. Of the broad areas and matters to be covered with them;
3. That when they are interviewed they may raise any matter they wish and which they feel may be relevant to the governance review, and;
4. That they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them;
5. That their interview will be digitally recorded, a confidential transcript prepared outside of BCUHB and a copy sent to them afterwards to sign; and that they will have the opportunity to make minor amendments or additions to the transcript;
6. Person specific roles which can be directly attributed to one individual will be anonymised in the final report to maintain the confidentiality of the individual concerned;
7. Staff will be identified by number only, with the number only known to staff/their staff side representative and Donna Ockenden Limited;
8. That interviewees have a named contact within the office of Donna Ockenden Limited throughout the entirety of the governance review;
9. Staff were contacted by the offices at Donna Ockenden Limited a minimum of six weeks prior to interview and were provided with a staff briefing document alongside their introductory letter.

## **6.2 Factual accuracy processes and maintaining anonymity of contributors to the Ockenden governance review**

Each interviewee was given the opportunity to review and amend where required their transcript of interview. Staff were given the opportunity to submit further evidence to the review and to correct any potential misunderstandings that may have occurred between final approval of the interview transcripts and writing of the draft report.

A full draft report (or excerpts from the draft report, as appropriate) were submitted to key individuals as part of the factual accuracy checking process. These were sent by individualised and named paper copies in secure packaging and staff were permitted to make amendments of fact only to ensure the accuracy of the content of the final report. Job titles were used when this was already a matter of public record.

All contributors to the Ockenden governance review were provided with a number known only to the Ockenden governance review team and the individual. Names were not used throughout the report.

### **Oversight arrangements for the Ockenden review of governance:**

Oversight arrangements for both the HASCAS investigation and the Ockenden governance review were originally led by BCUHB, first by the then Director of Workforce and Organisational Development at BCUHB and subsequently, from the summer of 2016 an external appointment to BCUHB as Director of External investigations.

The first Oversight Panel for the Ockenden review was held at the end of March 2016. From 31st January 2017 following an announcement by the Cabinet Secretary for Health, Well-Being and Sport an external Oversight panel was introduced. Subsequently the then Executive Director of Workforce and Organisational Development represented BCUHB at all Independent Oversight Panel meetings until the role Executive Director and Organisational Development was undertaken on an interim basis and the former Executive Director of Workforce and Organisational Development became the Director of External investigations.

Oversight meetings generally occurred monthly in North Wales with communication on an as required basis between Donna Ockenden, the Independent Oversight Panel, (usually the Chair) and BCUHB as required.

### **Updates to the BCUHB Board**

The BCUHB Board was updated on a number of occasions throughout 2016 and 2017 and a Board paper by the Director of External investigations dated 16th November 2017 provides details of those Board updates. The link of the Board minutes is provided below<sup>32</sup> and the discussion is found at 17.256.1. (BCUHB 2017, pages 9 and 10.)

A further update was discussed at the BCUHB Board<sup>33</sup> in February 2017 as 'Progress Report in Relation to Concerns about the Care and Treatment of Patients on Tawel Fan Ward.' The Board minutes say that 'The Chief Executive introduced this agenda item, highlighting the importance of ensuring that the ongoing review and review processes were robust and sufficiently detailed. '

At the Board meeting discussion ensued and members raised a range of issues. In response to a comment within the paper that completion of interviews was dependent on individuals making themselves available. The Director of External Investigations indicated a range of support services that were available to staff. The Chairman also noted that access to separate support sessions had been made available to the families. It was emphasised that it was important to conclude the reviews within the published timeframe and it was agreed to review the timetable for the publication of their reports with HASCAS and Donna Ockenden.

Reference was made in the paper to a delay in accessing and retrieving information, and it was acknowledged that this could be misinterpreted as an

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<sup>32</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20Health%20Board%2016.11.17%20Public%20V1.0.pdf>.

<sup>33</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20Board%2016.2.17%20Public%20V1.0.pdf>

unwillingness by individuals to provide information or refer to information not being available, rather than reasons to do with logistics. It was also felt that the conclusions and next steps section could be strengthened in the next Board paper to incorporate any high level themes and learning from quality and safety issues, whilst recognising that the paper's purpose was to provide an update on progress of the reviews not the findings.

### 6.3 Liaison with BCUHB throughout the time span of the Ockenden governance review

During the course of the Ockenden review a wide range of very senior current and former BCUHB staff participated in interviews and in the governance review process overall. Once the Independent Oversight Panel was in place all quality and monitoring processes were undertaken by that Panel.

The Ockenden governance review team is satisfied that all the work underpinning the governance review has been completed appropriately and at 'arm's length' from BCUHB. All participants in the Ockenden governance review have been able to correspond freely and in private with the Ockenden review team at all times.

*“The Ockenden governance review team is satisfied that the work underpinning the governance review has been completed appropriately and at ‘arm’s length’ from BCUHB.”*

### 6.4 Methodology underpinning the Ockenden governance review

The review focused on the following key methodologies:

1. Documentation review – both internal to BCUHB and external sources;
2. Former and current staff interviews from Ward to Board;
3. Stakeholder engagement and listening exercises across the six counties of North Wales;
4. Review of past governance arrangements from October 2009 to identify any failings in systems, structures and processes that contributed to the events on Tawel Fan ward;
5. Review of current governance arrangements, (from January 2014 to December 2017) to provide assurance that the organisation is working effectively to improve patient care.

### 6.5 Information governance and security throughout the Ockenden review

An arrangement has been in place since November 2015 to provide all required information safely to Donna Ockenden Limited via a secure portal mechanism. A data sharing arrangement has also been in use since that time so that all requests for information from Donna Ockenden Limited come to a single point in BCUHB. A communication logging system and document request system is maintained by the administration team working within Donna Ockenden Limited.

Throughout the Ockenden review of governance BCUHB have provided to the Ockenden team over 3200 individual documents for review via a secure portal arrangement. It is recognised by the Ockenden review team that this has been a significant undertaking for BCUHB. Large amounts of material sometimes arrived via the secure portal unsorted by subject, (although all files had a unique number) this often lead to the need for a great deal of administration by the Ockenden team on receipt. The Ockenden team has now created a fully listed and searchable index of all the documents supplied to the governance review by BCUHB which will be useful to BCUHB after handover.

*“Throughout the Ockenden review of governance BCUHB have provided to the Ockenden team over 3200 individual documents for review”*

As regards document presentation some of the documents provided by BCUHB have a year or a period of time referred to within the body of the document but not a date of production. Some documents have a date/month and not a year. A number of documents provided were both undated and without a title. A number of reports do not have an identified author. Many documents were provided as embedded documents, a significant number are placed four or five layers deep from the original title folder with a smaller number placed at six and seven layers deep. Some documents within documents have the appearance of being embedded but are possibly only scanned or copied and therefore cannot be opened.

The information considered have included the following relating to the time frame under review 2009 onwards to the current time.

- Any available information regarding the strategic planning for the mergers leading to the creation of BCUHB in 2009;
- Any available information regarding the planning for and delivery of the first Clinical Programme Group (CPG) structure in the 'new' BCUHB from October 2009;
- Documents pertaining to the MHLDP CPG and specifically older people's mental health care including documentation held by BCUHB pertaining to Tawel Fan ward.
- External reviews from a number of sources including HIW<sup>34</sup>, WAO<sup>35</sup>, the NHS Delivery Unit<sup>36</sup> and Welsh Government;
- BCUHB responses, action plans, and evidence of learning – where available – to these external reviews;
- BCUHB corporate documentation including risk assessment/risk analysis/ Board assurance documents and evidence of Board to ward assurance where this is available;
- BCUHB Annual Governance Statements and BCUHB Annual reports, 2009 to the current day, (the end of December 2017);

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<sup>34</sup> All, see glossary, main report

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- Stakeholder interaction, listening and engagement by BCUHB and its representatives (and the actions taken by BCUHB as a result of that interaction, listening and engagement);
- Review of the concerns process in BCUHB including review of the systems, structures and processes underpinning concerns and assessment of any evidence of system wide learning from concerns from October 2009 onwards.

A bibliography of additional documents to those provided by BCUHB (and those not available via a footnote or link) is provided at the end of the report.

The Ockenden governance review required additional and ongoing documentation requests to BCUHB in response to emergent themes and findings as the governance review has progressed.

The systems, structures and processes described within the documentation and said to be in existence have been tested and evidenced against patient, staff and stakeholder feedback and evidence from regulatory processes such as Healthcare Inspectorate Wales (HIW) inspections, joint reviews by HIW and WAO and other external processes. HIW provided a large amount of documentation to the Ockenden governance review team concerning mental health, older people's mental health and older people's care provided at BCUHB. Much of this was previously unpublished and was of great assistance to the Ockenden governance review team in understanding the 'wider picture' of the systems, structures and processes of governance underpinning older peoples mental health care, (OPMH) older peoples care and mental health care at BCUHB.

The key question to be answered is 'how was the Board assured that its organisation was working effectively in the delivery of patient care within Mental Health and specifically Older Persons Mental Health at BCUHB?'

The Ockenden review will focus on four key questions:

1. Were the Board aware of the effectiveness of methods used by BCUHB which involved communicating and involving staff, patients and stakeholders in the quality and safety agenda?
2. How the Board was assured that it was receiving the correct level of quality and safety information (and what were the key sources of assurance)?
3. Was there a clear audit trail of assurance underpinning any Board statements and declarations?
4. Were any Board Assurance Framework and local and CPG wide risk registers effective in capturing the risks to quality and safety in Older Persons Mental Health (OPMH) across BCUHB (and what evidence is there of the Board's understanding of any potential risks to quality and safety on the ground)?

## 7 Chapter 1

### 7.1 What was the Ablett unit?

The Ablett unit was made up of four wards and is a separate building from the main hospital campus on the Glan Clwyd Hospital site. It is commonly known as YGC. Tawel Fan ward was found within the Ablett unit.

The other wards found within the Ablett unit are:

Tegid ward, (10 beds and an acute psychiatric admission ward for male and female older adults – over the age of 65 with 'functional' mental health problems<sup>37</sup>)

Dinas ward, (twenty beds, 10 beds male and 10 beds female – for adults of 'working age' – up to the age of 65 years)

Cynydd ward, (a ward with eight beds, designated as a rehabilitation ward for male and female patients of 'working age'.)

The Ockenden review team has not seen any operational policies for the unit which may have explained the systems, structures and process by which the four wards related to one another (or not) and how the Ablett unit itself related to the main YGC campus upon which it was based, (or not).

### 7.2 What was Tawel Fan ward?

Tawel Fan ward was a seventeen bed acute psychiatric admission ward in the Ablett Unit at Ysbyty Glan Clwyd Hospital. Tawel Fan was described as a ward for organic<sup>38</sup> mental health problems. An internal BCUHB document prepared for an 'In Committee' (or private) meeting of the BCUHB Board dated December 13th 2013 describes Tawel Fan as a ward that provided 'assessment and treatment for dementia patients.' (BCUHB 2013, page 1). The SBAR<sup>39</sup> prepared prior to closure of Tawel Fan ward described it as 'an acute organic ward for patients with challenging behaviour.'

*“Tawel Fan ward was a seventeen bed acute psychiatric admission ward in the Ablett Unit at Ysbyty Glan Clwyd Hospital.”*

### 7.3 Closure of Tawel Fan ward

Evidence has been provided to the Ockenden review that Tawel Fan ward closed in two stages, being closed to admissions on the 13th December 2013 and temporarily closed and patients transferred on the 20th December 2013. The Ockenden review team was advised that transfer of patients occurred either to:

- Bryn Hesketh unit in Colwyn Bay, approximately 10.5 miles away from YGC with a fifteen minute car journey time;

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<sup>37</sup> See main glossary for definitions of 39 40 and 41

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- Cefni Hospital, (if that was closer to home);
- Care/EMI homes;
- Home.

The transfer/discharge of patients from Tawel Fan ward and closure happened on the 20th December 2013.

Evidence has been provided to the Ockenden review of a tabled paper, (brought on the 19th December 2013 by the Executive Director of Nursing and Midwifery). This paper was not specific to Tawel Fan ward but considers a wide range of other issues associated with mental health provision at BCUHB. The Ockenden review team has not seen evidence in the form of Board minutes that the closure of Tawel Fan ward was formally discussed at a BCUHB Board meeting prior to closure as would be expected and usual practice. The review team explains the background to this below. The Ockenden governance review has been provided instead with five documents dated between the 13th December 2013 and the 14th January 2015. These comprise:

- An SBAR (Situation, Background, Assessment, and Recommendation) paper for the Executive Director of Nursing and Midwifery, written by the then ACOS nursing (dated 13th December 2013). Evidence has been seen by the Ockenden review team that this was requested by the then interim CEO following contact made directly by the clinical lead for OPMH.
- The review has also been provided with an 'In Committee' Board paper described as 'Briefing for the Health Board' dated 19th December 2013 and titled 'Mental Health Services.' The author of the paper is not stated. The majority of the paper is devoted to issues within the Hergest Unit and Tawel Fan ward is mentioned only briefly on page 2. The section around Tawel Fan ward refers to the completion of an SBAR\* (see above) document and the escalation of this document to Executive level. The information within this paragraph around Tawel Fan ward is presented as suggesting that decisions to a) stop admissions to Tawel Fan ward and b) 'planned discharge/transfers of existing patients' had already occurred prior to this Board meeting.
- A further briefing for the Executive Director of Nursing and Midwifery with authorship as above and dated 21st January 2014.
- A briefing paper for Healthcare Inspectorate Wales (HIW) from BCUHB, authorship unknown.
- An informal briefing paper for the Chairman of BCUHB dated 14th January 2015 by the then Executive Director of Nursing and Midwifery.

*“Five other services across Mental Health are described as ‘in escalation’ in addition to Tawel Fan ward.”*

Of note within the SBAR<sup>40</sup> paper is that five other services across Mental Health are described as 'in escalation' in addition to Tawel Fan ward. The paper states these are:

- Hergest unit (Ysbyty Gwynedd)

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<sup>40</sup> See glossary

- North Powys
- Cemlyn ward, Cefni Hospital
- Hafan Day unit, Bryn Beryl Hospital
- Heddfan unit, Older Persons Mental Health Unit, Wrexham

The extent of the mental health services at BCUHB 'in escalation' as of December 2013 suggests a fragile mental health service approaching, if not already at crisis point.

a) **An SBAR\* (Situation, Background, Assessment, Recommendation) paper** written by the then Associate Chief of Staff, (ACOS) Nursing for the Executive Director of Nursing and Midwifery and interim Chief Executive Officer dated and sent by email to both on the 13th December 2013 has been considered by the review team. This recommends closure of Tawel Fan ward because of:

- 'An unstable staff complement notably a number of issues related to short and long term sickness absence.'
- Vacancies described as 'in the process of recruitment.'
- 'A growing number of staff who have been redeployed to non-patient duties.'
- 'The present predicament of possible further staff redeployments due to the above reviews.' (All, page 1)

The SBAR document describes that there were twelve (12) patients currently receiving inpatient care on Tawel Fan ward and that the MHL D Clinical Programme Group team regarded Tawel Fan ward as 'undoubtedly a ward in difficulty.' The SBAR document stated that this view of Tawel Fan as a 'ward in difficulty' was also supported by the then medical clinical lead for older persons services. The Executive Director of Nursing and Midwifery and CEO were advised via the SBAR document that:

'The CPG is currently not assured that Tawel Fan is able to provide an environment of care 24/7 which is consistent to safe standards of compassionate care to the most vulnerable patients suffering from advanced dementia in the present setting of Tawel Fan ward.' (Internal email, 13th December 2013, page 2.) The following recommendations were made:

- Full disciplinary review into the new concerns raised by the family with advice and support from WOD for risk assessments and actions for staff (WOD is the Workforce and Organisational Development structure at BCUHB.)
- With immediate effect to close to admissions into Tawel Fan ward;
- A safety plan to be put in place for the remaining patients on Tawel Fan ward and a safe transfer to alternative hospital settings with the temporary closure of Tawel Fan ward;

*"The extent of the mental health services at BCUHB 'in escalation' as of December 2013 suggests a fragile mental health service approaching, if not already at crisis point."*

*"The MHL D Clinical Programme Group team regarded Tawel Fan ward as 'undoubtedly a ward in difficulty.'"*

*"The CPG is currently not assured that Tawel Fan is able to provide an environment of care 24/7 which is consistent to safe standards of compassionate care to the most vulnerable patients suffering from advanced dementia in the present setting of Tawel Fan ward."*

- For the CPG to produce a communication plan to be provided to staff explaining the reasons for stopping admissions to the ward and any planned temporary closure thereafter;
- To inform the North Wales Community Health Council (NWCHC) on the decision for a temporary closure.

The SBAR informed the Executive Director of Nursing and Midwifery and CEO that the CPG would put in senior nursing management support for 'risk mitigation' until a decision regarding a temporary closure could be made. Internal CPG email communication supporting and adding to the information provided to the Executive Director of Nursing and Midwifery around poor staffing on Tawel Fan ward has been seen by the review team. As of December 9th 2013 an internal email provided to the Ockenden review team which says 'I feel we have no option but to reduce the bed capacity (on Tawel Fan ward) for the next couple of months.' The email between members of the Clinical Programme Group management structure describes insufficient staffing levels across all grades of nursing staff, bank staff that are difficult to obtain, agency nurses who have not turned up and are 'unreliable.' In the email staff morale is described as 'low and stress levels are rising amongst staff.' The email also states that Dementia Care Mapping has found that 'patient wellbeing is lower when staff cared for by bank/agency.' (Email dated 9th December 2013 @0940hrs.)

*“Staff morale is described as ‘low and stress levels are rising amongst staff.’”*

A further briefing for the Executive Director of Nursing and Midwifery with authorship as above and dated 21st January 2014 was provided to the Ockenden review. This described the updated position in the month after the temporary closure of Tawel Fan ward. The briefing paper using the 'SBAR' mnemonic described progress against a number of work streams including two Protection of Vulnerable<sup>41</sup> Adult (or PoVA) referrals, actions following receipt of a tape recording of a nursing handover, progress on the complaints raised by the original family and ongoing workforce and review activities. The paper recommends that there should be 'establishment of quality and safety criteria for a timely reopening of the ward as an older persons unit with a revised staff team and clinical function and for these plans to be provided to the Executive team and Health Board 'within two weeks.' The Ockenden review has not seen this documentation.

**b) A briefing paper for Healthcare Inspectorate Wales (HIW) from BCUHB.**

The authorship of this paper is unknown, the footer says 'Version 2RC/ HIW18/03/2014. This suggests the document was sent to HIW on or around that date. It summarises the events leading to closure and the progress since closure on a number of key areas. This paper had not previously been seen by the reviewer as part of the first Tawel Fan review and there are a number of areas of inaccuracy. This includes the start date for the first Ockenden review stated as 8th January 2014 when the initial conversation to discuss the possibility of Donna Ockenden Limited undertaking the first Tawel Fan review was cancelled on the day on the 9th January 2014. The Terms of Reference were described as still in draft form on the 23rd January 2014. Therefore the first Tawel Fan review could not have started on the 8th January 2014 as stated within the paper.

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<sup>41</sup> See glossary

Within the HIW paper is a proposal that Tawel Fan ward remains closed 'until the review is complete and clear criteria for reopening the unit made. The Board have agreed the reopening of the ward will not take place until the external review report has been received and findings considered....' (BCUHB 2014 page 6.) The briefing paper to HIW also refer to 'further external expert support' being provided by Margaret Flynn and Ruth Eley. The 'Flynn Eley Report' described as a 'Strategic review of Older People's Mental Health Services across North Wales (2014) has been widely discussed externally and will be further briefly considered in this review.

A document described as a briefing paper for the Chairman of BCUHB dated 14th January 2015 by the then Executive Director of Nursing is written utilising an informal style. The briefing paper describes that a 'lookback exercise has been conducted after a number of families reported lodging their concerns and raising POVA concerns formally to the Health Board for more than 12 months prior to the sentinel case being brought to the attention of the Director of Nursing in December 2013. The exercise has concluded that concerns letters and POVA concerns were being received by the Health Board with a limited response, or a failed action or response....' (BCUHB 2015, page 2)

With further reference to the closure of Tawel Fan ward the Ockenden review was provided with a statement prepared jointly by the then BCUHB Board and dated March 2017. This statement was provided jointly to the Ockenden review and HASCAS and describes that: In the 12 months prior to closure 'it is evident that a number of concerns were raised about the care and treatment of a small number of patients on Tawel Fan ward and reported in line with the Putting Things Right processes in place at that time.' (BCUHB 2017, page 13)

The Board statement (March 2017) states that an 'internal review' of Tawel Fan ward was instigated in 'Autumn 2013' the purpose of which was said to be 'to ascertain the facts and identify whether there were broader issues that needed to be addressed.' (BCUHB 2017, page 13.) The statement says that the then Executive Director of Nursing 'became aware of a covert recording of an alleged unprofessional nursing handover on Tawel Fan ward from the morning of 5th October 2013.' (BCUHB 2017, page 13). The Ockenden review has been advised that covert recording was subsequently provided to BCUHB in mid-December 2013.

Evidence has been seen by the Ockenden review of a comprehensive plan of action to be carried out around Tawel Fan ward and coordinated by the then ACOS Nursing of the Clinical Programme Group dated the 9th October 2013. This review was made up of a number of strands associated with the ward including:

- a) Observation of care;
- b) Review of an individual care and treatment plan;
- c) Dementia Care Mapping exercise to be completed – this was completed later in October 2013;

*“Lookback exercise has been conducted after a number of families reported lodging their concerns and raising POVA concerns formally to the Health Board for more than 12 months prior to the sentinel case being brought to the attention of the Director of Nursing in December 2013.”*

- d) A review of Datix,<sup>42</sup> 'Putting Things Right' and safeguarding;
- e) Review of restrictive practices, (including Deprivation of Liberty or DoLS<sup>43</sup>, Best Interests Assessor or BIA<sup>44</sup>, and the Mental Capacity Act<sup>45</sup>.)
- f) A review of the Tawel Fan ward staffing establishment.

In response to 'emerging concerns' from these and other sources the BCUHB Board statement of March 2017 provided to this review describes that the Executive Director of Nursing and Midwifery 'immediately advised the Health Board on the 19th December 2013 that as a consequence of the action being taken in the previous days, to remove a number of staff from the unit as part of the ongoing review, a temporary closure of the Tawel Fan ward would need to be enacted immediately to maintain patient safety and allow for a proper review to be conducted.' (BCUHB March 2017, page 13.)

The rapidly approaching Christmas and New Year holidays were an important part of the context at the time. (Tawel Fan ward closed on Friday the 20th December 2013, Christmas Eve was the following Tuesday and therefore Monday, 23rd December would (in all likelihood) have been the last full 'working' or 'office' day for many senior and Board level staff until the 2nd of January 2014, 10 days later. In addition, Monday 24th December, (Christmas Eve) is likely to have been a 'half' working day for administrative, senior and Board staff so the time of year and timing was clearly a significant issue in the urgency of the ward closure.

Staff number 4, a current Board member, advised the Ockenden review team of the closure of Tawel Fan ward: 'There were two key discussions ... in terms of information that had become known to the Director of Nursing ... this was ... in October, November time and the Director of Nursing was following up those concerns... (The decision to close the ward) 'was a Board briefing session that the Board were having ... and the opportunity was taken to brief the Board, confidentially, about the issues that had been raised, so the matters were such that the Director of Nursing and the Medical Director, could not be assured of the quality and safety of care for the patients involved, and they came with a clear recommendation that the Board needed to urgently move to close the ward... '.

Staff number 4 continued: 'They (the risks of closure of Tawel Fan ward or not) were articulated, they were not in a written form ... so there wasn't a paper that set out the pros and cons, the information was conveyed regarding the incidents that had occurred, the information that had come to light ... and therefore their assessment was that this needed to be transacted urgently ... their clear advice was it was in the patient's interest that their care be transferred ... they'd had a very clear clinical view from the lead consultant at the time around that as well

*“The Director of Nursing and the Medical Director, could not be assured of the quality and safety of care for the patients involved, and they came with a clear recommendation that the Board needed to urgently move to close the ward... .”*

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<sup>42</sup> Risk management system, see glossary

<sup>43</sup> See glossary

<sup>44</sup> See glossary

<sup>45</sup> See glossary



... and their view was that needed to be dealt with as a matter of urgency and, of course, we were rapidly marching towards Christmas.'

Email evidence has been seen by the Ockenden review team that the 'lead consultant' for OPMH was supportive of closure, and provided the clinical leadership required at the time. The Ockenden review has seen evidence of this clinical colleague discussing the reason for closure with the then interim CEO and following up proactively and quickly with a range of colleagues within and outside the CPG as required. Extensive clinical leadership was shown by the lead consultant at that time, (from the email evidence seen by the Ockenden review team). This includes suggestions for alternative clinical models during the closure of Tawel Fan ward, working collaboratively with other medical and non-medical colleagues and awareness of the need to enhance nurse leadership at Bryn Hesketh at the time of patient transfer. These emails cover the period of time from the 9th December 2013 to the evening of the 20th December 2013.

### **Conclusion reached by the Ockenden team on the closure of Tawel Fan ward**

It is agreed by the Ockenden review team that it would be usual practice to have briefed a full Board prior to the decision to close a ward and the decision to transfer patients to a neighbouring unit. This is especially the case as Bryn Hesketh and Cefni Hospital were both a 'standalone' unit without 24 hour medical cover and therefore the patients from Tawel Fan ward were transferring to a very different kind of care setting from one co-located on a main hospital site. The timing and the context of the closure set out, as above so close to Christmas, with only one working day remaining prior to the Christmas break means that the Ockenden team is less critical of the BCUHB Board at this time.

Usual practice would be that a formal 'In Committee' Board session should have been called, which could have been called at the Board Development day. It is also not clear to the Ockenden team if notice of the advice to close Tawel Fan ward and the fact that this decision was being discussed was conveyed to attendees prior to the Board Development session and whether this would have led to potentially increased attendance. Had a formal Board session been called at the Board Development day, then a report could have been 'tabled,' (presented at the meeting) minutes kept of the discussion and the recording of the discussion of the decision to close the ward and what were (if any) risks to patients in transfer to Bryn Hesketh and risk to patients in not transferring.

In conclusion, it is expected that the circumstances were discussed as above at an 'In Committee' meeting of the Board with an accompanying Board paper. This would have been particularly important as it was acknowledged by a number of interviewees participating in the Ockenden review that Board development sessions at that time were often poorly attended.



## 7.4 Findings on the complaints process within the CPG and BCUHB at the time of the first Ockenden Report

Feedback from the relatives who spoke to Donna Ockenden in spring 2014 as a part of the first Tawel Fan review were in line with the criticisms found of the BCUHB 'Concerns' 'Putting Things Right' process found within two external reviews in August and December 2013.

The NHS Wales Shared Services Partnership (NHSWSSP) review of August 2013 focused on BCUHB's management of complaints and its ability to learn lessons from them, finding limited assurance overall. The NHS Wales Delivery Unit 'Review of Management of Concerns' dated December 2013 found that it was 'not possible to obtain assurance that [BCUHB] has adequate mechanisms in place for managing concerns and learning lessons.' (Page 13).

Most of the relatives interviewed for the first Ockenden report stated they had raised their concerns either formally via the Health Board's 2013 Putting Things Right process; (formally known as the Concerns Policy, Complaints, Claims and Incidents) or stated they had raised concerns formally and informally at the time of their relatives stay on Tawel Fan with representatives of the CPG or on some occasions with members of the then Executive team. A number of emails sent to BCUHB from 2012 onwards had been shared with Donna Ockenden as part of the first report showing this information to be correct. Firstly, none of the relatives met with during the process of gathering evidence for the first report described themselves as being satisfied that their complaint or concern had been resolved regardless of whether it had been raised formally or informally. Typical responses from families which resonated with the findings of the reviews by NHSWSSP (2013) and/or the NHS Wales Delivery Unit review (2013) included:

*“The NHS Wales Delivery Unit 'Review of Management of Concerns' dated December 2013 found that it was 'not possible to obtain assurance that (BCUHB) has adequate mechanisms in place for managing concerns and learning lessons.'”*

## 7.5 The length of time taken to investigate concerns

This was a second recurring theme with relevance to this review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013. It also resonates with criticisms made of BCUHB by both the NHS Delivery Unit and the NHS Wales Shared Services Partnership (2013) reviews. A number of the original Tawel Fan families described long waiting times of more than six months in order to get responses to complaints. Families informed the first Ockenden report of the need to involve local Assembly Members (AM's) and the North Wales Community Health Council (NWCHC) to support resolution of complaints. This has been confirmed by a number of North Wales AM's and the NWCHC.

## 7.6 The lack of an accurate written response or minutes of meetings when requested

Was also cited as a concern. All of the concerns around the 'Putting Things Right' process in BCUHB as expressed within the first Ockenden report have been repeated in the extensive service user and service representative engagement as

part of the review of 'current' governance arrangement across older persons mental health that took place in the spring and summer of 2017.

In the original Ockenden review into Tawel Fan ward some families described the use of plaudits (thank you cards) to the Tawel Fan ward team rather than utilising the complaints process because of their fear that a complaint would mean their family member would receive worse treatment if he/she needed to return to Tawel Fan ward.

Reluctance to use the current 'PTR' and 'Concerns' process and either fear of raising or reluctance to raise concerns regarding poor care was repeated in the extensive service user and service representative listening and engagement across North Wales as part of the review of 'current' governance arrangements across older persons mental health that took place in the spring and summer of 2017.

## 7.7 Difficulty in gaining baseline information including 'Datix' incidents for the first Tawel Fan report

Throughout the first review into Tawel Fan ward there were numerous requests made of the then CPG senior team for information on incidents, incident review and examples of learning from incidents.

At the time of the first Ockenden review into Tawel Fan ward emails between Donna Ockenden Limited and BCUHB show it took more than five months, (until late August 2014) to obtain for the first Ockenden report a 'list' of Datix<sup>46</sup> incidents. Throughout the first Tawel Fan review and then report Donna Ockenden was not provided with any review reports associated with this list of Datix incidents. Neither was there clarity provided on the existence or otherwise of any 'Red' (most serious) incident reports. After more than seven months this particular line of enquiry ended with an email exchange between two members of BCUHB staff asking if it could be confirmed or not if Tawel Fan had ever had any red incidents in the previous two years. The email said 'Are we able to say there are no red IR1's relating to Tawel Fan ward in the two years prior to closure?' (Internal BCUHB email dated 29th August 2014 @1651 hrs). No response was received by the time the first Ockenden report was handed over to BCUHB.

## 7.8 What can review of minutes of meetings tell us about issues which are relevant to a review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013?

An important part of the evidence provided by the Clinical Programme Group (CPG) team for the first Tawel Fan report and this review of governance was a series of minutes of meetings within the CPG spanning the period of time in the year before and the six months after the closure of Tawel Fan ward. In those

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<sup>46</sup> Datix – see glossary

minutes (as supplied by BCUHB) and internal communication provided to the review by staff members at the time there was evidence of recurring themes/concerns that were also discussed in many interviews of current and former BCUHB staff and current service users and their representatives undertaken as part of this governance review. These included:

## 7.9 Staffing

Internal communication in the form of emails between ward managers, matrons, medical staff and members of the CPG senior team describe the following in Hydref ward and Tawel Fan ward in March 2011. (Email sent 31st March 2011@1648hrs.)

The emails describe that Hydref and Gwanwyn wards in the Heddfan unit had been amalgamated due to 'low pt. numbers and short staffing.' Following a number of admissions low staffing numbers meant that although Hydref ward was full, and therefore the unit overall was now short of beds Gwanwyn ward was unable to open.

The BCUHB staffing bank, (which was discussed as a concern by a number of interviewees throughout this review) had been unable to provide staff. The Ockenden governance review is also aware of the closure of inpatient wards within OPMH as part of service redesign where closure happened before the **redesign actually occurred**. Wards were closed, pending service redesign (staff and service user representatives have explained to the Ockenden review team, these closures were often at short notice.) This led to increased pressure on the wards remaining available. Combined with the Executive led vacancy control process<sup>47</sup> which frequently delayed the appointment of even those posts described as clinically essential the Ockenden governance review found extreme pressure on mental health services and specifically older persons mental health provision at BCUHB over many years from 2009 onwards.

Evidence has been seen by the Ockenden review showing that there was a consideration of admitting patients to beds on Hydref ward that were allocated to two patients on leave from the ward. The ward team was reluctant to do that as 'both pts are very high risk for the situation breaking down as we head into their first weekend at home.'

The staffing information for Heddfan unit, (containing Hydref ward and Gwanwyn ward) within the email stated an establishment of 36 WTE, (whole time equivalents or full time staff) and described 13 WTE 'missing' as a combination of vacancies (4 WTE), sickness (5WTE), 4 staff on annual leave and 1 member of staff on a 'supervised, phased return.'. This was described as circa 36% of the staff within the ward establishment unavailable for work due to the above reasons. Tawel Fan ward is described in a similar situation as regards staffing at the same time. The response to the email regarding Hydref and Gwanwyn wards says:

*“The emails describe that Hydref and Gwanwyn wards in the Heddfan unit had been amalgamated due to ‘low pt. numbers and short staffing.’”*

*“Evidence has been seen by the Ockenden review showing that there was a consideration of admitting patients to beds on Hydref ward that were allocated to two patients on leave from the ward. The ward team was reluctant to do that as ‘both pts are very high risk for the situation breaking down as we head into their first weekend at home.’”*

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<sup>47</sup> See glossary

'From Tawel Fans point of view, we have empty beds but staffing is dire (am desperately trying to access bank staff to bring us up to minimal staffing) and we have a high dependency/challenging behaviour mix of patients. I feel it to be potentially too risky to add more patients into the mix ... the bank office have not been able to provide us with any extra staff lately – so I'm not holding my breath. Under those circumstances we would definitely not be able to accept anyone into Tawel Fan.' (Email sent 31st March 2011 1726hrs.)

A multi-disciplinary team meeting took place on the 5th May 2011 to discuss the issues with staffing at the Heddfan unit. The minutes have been seen by the Ockenden review team and state that 'staffing levels are not safe [in the Heddfan unit] and this has resulted in wards being merged on occasions and patients having to be admitted to the Ablett on 3 occasions recently... ' (minutes, dated 5th May 2011, page 1.) The minutes also refer to:

- Difficulty in securing bank staff, due to the centralisation of the staff bank by BCUHB;
- The new Heddfan unit had not had an uplift in staffing from its historical establishment and it was estimated that the establishment needed an increase of circa 30% because of the different configuration of the unit – on two floors, increasing numbers of patients and their increasing acuity;
- There had recently been patients discharged 'before they were ready' and difficulties in admitting patients when they required admission;
- The minutes state staff concern 'regarding the Mental Health Act being used inappropriately.' No further details were provided.

The situation does not resolve in the short term as further emails provided to the Ockenden governance review dated the 20th May 2011 concerning staffing in the Gwanwyn unit state 'We have 17 pts across 2 wards and only 5 staff to cover tomorrow and 6 staff to cover them Sunday. Are currently trying to secure further bank staff... ' (Email sent 20th May 2011 @1525hrs to a number of multidisciplinary members of the senior team in the MHL D CPG.) Further emails in June 2011 describe a need to merge wards again, due to insufficient staff but at this point the patient numbers are too great. In line with a number of interviewees who have participated in this review and significant amounts of evidence seen by the Ockenden team of the significant challenges in safely staffing the wards' the email says 'We will need to request agency staff if we cannot secure further bank. We have rung 40 plus staff over the last few days and as yet we still have at least 4/5 days needing staff... ' (Email sent 6th June 2011 @1237hrs.)

Chronic problems with staffing across the MHL D CPG because of high vacancy rates and high sickness rates are discussed in the minutes of meetings. Also discussed and seen was evidence of poor rates of compliance with annual appraisals and mandatory training. The grid below has been provided by BCUHB and shows a snapshot of mandatory training as of November 2012. The Ockenden review team has noted some areas of concern in the text below.

*“From Tawel Fans point of view, we have empty beds but staffing is dire (am desperately trying to access bank staff to bring us up to minimal staffing) and we have a high dependency/challenging behaviour mix of patients. I feel it to be potentially too risky to add more patients into the mix ... the bank office have not been able to provide us with any extra staff lately – so I'm not holding my breath. Under those circumstances we would definitely not be able to accept anyone into Tawel Fan.”*

*“We have rung 40 plus staff over the last few days and as yet we still have at least 4/5 days needing staff... .”*

## 7.10 Information contained in a Memo dated 13th November 2012 from the Associate Chief of Staff – Nursing shows the percentage of staff trained in the following mandatory training areas:

In-patient – Ablett Unit, Dinas	Oct 2012	55	66		61	74		68		36		76	67	100	53	0		96		87	91		84	9	0	100	20	0	100	42	FALSE	FALSE
In-patient – Ablett Unit, Tawelfan (EMH)	Oct 2012	71	96		96		100	71		38	38	100	100	0	50	58		50	100	100	58	100	54	50	42	100	33	17	100	100	TRUE	TRUE
In-patient – Ablett Unit, Tegid (EMH)	Oct 2012	58	95		79	94	100	69		33	37	86	67	21	29	42		42	100	100	63	63	47	17	17	92	0	0	86	84	FALSE	TRUE
In-patient – Bryn Hesketh (EMH)	Oct 2012	69	53	100	81		81		56	38	0		69	0		25		67		81	13	0	69	11	11	100	17	17	100	75	TRUE	TRUE
In-patient – Heddfan, Gwanwyn (EMH)	Oct 2012	32	42	42	42	32	33	0		16	16	58		32	40	100		84	74	84	84	0	100	89	100	100	82	91	42	FALSE	FALSE	
In-patient – Heddfan, Hydref (EMH)	Oct 2012	40	55	55	50	36	40	0		25	25	55		40	60	100		75	75	75	75	0	100	70	100	100	60	100	60	FALSE	FALSE	
In-patient – Hergest Unit – Aneurin Ward	Oct 2012	58	92		27	68	100	100	100	62	69	46		100	100	100		100	100	100	100		0	100	29	100	100	0	100	12	TRUE	FALSE
In-patient – Hergest Unit – Taliesin Ward	Oct 2012	31	8		23		19	29	100	8	23	36		36	0	0		0	100	100	96		64	21	0	0	0	0	0	0	TRUE	TRUE
In-patient – Cefni Hospital	Oct 2012	60	75	100	33	100	15	0		5	0	25		42	0	0		98	50	29		0	100	0	10	100	0	7	8	TRUE	TRUE	
In-patient – Cynan	No Data																															

Key	
Greater than 80% compliance	
Between 50% & 80% Compliance	
Less than 50% Compliance	
Not Applicable for that service area	
Inputting Errors – Data Removed	

### Bryn Hesketh

0% in Mental Capacity Act

25% in Mental Health Act (Intermediate)

13% in Restrictive Physical Interventions

### Dinas Ward

0% in Compliance Mental Health Act

76% in Basic Life Support

61% in Infection Control

### Tawel Fan

0% in Mental Capacity Act

50% in Mental Health Act

58% in Restrictive Physical Interventions

### Hergest

27% in Infection Prevention

46% in BLS

### Cyan Ward (Hergest)

No data entry for a year

Efforts were clearly being made by matrons and other managers within the MHL D CPG in 2011-12, 2012 – 13 and 2013-14 trying to plan ahead on a weekly basis via the inpatient matrons meeting to ensure safe staffing of inpatient services. However at the same time as staffing was clearly such a significant concern there are references within other management minutes (October 2013)

*“However at the same time as staffing was clearly such a significant concern there are references within other management minutes (October 2013) to challenging savings plans described by [named external advisors] as ‘100 % high risk’ but ‘delivering.’”*

to challenging savings plans described by [named external advisors] as '100 % high risk' but 'delivering.' No further detail is given as to what '100% high risk' meant. One former Board member advised the Ockenden governance review team that '100% high risk' in this context means 100% risk of no-delivery of savings. No further clarity has been received by the Ockenden governance review team. There are also a number of issues around vacancies in community teams, agency being used to fill those vacancies and vacancies not being approved at the Executive vacancy control panel.

Poor staffing appeared to be impacting on patient care on a number of fronts including a stated lack of meaningful activity described on the wards. This had also been clearly described in the HIW visit to Tawel Fan ward in July 2013 and the Dementia Care Mapping<sup>48</sup> exercise undertaken on the same ward in October 2013. Communication from the lead consultant for OPMH within BCUHB from November 2012 provided to the Ockenden review support the concerns discussed around high sickness rates and poor staffing of services within Older Persons Mental Health. The emails seen state the need for 'a plan for arranging additional resources for a team struggling with medical sickness and lack of nursing resources. Also...need to have a plan to support our inpatient system where complaints are occurring about lack of staff to take this additional workload... .' (Email 20th November 2012 @1350hrs.)

**In summary, key conclusions on staffing leading up and after to the closure of Tawel Fan ward are:**

1. Clearly the problems with staffing are not new, and they continue up to and after the closure of Tawel Fan ward;
2. Further evidence around long term problems with staffing in Older Persons Mental Health in the Ablett Unit are referred to in evidence provided to the review by staff number 65. An email dated 14th December 2010 @1904 hrs says of Tegid ward; 'Staffing is chronically short but can be remedied post January 14th when Brynmor closes';
3. Linked to staffing problems and concerns around potentially poor staff behaviours in Cefni Hospital, (staff sleeping on duty) there are issues with potentially inappropriate use of agency medical staff on Bryn Hesketh ward, a standalone unit in Colwyn Bay to which patients were transferred after the closure of Tawel Fan ward.

## 7.11 Problems with Estates

There are a number of references to long term estates problems that do not seem to be resolved including ligature risks that were a concern expressed in multiple HIW inspections over a prolonged period of many years. One set of minutes say 'All units across North Wales have ligature risks....' In addition an

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<sup>48</sup> See glossary



email dated 14th December 2010, says the following regarding 'environmental and estates issues' in Tegid ward in the Ablett unit:

- Changes required to bathroom equipment;
- Carpets and beds that needing replacing;
- 'There is limited therapeutic space.' (Email sent 14th December 2010 @1904 hrs)

Tawel Fan ward was also visited at the same time. The emails says 'similar issues in terms of necessary bathroom facilities, some of the carpeted areas definitely need changing. There is plenty of therapeutic space and pictures are being put up tomorrow. Ward does appear cluttered with old furniture and décor needs attention....' Extensive evidence has been seen of escalation to the CPG senior management team and beyond that senior management team to members of the Executive team. There is no evidence of resolution of estates issues across a number of older persons inpatient units up to and after the closure of Tawel Fan ward..

It is clear from staff interviews and minutes of meetings seen that serious incidents, (SI's) are an ongoing concern for the CPG as they are across BCUHB at the time with a number of references to 'legacy' SI's— although the length of time they have been open are not specified in the minutes seen. Overall the problems facing the CPG senior management team are considerable both before and after the closure of Tawel Fan ward and there are a lack of systems, structures and processes in place to support timely and effective resolution of those problems. In interview Staff number 15 a former senior manager working within Older Peoples Mental Health at BCUHB advised this governance review 'There was a governance structure and regular governance activity, the challenge was systematically connecting this activity to service improvement activity. This became even more challenging when attempting to do so across North Wales with a stretched MH/LD governance team.'

#### **Specific issues seen in the minutes included the following:**

##### **Minutes of the MHL D CPG Senior Management Team dated April 14th 2014**

This appears to be the first meeting for three months as the last meeting appeared to be 17th January 2014. It is noted regarding Healthcare Standards 'we are currently scoring 1 – 38%.' The action to be undertaken was '1. Ops manager to supply detail; 2. Somebody to pick it up....' (BCUHB 2014, pages 2 and 3)

The actions outlined above were neither specific, or measureable and therefore not achievable in a timely manner. There also followed in the same minutes discussion about falls at the Heddfan unit which stated that:

'CPG had 5 falls in Wrexham OPMH over a period of time... . The 5 falls have also been identified as a risk (outlier)' – presumably by BCUHB, although this is not clear. There was a lack of clarity in the minutes as to whether this constituted a problem or not. 'We need to be clear as to whether we have a problem with falls. X trying to get some evidence to send to Flynn Team and

let them get guidance on whether we have a problem with falls or not.'  
(BCUHB 2014 p2)

**Other areas of significant risk discussed at this meeting, (14th April 2014) were the following:**

1. 'We have an agency locum staff grade doctor who is not on our establishment looking after patients at Bryn Hesketh.' This stated lack of process in the recruitment of temporary staff at Bryn Hesketh in mid April 2014 following the transfer of patients from Tawel Fan ward to Bryn Hesketh four months earlier is of very significant concern.
2. We don't have a pathway, we should have a pathway around admissions, and we have a problem because we don't have a pathway. We should have a moratorium on Out of hour's (sic) admissions, we have had a few problems. Don't know if we've told YGC ... Scheduled organic unscheduled care to go to Care of Elderly Wards, not agreed with YGC. Every admission needs to be seen by a consultant. (BCUHB p2) The action agreed in the minutes was that two members of the senior management team were 'to discuss at Ops meeting today and ask for somebody to complete paper.'
3. Estates Issue: 'Ligature work carried out by X needs to come to SMT. HB (BCUHB) needs to understand that we are admitting patients into high risk areas.... All units across N Wales have ligature risks. Chief of Staff needs to be aware that patients are being admitted to high risk areas. Review on-going at present in Wrexham.' The action agreed was 'X to make list of priority estate issues. '(p3)

*"We have an agency locum staff grade doctor who is not on our establishment looking after patients at Bryn Hesketh."*

**The next Senior Management Team meeting – the 19th May 2014**

In the next Senior Management Team meeting with minutes dated 19th May 2014) there is continuing discussion around ligature<sup>49</sup> risks. The minutes note 'An issue has come up on Hergest regarding profiling beds<sup>50</sup>.'(p1) (With the profiling beds presumably being seen as a ligature risk). A further issue from reviews undertaken by Matrons is recorded in the minutes as 'the poor response from estates depts....' Staff number 57 advised the Ockenden review of highlighting issues with poor estates support at the 'Ablett Redevelopment Group' from 2011. Staff number 57, a senior nurse described to the Ockenden review team in June 2017 the very slow progress at achieving anything for the wards within the Ablett unit as 'We'll look at it as part of the Ablett Redevelopment Group, but those meetings ceased and ... it took...about two, three years to get the carpet in Tawel Fan replaced ... it was always about finance ... we always had to get three quotes ... it was just such a slow process ... if you were successful in getting the money the price had gone up ... you'd start all over again.'

*"It took...about two, three years to get the carpet in Tawel Fan replaced ... it was always about finance ... we always had to get three quotes ... it was just such a slow process ... if you were successful in getting the money the price had gone up ... you'd start all over again."*

<sup>49</sup> See glossary

<sup>50</sup> A profiling bed is an adjustable height, variable posture bed. They can be adjusted normally or electrically to change slope/height of the bed

Review of minutes and correspondence for the years 2011-2012, 2012-2013 and 2013-14 focusing on workforce showed the MHLD CPG to be under considerable pressure with staffing. A number of staff interviewed for this governance review have confirmed the pressure the CPG was under to make savings, including staff numbers 3, 11, 15, 22, 63 and 57). The Senior Management Team minutes of the 13th September 2013 note the result of the Vacancy Control Panel – which has been described by a number of interviewees (3, 11, 15, 22, 57, 63) as a process when vacancies that were approved as essential by the CPG then had to go through a process of further Executive scrutiny prior to approval. The minutes say 'vacancy control, not all went through....' No further detail is provided.

*“Each CPG had to have a vacancy control panel which agreed every vacancy and then would get agreed or not via the Health Board.”*

Staff number 22, a former senior manager within Mental Health told the Ockenden review team at interview in November 2016: 'Each CPG had to have a vacancy control panel which agreed every vacancy and then would get agreed or not via the Health Board. Staff number 63, formerly working within finance at BCUHB stated at interview in June 2017: 'There was a directive that every vacancy had to go for Exec approval, even the ones you had the money for.... Staff number 57 said at interview that when a post 'went through the vacancy control process it would come back as more information needed or resubmit in three months, six months.' Staff number 3, a senior manager told the Ockenden team at interview in September 2016 that as regards staffing 'they were very very lean times. We had wards which traditionally had had 2 x Band 6 Deputy ward managers as wards were getting increasingly acute and being told now they were only going to have 1 x band 6 in the future.'

*“They were very very lean times. We had wards which traditionally had had 2 x Band 6 Deputy ward managers as wards were getting increasingly acute and being told now they were only going to have 1 x band 6 in the future.”*

On the 11th October 2013 (two months before the closure of Tawel Fan and at time when the CPG was under considerable pressure regarding the Hergest unit) the minutes describe feedback from [an external company] regarding savings plans 'Our plans are seen as 100% high risk but are delivering...' (BCUHB 2013, page 2.) In the same minutes difficulties with community staffing and what appears to be a lack of knowledge of the community staff structure is described as 'currently getting accurate list of all the teams, need to make a decision regarding community vacancies. Flintshire carrying 5 vacancies, Agree to 2x agency and authorise the vacancies for filling....' (BCUHB 2013, page 3.)

*“An incident where a young patient 'with a forensic history' was admitted to a bed of an elderly patient who was 'on leave' from Tegid ward overnight. When the elderly patient returned to his bed the next morning to find another patient in it the young patient threatened the elderly patient.”*

In summary, estates problems, staffing concerns and bed 'pressures' across mental health were not new at the time of the closure of Tawel Fan ward. Neither did they improve or stop when Tawel Fan ward closed.

A letter written by the clinical lead for OPMH to senior colleagues within the CPG provided to the Ockenden review dated 10th February 2011 highlights 'several risk issues associated with inpatient care arrangements in Ablett.' (The Ablett unit had both Tegid ward and Tawel Fan ward within it at the time.) The letter is written to senior managers within the CPG and says the following:

- There are an increasing number of out of hours general adult admissions occurring to the Ablett Unit and that the 'care of elderly patients is affected;'
- The letter describes an incident where a young patient 'with a forensic history' was admitted to a bed of an elderly patient who was 'on leave' from

Tegid ward overnight. When the elderly patient returned to his bed the next morning to find another patient in it the young patient threatened the elderly patient;

- That a further incident had happened the next night where an elderly person was moved overnight from Tegid to Tawel Fan to accommodate another young person requiring admission. The letter also says that on that night 'there were no qualified staff nurses in Tawel Fan ward;'
- The letter refers to 'several complaints.....including an Ombudsman recommendation which highlighted the same issues.....we should take urgent action to make sure this unsafe practice should not be continued.' (Letter from clinical lead OPMH to senior staff within the MHL D CPG dated 10th February 2011, page 1.)
- The letter recommends the following four actions: ring-fencing OPMH beds in Tegid ward urgently, reviewing out of hours admission arrangements to the Ablett unit, arranging a structured managerial framework for OPMH inpatient units, and priority action for the environmental issues highlighted in Tegid and Tawel Fan wards. It is also requested that these issues are discussed at a range of CPG meetings.

## 7.12 Staff development, sickness and training

With reference to staff development and training the minutes from the 19th May 2014 describe the CPG as only 53% compliant with PADR<sup>51</sup>, (also known as staff annual reviews or objective setting.) Sickness absence is described as increasing 'since qtr. 3 to 6.35 % (6.21% cumulative). Cost >3 million Apr 13 – Mar 14.' (Page 2.) Of note is that this period of time commences with the nine months leading up to the closure of Tawel Fan ward and the three months immediately after it. The use of temporary staff via agency is described in these minutes as 'a cost just under one million Apr 13 – Apr 14.'

Staffing levels are also described as a continuing concern in the minutes of the 'Older Peoples Mental Health review Steering Group' on the 3rd April 2014. The minutes say 'Staffing – not always sufficient to enable real engagement with patients.' (Page 1). The meeting minutes, in line with a number of internal and external reviews also note a 'lack of psychological interventions, meaningful activity on wards.' This is noted in a number of interviews with staff managing the service at the time with Staff number 57 advised the Ockenden review of the decreasing resources available in Older Persons Mental Health in physiotherapy to support older people in both Bryn Hesketh and Tawel Fan ward over a number of years up to the end of 2013. Staff number 57 said 'Both Bryn Hesketh and Tawel Fan had dedicated physios and then over time, they were recalled back to the group model and.....everything was done on a referral basis...the difficulty with somebody with dementia and challenging behaviour is that, if you don't seize the moment, you can't recreate it to explain what the difficulty is.' This was an example of the lack of connectivity seen within the CPG structure at BCUHB.

*“Both Bryn Hesketh and Tawel Fan had dedicated physios and then over time, they were recalled back to the group model and.....everything was done on a referral basis...the difficulty with somebody with dementia and challenging behaviour is that, if you don't seize the moment, you can't recreate it to explain what the difficulty is.”*

<sup>51</sup> See glossary

The Ockenden team was informed that 'therapies' such as physiotherapy and occupational therapy were provided via the 'Therapies' CPG. Whilst the provision of 'therapies' would have been vital to the effective provision of mental health care and specifically older persons mental health care this was an area of provision which the MHLDP CPG had no control over.

The minutes of this group also note the following feedback from staff engagement events:

- Paperwork, absence of electronic health records, and lack of computer access – the review team found the medical notes difficult to follow
- Lack of performance monitoring related to outcomes
- Issues around some physical environments – programme of work around dementia supported environment but no resource. Limitations due to buildings.
- Uncertainty about futures – lack of decision making
- Positive about training and support
- Clinical leadership – concerns some localities have very little engagement from consultants
- Post-diagnostic support very patchy – offered in each locality but may differ
- Consider nursing home care – identified some complex patients are returning to inpatient wards, a lack of capacity in homes in North Wales is influencing health care. (p3)

In addition to the feedback above, the Ockenden governance review team have also been advised of a lack of metrics to measure quality in Mental Health at BCUHB. Staff number 4, told the Ockenden team 'the range of metrics and the information systems that we had to... support us were far less than .....in the acute sector....we didn't have a single clinical system for mental health so.... developing some of the metrics on which you could look for assurance or look to identify areas of concern was also a challenge....' Similar information deficits to those found in mental health were also described in interview by staff number 4 as being found in community and primary care services, but this was not a focus for this review of governance in mental health and older persons mental health.

The systems, structures and processes of governance is discussed briefly in the MHLDP CPG Senior Management Team (SMT) meeting of the 19th May 2014. The excerpt from the minutes say 'SMT and the governance meeting structure, agree to carry with for the time being. Need TOR.' What this appears to mean is that at this point in time (with BCUHB and the CPGs approaching their fifth birthday), the development of a TOR (Terms of Reference) for the governance group within the Mental Health and Learning Disabilities Group appears to have not yet occurred.



### 7.13 What was the position in the MHL D CPG and the wider BCUHB with SUI reporting, investigation and understanding of findings and trend data from 2009 to 2014?

There is discussion around Serious Untoward Incidents (SUI) in the MHL D CPG Senior Management Team (SMT) meeting of the 19th May 2014. which show some positive progress with the management of new SUIs but a concerning situation with 'legacy' SUIs. The minutes say:

'A number of SUI's are still outstanding. A screening panel (weekly on a Thursday) has been organised which is where an SUI will be looked at initially for the first time and they will make sure policy has been followed and these will then go to scrutiny panel for sign off.....Some SUI's that are still in date have been signed off which is showing the quality of the reports are improving and they are being completed in a timely manner – ongoing issue to resolve legacy SUIs asap.' This is likely to reflect the changes BCUHB wide with the appointment of a BCUHB interim Director of Quality from September 2013.

The Mental Health and Learning Disabilities CPG Operational Group Minutes of the week before (12th May 2014) state the need for the CPG to 'concentrate on legacy SUIs,' There is a short timescale stated stating that assurance is required (to the colleague leading this on behalf of the Executive Director of Nursing) 'that some will be complete in two weeks' (BCUHB 2014, page 1.)

In the Senior Management Team meeting of the 19th May 2014 there is further discussion around SUIs. Two members of staff, (identified by initials) 'to look at SUI themes ...today.' What is being 'looked at' and what the output would be (and when) is not specified. Staff number 68, medical colleague described at interview in June 2017 the BCUHB processes involved in the investigation of SUIs at the time as 'review lots of reports in a relatively short space of time, that most of these reports were not SUI reports, they weren't even tabular timelines, they were simple timelines..' From the evidence seen by the Ockenden governance review team this was more than likely to be a BCUHB wide problem rather than one solely within the MHL D CPG.

The minutes discussing critically important issues around the systems, structures and processes of governance is five months after the closure of Tawel Fan ward. There is no apparent sense of urgency from the minutes of the meeting regarding the need to resolve the issues regarding the reporting, investigating and learning from serious incidents (or SUIs/SIs) in the CPG. The actions are vague for example, the minutes say '[name of person]project – SUI's, [name of person]invited to Operational Group to discuss. X [initials provided] to write to [name]? To invite to future SMT....' (BCUHB 2014, page 2.)

There is no date identified when the letter should be written and what its output is intended to be; neither is there a plan as to when X should be invited to either the Operational Group and whether it is [person 1] or [person 2] (or both) who



are to be invited to a 'future SMT.' However, the Ockenden review has been informed (and has seen the evidence) that there was enthusiasm within the CPG for work to be carried out around improvements in the CPG SUI system. A significant problem was the lack of resource that BCUHB as an organisation were able to provide to support the systematic improvements. The Ockenden review team has seen evidence that this resource was likely to be one administration person over the course of six months. In the evidence seen it was said that BCUHB were unable to fund this role. Recent communication seen by the Ockenden governance review team shows dialogue between the MHL D CPG, and external colleagues with the skills and knowledge to support development of SUI processes within mental health and a number of Executive Directors of the time. This dialogue did not progress to action. The Ockenden review has been advised: 'where action required Board level support, this was not forthcoming.'

*"With SUI's you didn't necessarily have closure then."*

In agreement with multiple other colleagues who participated in the governance review staff number 55, a nurse at the time at interview with the Ockenden team in April 2017 that there was poor communication with staff on the ground concerning all aspects of risk management including SUIs. Staff number 55 told the Ockenden team 'With SUI's you didn't necessarily have closure then.' Staff number 68, told the Ockenden team of having to request to see an SUI report for individual patients they had cared for and that there was no opportunity to participate in the SUI panel despite having a great deal of information regarding the patient. Overall a wide range of staff described a fragmented system where feedback from Datix submissions, complaints and SUIs to staff on the ground could not be recalled.

*"A wide range of staff described a fragmented system where feedback from Datix submissions, complaints and SUIs to staff on the ground could not be recalled."*

### **In summary – SUIs – what do we know?**

Clearly the issue with SUIs as seen within minutes of 2014 was not a new problem, nor was it resolved quickly. Staff number 68 also describes SUI panels in 2012 that were chaired poorly, with a lack of preparation and information available to a panel process. Staff number 68 recalls telling members of the senior management team 'one of the problems ...with this arrangement (SUIs) is you don't spend enough on it, it's not enough of a priority...' It is likely however that this was a problem across BCUHB and to some extent influenced by the systems, structures and processes of governance around SUIs across Wales – not one that was within the 'gift' of the MHL D senior management team to resolve on their own.

*"One of the problems ...with this arrangement (SUIs) is you don't spend enough on it, it's not enough of a priority..."*

Professor Robert Poole (2012) and in recent communication with Donna Ockenden, (2018) notes the issue that 'the NHS Wales [SUI] criteria generated far too many full investigations.' Poole stated that 'a more targeted approach, with a different method of deciding the intensity of investigation would be more effective. It would lead to better investigation of the incidents of greatest concern, and avoid great effort being expended on incidents that could not be prevented and thus generated no learning for the service..<sup>52</sup>

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<sup>52</sup> Communication Poole R to Ockenden D April 2018

**Key point: Were the problems with SUIs within the MHLDP found elsewhere in the systems, structures and processes of governance within the MHLDP?**

**Yes**

There is similar uncertainty to the process around SUIs found within the MHLDP CPG 'Infection Control' Minutes dated 10th April 2014. The heading states 'extra meeting as the last 2 meetings cancelled – therefore the meeting planned for the 22nd April will be cancelled.' A further internal email provided to the review shows other key meetings within the CPG cancelled at a few days' notice. The email sent on the 30th November 2012 states 'The Acute Care and Older Persons Programme Development Meetings on Monday will be cancelled....' (Email sent to the CPG senior team on 30th November 2012 @1505hrs.) No minutes of these Development Meetings have been provided to the Ockenden review, therefore the Ockenden review team is not clear on the longevity and Terms of Reference or scope of this particular meeting.

In the Inpatient Matrons operational minutes (18th November 2013) the minutes note 'safeguarding training compliance steadily improving – 50%.' A target of 90% for completing safeguarding training was set by March 2014. In minutes of the 'Safeguarding Children and Vulnerable Adults Group.' (Dated 15 April 2014.) There is a note of the target for compliance with safeguarding training being 80-100%. It is noted that current staff compliance was circa 50%. (The same as it had been in November 2013.) The action is described as 'this requires a big push from all' (BCUHB 2014, Page 1) There was no detail regarding the steps the CPG intended to take to improve upon this long term inadequate position. In addition, all action columns were blank with no one attributed to taking forward (and therefore no timescale confirmed) for the many actions required.

Non-attendance by ward staff is noted as a concern regards safeguarding training. The minutes say 'Scarce places being wasted and managers need to be aware of bigger picture beyond immediate ward staffing needs...' Staff number 38, a senior clinical nurse told the Ockenden review team of the current situation as of February 2017 'It feels as though you are just constantly trying to staff the ward and keep it safe..... all the other things you need to do, the practice development things, the supervision which is core.....You feel as though you're trying to squeeze it in, not managing to do it..'

On page 2 of those minutes, (BCUHB 2013, page 2) there is evidence of the Matrons group thinking proactively about staffing in the week ahead. There is a section headed 'Staffing alerts for the week ahead.' One area is described as having 'sickness still 30%.' It is noted that there may be a need to arrange agency.

The Matrons minutes of the 18th November 2013 appear to show a serious incident with a poor outcome associated with a lack of training and a lack of basic equipment. A failed resuscitation attempt in a mental health inpatient unit is described. The minutes say 'issues with lack of availability of equipment and staff familiarity with procedure, identified as training required/lessons to be

*"It feels as though you are just constantly trying to staff the ward and keep it safe..... all the other things you need to do, the practice development things, the supervision which is core..... You feel as though you're trying to squeeze it in, not managing to do it.."*

Describing staffing within OPMH as of February 2017

learned....' (BCUHB 2013, page 2.) An allegation of staff sleeping on duty in Cefni Hospital is also noted.

## 7.14 Summary: What do we know about availability of information around service provision?

A further theme that occurs repeatedly over a long period of time from both BCUHB staff members (current and former) and service users and their representatives is the lack of clear and readily available information regarding Older Persons Mental Health service provision at BCUHB. Minutes of the 'OPMH review Steering Group' of the 26th June 2014 state 'Big issues re information people knowing where to get help. Professionals don't know where to get information.' This was a continuing area of concern voiced by service users, carers and service user representatives across North Wales in the listening and engagement exercises across the six counties of North Wales in the spring and summer of 2017, with carers, service user representatives and voluntary organisations expressing concern regarding the responsibilities they shouldered for care provision and current BCUHB employees also expressing confusion around where to find relevant information. A medical colleague, staff number 79 working within OPMH told the Ockenden review in summer 2017 'Sometimes we are uncertain who does what, like there is Crossroads and then suddenly somebody says no, Crossroads is no longer and then somebody says no, they're still there....so it's a bit of a minefield..'

Staff number 16, a Board member, in interview for this review was critical of the senior management team within the Mental Health and Learning Disabilities (MHL) CPG in 2012 to 2013 across both the Hergest unit at Ysbyty Gwynedd and Tawel Fan ward. 'There was a Hergest Improvement Programme which was ...pages and pages of stuff...There's all this stuff going on, but HIW have come in... identifying issues so where's the improvement? You know organisations get into action plan mode don't they, they don't think they just tick....' It is of note and importance that the Ockenden review team has subsequently been provided with evidence outlining the following:

- Many of the key leadership and management roles within the MHL CPG were part time – including the Chief of Staff from October 2009 onwards and the ACOS Nursing from August 2010 to the summer of 2012. There was no one appointed to the role of ACOS Nursing from October 2009 to August 2010.
- There was a significant stripping out of management posts following the merger creating BCUHB which left the MHL CPG with a wholly insufficient management structure to deliver mental health services across the six counties of North Wales.
- There was a long and complex Executive led vacancy control process before posts could be approved for advert. This was after the CPG Senior Management team had authorised the post for filling, and even when the finance and managerial team in the CPG could show they had the budget. This could often add many months to the process of filling vacancies – even those considered clinically essential.

*"Sometimes we are uncertain who does what, like there is Crossroads and then suddenly somebody says no, Crossroads is no longer and then somebody says no, they're still there....so it's a bit of a minefield.."*

*"There was a significant stripping out of management posts following the merger creating BCUHB which left the MHL CPG with a wholly insufficient management structure to deliver mental health services across the six counties of North Wales."*

- The senior leadership team of the MHLDP CPG were not authorised to recruit administration support, often leaving already part time senior leaders responsible for the administration of governance meetings etc.
- The BCUHB Board were already aware by December 2013 – i.e. at the same time as Tawel Fan ward closed that a total of six mental health services units were in escalation (or a heightened state of concern). The Ockenden review team could find no evidence of consideration by the BCUHB Board as to how an already overstretched management team would be able to cope with, (and ensure patient safety) when six of their mental health services across North Wales were already in escalation.

*“The BCUHB Board were already aware by December 2013 – i.e. at the same time as Tawel Fan ward closed that a total of six mental health services units were in escalation (or a heightened state of concern).”*

### 7.15 Key points regarding service risks in the MHLDP CPG leading up to the closure of Tawel Fan ward

Staffing problems, across a range of roles with delay built into approving vacancies, long term lack of action regarding known estate problems, financial pressures and lack of opportunities for mandatory training all formed part of the backdrop against which the CPG team were attempting to deliver an Older Peoples Mental Health service from 2009 to 2013.

### 7.16 What did the BCUHB Board know about Mental Health?

An ‘In Committee’ (or private) Board paper of December 2013, that would have provided essential context and detail to Donna Ockenden in the first Tawel Fan review was not disclosed to Donna Ockenden until this current review of governance was underway. This showed clearly that the BCUHB Board were aware of the extent of the extreme fragility in mental health services with six aspects of the services described as ‘in escalation’ as of December 2013. That five other mental health services (or parts of the mental health service) were in escalation at the same time as Tawel Fan ward closed suggests a mental health service across North Wales fast approaching, if not already at crisis point. Despite the grave concerns around Tawel Fan ward at the time it merits only one paragraph in the bundle of 19 pages. Most of the document discusses BCUHB Board concerns around the Hergest unit in Ysbyty Gwynedd The Hergest unit and the vast amount of time and attention it required from the CPG senior management team in the year leading up to the closure of Tawel Fan ward will be further discussed later in this report.

## 8 Chapter 2

### 8.1 Was there sufficient Welsh Government policy and guidance around the systems, structures and processes of governance available to BCUHB leading up to and following the merger creating BCUHB in 2009?

**In responding to the Terms of Reference the Ockenden review considered:**

- The rationale and preparation for merger and the creation of BCUHB in 2009;
- The historical position across the NHS in Wales prior to the creation of BCUHB in October 2009,

To understand the creation of the systems, structures and processes of governance across BCUHB, the Mental Health and Learning Disabilities CPG and Older Peoples Mental Health, (OPMH) the Ockenden review team needed to understand the context in which BCUHB and its systems, structures and processes of governance was formed in 2009. The following documents were considered by the Ockenden team.

Name of Guidance (order as found in report)	Date Published
'One Wales' – A progressive agenda for the Government of Wales	2007
The Good Governance Institute – The Guide to Governance in NHS Wales	2009
The Welsh Assembly – Government Citizen Governance Principles	2010
The Francis Report Inquiry	2013
The Healthcare Commission – Learning from Reviews	2008
The Healthcare Commission – Organisation with a Memory	2002
Welsh Government – Safe Care, Compassionate Care	2013
The NHS Leadership Academy – The Healthy NHS Board Principles of Good Governance	2013
The Welsh Assembly Government – World Class Health Care – Designed for Life Creating World Class Health and Social Care for Wales in the 21st Century	2005
The Welsh Assembly – Annual Quality Framework (AQF) – 2011/2012	2011/2012



The Welsh Assembly document '**One Wales' – A progressive agenda for the Government of Wales – 2007**<sup>53</sup> identified that a redesign of NHS structures was required to deliver effective health care in and across Wales. The aim of this reorganisation was to improve health outcomes and ensure that the NHS in Wales delivered healthcare effectively with its partners. In summary, simpler management structures were proposed which had the aim of moving more money to front line care.

As a result of this the NHS in Wales underwent a major reorganisation in 2009. The outcome was that the existing 22 Local Health Boards (LHBs) and 7 NHS Trusts being replaced with 7 integrated Local Health Boards, responsible for all health care services. At the same time the new unified public health organisation, Public Health Wales NHS Trust would become fully operational. Velindre NHS Trust, the specialist Cancer Trust would continue to operate along with the existing Wales Ambulance Services NHS Trust.

Staff number 90 a former Board member at BCUHB said the following of the merger creating BCUHB in a statement provided to the Ockenden review in February 2017 'The establishment of a combined health authority with the requirement of consistent standards across North Wales was complex and extremely demanding on both staff and Board members. In particular the Health Board was confronted with differing models in the delivery of mental health services across North Wales and a major effort was made to standardise care across Betsi Cadwaladr University Health Board. This, together with the restructuring of clinical teams placed significant strains on all the departments. There was little additional support in the area of staff support or finances from the Welsh Assembly Government who were tightly constrained by economic conditions and the complexities in reorganising services across the Principality... ..I was constantly aware of the enormous pressure on staff and Board members but I had no serious reservations about the ability of staff to deliver their very best to the service...'

Staff numbers 100, 106 and 111 provided a combined written statement to the Ockenden review team. In this statement they also recalled the 'major issues' and 'challenge' found in uniting the three Trusts and six Health Boards making up the 'new' BCUHB in 2009. They say the 'major issues, from the outset, were the challenge of uniting all those prior organisations into a single cohesive service, with particular regard to the recognised need to centralise some specialised hospital services on clinical safety grounds, and the enormous size of the HB.' (Health Board.)

Staff numbers 100, 106, and 111 in a joint written statement submitted to the review reflected on the development of the Clinical Programme Group (or CPG) structure. In their joint statement they describe the CPG structure as 'a novel, devolved structure, with a single clinician Chief of Staff leading each CPG Board to deliver an all North Wales health programme. This model emphasised clinical

*“The establishment of a combined health authority with the requirement of consistent standards across North Wales was complex and extremely demanding on both staff and Board members. In particular the Health Board was confronted with differing models in the delivery of mental health services across North Wales and a major effort was made to standardise care across Betsi Cadwaladr University Health Board.”*

<sup>53</sup> <http://webarchive.nationalarchives.gov.uk/20080912104103/http://new.wales.gov.uk/about/strategy/strategypublications/strategypubs/onewales/?lang=en>



leadership in a structure with devolved clinical, financial and management authority and required clinicians to work collectively across hospitals rather than within their DGH.'

There were a number of social, health and financial challenges facing Wales at the time of the merger creating BCUHB including:

- An increasing ageing population;
- More people living with chronic conditions;
- Challenges regarding health provision in rural locations;
- Increasing obesity rates and low levels of physical activity.

## 8.2 Outcome of the 2009 NHS Wales reorganisation:

The NHS reorganisation came into being across Wales on 1st October 2009 creating single health organisations that were responsible for the entirety of health delivery across a designated geographical area. This replaced the NHS Trusts and local health systems that previously existed.

7 integrated Local Health Boards replaced the existing 22 Local Health Boards and 7 NHS Trusts:

- Aneurin Bevan Health Board
- Abertawe Bro Morgannwg University Health Board
- Cardiff and Vale University Health Board
- Hywel Dda Health Board
- Cwm Taf Health Board
- **Betsi Cadwaladr University Health Board**
- Powys Teaching Health Board

## 8.3 What is Betsi Cadwaladr University Health Board (BCUHB)?

Betsi Cadwaladr University Health Board was the largest of the nominated Health Boards at its establishment on the 1st of October 2009. It provided a full range of primary, community, mental health and acute services across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham) as well as some parts of Mid Wales, Cheshire and Shropshire. The Health Board came into being following the merger 9 months earlier of 2 former NHS Trusts and 6 Local Health Boards in 2009:

- North Wales NHS Trust (formed from the previous Conwy and Denbighshire NHS Trust and North East Wales NHS Trust.)
- North West Wales NHS Trust
- Anglesey LHB

*“There was little additional support in the area of staff support or finances from the Welsh Assembly Government who were tightly constrained by economic conditions and the complexities in reorganising services across the Principality... ..I was constantly aware of the enormous pressure on staff and Board members but I had no serious reservations about the ability of staff to deliver their very best to the service...”*

- Conwy LHB
- Denbighshire LHB
- Flintshire LHB
- Gwynedd LHB
- Wrexham LHB

BCUHB serves a population of circa 670,000 people across the six counties of North Wales. Some services were also provided for the population of Powys, Cheshire and Shropshire. BCUHB employed circa 17,000 staff and had a budget in the region of £1.2 billion. BCUHB had three main district general hospitals (or DGHs). These were:

Ysbyty Glan Clwyd at Bodelwyddan, (where the Ablett unit containing Tawel Fan was found)

Ysbyty Gwynedd in Bangor

Ysbyty Wrexham Maelor

Eleven (11) CPGs were set up at the 'birth' of BCUHB. The first annual report published by BCUHB for 2009/10 was titled 'Bringing Services and People Together.' The report acknowledged the importance of strong clinical leadership in meeting the challenges found in healthcare provision across Wales. The CPGs were led by a Chief of Staff described as 'a clinically qualified practicing professional, who takes responsibility for services and is supported by a team of clinicians and managers.'

The then Chief Executive designate said the following of the CPGs<sup>54</sup>. They were to act as 'clinical units with service line reporting<sup>55</sup> and management and are held to account for sound resource management and performance. They are part of the discussion and decision making to deliver cost improvement. Being accountable for clinical efficiency, safety and quality, reinvesting in services through good management is a key requirement of their management responsibility.'

BCUHB's vision was one of the CPGs working together with primary care and multi-agency partners to ensure cohesive and clear care pathways across North Wales for BCUHB's patients. Multiple interviewees participating in the Ockenden review of governance have described the model with phrases such as 'light touch and high trust..' and working within a system of 'earned autonomy.'

As one of the 11 CPGs at the time of the creation of BCUHB, it could be said that the MHLDP CPG Mental Health and specifically Older Persons Mental Health was a relatively small part of the BCUHB Board's responsibilities. However older people's mental health is a very significant issue in that it is acknowledged that

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<sup>54</sup> Burrows M, (2009) Clinical Programme Groups – a briefing

<sup>55</sup> See glossary

people aged over sixty are the greatest users of the NHS and according to the Older Peoples Commissioner for Wales account for around 47%<sup>56, 57</sup> of acute inpatients; of these around 60% are expected to have a degree of cognitive impairment. Within a general hospital setting older persons mental health needs including depression and dementia can go undetected which can lead to longer inpatient stays, loss of independence and a reduction in the chances of the older person returning home to a pre hospital environment. All this can significantly increase care costs.<sup>58</sup>

## 8.4 Features of the new Health Boards

The Welsh Assembly Government 'One Wales – A progressive agenda for the government of Wales' (2007) document described the features of the new services as summarised below. These features were intended to develop criteria by which the new health organisations performance and progress could be judged. These can be summarised as:

- A patient centred approach with patients able to exercise as much (or as little) influence over their care as they choose, except where strong evidence advises against this;
- Strong leadership and clear governance arrangements with every organisation held to account for its clinical performance
- Services that are efficient, timely and safe;
- Care that is consistent, based on sound evidence and meeting agreed standards, (to be determined;)
- A health service that changes the balance of care into people's homes and communities away from traditional hospital care.

In addressing these criteria, the leaders of the new Health Boards were described as 'the frontline regulators' of care and were required to satisfy themselves that their organisation was acting within the law, abiding by agreed codes of practice and meeting all relevant compliances.

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<sup>56</sup> [http://www.olderpeoplewales.com/Libraries/OPCW\\_Publications/Dignified\\_Care\\_Full\\_Report.sflb.ashx](http://www.olderpeoplewales.com/Libraries/OPCW_Publications/Dignified_Care_Full_Report.sflb.ashx)

<sup>57</sup> <https://www.jcpmh.info/wp-content/uploads/jcpmh-olderpeople-guide.pdf>

<sup>58</sup> [https://www.rcpsych.ac.uk/pdf/jcpmh-publicmentalhealth-guide\[1\].pdf](https://www.rcpsych.ac.uk/pdf/jcpmh-publicmentalhealth-guide[1].pdf)

**Table 1: Summary of the proposed benefits of the changes to the NHS across Wales**

(See The Guide to Governance in NHS Wales by the Good Governance Institute 2009<sup>59</sup> for further information.)

Benefit	Expectations
Service Quality Benefits	<p>An improvement in the services offered to the population which should result in:</p> <ul style="list-style-type: none"> <li>• Improved health outcomes</li> <li>• Improved access to services</li> <li>• A shift in the balance of care towards more services to support people in the community, and</li> <li>• Reductions in geographical health inequalities</li> </ul>
Operational Benefits	<ul style="list-style-type: none"> <li>• A reduction of the administrative burden of working across multiple organisations</li> <li>• Strategic planning to be undertaken at an All-Wales level</li> <li>• A planning process to be developed that is responsive to local need</li> <li>• Enhanced service delivery through the removal of vertical boundaries, and</li> <li>• More efficient use of resources across organisations</li> </ul>
Money Moved into Front-Line Services	<ul style="list-style-type: none"> <li>• A reduction of the administration costs of NHS Wales through the reduction in the number of organisations</li> <li>• More effective management of arrangements held with external organisations, and</li> <li>• Improved purchasing and negotiating power at a National and local level</li> </ul>
Better Working Across the NHS	<ul style="list-style-type: none"> <li>• A reduction in conflicts between NHS bodies</li> <li>• Improved perception of NHS Wales amongst patients, the public and stakeholders</li> <li>• A greater sense of stability of direction, and</li> <li>• The achievement of improved service integration through closer working with its partners</li> </ul>
Staff Benefits	<p>An improvement in morale and individuals' experiences of working within NHS bodies through:</p> <ul style="list-style-type: none"> <li>• Increased career opportunities in unified and larger organisations</li> <li>• Working in a positive and progressive culture, and better opportunities for staff development</li> </ul>

<sup>59</sup> <https://www.good-governance.org.uk/services/the-pocket-guide-to-governance-in-nhs-wales/>

## 8.5 Local Health Board and Trust Values as expected by the NHS in Wales 2009 onwards

The clear expectation from Welsh Government was that the new Local Health Boards and NHS Trusts values should be built upon the Welsh Assembly Government Citizen Governance Principles (2010) (See footnote<sup>60</sup> for further details.) In summary these principles stated that consumers of health care should be put first and at the heart of everything an organisation did, that everyone involved in the delivery of care should understand each other's roles and how by working together they could deliver the best possible outcomes. Organisations were expected to be driven by values, be creative and innovative and to commit to learning. It was a clear expectation that through a commitment to learning that service delivery would continue to improve. It was expected that adherence to these principles would provide a framework for good governance and set a standard of behaviour and service delivery expected to be seen by all levels of the services provided both locally at Health Board level and nationally across Wales.

## 8.6 An overview of quality concerns relating to the NHS in England and Wales 2009 – 2013

The NHS across England and Wales at that time was experiencing a period of challenge, both countries had experienced or were in the process of reorganisation and there had been a series of national reports relating to quality concerns. The most significant was the publication of the Francis Report Inquiry (2013). Robert Francis<sup>61</sup> QC chaired a public enquiry into how poor care at Mid Staffordshire NHS Foundation Trust was allowed to occur between 2005 and 2009.

The Healthcare Commission had previously published a report 'Learning from reviews (2008)<sup>62</sup> which concluded that:

- Senior managers need to encourage a culture of openness;
- Every Board member should understand the nature of incidents;
- Systems for running governance should be built in and not bolted on;
- Boards and senior management teams should regularly build in protected time to reflect on whether they are meeting the needs of their most vulnerable patient and how they can be assured that the individuals are safe from harm within their organisations.

This report in 2008 built upon the much earlier learning from the Health Care Commission Report 'Organisation with a Memory<sup>63</sup>' (2000).

*“Boards and senior management teams should regularly build in protected time to reflect on whether they are meeting the needs of their most vulnerable patient and how they can be assured that the individuals are safe from harm within their organisations.”*

<sup>60</sup> <http://www.wales.nhs.uk/governance-emanual/citizen-centred-governance-principles>

<sup>61</sup> <http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report>

<sup>62</sup> [http://webarchive.nationalarchives.gov.uk/20080609174514/http://www.healthcarecommission.org.uk/\\_db/\\_documents/Learning\\_from\\_reviews\\_tagged.pdf](http://webarchive.nationalarchives.gov.uk/20080609174514/http://www.healthcarecommission.org.uk/_db/_documents/Learning_from_reviews_tagged.pdf)

<sup>63</sup> <https://www.aagbi.org/sites/default/files/An%20organisation%20with%20a%20memory.pdf>

Whilst these documents related to the NHS in England they have been directly referred to in the NHS Wales national documentation such as Welsh Governments 'Safe Care, Compassionate Care'<sup>64</sup> published in January 2013 and the spirit of the recommendations is consistently found throughout all the NHS Wales documentation seen as part of this review. In addition The NHS Leadership Academy document 'The Healthy NHS Board Principles of Good Governance'<sup>65</sup> (2013) which was originally published in 2010 following wide consultation was recognised within the governance documentation for NHS Wales in a comprehensive 56 page document which clearly articulates:

- The purpose and role of NHS Boards in Wales
- Individual and collective Board member responsibility in NHS Boards in Wales

## 8.7 The national governance agenda across NHS Wales from 2009 onwards

A Guide to Governance in NHS Wales was published in 2009. (See The Guide to Governance in NHS Wales by the Good Governance Institute.)<sup>66</sup>

In summary this said that in order to ensure that Boards in the NHS in Wales had a total overall view of their organisation Boards needed to consider, understand and have visible to them all the streams of governance underpinning their organisation. These streams of governance included corporate, clinical information and research, risk, quality, value for money, Health Board priorities and understanding of performance.

**The Good Governance Institute (2009) stated that effective Board governance has 9 key elements:**

1. Clarity of purpose aligned to objectives and intent;
2. A strategic annual Board agenda cycle with all agendas integrated and encompassing activity, resources and quality;
3. An effective Board assurance system in place;
4. Decision taking by the Board that was supported by intelligent information;
5. A streamlined committee structure with clear terms of reference;
6. An Audit committee strengthened to enable it to cover all governance issues;
7. Ongoing development reviews of Board members;
8. Appointment of a Board secretary;
9. Board etiquette.

*“Boards needed to consider, understand and have visible to them all the streams of governance underpinning their organisation. These streams of governance included corporate, clinical information and research, risk, quality, value for money, Health Board priorities and understanding of performance.”*

<sup>64</sup> <http://www.wales.nhs.uk/governance-emanual/document/219549>

<sup>65</sup> <https://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf>

<sup>66</sup> <https://academiwales.gov.wales/pages/good-governance-guide-canllaw-llywodraethu-da>



The **Guide to Governance in NHS Wales** stated that all Board papers should ensure that all of the above elements were addressed and formed part of public presentation.

## 8.8 The NHS Wales Annual Operating Framework (AOF) – 2010/2011

The AOF required that the quality of core services and all national targets were achieved by Health Boards across Wales in line with the requirements of the AOF<sup>67</sup>. All organisations in the NHS in Wales were required to secure holistic service improvement and not to simply focus on achieving national targets.

Organisations were given the freedom by Welsh Government to develop a series of additional measures, relevant to their local populations and priorities which when considered and combined with the nationally set AOF targets would provide a much more effective assessment of the organisation's overall performance. The NHS Wales AOF for 2010/2011 clearly defined the challenges for the NHS across Wales balancing the improving of the quality of the healthcare services provided against increasing efficiency, reducing waste, empowering the workforce and providing a citizen centred care, all within tight financial limits.

The AOF clearly identified the expectation that improving quality was at the heart of the 5 year strategic framework for all NHS organisations across Wales.

The development of 'World Class Health Care – (Welsh Assembly Government Designed for Life Creating World Class Health and Social Care for Wales in the 21st Century<sup>68</sup>) was published in May 2005.

There was an acknowledgement that such success could only be achieved through cultural and behavioural change and would only be assured for the NHS in Wales in the medium to long term. Therefore in the short term the new NHS organisations across Wales from 2009 would require a robust mechanism to ensure that the systems, structures and processes of governance in place assured both the Board and their public that patient care and safety were a key priority and constantly improving and in line with the performance measures identified in the AOF of 2010/11.

### Annual Quality Framework (AQF) – 2011/2012

This document<sup>69</sup> clearly set out expectations for all organisations across the NHS in Wales to produce a set of metrics developed with increased focus on quality against an expectation of sustained improvement and better outcomes for the citizens in Wales. The Chief Executive for Wales at that time clearly set out in the document the requirement for more meaningful engagement between clinical

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<sup>67</sup> <http://www.wales.nhs.uk/sites3/Documents/338/NHS%20Wales%20Annual%20Operating%20Framework%202010-2011%20Final%2022%20Dec%202009.pdf>

<sup>68</sup> <http://www.wales.nhs.uk/document/41738/info/>

<sup>69</sup> <http://www.wales.nhs.uk/document/173567>

Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health

teams, managers, citizens and stakeholders about the issues which needed to be tackled, and ultimately more transparency about outcomes.

## **The wider picture of governance across the NHS in Wales**

### **8.9 The HIW Annual Report 2010/11**

**A summary of key themes relevant to an overview of the systems, structures and processes of governance across the NHS in Wales, BCUHB, the Mental Health and Learning Disabilities CPG, and Older Peoples Mental Health care in BCUHB.**

In order to fully understand the systems, structures and processes of governance in for example Older Persons Mental Health it was crucial for the Ockenden review team to understand the context in which this existed, (the Mental Health and Learning Disabilities CPG.) Subsequently the Ockenden review team needed to understand the context in which the CPG, then BCUHB as a whole existed. Essentially, the context around the systems, structures and processes of governance are multi layered and to do justice to any of those 'layers' of governance means an understanding of the whole context is necessary.

**What role does Healthcare Inspectorate Wales (HIW) play in understanding the systems, structures and processes of governance within Older Peoples Mental Health at BCUHB?**

The Ockenden review team was unable to locate a copy of any HIW annual report prior to the first report found in 2008/9. It appears the HIW Annual report in 2008/9 was the first such report, since the establishment of HIW in 2004.

Following on from the extensive reforms of the NHS in Wales in 2009<sup>70</sup> HIW noted the publication in November 2011 of a new 5 year vision for the NHS in Wales 'Together for Health.'

This document outlined the challenges facing the health service in Wales at the time and the action necessary to ensure it was capable of world class performance. Health services across Wales needed to continue to transform their ways of working and work effectively with their statutory and third sector partners if they were to realise the vision of a new model for health services that was based around community services with patients at the centre and placed prevention, quality and transparency at the heart of healthcare. HIW stated that in 2010/11 it had encouraged health service organisations to 'get things right first time' by working together with colleagues from across the NHS and the Welsh Audit Office (or WAO) to develop new arrangements for self-assessment through the framework of 'Doing Well, Doing Better: Standards for Health Service in Wales.'

BCUHB reported upon this in their Annual Quality Statement for 2012/13.<sup>71</sup>

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<sup>70</sup> <http://www.wales.nhs.uk/sitesplus/documents/829/togetherforhealth.pdf>

<sup>71</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Annual%20Quality%20Statement%20%20final%20version.pdf>

Their assessment was that remedial and ongoing work was required. The Statement said 'although progress has been made across all sections of the Governance and Accountability Module... the overview and scrutiny process concluded that the progress made was not significant enough to increase the overall scores..... It was agreed by the Quality and Safety Committee that, over and above the completion of the Governance & Accountability assessment module, five Standards for Health Services in Wales would also be completed for 2012/13 to provide additional assurance' (BCUHB 2013)

In 2010/11 HIW undertook a joint review of the Older People's National Services Framework and worked with CSSIW on the utilisation of the Deprivation of Liberty Standards (or DoLS,) in health and social care across Wales.

HIW noted that one of the issues identified by the Chief Medical Officer for Wales in his annual report 2010<sup>72</sup> (published October 2011) was around depression and poor mental wellbeing. HIW noted that there remained a stigma around mental health and that many people in Wales did not consult with health professionals or confide in friends or family regarding mental health. HIW stated that they used the information collected from a range of work they undertook to monitor mental health services, 'and in particular to report upon the effectiveness of the relationship between mental health services and medical services.'

*"HIW noted that there remained a stigma around mental health and that many people in Wales did not consult with health professionals or confide in friends or family regarding mental health."*  
(HIW 2011)

## 8.10 Key themes from the Self – Assessment across the NHS in Wales

HIW stated that overall, NHS organisations' first self-assessment of their performance identified a good level of self-awareness of their strengths and a clear focus on where they needed to further develop and improve. Many of the areas identified as requiring further development related to a need to further embed corporate arrangements following on from the restructure in late 2009 and the formation of the new Health Boards as set out in this report. HIW stated that the NHS in Wales needed to:

- Ensure clarity and simplicity in the way their organisation works – which should ensure greater clarity around performance of an organisation;
- Improve their communication;
- Ensure that there is effective working between leaders, managers and clinical staff;
- Strengthen the capacity, capability and deployment of the workforce;
- Further embed internal systems for identifying and addressing risks to the achievement of their objectives;
- Improve arrangements for information and records handling;
- Strengthen internal scrutiny – respond quickly and effectively to areas of concern and drive overall improvement;

<sup>72</sup> <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/cmo-annual-report-2010.pdf>

- Ensure wider organisational learning in response to concerns and complaints.

During 2010-11 HIW received and reviewed the action plans submitted by all healthcare settings across Wales that had been subject to a spot check visit. HIW shared their findings with the Older People's Commissioner for Wales to inform the report 'Dignified Care'.<sup>73</sup>

The information was also used to inform the HIW joint review with CSSIW 'Growing Old My Way'.<sup>74</sup>

The two reports were used to raise the profile of services received by older people in Wales and highlighted the need for them to be treated as individuals and without discrimination. HIW found that there were still many issues affecting older people across Wales when they were admitted to hospital. These included concerns around the quality of the patient environment; staff attitudes and behaviour; care planning and provision, fluids and nutrition; personal care and hygiene; medicines management and pain management; activities and stimulation; discharge planning and the management of patients with confusion.

In summary HIW found that:

- Older people with complex needs were often admitted to hospital unnecessarily
- When older people were admitted to hospital their length of stay was often excessive which then impacted upon their independence and confidence
- Many of the concerns identified by HIW centred on the fundamental aspects of care, including dignity and respect
- HIW concluded that health and social care providers across Wales still had much to do in terms of refocusing their approach and agenda to one of prevention and empowerment for older people

**Key point:**

### 8.11 Was there sufficient guidance available from Welsh Government and other agencies in the setting up of Local Health Boards and the setting up of BCUHB specifically?

Yes.

The Ockenden review team has scrutinised a large amount of documentation from across the NHS in the UK, (much of which is referred to in NHS Wales documents) and documents published by Welsh Government, HIW and WAO and The Older Peoples Commissioner for Wales. It is very evident that there was sufficient guidance containing sufficient clarity around the requirements and expectations of Local Health Boards including BCUHB from 2009 onwards.

*“That there were still many issues affecting older people across Wales when they were admitted to hospital. These included concerns around the quality of the patient environment; staff attitudes and behaviour; care planning and provision, fluids and nutrition; personal care and hygiene; medicines management and pain management; activities and stimulation; discharge planning and the management of patients with confusion.”*

<sup>73</sup> [http://www.olderpeoplewales.com/en/Publications/pub-story/11-03-14/Dignified\\_Care\\_Report.aspx#.Wt9KIBGQLIU](http://www.olderpeoplewales.com/en/Publications/pub-story/11-03-14/Dignified_Care_Report.aspx#.Wt9KIBGQLIU)

<sup>74</sup> <http://careinspectorate.wales/docs/cssiw/report/090112growingolden.pdf>

## 9 What was the Strategy for Dementia across Wales from 2008 to the current day?

### Background

The information that follows is to provide the reader with a brief overview about the national picture across Wales associated with mental health, older person's mental health and dementia specifically from 2008 to the current day. This will help explain the context in which BCUHB and the MHL D CPG delivered its services and the context too, that older people, their families and carers received their care in and support from. This is not intended to be an exhaustive and detailed picture, but where it is available documents for further reading are available via footnotes, if required.

### 9.1 The 1000 Lives Campaign<sup>75</sup> (from 2008 onwards)

The 1000 Lives Campaign was set up in 2008 and ran until 2010 across Wales. It was set up with the aim to save 1000 lives and to prevent another 50,000 episodes of harm across healthcare in Wales. Due to its success it was extended into 1000 Lives Plus which continued for a further five years. Information<sup>76</sup> on the current 1000 Lives work is found in the reference and footnote. The 1000 Lives campaign worked with Health Boards across Wales to improve the quality of life for people with dementia<sup>77</sup> from 2015.

### 9.2 The National Dementia Vision for Wales 2011

The Welsh Assembly Government working with the Alzheimer's Society published the 'National Dementia Vision for Wales; Dementia Supportive Communities.'<sup>78</sup> This document recognised that the numbers of people with dementia in Wales was increasing and would continue to increase. It was acknowledged that if people were given an early diagnosis with appropriate levels of information, support and care that people with dementia could continue to live well. It was recognised that there were several gaps in the service provision across Wales that needed addressing. These included:

- The need for a 'young onset' dementia service for Wales;
- Developing education and information for those diagnosed with dementia;
- Providing education, support and information for carers;
- Providing dementia training for professionals.

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<sup>75</sup> <http://www.1000livesplus.wales.nhs.uk/about-us>

<sup>76</sup> <http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/1000%20Lives%20Improvement%20Brochure%202018%20%28web%20version%29.pdf>

<sup>77</sup> <http://www.1000livesplus.wales.nhs.uk/mh-dementia>

<sup>78</sup> <https://gov.wales/docs/dhss/publications/110302dementiaen.pdf>

### 9.3 The Mental Health Measure Wales<sup>79</sup> (2010)

This was a new law made by Welsh Government which set out a number of important changes in the assessment and support of people with mental health problems. The Measure<sup>80</sup> was divided into four parts which in summary sought to ensure that mental health care when provided was focused on people's needs across community and across primary care, (part 1), secondary care, (part 2), when discharged from mental health care the ability to refer oneself back, (part 3) and the availability of an independent mental health advocate, (part 4)

### 9.4 'Together for Mental Health' The National Mental Health strategy<sup>81</sup> for Wales 2012 to 2016

This was the first five years of a ten year integrated strategy across Wales. The aim of the strategy was to address the mental health and well-being needs for people of all ages. The strategy aimed to ensure that transition and transfers between services were based on need and not on artificial boundaries. To be successful the strategy would rely on effective and integrated partnership working across the NHS, social services and the third sector.

It noted that with an ageing population, that 1 in 6 people over the age of 80 will be affected by dementia. It estimated that 43,000 people were experiencing dementia, (as of 2012) and this was expected to increase by 30% in the 10 years to 2022.<sup>82</sup>

### 9.5 The 'Delivery Plan' for the National Mental Health Strategy<sup>83</sup> in Wales 2016-2019

This 'delivery plan' consisted of eleven strategic goals, further information is found within the link. A number of them were key to the well-being of older people. Goal 10 was that Wales should be a 'Dementia Friendly' nation. Central to achievement of goal 10 was the following:

- The improvement of the quality of life and care for people with dementia and their carers;
- Health Boards across Wales to provide support workers in primary care who can deliver face to face support, information and advice about dementia;
- Health Boards must ensure effective liaison services are in place to meet the needs of people with cognitive impairment in acute hospitals;
- Welsh Government were to roll out a training and development framework for dementia across Wales called 'Good Work.'

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<sup>79</sup> <http://www.mentalhealthwales.net/mental-health-measure/>

<sup>80</sup> See glossary

<sup>81</sup> <https://gov.wales/topics/health/nhswales/mental-health-services/policy/strategy/?lang=en>

<sup>82</sup> See reference 81 above, page 12

<sup>83</sup> <https://gov.wales/topics/health/nhswales/plans/mental-health/?lang=en>



## 9.6 Together for a Dementia Friendly Wales 2017-2022<sup>84</sup>

This is the current dementia strategy across Wales. There are ten key priority areas that are described in detail in the reference below. In summary these are:

- Improvement in early diagnosis rates with assessments available in English and Welsh;
- Working in partnership with the third sector
- Access to dementia support workers;
- An increase in health care settings that are 'dementia friendly';
- By 2019 75% of NHS employed staff who come into contact with the public to have an appropriate level of dementia awareness;
- Increased assessment and support for carers including information and respite care;
- Younger Onset dementia services to be provided;
- A 'Life Course' approach to dementia with services developed and delivered in a structured manner from support at (early) first diagnosis to end of life care;
- Limiting the use of anti psychotic medication;
- End of life care.

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<sup>84</sup> <https://beta.gov.wales/sites/default/files/consultations/2018-01/170109dementia-consultation-en.pdf>

## 10 What HIW found across the NHS in Wales in 2012-13

The HIW Annual Report 2012/13 considered how health service organisations across Wales were performing against 'Doing Well Doing Better: Standards for Health Service in Wales.'<sup>85</sup> HIW described the following key themes arising from the 2012-13 Standards for Health Services assessment across the NHS in Wales:

A mixed picture in tackling the governance challenges identified in earlier years. Overall HIW found that the majority of Health Boards considered their organisation to be at the same level of organisational maturity as in the previous two years. Most Health Boards across Wales were considered by HIW to have had a realistic assessment of the challenges they faced.

Organisations across the NHS in Wales identified a continuing challenge in maintaining a strong sustainable infrastructure; consistent ways of working and the effective deployment and development of their workforce to support the day to day delivery of services.

### 10.1 There was a need for NHS organisations across Wales to continue to:

- Focus on ensuring all work carried out across their organisations is instilled with a strong sense of values, supported by clear standards of ethical behaviour;
- Take action to strengthen the capacity, capability and deployment of their workforce;
- Further develop their arrangements and infrastructure for information and secure records handling so that leaders, managers and front line staff have access to the information they need, when they need it to carry out their jobs effectively.

#### **HIW said that further ongoing attention was needed across the NHS in Wales to:**

- Ensure wider organisational learning takes place in response to feedback and concerns from patients, the public and their representatives;
- Continue to strengthen internal scrutiny and assurance through better performance management and reporting arrangements so that they may respond quickly and effectively to areas of concern and drive overall improvements.

HIW noted that they had undertaken a joint overview with WAO of the governance arrangements of Betsi Cadwaladr University Health Board. HIW noted that other Health Boards should 'themselves reflect on the findings and seek to assure

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<sup>85</sup> <http://www.wales.nhs.uk/document/169664>. (Link accessed 27th March 2018.)

themselves that any relevant issues are being addressed appropriately....within their own organisations (See HIW/WAO 2013 page 5.)<sup>86</sup>

In 2012/13 HIW considered how well NHS organisations across focused on matters of essential care, dignity, respect and safety. These were assessed by HIW during a series of unannounced 'spot check' visits. HIW identified a number of emerging themes where improvement was needed across the NHS in Wales:

- Standards of patient documentation was variable. The level of detail in patient assessments varied and it was not always clear that assessments reflected patient needs;
- Care plans were often generic in nature and did not record specific patient progress or the level of support required;
- Patient documentation had been completed retrospectively by staff;
- Access to medication was not always properly restricted;
- The environment of care was not always acceptable.

## 10.2 HIW and its role in Mental Health Act Visits across Wales

### What were Mental Health Act visits?

HIW Mental Health Act reviewers undertook visits to hospitals and wards where someone may be detained under the auspices of the Mental Health Act. The purpose of these visits was to ensure that the Act was being administered and used appropriately. Overall HIW stated that they had found that in general detained patients were cared for and treated by staff that had the necessary knowledge and skills. However, HIW found that there were gaps in provision, in particular:

- Staffing levels on some wards had resulted in a lack of access to therapies;
- The standards of record keeping were insufficient.

HIW undertook a Mental Health Act monitoring visit to Tawel Fan ward in July 2013 which it wrote to the then BCUHB interim CEO three months later in October 2013. This is further discussed later in the report.

## 10.3 Consideration of the Deprivation of Liberty Safeguards<sup>87</sup> (or DoLS)

CSSIW and HIW worked together to collect and analyse relevant data in order to monitor the operation of the Deprivation of Liberty safeguards, (DoLS) in Wales. In April 2013, HIW published a joint report<sup>88</sup> with CSSIW setting out the results of their monitoring activity across health and social care in Wales during 2011-12. Overall HIW/CSSIW concluded that the safeguards were still not being used

*“Standards of patient documentation was variable. The level of detail in patient assessments varied and it was not always clear that assessments reflected patient needs.”*

*“Care plans were often generic in nature and did not record specific patient progress or the level of support required.”*

*“Patient documentation had been completed retrospectively by staff.”*

*“Access to medication was not always properly restricted.”*

*“The environment of care was not always acceptable.”*

<sup>86</sup> [https://www.wao.gov.uk/system/files/publications/BCUHB\\_Joint\\_Review\\_English\\_2013.pdf](https://www.wao.gov.uk/system/files/publications/BCUHB_Joint_Review_English_2013.pdf). (Link accessed 27th March 2018.)

<sup>87</sup> See glossary

<sup>88</sup> <http://hiw.org.uk/docs/hiw/reports/150313dols1314en.pdf>

consistently across Wales, although 2011-12 saw the highest numbers of standard authorisations<sup>89</sup> being granted since the safeguards were introduced. In light of what HIW described as the 'continued variations' in the use of Deprivation of Liberty Safeguards in Wales, HIW and CSSIW were to undertake a focused awareness raising programme with key partners and stakeholders in 2014.

#### 10.4 HIW, their 2012 review of patient care at Ysbyty Glan Clwyd at BCUHB – what does it tell us about the systems, structures and processes of governance at BCUHB from 2009 onwards?

Following concerns about the standard of patient care at Ysbyty Glan Clwyd, (where the Ablett Unit containing Tawel Fan ward was found) HIW started a review<sup>90</sup> in February 2012 which was published in December 2012.

HIW (2012) found that Ysbyty Glan Clwyd (or YGC) was a hospital working to capacity, with committed staff who were working under intense pressure. Staff were observed to be professional in their dealings with patients and care was being delivered in a way that was compassionate and maintained patients' dignity. HIW concluded that BCUHB had significant work to do, and found, there were clear challenges across Ysbyty Glan Clwyd in ensuring that the patient pathway through the hospital was efficient, of high quality and safe.

HIW found that in 2012 BCUHB's performance in relation to the handling and management of concerns was poor. Three years after the creation of BCUHB there were issues both in relation to providing responses to complainants in a timely manner and also in ensuring the comprehensiveness of eventual responses. Most importantly, BCUHB needed to ensure that complainants were communicated with in a sensitive and compassionate manner. These themes were further repeated in external reviews<sup>91</sup> into the management of concerns at BCUHB throughout 2013 by the NHS Delivery Unit and NHS Wales Shared Services Partnership and shows limited Board level learning from one external review (telling the BCUHB Board of significant concerns) to another series of external reviews more than a year later.

The HIW report of 2012 made 23 recommendations. The HIW review of patient care at Ysbyty Glan Clwyd resulted in the conduct of a wider quality and safety review which began in late 2012. The preliminary findings of that review were reported to BCUHB in March 2013 and taken together with HIW's earlier findings highlighted growing concerns about the effectiveness of the BCUHB Board's collective leadership and its ability to address the challenges it faced at the time.

*“HIW (2012) found that Ysbyty Glan Clwyd (or YGC) was a hospital working to capacity, with committed staff who were working under intense pressure.”*

*“Three years after the creation of BCUHB there were issues both in relation to providing responses to complainants in a timely manner and also in ensuring the comprehensiveness of eventual responses.”*  
(HIW 2012)

*“HIW concluded that BCUHB had significant work to do, and found, there were clear challenges across Ysbyty Glan Clwyd in ensuring that the patient pathway through the hospital was efficient, of high quality and safe.”*

<sup>89</sup> See glossary

<sup>90</sup> <http://gov.wales/docs/hiw/inspectionreports/Betsi%20Cadwaladr%20-%20Report%20-%20Glan%20Clwyd%20Report%20-%20English%20-%20PDF.pdf>

<sup>91</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/BCUHB%20Prof%20Duerden%20Report%20Final%20version%2011th%20August%202013.pdf>

### **Safe Care, Compassionate Care (2013)**

Set out the Welsh Government response to the Robert Francis Inquiry (2013.) The document Safe Care Compassionate Care<sup>92</sup> provided a national governance framework to enable high quality care in the NHS across Wales. It involved the fundamentals of care and made reference to NICE standards.

The Board of each NHS organisation across Wales was accountable for ensuring the quality and safety of all services it provides and commissions. This included promoting an open and supportive organisational culture where patients, staff and stakeholders could all be assured of having their voice heard. All NHS organisations across Wales were required to have a Quality and Safety Committee to ensure sufficient focus and attention was given to such matters.

Each NHS Wales organisation was also required to publish an Annual Quality Statement or AQS.<sup>93</sup>

The Annual Quality Statement, (or AQS) required organisations across NHS Wales to routinely assess and inform the public and other stakeholders in an open and transparent way about:

- An overview of how well they were performing across all the services they provided;
- The sharing of good practice;
- Areas for improvement;
- Progress over the previous years;
- Priorities and commitments going forward.

All organisations, including BCUHB published their first AQS in September 2013. This represented a key step forward in meeting the commitment set out in 'Welsh Government Together for Health – 2011'<sup>94</sup>, the purpose of which was to determine and share how organisations went about building their Annual Quality Statement and how accessible and comprehensive the final statement was.

Each NHS Wales organisation received feedback summarising the overall findings from the peer review process of their Quality Statement to inform their 2013/2014 statement. This was then considered by the NHS Wales National Quality and Safety Forum and subsequently led to revised guidance. A review of the first BCUHB Annual Quality Statement (AQS) dated 30th September 2013 identified within the quality section the many improvements that BCUHB were aware were required around quality of care.

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<sup>92</sup> <http://www.wales.nhs.uk/sitesplus/documents/888/Appendix%20Item%206%20Safe%20Care%2C%20Compassionate%20Care.pdf>

<sup>93</sup> <http://www.wales.nhs.uk/sitesplus/documents/888/Appendix%20Item%206%20Safe%20Care%2C%20Compassionate%20Care.pdf>

<sup>94</sup> <http://www.wales.nhs.uk/sitesplus/documents/829/togetherforhealth.pdf>

## 10.5 The Welsh Assembly Government and 'Putting Things Right' (2011)

The National Health Service (Concerns, Complaints and Redress Arrangements for Wales Regulation (2011) policy replaced the NHS Wales Management and Handling of Complaints policy dated 2003. Most of the changes came into being in April 2011. Within the policy was the clearly stated requirement that all NHS Wales organisations were to investigate and resolve concerns in an open, timely and meaningful way. There should be a focus on learning and service improvement from the concerns raised by patients and/or their families and representatives.

The full all Wales policy can be found at<sup>95</sup>. Updated patient level information can be found at<sup>96</sup>.

The general principles underpinning the 2011 changes were to ensure:

- A single point of entry for submission of concerns into NHS bodies;
- Concerns were to be dealt with efficiently and openly;
- The organisation should establish the expectations of the person identifying or notifying the concerns;
- The person raising the concerns should be informed about any assistance to them to resolve their concern and the name of the person who will act as their contact throughout the concerns process;
- All organisations acted upon and monitored the learning from any deficits identified as part of any review into a concern (see Welsh Government 2011, page 19.)

## 10.6 What did BCUHB do in response to 'Putting Things Right' (2011)

BCUHB developed its own policy following on from the new NHS Wales arrangements. This was known as PTR01<sup>97</sup> with a full title of the Concerns Policy, (Complaints, Claims and Incidents). This was first operational in January 2012 – nine months after the Welsh Government introduced the new pan Wales guidance. Further guidance was issued by Welsh Government in April 2012. A BCUHB working group comprised of thirteen senior people at Director/ Assistant Director and other senior roles made up the working group developing the policy according to the BCUHB PTR01 policy, (page 14.) This included the then Executive Director, the Director of Governance and Communications and the Deputy Director of Corporate services.

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<sup>95</sup> <http://www.wales.nhs.uk/governance-emanual/putting-things-right/>

<sup>96</sup> [www.puttingthingsright.wales.nhs.uk](http://www.puttingthingsright.wales.nhs.uk)

<sup>97</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/PTR01\\_concerns\\_policy%20BCUHB%20Dec%202016%20%281%29.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/PTR01_concerns_policy%20BCUHB%20Dec%202016%20%281%29.pdf)



## 10.7 What is a concern?

A 'concern' submitted by a service user or their representative, (for example a family, carer or advocate) can be a complaint, claim or incident. Responses were required to be based on statutory procedure as set out by Welsh Government and best practice from across the NHS. This includes the NHS Wales (2011) Regulations for Concerns, Complaints and Redress Arrangements and the Model Complaints Policy and Guidance for Public Services in Wales<sup>98</sup>.

Also of importance were NHS wide best practice such as the National Patient Safety 'Being Open' Guidance published in November 2009. (National Patient Safety Agency 2009) 'Being Open: communicating patient incidents with patients, their families and carers.'<sup>99</sup>

The purpose of the BCUHB PTR01 policy was to set out clear timescales and a framework for the management of complaints, claims and incidents in line with the expectations set by Welsh Government. However a subsequent review by the NHS Wales Shared Services Partnership (NHSWSSP) audit and assurance service in August 2013 found that the 'new' BCUHB 'PTR' policy was not up to date and required review to ensure it incorporated all the statutory requirements and relevant guidance (NHS Wales SSP August 2013, page 4.) A review of this policy in March 2018<sup>100</sup> highlights it was due for review in December 2017 and therefore at the time of writing this report in March 2018 it is already three months overdue for review.

By the summer of 2013 it was clear to both BCUHB and more widely within Welsh Government that there were also considerable concerns about the way that 'PTR' operated within BCUHB. In information submitted to the Ockenden review Staff number 20, a former Board member confirmed that 'the CPGs were expected to manage the SI's and there was very limited centralised focus on the process. There was no clarity on the extent of the outstanding issues and it became clear.....that review, engagement and learning were at an extremely poor level in the majority of the CPGs.'

Staff number 20 further described very poor oversight and leadership of complaints, claims and serious incidents across BCUHB. 'The majority were poor, many had to be taken all the way back to the beginning, investigated using [a] root cause analysis approach as there was little or no evidence of any robust review up to that point, though many were years old...' External reviews of management of the concerns process at BCUHB were commenced in June 2013. A clinically based nurse in post at BCUHB at the time confirmed with the Ockenden review team at interview that post-merger 'there was not really feedback' from SUI's and complaints to staff working clinically.

*“A ‘concern’ submitted by a service user or their representative, (for example a family, carer or advocate) can be a complaint, claim or incident.”*

*“The CPGs were expected to manage the SI's and there was very limited centralised focus on the process. There was no clarity on the extent of the outstanding issues and it became clear.....that review, engagement and learning were at an extremely poor level in the majority of the CPGs.”*

<sup>98</sup> [https://www.ombudsman-wales.org.uk/~media/Files/Documents\\_en/Model%20Complaints%20Policy%20Final%20PSOW.ashx](https://www.ombudsman-wales.org.uk/~media/Files/Documents_en/Model%20Complaints%20Policy%20Final%20PSOW.ashx)

<sup>99</sup> [www.nrls.npsa.nhs.uk/beingopen](http://www.nrls.npsa.nhs.uk/beingopen)

<sup>100</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/PTR01\\_concerns\\_policy%20BCUHB%20Dec%202016%20%281%29.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/PTR01_concerns_policy%20BCUHB%20Dec%202016%20%281%29.pdf)

An NHS Wales Shared Services Partnerships team undertook an audit and assurance review to establish if lessons were being learnt from complaints in August 2013. At this point in time the new Executive Director of Nursing and Midwifery was about to take over responsibility for this service and therefore the review and its subsequent report serves as a useful reminder of the position of the service at the time of their assuming responsibility for this function across BCUHB.

The final audit and assurance report found the following as of August 2013:

- There was limited assurance overall as to whether BCUHB were learning from complaints;
- Non-compliance with corporate policy and statutory procedures;
- Complaints received into BCUHB were not subject to timely, consistent or effective review;
- Lessons to be learned were not identified and therefore no action was taken to improve service design, delivery, guidance and policy at BCUHB;
- Recommendations and actions taken to address lessons were not subject to scrutiny or review;
- The Health Board failed to provide a strategic independent overview of the complaints process.

(NHS Wales Shared Services Partnership, August 2013, page 3).

*“There was limited assurance overall as to whether BCUHB were learning from complaints”*

*“Lessons to be learned were not identified and therefore no action was taken to improve service design, delivery, guidance and policy at BCUHB”*

## 10.8 Specific issues identified for the Mental Health and Learning Disability (MHL) Clinical Programme Group (CPG) in the August 2013 NHSWSSP audit

- There was no flowchart in place identifying the documented operational procedures in place to manage concerns within the MHL CPG as of August 2013 – measures were being taken to introduce this;
- The Datix system was operational within the MHL CPG but no training had been provided prior to the system being introduced;
- There were examples found of non-completion of information that would be critical to understanding a complaint process or timeline going forward. This information was to be distributed to all complaint reviewers;
- Procedures around a patient absconding from an inpatient unit were found to lack robustness ‘and do not protect the integrity or safety of staff.’ (NHSWSSP 2013 page 21.);
- A complaint response reviewed by the NHSW SSP team noted ‘the vague statement lessons have been learned.’ The review also noted that ‘no lessons learned had been identified and no actions taken....’ (NHSWSSP 2013, page 22);
- The doctor named in one of the complaints reviewed was party to the review – staff named in complaints should not be party to reviews and final

*“The Health Board failed to provide a strategic independent overview of the complaints process.”*

*“The Datix system was operational within the MHL CPG but no training had been provided prior to the system being introduced”*

responses should be checked to ensure accuracy of all statements made. This raised concerns around a lack of knowledge within the Mental Health and Learning Disabilities CPG regarding the management of complaints overall. (NHSWSSP 2013, page 22.)

A further 'Management of Concerns – Learning Lessons Assurance review' was undertaken by the NHS Delivery Unit in December 2013. This was at the request of the then Executive Director of Nursing and Midwifery, who had taken up post at the beginning of June 2013.

In summary, the Lessons Learned Assurance review found the following around the management concerns process at BCUHB in December 2013:

- There was no strategy/process in place to ensure organisational learning from concerns. (page 3)
- There was a lack of governance arrangements and a lack of clear organisational processes for organisational learning from concerns at BCUHB. (page 3)
- There was a lack of clear lines of accountability and management arrangements at BCUHB between CPGs, hospital management teams (or HMT's) and Executives for learning from concerns. (page 3)
- There were inconsistent processes for managing concerns across BCUHB leading to delays in review and communication with patients and their representatives. (page 3)
- There was evidence of a backlog of Serious Untoward Incident (SUI) reviews remaining open at BCUHB, (including 'Never Events'). (page 3)
- There had been a number of 'Never Events'<sup>101</sup> with repeated themes and the review could not ascertain what action had been taken to investigate or learn from these. (page 5)
- Risk management processes across BCUHB did not appear to be integrated with patient and staff safety, complaints and clinical negligence, financial and environmental risk. (page 5)
- Not all risks appeared on risk registers at BCUHB (page 5). This was confirmed in interview also with staff number 20, and staff number 1, both former Board members. Staff number 1 confirmed the BCUHB position with governance overall as being 'way behind' that which was expected in the autumn of 2013.
- BCUHB's concerns management did not contain reference to the principles known as 'Being Open' as of the end of 2013. (This had been introduced to the NHS in November 2009. (page 6)
- CPGs retained responsibility for learning lessons from concerns. Each CPG had autonomy and responsibility for its own arrangements. Therefore there was difficulty in identifying learning processes at a corporate level and across CPGs, HMTs and the wider BCUHB. (page 7.)

*“There were inconsistent processes for managing concerns across BCUHB leading to delays in review and communication with patients and their representatives”*  
(page 3)

*“There had been a number of 'Never Events' with repeated themes and the review could not ascertain what action had been taken to investigate or learn from these.”*  
(page 5)

*“The BCUHB position with governance overall as being 'way behind' that which was expected in the autumn of 2013.”*

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<sup>101</sup> See glossary

The NHS Delivery Unit review identified eighteen individual recommendations around the reporting, escalation, timely review and learning from complaints.

**With specific reference to a review of governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013 the NHS Delivery unit review concluded:**

'Based on the information available at the time of this assurance review it was not possible to obtain assurance that the Board has adequate mechanisms in place for managing concerns and learning lessons. The HB (BCUHB) needs to develop systems for managing concerns effectively through a clear governance framework....' (NHS Delivery Unit December 2013, page 11.).

At this point in time (December 2013) which was in the same month as the closure of Tawel Fan ward BCUHB was more than four years old, having been formed in October 2009. The NHS Delivery Unit found that with reference to the management of concerns BCUHB had not yet put in place arrangements that would have been considered the 'building blocks' or foundations of any safe organisation. This was despite evidence of extensive guidance available to the Board of BCUHB both from Welsh Government and other public bodies across Wales.

**Summary of key issues identified in the BCUHB Putting Things Right Report – 2011/2012 with relevance to a review of governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013.**

A summary is found within the BCUHB Board<sup>102</sup> paper dated 26th July 2012 at item 12/80.1.

This report was presented by the then Director of Governance and Communications who had responsibility for this portfolio of work until handover to the new incoming Executive Director of Nursing and Midwifery the following summer.

**The highlights of the report were:**

- 1339 formal complaints received into BCUHB in that year, described as an increase of two thirds on the previous year. Staff number 19, level noted at interview with the Ockenden review team in June 2017 that this increase was examined 'across Wales because there were similar patterns.'
- An overall decline in compliance rates for complaints both 'acknowledged within two working days' and 'responded to within thirty working days' was reported.

Whilst there were fluctuations across months the overall annual compliance rate for completion of responses to complaints within thirty working days was only 32%. The report highlighted the ongoing failure of the BCUHB Board to put in

*"The NHS Delivery Unit review identified eighteen individual recommendations around the reporting, escalation, timely review and learning from complaints."*

*"Based on the information available at the time of this assurance review it was not possible to obtain assurance that the Board has adequate mechanisms in place for managing concerns and learning lessons."*

*"The overall annual compliance rate for completion of responses to complaints within thirty working days was only 32%."*

<sup>102</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/12\\_80\\_1%20ptr%20annual%20report%202011\\_12.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/12_80_1%20ptr%20annual%20report%202011_12.pdf)

place basic systems, structures and process of governance underpinning the 'Concerns' process and therefore patient care. The report concluded that data regarding receipt, acknowledgement and responses to concerns 'has been recorded via a number of different systems currently in use across the Health Board...' (BCUHB 2012, page 5).

The report concluded 'The Concerns team continue to explore new ways of ensuring that actions are implemented and lessons are identified, learnt and shared across the organisation to minimise the risk of reoccurrence...' (BCUHB 2012 p26.) No detail of the 'new ways' being 'explored' was provided in the report. Ultimately the external reviews undertaken in August and December 2013 by the Delivery Unit and NHS Wales Shared Services Partnership highlighted the very limited success of the 'new ways' referred to in the BCUHB 2011/12 annual 'Putting Things Right' report.

## 10.9 Summary of key issues identified in the BCUHB Putting Things Right Report<sup>103</sup> – 2012/2013

The report identified that work had been undertaken to build on the initial work on the strategic arrangements required to oversee the implementation of the 'Putting Things Right' regulations. This was said to have resulted in significant work in further developing the operational arrangements to support the delivery of the requirements of the regulations. The report stated that there had been a programme of raised awareness of the detail of the regulations and delivering specialised training across BCUHB in order to assist implementation.

The most significant areas of concern across BCUHB to be considered in the report were:

- The increased number of formal complaints received, a two-thirds increase since the commencement of Putting Things Right.
- The low number of BCUHB complaints receiving a response within the target of 30 working days.
- The number of incidents reported within the complaints/PTR process but not validated via the management structure (e.g. through prior internal alert via Datix or internal to BCUHB/via the CPGs declaration of serious incidents.) This showed a lack of effective systems, structures and processes of governance underpinning clinical care at BCUHB where the first time that 'management' at BCUHB became aware of an incident was via a patient raising a concern.
- The 32% increase in the number of legal claims received. (BCUHB 2013, page 5)
- The report stated that in the year 2012/13 BCUHB received 1597 formal complaints, this was an increase of 258 or an increase of 19% on the previous year.

*"A lack of effective systems, structures and processes of governance underpinning clinical care at BCUHB where the first time that 'management' at BCUHB became aware of an incident was via a patient raising a concern."*

<sup>103</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/ptr%20annual%20report%202012-13.pdf>



- 98% of complaints were now acknowledged in two working days
- 40 – 42% of complaints were responded to within the required 30 working day target. (BCUHB 2013, page 4)
- Overall in that year the MHLDP achieved an annual compliance rate of successfully responding to complaints/concerns within thirty working days of 49%. (BCUHB 2013, page 12.) This was better than the average across BCUHB but still less than half of the complaints received within the MHLDP were being responded to within the target set by Welsh Government.

Staff number 19 at interview with the Ockenden review team in June 2017 acknowledged the failings in the management of concerns in stating 'the arrangements for managing complaints and concerns and also learning from complaints and concerns were not robust...' Staff number 19 further describes the need to put in place a new complaints and concerns process for BCUHB as BCUHB had 'inherited the concerns processes that were in place in eight former organisations and that includes primary care..' Staff number 19 describes that this process bringing together people that had previously existed across 'different systems, different cultures, different sites, different regulations and build a new corporate team to support the emerging CPGs probably took.... about a year to get the basics in place....'

Staff number 19 reflected in interview that the focus in the first year of BCUHB post-merger as regards the management of concerns and complaints was focused on 'making sure that we'd got process in place, but obviously the management of concerns and complaints is much more than process, it's about the change that happens as a consequence of what people have told us about their experiences...'

## 10.10 What are the key points from consideration of the evidence around BCUHBs management of the concerns function from 2009 to 2013?

Comprehensive external reviews by two different organisations shows that the Board of BCUHB had completely failed in the first four years of the organisation to put in place a system for effectively investigating serious incidents, 'Never Events' and patient and family complaints. In the absence of investigating these issues appropriately BCUHB was unable to learn from them. The external reviews in 2013 found evidence of repeated 'Never Events' where BCUHB had failed to investigate effectively and therefore failed to learn. There was also a significant backlog of 'open' serious incidents and where serious incidents had been closed, a significant number needed to be reopened and reinvestigated.

2013 proved to be a tumultuous year for BCUHB both organisationally and from a governance and patient safety perspective. During that year there had been significant Board level resignations and changes at Chair and Vice Chair level. The CEO had prolonged sickness absence prior to departure at the end of 2013 necessitating similarly prolonged acting CEO cover arrangements of over a year.

*“Comprehensive external reviews by two different organisations shows that the Board of BCUHB had completely failed in the first four years of the organisation to put in place a system for effectively investigating serious incidents, 'Never Events' and patient and family complaints.”*



The Executive Medical Director and acting Executive Medical Director both also experienced periods of absence through sickness requiring a third person to step into the role of Executive Medical Director for the last three months of 2013. The Executive Director of Nursing and Midwifery left in early March 2013 leading to interim cover for a three month period until the new Executive Director of Nursing and Midwifery took up post at the beginning of June 2013. A new Chair took up post in October 2013 with an interim Director of Finance replacing the substantive post holder also in October 2013. The links below for the BCUHB Annual Reports from 2009-13 provide full details of BCUHB Board and senior personnel at BCUHB from 2009 to the end of 2013<sup>104,105,106,107</sup>

## 10.11 A summary of external concerns informed to the BCUHB Board regarding the systems, structures and processes of governance by the summer of 2013. What do we know?

From a governance and patient safety perspective 2012 saw the start of a lengthy series of external reviews telling the BCUHB Board very clearly that there were significant flaws in their ability to understand the real nature of the risks facing their organisation. The Clostridium Difficile outbreak in Ysbyty Glan Clwyd from January to May 2013 culminated in 96 known and reported cases from January to May 2013. (Duerden 2013, page 1.) Two external reviews, the first by Public Health Wales in May 2013, the second by Professor Brian Duerden<sup>108</sup>, completed in August 2013 demonstrated to the Board that they had failed to ensure an effective 'line of sight' from 'Board to Ward,' failed to ensure the adoption of essential BCUHB wide systems, structures, processes and policies associated with infection prevention and control and failed to ensure adequate resourcing of key posts essential to keeping patients safe.

The first joint HIW/WAO review of Governance Arrangements at BCUHB took place in June 2013, This again highlighted very significant failings in the way the Board operated at BCUHB and can be seen as a continuum in the very serious nature of failings already highlighted to the Board by HIW, Public Health Wales and Professor Duerden. In the midst of this came further external reviews regarding the management of 'concerns' at BCUHB examining the process that had been in place from the 'birth' of BCUHB up to and including the early months of 2013 from the NHS Wales Shared Services Partnership, Audit and Assurance service and the NHS Delivery Unit. These external reviews and their subsequent reports highlighted a lack of assurance around the recording, investigating and learning from complaints and serious incidents in BCUHB with significant concerns around BCUHBs timeliness and systems, structures and processes in investigating and 'closing' complaints and serious incident reviews.

*“From a governance and patient safety perspective 2012 saw the start of a lengthy series of external reviews telling the BCUHB Board very clearly that there were significant flaws in their ability to understand the real nature of the risks facing their organisation.”*

<sup>104</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/Annual\\_Report\\_%2009-10.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/Annual_Report_%2009-10.pdf)

<sup>105</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Final%20Annual%20Report%202010-11.pdf>

<sup>106</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Annual%20Report%20FINAL%20ENGLISH.pdf>

<sup>107</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/BCUHB%20Annual%20Report%202013.pdf>

<sup>108</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/BCUHB%20Prof%20Duerden%20Report%20Final%20version%2011th%20August%202013.pdf>

## 10.12 Conclusion following a review of a number of key NHS Wales wide documents available to BCUHB from 2009 onwards

Following the NHS Wales reorganisation in 2009, the Annual Operating Framework or AOF provided clear guidance for the development and embedding of good governance within all NHS organisations in Wales. Whilst in the initial phase this was not centrally prescriptive there was clear evidence and expectation from Welsh Government that Board governance across the NHS in Wales should extend beyond the response to the national targets. Different Health Boards chose to implement the requirements of the guidance in different formats or ways. However an extensive review of pan NHS Wales documentation by this review showed that there was sufficient national guidance available to the new Health Boards, (including BCUHB) in and across Wales at the time.

The NHS in Wales supported the principles and recommendations of 'The Healthy NHS Board – 2013.' (See The NHS Leadership Academy document 'The Healthy NHS Board (2013) Principles of Good Governance which was originally published in 2010) There is limited, if any evidence seen by this review that the BCUHB Board systems, processes and structures of governance in place prior to the end of 2013 supported or utilised these recommendations. This was further reinforced by the first joint review by Healthcare Inspectorate Wales (HIW) and the Welsh Audit Office (WAO) in 2013 which identified that the BCUHB Board structures at that time were compromising its ability to adequately identify problems that may arise across BCUHB. This included issues which could and did impact significantly upon the quality of care delivered to patients across North Wales.

## 11 Chapter 3

### 11.1 The merger

Interviews with current and former Board members have described the arrangements put in place for the creation of BCUHB. It has been explained to the Ockenden review team that the merger was overseen by a project board chaired by the Chief Executive elect, with Chief Executives of the various contributing organisations leading on particular work-streams. Progress on the restructuring that ultimately led to the creation of BCUHB was described as being reported to the Boards of the organisations that would go on to form BCUHB and to Welsh Government.

Despite the precise arrangements outlined above by Board members communication with staff working throughout the merger that formed BCUHB was often experienced as poor. A member of staff who worked within the Mental Health and Learning Disabilities CPG, (MHLD CPG) within the 'new' BCUHB from merger described the confusion for (and lack of communication with) staff at that time. Staff number 54 said 'We didn't really quite know what the system was and how it would look and it was forever in flux, so you couldn't really have anything to work with, or against even, or have an opinion about because it was all very vague and the management weren't accessible, I didn't ever see them and I was quite senior....I didn't meet these people... .. 'I never had contact' This feedback to the review around poor communication at the time from staff number 54 was replicated by other colleagues including medical colleagues. Staff number 79 advised the review team 'I dealt with the people just immediately connected to me, higher management didn't get involved...'

Staff number 38, working within Older Persons Mental Health also noted in interview in February 2017 how post the merger creating BCUHB communication with staff at ward level was poor. Staff number 38 described how a number of senior staff retired in the short period of time during and after the merger and 'everything changed.' Staff number 38 stated 'Senior management decisions that were being made seemed to be far away.....I didn't feel they were communicating with me as (X – individual role.) and ever since then really I haven't felt, although I know there is a lot of good work going on in the background I haven't felt..... valued in that.'

Staff number 78, working within Workforce and Organisational Development at BCUHB noted at interview with the Ockenden team in September 2017 the lack of effort made by the BCUHB Board to 'merge cultures' post the merger which created BCUHB and said at interview that BCUHB 'spent virtually nothing on that.....it was a disaster waiting to happen....' Staff number 78 described at interview the lack of workforce and organisational development support provided to the CPGs including the Mental Health and Learning Disabilities CPG, (MHLD CPG.) Staff number 78 described to the review the need to work across three CPGs plus the need to take on specific corporate functions in addition to the CPG roles. In line with feedback from numerous other staff working within

*"We didn't really quite know what the system was and how it would look and it was forever in flux, so you couldn't really have anything to work with, or against even, or have an opinion about because it was all very vague and the management weren't accessible, I didn't ever see them and I was quite senior.... I didn't meet these people... .. 'I never had contact'"*

*"I dealt with the people just immediately connected to me, higher management didn't get involved..."*

management roles from the creation of BCUHB the interviewee said 'It was three separate jobs,'

Staff number 78 described a CPG structure that was 'unmanageable...there were three distinct cultures....East, West and Central, also thrown into the mix was an untried format of the CPGs....' Echoing feedback from many other BCUHB colleagues including staff numbers 3, 11, 15, 22, 38, 55 and 57, staff number 78 told the Ockenden review 'A lot of people were stripped out of the initial CPG structure..' Staff number 78 also confirmed that which many other BCUHB staff of the time have told the Ockenden review that 'a lot of people left, you lose organisational memory and you lose experience and they're hard to replace....' Staff number 21 agreed and stated at interview 'organisational memory just was lost from the organisation.'

Staff number 55 agreed and told the Ockenden team at interview 'There was a lack of personnel to do all the roles, there were some differences in management style...I didn't particularly feel the support was there.....I look back, this is a dark period, or was the dark period...' Other staff interviewed described the period immediately post the merger as 'difficult' and 'confusing.'

## 11.2 The BCUHB Board structure from 2009 to the end of 2013 – what do we know?

### 11.3 What is the difference in the role of CEO and Chair of a Local Health Board such as BCUHB?

The structures of NHS Local Health Boards in Wales are helpfully set out in the '109 Pocket Guide to Governance in Wales' (2009) written by the Good Governance Institute or GGI for the NHS Confederation in Wales. The 'Pocket Guide' outlines the different but complementary roles of the Chair of the new Local Health Boards as 'The Chair and the CEO have discrete, complementary responsibilities. The Chair has overall responsibility for the organisation and its governance, while the CEO is the accountable officer and responsible for executing policy.' (NHS Confederation 2009, page 8)

### 11.4 The role of the Chair

The Guide continues that 'The Chair is responsible for providing strong, effective and visible leadership, and is accountable for maintaining the highest standards of clinical care. The Chair is ultimately accountable for LHB/NHS Trust performance.' The Pocket Guide continues thus: 'The Chair directly holds the CEO to account, and ensures that there is proper stewardship for resources for which the Board is accountable.' The 'Pocket Guide' concludes:

'Responsibility for ensuring the LHB/NHS Trust is governed effectively within the framework and standards set by the NHS in Wales resides with the Chair.'

*"The lack of effort made by the BCUHB Board to 'merge cultures' post the merger which created BCUHB and said at interview that BCUHB 'spent virtually nothing on that.....it was a disaster waiting to happen....'"*

*"I didn't particularly feel the support was there.....I look back, this is a dark period, or was the dark period..."*

*"A lot of people were stripped out of the initial CPG structure.."*

*"Organisational memory just was lost from the organisation."*

*"The Chair directly holds the CEO to account, and ensures that there is proper stewardship for resources for which the Board is accountable."*

<sup>109</sup> <http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Confed%20-%20Governance%20Pocket%20Book%20FINAL%5B1%5D.pdf>

Ensuring that board members have the right information available to them to discharge their responsibilities is a crucial role for the Chair.

## 11.5 The role of the CEO:

The role of the CEO is described by the 'Pocket Guide' as 'The CEO is responsible for the delivery of policy as agreed by the Board. As the accountable officer, the CEO needs to ensure that the systems and structures of the LHB/NHS Trust are fit for purpose and ensure the highest standards of executive control.' (p6)

The 'Pocket Guide' explains the term 'Independent Member' (also known as 'IM') and says that the term is used to describe the role of Non-Officer Members in Local Health Boards and Non – Executive Directors in NHS Trusts in Wales. They have no direct executive portfolio, but independent members have full director responsibility and the additional responsibility of ensuring the best quality decision taking through holding the executive team to account. All Board directors have a responsibility to ensure that they understand the purpose of the organisation, and the communities and wider environment in which it operates.

*“The CEO is responsible for the delivery of policy as agreed by the Board. As the accountable officer, the CEO needs to ensure that the systems and structures of the LHB/NHS Trust are fit for purpose and ensure the highest standards of executive control.”*

## 11.6 The role of Independent Members or IM's:

The following is said of IM's:

- Independent members need to support the Chair in being clear about the information they need in order to discharge their role, including assurance and scrutiny.
- Aside from attending Board and committee meetings, independent members should always ensure they have read all papers they are sent and have a good understanding of the work of the Board.
- Independent members will often have a designated area of interest or focus, but are not representative of a particular constituency, and should actively participate in all aspects of assurance and scrutiny. They should not absent themselves from particular discussions.
- Independent members should discuss matters they feel uncomfortable with or uncertain about, with the Chair.
- Independent members will be supported by an annual development appraisal discussion with the Chair. (p7)

*“Independent members have full director responsibility and the additional responsibility of ensuring the best quality decision taking through holding the executive team to account.”*

## 11.7 What is the role of the Board in an NHS Wales organisation?

The role of the Board is to provide leadership of the organisation within a framework of prudent and effective controls which enables risk to be understood, assessed and managed. The Board should:

- Set the organisation's strategic aims;

*“The role of the Board is to provide leadership of the organisation within a framework of prudent and effective controls which enables risk to be understood, assessed and managed.”*



- Ensure that the necessary financial and human resources are in place for the Health Board to meet its objectives;
- Review management performance.
- Set the organisation's values and standards, and ensure that its obligations to its stakeholders are understood, articulated and met.

All Board members must take decisions objectively in the interests of the organisation. As part of their role as Board members, independent members should:

- Constructively challenge and help develop proposals on strategy;
- Scrutinise the performance of management in meeting agreed goals and objectives;
- Monitor the reporting of performance.

Finally, Board members must satisfy themselves on the integrity of financial information and that financial controls and systems of risk management are robust and defensible. (See Wales NHS Confederation 2009 p8)

A number of contributors to the Ockenden governance review noted that one of the challenges facing the Health Board was the 'general confusion as to what is actually meant by the term 'Health Board.' They stated that there was a great deal of uncertainty amongst BCUHB staff as to whether the Board was 'the whole organisation, or the top level – Board meeting.....or indeed one of the many other 'boards' established at lower levels, such as CPG boards..' (Written communication to D Ockenden, January 2018.)

It is widely acknowledged that BCUHB had significant churn and organisational turmoil in Board membership from its inception in 2009 until late in 2016. The churn and turmoil has been made up of four key issues

- Change in Board members, including leavers, joiners, and interim positions;
- Significant periods where both Board members and interim Board members suffered ill health and other long absences;
- 'Acting up arrangements' to cover the leavers, joiners and those absent for illness and other reasons.
- Insufficient management capacity and long standing recruitment issues. One example informed to the review of a key BCUHB Executive post that remained unfilled for almost three years was the Executive Director of Therapies and Health Sciences (also known as EDOTHS). The substantive post-holder retired in May 2013, with an interim in post until October 2013 and then no post-holder at all, either substantive or interim from October 2013 to August 2016. At the request of the then CEO in 2014 the Executive Director of Nursing and Midwifery was asked to take on this additional portfolio, (previously held by a full time Executive Director.) The then Executive Director of Nursing and Midwifery agreed to this and described to



the Ockenden review team being asked to provide 'Executive leadership to therapies and health sciences, which I did to the best of my abilities.'

In summary from 2009 to the end of 2017, as advised to the Ockenden review by BCUHB there has been:

Chair – 3;

Vice Chair – 3 (including one acting post);

Chief Executive – 5, 3 substantive, 2 interim or acting plus 'assistance' from the CEO of another NHS Wales LHB for several months;

Medical Directors – 3 with an additional 3 interim or acting Medical Directors;

Director of Nursing and Midwifery – 3 with an additional 2 interim or acting Director of Nursing and Midwifery;

Director of Finance – 2 substantive, with 2 additional interim Director of Finance;

Chief Operating Officer – 1 interim and one substantive (in post from September 2014).;

Executive Director of Workforce and Organisational Development – 1 substantive and one interim.

The continuing background of vacant and interim posts caused concern, especially with reference to Executive accountability. Evidence provided to the Ockenden by multiple interviewees paints a bleak picture and describes the degree of organisational churn and change at senior levels and in the Board from early 2013 onwards. At this time there were various interim and acting arrangements including an acting Chief Executive, interim Medical Director, an interim Chief Operating Officer and an interim Finance Director. There was also no substantive Executive Director of Therapies and Health Sciences with the then Executive Director of Nursing and Midwifery taking on these responsibilities from mid-2014 to the summer of 2016. Staff working at Board or sub Board level at that time frequently used the term 'vacuum' to describe the situation at BCUHB from the spring of 2013 onwards. There followed three CEOs after the arrival of the new Chairman in October 2013; two substantive and one interim, with the current CEO taking up role at the end of February 2016.

The structure introduced at the creation of BCUHB in 2009 whilst designed to achieve the aim of a clinically led organisation had created a number of further challenges. The progress to address the challenges was slow. Any review of the CPG structure needed to ensure clear connectivity, line accountability and geographical site management was realised, along with sufficient time and resource for clinical staff appointed to senior leadership roles to be able to perform in their roles. Evidence seen by the Ockenden governance review suggests that this did not happen.

Staff member 16, a Board member noted the lack of hospital site management in the CPG structure describing Ysbyty Glan Clwyd (where Tawel Fan ward was

*“Staff working at Board or sub Board level at that time frequently used the term ‘vacuum’ to describe the situation at BCUHB from the spring of 2013 onwards. There followed three CEOs after the arrival of the new Chairman in October 2013; two substantive and one interim, with the current CEO taking up role at the end of February 2016.”*

based in the Ablett Unit) as 'the hospital down the road (YGC) that everybody and nobody was in charge .....because every CPG had a finger in it, but there was no hospital management so you had .... ..well who is actually in charge when something goes wrong?' Staff number 21, a former Chief of Staff said at interview 'there was very little attention paid to that question of actually, who is running the hospital?'

*“The hospital down the road (YGC) that everybody and nobody was in charge ..... because every CPG had a finger in it, but there was no hospital management so you had .... ..well who is actually in charge when something goes wrong?”*

There remained an urgent need to strengthen the clinical leadership at Executive level which had been constrained by the extended interim arrangements for the role of Executive Medical Director due to illness in both the substantive and replacement post holder. Records provided to the Ockenden team by BCUHB show a total of six substantive or interim Executive Medical Directors at BCUHB from 2009 to the current day. (BCUHB 2017)

### 11.8 What are the key points regarding the BCUHB Board structure from October 2009 to the end of 2013?

The four years from the formation of BCUHB in October 2009 to the closure of Tawel Fan was characterised by Board turmoil, change and churn.

There were significant change and in some cases extended acting and interim arrangements for key Board positions including the CEO and Executive Medical Director from 2009 to 2013.

*“There was very little attention paid to that question of actually, who is running the hospital?”*

There was insufficient management capacity at Board level with the complication of some key posts (e.g. the Executive Director of Therapies and Health Sciences) being filled on both an interim basis post retirement and then held as part of an already full Executive Director of Nursing and Midwifery role for a number of years.

### 11.9 BCUHB and its development of its governance structure post-merger in 2009

In the 'new' BCUHB from October 2009 operational delivery was based around clinically led 'Clinical Programme Groups' (CPGs) across North Wales. Staff number 28 wrote that 'The operating structure was designed by the then Chief Executive and reflected structures that had previously operated within the former North Wales NHS Trust...'

Multiple external reviews (and all of the subsequent interviews for this governance review) describe that the development of governance structures in the new BCUHB 'was left to them' (the CPGs). Staff number 4, said "In terms of the detail there was a broad architecture which most of the CPGs followed which matched the committee structure of the Health Board.....so each of them had a governance, whether they called it a Clinical Governance Committee or a Governance Group, they had that...broad architecture. The content of the reporting and the nature of the debate and the discussion... they had was very much left to them and their own leadership.....it took on very different

flavours depending upon the experience and the background of the individuals involved....'

## 11.10 The implication of a 'broad architecture' of governance for adult safeguarding at BCUHB 2009 onwards

Staff number 25, working within safeguarding explained to the Ockenden review team the implication for adult safeguarding across BCUHB as CPGs followed only a 'broad architecture' in the setting up of individualised governance structures across the CPGs. Staff number 25 said in a written statement dated September 2017 'Each CPG had autonomy and accountability for the implementation of governance and reporting arrangements. This required corporate teams to have to negotiate with the lead managers of CPGs to engage and implement safeguarding interventions/systems and processes.'

Staff number 1, at interview in September 2016 noted at interview that although from merger in 2009 BCUHB had 'established clinical leaders to manage governance arrangements, the framework of support for CPGs was not clear. There was not an explicit document that provided a framework around these arrangements (i.e. how you need to affect your governance arrangements. The organisation.....also didn't establish objectives for each of the CPGs...' Staff number 52, a current Board member stated at interview in April 2017 'There had been a theoretical governance structure that went with the CPGs, they all had a different version of it, so I think we had eleven different versions of the world....' Staff number 52 continued 'They did safeguarding differently, they did management of their risks differently, and they did management of Datix differently....' The views of staff numbers 1, 4, 25 and 52 have all been replicated within multiple external reviews from 2012 onwards and almost all of the interviews carried out with BCUHB staff in post at the time.

In summary, the Ockenden review has heard from numerous interviewees that the connectivity that should have existed between the different strands of governance simply did not exist post the creation of BCUHB and instead these different strands around complaints, incidents, Datix and SUIs were managed in different compartments, rather than being seen as one whole unified system.

Staff number 25 further adds to the lack of a strategic approach to the implementation of governance in the new BCUHB noting the 'sporadic implementation of Datix by the organisation and individual and inconsistent CPG management of identified reporting [of risks]....' (Staff number 25, written statement) This view by staff number 25 resonated with feedback from multiple external reviews including those of the management of concerns at BCUHB (NHS Delivery Unit 2013) and a review of BCUHB's ability to learn lessons from complaints in 2012/13. (NHS Wales Shared Services Partnership 2013.) The NHS Wales Shared Services Partnership found limited assurance that BCUHB could implement lessons learned from complaints and the NHS Delivery Unit identified the following 'common findings' that have relevance to the Terms of Reference

*"Each CPG had autonomy and accountability for the implementation of governance and reporting arrangements. This required corporate teams to have to negotiate with the lead managers of CPGs to engage and implement safeguarding interventions/systems and processes."*

*"There had been a theoretical governance structure that went with the CPGs, they all had a different version of it, so I think we had eleven different versions of the world...."*

of the Ockenden review which reviews governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013:

- Lack of governance arrangements;
- Lack of clear lines of accountability;
- Inconsistency of practice and policy across the BCUHB sites;
- Lack of training prior to introduction of significant new systems – e.g. Datix;
- Unclear management arrangements between CPGs, hospital management teams and the Executive team (NHS Delivery Unit 2013, pages 2 and 3.)

### 11.11 What was the implication of the 'broad architecture' of governance for the MHL D CPG overall?

- The MHL D CPG was, (as in all likelihood were other CPGs) disconnected from the BCUHB Board.
- There is little (if any evidence) that the pre-existing skill set and experience of the senior team in matters of governance were considered prior to appointment.
- There was a toxic mix of lack of Board direction and lack of managerial capacity which when combined with lack of resource meant that governance processes that should have been in place quickly after the 'birth' of BCUHB took several years to begin to progress.
- The Ockenden review saw no evidence of feedback to staff working clinically on the ground from issues around complaints, serious incidents and Datix. This meant that there was limited, if any opportunity for BCUHB as an organisation and the workforce within the MHL D CPG to learn.

*“There was a toxic mix of lack of Board direction and lack of managerial capacity which when combined with lack of resource meant that governance processes that should have been in place quickly after the 'birth' of BCUHB took several years to progress.”*

### 11.12 Setting up the Clinical Programme Group (CPG) Structure across BCUHB 2009-2013

The intention of the new CPG structure was to cut across any pre-existing cultural, geographical and service boundaries to deliver instead a unified and cohesive approach to delivery of strategy and operational service. The new CPG model would champion clinical leadership and was intended to develop along a gradually increasing continuum of 'earned autonomy.' However multiple interviewees, particularly former Board members told the Ockenden governance review team of their concern that CPGs had a high degree of autonomy from the outset. The new CPG structure was described as originating from teaching hospitals in London. Interviewees have stated that the introduction of the new CPG structure into BCUHB followed a very short pilot in the former North Wales NHS Trust, of which the new BCUHB CEO had previously been CEO.

Multiple interviewees participating in the Ockenden governance review had significant reservations regarding the CPG structure the outset and these concerns grew significantly over time.

## The overall CPG Structure:

Staff number 28, said at interview in January 2017 'In the run up to the creation of BCUHB [the CEO] set out a vision of employing CPGs as part of that structure.' (Page 2) and '[the CEO] championed the CPG structure and secured the support of the Board for its implementation within BCUHB....' Staff number 19 in interview and correspondence with the Ockenden team noted that the 'CPG model was championed by the then Chief Executive and a number of events were held with senior clinicians and stakeholder organisations to seek their views. Welsh Government was aware of the organisational design which I believe, although novel was not contentious.'

A former Chief of Staff was supportive of the principles behind the formation of the clinically led Clinical Programme Group, (CPG) structure. At interview in March 2017 this former Chief of Staff said: 'the principles were absolutely the right ones....' These 'principles' were described as 'the principles of integration, improvement of scale, the opportunity to apply clinical standards consistently across a large area....' Staff number 21 continued: 'there was a degree of naivety around how the transition should be managed.....there was very little attention to some of the cultural issues and the governance issues.'

The Ockenden review team has been informed of a significant delay in appointment to key roles within the new BCUHB structure post 2009. Staff number 91, a former Board member advised the Ockenden review through a written statement that 'the initial organisational change the Health Board went through to form the CPGs took a long time in many areas with a negative effect on our workforce and hence services.'

At interview the Associate Chief of Staff, Nursing for the Mental Health and Learning Disabilities CPG advised the Ockenden review of appointment to this role in August 2010 – a ten month gap between the creation of BCUHB and the appointment of the lead nurse for the CPG. It remains unclear to the Ockenden review how this significant gap in nursing capacity and leadership within the Mental Health and Learning Disabilities CPG was filled over an extended and critical period of time when vital systems, structures and processes of governance were inevitably being formed across BCUHB and the CPG. Staff number 21, described at interview 'quite a bit of instability as the new organisation formed.'

A basic tenet of good governance is that the more autonomous a clinical leadership model is then the stronger, more mature and more embedded the underpinning systems, structures and processes of governance should be within an organisation. With reference to BCUHB and its CPG structure the new 'BCUHB' and the CPG structure were 'born' together. This meant that both the corporate structures of the new BCUHB and the structures within the new CPGs both lacked maturity and both were untested. To add to the complexity Staff number 4, acknowledged at interview the lack of structure in the way CPGs operated from 2009 to 2013 as 'different Clinical Programme [groups] doing things in their own way and differential cover on most things....'

*"There was a degree of naivety around how the transition should be managed..... there was very little attention to some of the cultural issues and the governance issues."*

*"The initial organisational change the Health Board went through to form the CPGs took a long time in many areas with a negative effect on our workforce and hence services."*

*"Different Clinical Programme [groups] doing things in their own way and differential cover on most things...."*



Staff number 1 stated 'They [the CPGs] were more clear in terms of operational issues, performance, finance, but not on the quality and the safety and also there was a mixed presence/portfolio of experience, so some of the Chiefs of Staff were happy about what they thought governance was and what they needed to do about it and the committees they needed to form....but it was variable, so some people had got some quite good processes in place, others had got really poor processes and were way behind in terms of backlog of incidents and issues that they were looking at and particularly with [the] Mental Health CPG then that was very clear.'

In a written statement supplied to the review staff number 4 confirmed 'Each CPG developed its own governance structure and ways of working to connect with corporate functions and facilitate reporting and accountability through the Board's Committee structure, in large part these mirrored the sub-committee structure of the Board. There was not a mandated, consistent approach to governance structures and management principles across CPGs. This flexibility was reflected in other aspects of the Board's undertakings where CPGs were given flexibility to design structures and organisational arrangements reflecting their understanding and interpretation of the requirements placed upon them.'

In a written statement submitted to the Ockenden review staff 91, commented on the effect of the lack of structure in the governance arrangements in the new BCUHB and said 'The lack of a prescribed governance structure for the CPGs below the management triumvirate meant there was no clarity on who had responsibility for some areas. This was also made more difficult as staff from previous organisational structures did not know what their responsibility was....' [In the 'new' BCUHB.] Throughout many interviews with current and former BCUHB staff it was very clear to the Ockenden governance review team that there was considerable confusion as to how the CPG system actually worked within BCUHB from 2009 to 2013.

In a written submission for the Ockenden review staff numbers 100, 106 and 111, stated that the Mental Health and Learning Disabilities CPG delivered their first report to the BCUHB Quality and Safety Committee (or Q and S) in October 2010, a year after the formation of BCUHB. Their report to Q and S included 'a reported 99% compliance for enhanced health care standards and an 85-100% compliance with the Dementia bundle. Additionally they reported they had formed a scrutiny group which met every 2 weeks to consider incidents and lessons learned. Further that the Mental Health CPG had more than 60 members of staff trained in root cause analysis....'

The Mental Health and Learning Disabilities CPG next came to the Q and S Committee well over a year later (not until March 2012) At this Committee the CPG team described to the Q and S Committee the already 'developed sub CPG structures' which were said to include committees for service user experience, clinical effectiveness, risk management, safeguarding and statutory compliance. Staff numbers 100, 106 and 111 describe the CPG presentation as 'dominated by

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processes rather than outcomes, [but] there was considerable debate on outcomes, risks and challenges.'

The 2013/14 BCUHB Annual Governance Statement published in June 2014 stated that 'all CPGs have been subject to a level of detailed and challenge by members of the Quality and Safety Committee.' (BCUHB 2014, page 11.) Staff number 1, stated at interview 'So were the Quality and Safety Committee managing the governance arrangements? Were they as informed as they needed to be? They had updates from the CPGs at the time, so the CPGs probably once a year were called to present to the Quality and Safety Committee, so that was the way for that Committee as a sub-Committee of the Board to listen directly to the CPGs, but in reality did it get underneath the detail, did it see the detail, was it able to see warts and all? No, it wasn't, so truly, knowing whether you had got effective processes they wouldn't be able to state that...'

Staff number 19, at interview stated of these annual visits to the Quality and Safety Committee 'so they would have 2 or 3 hours in front of the Quality and Safety Committee directly providing assurance and evidence on everything from numbers of complaints, to themes, to issues, to incidents...'

Staff numbers 100, 106 and 111 state that there were no 'reported concerns or issues' discussed around Tawel Fan ward at this meeting in March 2012. In addition they confirm that no concerns around Tawel Fan ward were brought to the BCUHB Mental Health Act Committee. Staff number 100, 106 and 111 described 'regular meetings (at least monthly)' with the then Executive Director of Primary Care, Community and Mental Health and say 'The principal issue of concern in the Mental Health CPG was the Hergest Unit in Ysbyty Gwynedd, where staff relations, particularly between that unit and the CPG leadership, were challenging....'

Staff number 28, stated at interview in January 2017 'Much of the debate on mental health services or much of the prominence of mental health services was probably more about acute adult mental health patients. There was certainly a lot of dialogue about the Hergest unit and it tended to be in the West.....as opposed to older person's mental health services and the Centre....' This was evidenced in the review of the 'Briefing for Health Board' paper on Mental Health Services dated 19th December 2013 describing six BCUHB mental health units/services as 'in escalation.' Whilst the closure of Tawel Fan ward involved first closing to admissions and then ultimately closing and transferring elderly and vulnerable patients to other units Tawel Fan ward itself merits only one short paragraph for information, (see BCUHB 2013, page 2) The vast majority of the 19 page paper is devoted to issues concerning the Hergest unit. Staff number 4, stated at interview that 'there were a number of areas where the Board were particularly sighted on Mental Health, mainly Adult Mental Health Services. There were concerns around the Hergest unit and some of the issues there, and there were very focused responses from the Board in those areas...'

Staff number 52, stated at interview with the Ockenden team in April 2017: 'Although the Mental Health CPG....was the first one to be put in place, it was just

*“The lack of a prescribed governance structure for the CPGs below the management triumvirate meant there was no clarity on who had responsibility for some areas. This was also made more difficult as staff from previous organisational structures did not know what their responsibility was....”*

a CPG in name and, for the general Mental Health services, there didn't appear to have been an attempt to become a Betsi Cadwaladr Mental Health service, it was still very much....West, Centre, East.....there were different cultures and different governance mechanisms and even different clinical practices between the three areas...'

### 11.13 Selection for the Chief of Staff role

All interviewees participating in this governance review who have commented on the formation of the CPGs have described the CPG as 'semi-autonomous' units. In describing the appointment of the CPG Chief of Staff role interviewees have described a process of appointment restricted to clinicians working within the Health Board. There were no external advertisements and a lack of clarity/memory from former Chiefs of Staff as to whether formal interviews took place for the roles of Chiefs of Staff. One former Chief of Staff described the process of appointment to the role as 'It felt like a tap on the shoulder'. Staff number 21 continued and described the selection process further as 'He seems quite a nice guy, he's quite enthusiastic.....we'll have X because I know him and I quite like him...'

Of note is that nine out of the eleven original CPG Chiefs of Staff were doctors and of the seven 'Heads of Programmes' (known as HOPs and similar to Clinical Directors) six were consultant psychiatrists. There were few, if any opportunities for nurses to undertake very senior leadership roles in the 'new' BCUHB from 2009 onwards.

### 11.14 The span of responsibilities of the Chief of Staff role:

Many interviewees have explained a key challenge for Chiefs of Staff. This was that their leadership role encompassed the spectrum from clinical leadership through to operational leadership and management. This was despite the fact that it was acknowledged by Board members at the time that many of the new post holders as Chiefs of Staff had very little experience. Staff number 4 advised the Ockenden review team 'there were people who had very little experience, who were brand new to it, and others who'd had more experience but more experience in a Clinical Director type environment.' Staff number 28, added in a written statement 'The CPGs led the strategic clinical development and were operationally responsible for their staff in the delivery of safe and effective care...'

### 11.15 Professional development and preparation for the Chief of Staff role

All staff who discussed the CPG structure at interview describe the lack of preparation for what were very significant senior leadership and management roles. The Ockenden review team has been informed that a number of the Chiefs of Staff secured an external 'coach' via the then Chief Executive. However no further detail has been provided. Staff number 4 described to the Ockenden

*“Although the Mental Health CPG....was the first one to be put in place, it was just a CPG in name and, for the general Mental Health services, there didn't appear to have been an attempt to become a Betsi Cadwaladr Mental Health service, it was still very much.... West, Centre, East.....there were different cultures and different governance mechanisms and even different clinical practices between the three areas...”*

*“One former Chief of Staff described the process of appointment to the role as 'It felt like a tap on the shoulder.'. Staff number 21 continued and described the selection process further as 'He seems quite a nice guy, he's quite enthusiastic..... we'll have X because I know him and I quite like him...'”*

review team a small number of 'workshops' suggested to the Ockenden review as 'about three or four externally facilitated....that was very early on in their appointment ....but I don't recall anything more structured than that.'

The general lack of preparedness for the role of Chief of Staff in the new CPGs across the new BCUHB has been referred to in a number of staff interviews including staff numbers 14 and 21. Some of the new Chiefs of Staff were said to have had very little experience, whilst others who had some experience had operated in one of the smaller Trusts making up BCUHB prior to 2009 usually as a Clinical Director. There is acknowledged to be a significant difference in the role of Clinical Director which is generally considered to be a role for clinical advice and leadership across one discrete aspect of a service. The new Chief of Staff role was a role involving responsibility for operational, strategic, and financial management and leadership of multiple BCUHB services across the six counties of North Wales. This role was made all the more complex in a new organisation which had just formed from multiple pre-existing organisations.

Staff number 4, expressed concerns regarding the lack of preparation for Chiefs of Staff to take on roles that were both large and complex. Staff number 4 said 'They had operational management responsibility which...is quite distinct from clinical leadership. The two got rolled together and so they ran everything, were responsible for all functioning and execution which is a certain take on clinical leadership..... It was a big ask I thought of clinicians to be put in such a huge organisation that had just brought eight different individual organisations together. The context, the complexity of relationships, behaviours all those sort of challenges you see at periods of change and individuals who to be fair I don't think had had a great deal of structured development to enable them to manage that...' The review has seen little (if any) evidence that Board Members at the time thought through the consequences of the very significant challenges that were being presented to new Chiefs of Staff many of whom were completely unprepared for the role they were taking up.

*“The new Chief of Staff role was a role involving responsibility for operational, strategic, and financial management and leadership of multiple BCUHB services across the six counties of North Wales. This role was made all the more complex in a new organisation which had just formed from multiple pre-existing organisations.”*

### 11.16 Time allocation for the Chief of Staff role with particular reference to the Mental Health and Learning Disabilities CPG

Staff number 16 noted at interview that the CPGs 'while the intention was clearly very worthy, and very proper [they] – the Chiefs of Staff were not properly resourced....' As with previous interviewees Staff number 16 noted a lack of training, time and ongoing support for the role and commented specifically on the very part time nature of the role. A number of former Board members referred to attempts to change the CPG structure in late 2012. This was a review of the CPG structure chaired by the then Vice Chair. The Ockenden review team has been advised by a number of former Board members that the CPG review included the then substantive CEO and one representative of the Chiefs of Staff group, (out of the eleven CPGs.) The recommendation at that point in time was said to be that a new leadership arrangement should be adopted at BCUHB with existing Chiefs of Staff as 'clinical lead' and a professional manager as

management lead. This proposed model was said to have been rejected by the then CEO and the single Chief of Staff taking part in the CPG review.

The concern around the 'part time' nature of the CPG leadership and management role was also highlighted by staff number 14, a former Chief of Staff who took up post as Chief of Staff at the 'creation' of BCUHB. Staff number 14 described how from 2009 until circa 2014 they had:

A 7 session clinical workload, (a session being half a day so the clinical workload being 3 and a half days of the working week.)

2 sessions (or one day a week) Allocated to 'Supporting Professional Activity' (or 'SPA'.) Activities carried out in these sessions would include audit, governance and professional updating. SPA is a common feature across all consultant contracts.

This equated to a nine session (or four and a half day working week) before the allocation of the Chief of Staff responsibilities.

In order to take on the Chief of Staff responsibilities Staff number 14 described being allocated two 'management' sessions, (i.e. payment to work a day a week as the Chief of Staff in a typical week.)

Taking into account that the role of the Chief of Staff in the case of staff number 14 included overall responsibility and accountability for a CPG providing services to patients across the six counties of North Wales (which at the time had a budget of circa £100 million pounds a year) the 'ask' of the Chiefs of Staff by the BCUHB Board, to be responsible and accountable for a Clinical Programme Group in a day a week was clearly an impossible one. The budget of 100 million pounds, the staff numbers involved and the geographical spread across North Wales was the equivalent of a small to medium sized NHS Trust in England, which would have had its own Board with a full complement of Executive and Non-Executive Directors and a comprehensive underpinning management structure. The Chiefs of Staff did not have this underpinning structure and support.

Staff number 21, also a former Chief of Staff described at interview in March 2017 the Chief of Staff role on top of five clinical sessions and acknowledges his working week was likely to have been 'fifteen sessions' (i.e. typically working every day of a seven day week.)

Clearly the experience of staff numbers 14 and 21 was not one that was sustainable. Whilst much has been written of the apparent 'failure' of the Chiefs of Staff to undertake their roles effectively, the initial and ongoing failure from 2009 up until dissolution of the CPGs in 2014 appears to have been one at Board level for putting in place a structure that on the balance of probabilities had very limited chance of success. The commitment and effort of the Chiefs of Staff and their senior teams has not been doubted by any of the interviewees contributing to the Ockenden review.

*“A former Chief of Staff described at interview in March 2017 the Chief of Staff role on top of five clinical sessions and acknowledges his working week was likely to have been 'fifteen sessions' (i.e. typically working every day of a seven day week.)”*

*“Whilst much has been written of the apparent 'failure' of the Chiefs of Staff to undertake their roles effectively, the initial and ongoing failure from 2009 up until dissolution of the CPGs in 2014 appears to have been one at Board level for putting in place a structure that on the balance of probabilities had very limited chance of success.”*

Staff number 14 in interview highlights further issues that combined with a lack of time to undertake the role of Chief of Staff effectively also further impacted negatively on the ability of the Chief of Staff to fulfil their role. This included little, (if any), administration support to undertake the role of Chief of Staff. Staff number 14 in interview confirmed that whilst in post 'there was limited dedicated admin support, so administration had to be carried out piecemeal. There were ongoing difficulties delegating a range of administrative tasks..... In the absence of a secretary, I would have written notes, for them to be typed up elsewhere. In terms of reports, papers etc. I had to write or rewrite papers in the absence of sufficient managers..'

*"In the absence of a secretary, I would have written notes, for them to be typed up elsewhere. In terms of reports, papers etc. I had to write or rewrite papers in the absence of sufficient managers.."*

Staff number 14 and others also confirmed at interview that despite having overall responsibility and accountability for running the CPG with its £100 million budget the Chief of Staff was unable to make the decision to advertise and appoint to a number of roles including clinical and administration roles since this decision was made at an Executive level vacancy control panel over a prolonged period of time. (Staff number 14, plus many other staff including numbers 3, 11, 15, 22, 57, 63).

### 11.17 How the Chiefs of Staff undertook their roles 2009-2013 and the effect of the Chief of Staff role on the development of the systems, structures and processes of governance at BCUHB

The Health Board had developed its operational performance through clinically led, (generally medically led) Clinical Programme Groups (CPGs). The Health Board had an Executive Board with defined accountabilities. The functional management of the Board, known as the Board of Directors comprised the Executive Directors and the Chiefs of Staff from the Clinical Programme Groups. Staff number 28, in interview described 'the vision of ... a clinically led organisation which would .... secure a different type of engagement with key clinical staff and the involvement of the clinicians in terms of key decision making resource utilisation.

Staff member 16 said at interview 'I think the model was ... flawed in that the Chiefs of Staff.....went straight to the CEO and the Directors were disabled in their roles.' Staff number 47, agreed noting that the Chiefs of Staff met directly with the CEO. The Ockenden review has been advised by a number of senior members of staff including former Chiefs of Staff, that no minutes were kept of the discussions; (and none have been provided by BCUHB for the purposes of the Ockenden review.) Staff number 19 recalled at interview in November 2016 'They, [the Chiefs of Staff] used to have breakfast meetings every Friday morning to which the Chief Executive was invited and it was unscripted....'

In the absence of any minutes from the Chief of Staff meetings with the CEO this governance review has relied upon findings from multiple interviewees and a range of external and internal documentation to understand the complexities and issues facing BCUHB during the period of time 2009-2013. Staff number 21, recalled the formation of 'a bit of a loose group, called the Chiefs of Staff....we



met weekly and just .....tried to work through some of that stuff....' ('That stuff' being finance, workforce and operational issues.)

### 11.18 Summary: What do we know about the Chief of Staff role from the creation of BCUHB?

The role was largely undertaken by clinicians, usually doctors who had very little management, operational or financial experience;

The role was undertaken often on a very part time basis;

There was limited if any professional development available to new Chiefs of Staff to 'grow' into their role;

There was often a lack of supporting roles – e.g. administration underpinning the Chief of Staff role which further complicated delivery of what was already an impossible 'ask' by the BCUHB Board.

*“A former Chief of Staff recalled the formation of ‘a bit of a loose group, called the Chiefs of Staff.... we met weekly and just ..... tried to work through some of that stuff....’ (‘That stuff’ being finance, workforce and operational issues.)”*

### 11.19 Key supporting roles and services to the Mental Health and Learning Disabilities (MHL D CPG)

#### 11.20 Finance

Interviews with a number of staff including former and current senior BCUHB staff reflected on the scale and size of the budget within the MHL D CPG which became the responsibility of the Chief of Staff. Staff number 78 advised the Ockenden review in June 2017 that the MHL D budget was circa a hundred million pounds at the time of merger. The workforce for the MHL D CPG was circa 2000 members of staff.

Staff numbers 15, 22, 38, 63 and 78 all described to the review the need to save '20% of management costs' within the MHL D CPG and a number of staff described senior and experienced clinical and managerial staff leaving the MHL D CPG through a scheme known as Voluntary Early Release or VER. Staff numbers 63 and 78 recalled to the Ockenden review that this scheme ran for more than three years. Staff number 63 said to the Ockenden review in June 2017. 'If someone asked for it, [VER]; it was difficult to make a case for them not going...'

Highlighting the lack of previous experience many of the Chiefs of Staff had with budget management Staff number 21, said of a typical appointee to the role of Chief of Staff at interview: 'He's going to be responsible for a budget of XX million. What does he know about managing a budget, what does he know about... processes of assurance and governance.....It was.... let's ..... bring you along and it will be fine really....'

*“He's going to be responsible for a budget of XX million. What does he know about managing a budget, what does he know about... processes of assurance and governance.....It was.... let's ..... bring you along and it will be fine really....”*

### 11.21 Workforce and Organisational Development

Interviewees have explained to the Ockenden review how the Workforce and Organisational Development (WOD) service was structured post the creation of



BCUHB in late 2009. It has been described that there were three assistant Directors whose portfolios covered one of either employment policies and practices, organisational development and workforce governance. The employment strategies and practices section provided support to departments and Clinical Programme Groups. It was stated that the three assistant Directors were nominally allocated to 3-4 of the Clinical Programme Groups (CPGs) as a point of contact for the CPG management teams and would attend meetings of the management teams of the CPGs. However it was acknowledged that through conflicts of commitments, particularly where one person was covering WOD responsibilities across three or four CPGs across the six counties of North Wales meant this did not always happen.

A former Chief of Staff advised the Ockenden review at interview that there was often limited workforce and organisational development support provided when it was needed. 'What would generally happen is that if I asked for advice I would be sent copies of the policy'. Former employees of BCUHB working within WOD have agreed with this interpretation and acknowledged that it was rarely possible to attend senior management team meetings, performance management or governance meetings within the CPG. Staff number 78 stated at interview in September 2017 that this was a combination of 'failings on the [WOD] set up as much as on the CPG.....I don't know if they knew what they wanted.....but we weren't configured to be able to provide it anyway..'. Subsequent to this interview the Ockenden review team was advised that there was further investment in further WAD (human resources) posts once 'special measures' was enacted. (This was after June 2015.)

*“A former Chief of Staff advised the Ockenden review at interview that there was often limited workforce and organisational development support provided when it was needed.”*

## 11.22 Operations and Nursing support to the Clinical Programme Groups with specific reference to the Older Persons Mental Health (CPG)

The Ockenden review has been advised that each Chief of Staff was supported by 2 Associate Chiefs of Staff, one drawn from nursing and one from a management background. These were known as ACOS-Nursing and ACOS-Operations. Whilst these post-holders were initially advised to the review by BCUHB to be full time, permanent appointments this was not always true 'on the ground.'

In the Mental Health and Learning Disabilities CPG (MHLDP CPG) the ACOS Nursing took up post in the summer of 2010. The Ockenden review team has been advised that the job description for ACOS Nursing specified 5 sessions nursing management and 5 academic clinical sessions. During the first two years in post (summer 2010 to summer 2012) the post holder was both ACOS nursing and also a clinician. The clinical commitments included being a responsible clinician with a small caseload and being a member of a multi-disciplinary team. The clinical sessions ended approximately May 2012 and then the post holder undertook the role on a fulltime basis. The post-holder advised the Ockenden review team that whilst the 'job description was couched in those terms [that of a 50:50 split between nursing management and clinical academic role] this did not reflect the

reality.....The role of ACOS nursing continued throughout the working week and clinical sessions fitted around this and may not in any particular week have amounted to 50% of my time.' The post-holder continued that even the full time nature of the role 'did not reflect the reality of the hours actually worked which were far in excess of this most of the time..'. In addition the Ockenden review team notes the lack of support underpinning the ACOS Nursing role from 2010 onwards. Until the appointment of Matrons in 2012 it appeared that there were no nurse management posts between ACOS Nursing and Band 7 ward managers. At the time the Ockenden review has been informed there were 24 wards providing inpatient care on four sites across North Wales. Clearly therefore the role of ACOS was a role that was completely unmanageable with the lack of nurse leadership structure underpinning it.

### 11.23 The matron role in the MHLD CPG

Other key roles supporting and underpinning Older Peoples Mental Health have been advised to the review as being inappropriately part time. These include the matron for Older Persons services role for the 'Central' area, (covering Conwy and Denbighshire) which a number of interviewees have advised the Ockenden review was only three days a week. This would have been wholly insufficient but the review has been further advised and provided with evidence that for a period of time from November/December 2012 the part time matron role for Central area was required to include the Wrexham area too. Due to the inability to recruit to the matron role at Cefni Hospital on Anglesey the matron for Older Persons services role for the 'Central' area subsequently covered Cefni Hospital once the Wrexham matron returned to work.

The Ockenden team has been advised by interviewees that each week there was the need for a fourth 'matron' day' to be agreed on an 'as required' basis. This clearly became a weekly necessity. The request for the substantive increase in the matron role from three days to four was submitted via the 'Vacancy Control Panel.' The Ockenden team was subsequently advised that this was agreed in 2014. However this would have still left a part time matron role covering a large geographical area, which in the opinion of the Ockenden team was still insufficient cover, despite the eventual increase.

Other senior managers both within Mental Health and Older Persons Mental Health including staff number 3, 15 and 22 within the MHLD CPG described taking on a role 'that had previously been carried out by three people. The three former trust areas had different cultures and histories, so it wasn't just a matter of 3 times the workload.....services and ways of working in South Gwynedd would look very different to services and ways of working in Wrexham..'. Another senior manager, staff number 22, working within the former MHLD CPG described that immediately after the merger creating BCUHB, three former 'General Manager' type roles that would have existed for the Mental Health and Learning Disabilities services across Wrexham and Flintshire, (1 role), Conwy and Denbighshire, (1 role) and Gwynedd and Anglesey, (1 role), were replaced by one ACOS Operations for the CPG operating across the six counties of North Wales.

*“Until the appointment of Matrons in 2012 it appeared that there were no nurse management posts between ACOS Nursing and Band 7 ward managers. At the time the Ockenden review has been informed there were 24 wards providing inpatient care on four sites across North Wales.”*

*“The three former trust areas had different cultures and histories, so it wasn't just a matter of 3 times the workload..... services and ways of working in South Gwynedd would look very different to services and ways of working in Wrexham..”*

Staff number 3 told the Ockenden review in September 2016: 'Previously you would have had 3 General Managers, 1 in your East Trust, 1 in your Central Trust, 1 in your West Trust, you had 3 Clinical Director type posts, 3 Senior Nurse Type posts. A lot of these posts [were] amalgamated into 1 and I think it was well intentioned.....people worked very hard and were very dedicated, it didn't always work...' In reality, the reduction in the management structures happened at the time when the new infant BCUHB needed them most.

#### 11.24 Other support to the Clinical Programme Groups with specific reference to the MHLDP CPG and Older Persons Mental Health

A number of interviewees including staff numbers 38 and 57 have informed the Ockenden review about a lack of support roles to clinical areas from 2009 to 2013. These have included the long term non-availability of ward housekeepers and ward clerks, (meaning that nurses spent time on non-clinical duties.) Interviewees have described lengthy recruitment processes for these roles and reducing hours for support services to older people's mental health such as physiotherapy and occupational therapy. Interviewees have described how services such as physiotherapy and occupational therapy were initially dedicated to individual wards such as Tawel Fan and Bryn Hesketh, gradually moving to a more restricted 'on referral basis.'

#### 11.25 Key conclusions – How effectively staffed was the senior management team of the Mental Health and Learning Disability CPG?

The senior management team of the Mental Health and Learning Disabilities CPG was inadequately staffed from the time BCUHB was formed.

The Organisational Change Process following the creation of BCUHB took too long meaning that key posts were either interim unfilled for long periods following the creation of the MHLDP CPG;

There was grossly insufficient management capacity within nursing, operations and service management to support a pan North Wales mental health service;

There was too little attention paid by the Board to the significant loss of management capacity and capability achieved via the VER scheme.

#### 11.26 Overview of staffing within the Mental Health and Learning Disabilities CPG

With many concerns expressed around the management and leadership infrastructure supporting the Mental Health and Learning Disabilities CPG multiple current and former staff from BCUHB have also advised the Ockenden review of long term issues with clinical staffing. These issues started with the formation of the Mental Health and Learning Disabilities CPG at the creation of

*“Immediately after the merger creating BCUHB, three former ‘General Manager’ type roles that would have existed for the Mental Health and Learning Disabilities services across Wrexham and Flintshire, (1 role), Conwy and Denbighshire, (1 role) and Gwynedd and Anglesey, (1 role), were replaced by one ACOS Operations for the CPG operating across the six counties of North Wales.”*

*“A lot of these posts [were] amalgamated into 1 and I think it was well intentioned..... people worked very hard and were very dedicated, it didn't always work...”*

BCUHB in late 2009. A number of these issues, are particularly relevant to safe provision of Older Persons Mental Health care from 2009 to December 2013 at BCUHB. The review has been advised by a number of current and former BCUHB staff including staff numbers 5, 11, 15, 22, 38, 55, 57, 63 and 78 that there were multiple concerns around staffing in mental health and specifically Older Persons Mental Health over a prolonged period of time. These included the following:

- Inpatient ward staffing allocations in Older Persons Mental Health that had been decided historically were not aligned to the then current need which had seen increasing acuity and complexity in the inpatient population;
- There was a need to enhance leadership of inpatient wards by making ward managers supernumerary to the clinical workforce;
- 'The skill mix needed to be richer and overall there was a significant gap between required staff and actual staff.' (Staff number 15)
- There were long term concerns regarding the level of nurse vacancies specifically across inpatient wards with up to 50 WTE inpatient nurse vacancies at various times. Former and current BCUHB staff describe a prolonged process of seeking authorisation to fill clinically essential vacancies at Executive level once they had been approved at CPG level. (Staff numbers 5, 11, 15, 22, 57, 63, 78)
- There had been significant costs associated with use of overtime and agency, but on a daily basis there was a protracted process described as a 'paper exercise' to follow to gain authorisation for agency which meant that it was frequently not possible to fill gaps in rotas because the search for agency staff started too late in the day. (Staff numbers 11, 38, 57). This 'paper exercise' involved phoning around all inpatient wards in the search for 'spare' staff knowing that those wards were also very likely to be short staffed.
- Prior to the merger of BCUHB current and former staff informed the review that there had been a well-functioning 'bank' system for Mental Health where existing substantive staff could be offered extra shifts to work within a clinical environment they were often familiar with. With the merger that created BCUHB the review has been informed that 'bank' functions were centralised and mental health had to rebuild their bank function once again. The Ockenden review was informed by staff number 15 as a result of the bank centralisation the existing mental health bank had 'almost dissipated away to nothing'.

*“On a daily basis there was a protracted process described as a ‘paper exercise’ to follow to gain authorisation for agency which meant that it was frequently not possible to fill gaps in rotas because the search for agency started too late in the day.”*

*“This ‘paper exercise’ involved phoning around all inpatient wards in the search for ‘spare’ staff knowing that those wards were also very likely to be short staffed.”*

### 11.27 Key points about staffing in the MHL D CPG from the formation of BCUHB

- Staffing numbers that had been decided historically were no longer fit for purpose due to a change in the configuration of service, increased patient numbers and acuity.
- There was long term concern around the number of nurse vacancies in Mental Health.

- This was further complicated by a prolonged process of 'vacancy control' at Executive level.
- There was a protracted process of seeking help via agency and bank on a daily basis meaning that many clinical shifts were not filled.
- The centralization of 'bank' services by BCUHB led to a loss of the previously successful bank for Mental Health and much greater difficulty in filling gaps in the staffing complement on a daily basis than had previously been the case.

## 11.28 How the CPGs reported to the Board at BCUHB:

### Relationships between the CPGs, the Chiefs of Staff, the Chief Executive and the Board of Directors

Multiple interviewees including Board members at the time and the Chiefs of Staff have commented on the very strong relationship, individually and collectively between the Chiefs of Staff and the first Chief Executive of BCUHB. Former Chiefs of Staff contributing to the review have explained that they held weekly meetings and on a more often than not basis the CEO would join them. These meetings were not joint with others, for example the Executive Directors.

Board members at the time have also confirmed that when there was a collective meeting as a Board of Directors, the Chiefs of Staff and the Executive Directors were very much meeting as equals. If there were issues in any particular service or area that came to the attention of the CEO, the first 'port of call' for advice or a response would be the Chief of Staff. This has been seen by the review where complaint correspondence from a complainant or a family reaching the CEO's office was sent directly to the Chief of Staff, from the CEO to draft a response, copied to the Executive Director.

A number of current and former Executive Directors have reflected on the role of Executive Directors in being given Executive responsibility for 'oversight' of a number of CPGs. In a written statement submitted for this review Staff number 4 confirmed 'The expectation of the Chief Executive was that the essence of this role, [as an Executive Director] was to support and offer guidance to the Chiefs of Staff as they developed their CPGs and grew into their leadership roles...' A Board of Directors meeting was held on a fortnightly basis, attendees were Executive Directors, and Chiefs of Staff and the Chief Executive chaired the meeting. One Board member at the time explained that all the CPGs 'fed through' an Executive Director. BCUHB had eleven CPGs and it was described that four Executive Directors had either 4 or 3 CPGs each. This appeared to be an arrangement that again had not been thought through by the Board in how effective it could be.

It has been explained to the Ockenden review team that to have the additional responsibility of three or four CPGs to support, sponsor and oversee in a newly merged organisation covering the breadth and depth of North Wales was clearly not a workable solution and one that an Executive Director could hope to give

*“With the merger that created BCUHB the review has been informed that ‘bank’ functions were centralised and mental health had to rebuild their bank function once again. The Ockenden review was informed by staff number 15 as a result of the bank centralisation the existing mental health bank had ‘almost dissipated away to nothing’”*



more than cursory attention to. Staff number 20, described at interview with the Ockenden team in November 2016 the 'nominal attention' Executive Directors could give to the CPGs and 'the attempt to hold them to account when eventually you knew that they were going to side-line you and go straight up to the Chief Exec..'

Staff number 48, a former Board member described to the Ockenden review the CPG and Chief of Staff structure as 'farcical.' Staff number 48 said the structure had 'disaggregated management from the clinical line.' Another interviewee, staff number 4, advised the Ockenden review team 'There were Executive Directors and if you look at the lines on a chart, it says there were Chiefs of Staff who worked to that, so there was an accountability there and that accountability was exercised to varying degrees in the context within which the organisation functioned...'

Staff number 20, told the Ockenden review of a request in 2013 to all CPGs 'for evidence of clinical governance arrangements.....draw for me your clinical governance arrangements, send me copies of your Terms of Reference....tell me how you hold people to account, show me what metrics you use at ward level...' The result was described to the Ockenden team as 'only 50% of CPGs even bothered responding which I could not believe....' Staff number 20 continued 'of those 50% that came through I was horrified....what I could see was there was no clinical governance framework, there really wasn't.'

*“Staff number 20, described at interview with the Ockenden team in November 2016 the ‘nominal attention’ Executive Directors could give to the CPGs and ‘the attempt to hold them to account when eventually you knew that they were going to side-line you and go straight up to the Chief Exec..”*

*“A former Board member described to the Ockenden review the CPG and Chief of Staff structure as ‘farcical.’ ”*

## 11.29 Key points in understanding the relationship between CPGs and the BCUHB Board

- There was a strong relationship between BCUHBs first CEO and the Chiefs of Staff which effectively disempowered the then Executive Directors;
- Long term concerns regarding the CPGs from the Independent members were not acted upon;
- The role of Executive oversight of the CPGs, by some Directors (not all) has been described by a number of Executive Directors as one that could be given only nominal or cursory attention. It was ineffective as a method of Board scrutiny.

*“I could see was there was no clinical governance framework, there really wasn't.”*



## 12 Chapter 4

12.1 What were the reports and feedback around the systems structures and processes of governance from the external scrutiny, external reports and reviews into BCUHB from 2009-13?

12.2 Reports into various aspects of the systems, structures and processes of Governance in BCUHB:

- a) The Hurst report (2012)
- b) The Allegra Report (2012)
- c) The Poole Report (2012)
- d) HIW Report into Ysbyty Glan Clwyd (2012)
- e) HIW/WAO Joint review (2013)
- f) The Public Health Wales (PHW) report (2013)
- g) The Duerden Report (2013)
- h) External reviews of Maternity Services at YGC in 2012-2013
- i) The Francis Report and BCUHB actions undertaken following receipt of the Francis report
- j) The NHS Delivery Unit (2013)
- k) NHS Wales Shared Services Partnership (2013)

12.3 A consideration of findings from the Hurst review (2012), the Allegra review (2012) and the first joint review by HIW/WAO in 2013

### Consideration of findings from the Hurst review April 2012:

BCUHB has provided the Ockenden review team with a summary of key findings from the Hurst review. In a short (six page) document provided to this review by BCUHB which Hurst describes as a 'brief informal note' intended for the acting Chief Executive (Hurst 2012, page 1) Hurst states 'the Health Board's current position and outlook makes it clear there is a need for urgency of action by the BCUHB Board of Directors.' The document states that the Board of Directors need to reach a consensus about what changes would be helpful and then commit individually, and jointly to put them in place without delay. (Hurst 2012 pages 1 and 2)

Whilst the Hurst review concentrated on finance it made a number of useful observations that were subsequently repeated in multiple external reviews going forward after 2012.

*“The Health Board's current position and outlook makes it clear there is a need for urgency of action by the BCUHB Board of Directors.”*  
(Hurst 2012)

The leadership team need to behave differently, they need to ensure they had the time and space to work together in collaboration as a team; (Hurst 2012, page 3.)

Communication with staff in the organisation needed to improve – did clinical staff know BCUHB's top priorities for delivery in 2012-13? (Hurst 2012, page 4.)

There was a perceived tolerance for long term divergence in practice across BCUHB, (the issue of different processes for SUIs across BCUHB) (Hurst 2012, page 4.)

Hurst noted that the Health Board had a track record of financial delivery from establishment, (the first 6 months of 2009-10), in 2010-11 and in 2011-12. (Hurst 2012 page 1). BCUHB did not deliver the financial plan it had set for 2012-13 and had to use significant non-recurrent measures to compensate for the under delivery of its savings programme. Therefore in 2012/13 this more than doubled BCUHBs requirement for savings and significantly increased the risks to delivery of the 2012-13 Annual Plan. Hurst noted that whilst the original savings ideas and plans 'are not at question' it was 'the delivery arrangements that have not worked as well as expected.' (Hurst 2012, page 5.)

Staff number 21, described the approach to savings plans/cost improvement plans thus: 'Our CPGs were like burrows...we would.....say right save 6% and we would scurry off into our burrows and...all emerge waving a piece of jigsaw....and then we would put our piece of jigsaw down and they never quite fitted together.'

*“Our CPGs were like burrows... we would.....say right save 6% and we would scurry off into our burrows and...all emerge waving a piece of jigsaw....and then we would put our piece of jigsaw down and they never quite fitted together..”*

## 12.4 The 2012 Allegra review at BCUHB

Following on from Hurst (2012) there was subsequent work undertaken by Allegra Limited in the autumn of 2012 which was completed in December 2012. BCUHB have provided the Ockenden review with a 12 page document summarizing this work. The document noted a number of areas of continuing concern, particularly around the governance of the BCUHB workforce. This included a 'high dependency on temporary medical and nursing staff....' (Allegra, December 2012 page 2.) The report noted that in May 2012 a 'significant level of savings themes still lacked detail (Allegra, December 2012 page 3.) A number of other key workforce concerns across BCUHB included high levels of sickness absence, and lack of progress in consultant job planning. Staff number 47 confirmed in interview with the Ockenden governance review that 'another matter of constant concern for the Board was the ...dependence on locum right across the system.' All of the issues highlighted in the Allegra (2012) review have been referred to in multiple current and former staff interviews with the Ockenden team throughout this governance review.

In a section headed 'Effectiveness of organisational management structure.' The Allegra report notes the 'Confused accountability around the clinically led structure means (the) Health Board appear to lack commercial grip and NOTE: LIMITED REVIEW OF THIS OBJECTIVE AT REQUEST OF CEO....' (Capitals as used in the report; 2012 page 9). In section 6 the report notes 'Strong clinical input and

informal reporting networks mean formal governance processes may not be fully effective.... The report states 'Some recent confidential Board sessions seem to have no formal papers making an effective review of governance difficult..' and 'Confirmation of processes for confidential Board sessions is required..' (Page 10). The report notes (capitals as used in the original report) NOTE: 'LIMITED REVIEW OF THIS OBJECTIVE AS EXPECTED TO BE PART OF WIDER REVIEW BY HIW....' and 'Findings and risk identified within this review should be shared with HIW and WAO....' (Allegra 2012 page 10.) It is clear therefore that the need for the 2013 joint HIW/WAO review was known by the time the Allegra report was shared with BCUHB.

The Allegra report (2012) recommended the appointment of a turnaround Director and the establishment of a full Programme Management Office. (Allegra Limited 2012, page 5). In its summary of conclusion it says 'Whilst the clinically led management structure provides strength in some areas, there appears to be a lack of commercial and financial rigour at operational levels...there is limited cross functional/cross geographical inter-operation. These issues have been exacerbated by an apparent historic lack of accountability and effective line management at senior levels. Consideration should be given to changing the organisational management structure to address these concerns...' (Allegra 2012, page 12).

Staff number 107 provided contemporaneous evidence to the Ockenden review to the effect that in some parts of the organisation there was a lack of ownership of budgets and overspends, demonstrated by a belief that inequitable funding was the cause of the problem, that 'bail outs' were inevitable, and that this tended to dominate the management culture.

## 12.5 Key points in the Hurst (H) report (2012) and Allegra (A) report (2012)

- The leadership team at BCUHB needed to behave differently in order to improve upon their effectiveness, they needed to spend time together, communicate more effectively with the workforce about BCUHBs key priorities (H)
- There needed to be articulated one BCUHB 'way of doing things' (H)
- Delivery of financial plans had not been effective and there needed to be structural change around this (H)
- A high use of temporary staff and other workforce related issues were causing significant issues in BCUHB (A)
- There was confused accountability in the organisational structures (A)

## 12.6 Locum staff use within the OPMH CPG service

The dependency on expensive locum medical staff within Older Persons Mental Health, (OPMH) was known to the then CEO and members of the Executive team by July 2012. An email from the lead consultant within OPMH (dated 31st July

*"Some recent confidential Board sessions seem to have no formal papers making an effective review of governance difficult.."*

*"Whilst the clinically led management structure provides strength in some areas, there appears to be a lack of commercial and financial rigour at operational levels...there is limited cross functional/cross geographical inter-operation. These issues have been exacerbated by an apparent historic lack of accountability and effective line management at senior levels. Consideration should be given to changing the organisational management structure to address these concerns..."*

(Allegra 2012, page 12).

2012 @1513hrs) informs the CEO, the then BCUHB Medical Director and then Director of Primary, Community and Mental Health of the following:

- That the service was needing to urgently appoint locum medical staff;
- That the advice from the BCUHB 'medical workforce department' was that 'regardless of the urgency to recruit NHS locum doctors [BCUHB] needed to run each advertisement for a minimum of two weeks....and 3 weeks thereafter for the interview;'
- The delay in recruitment which resulted from this policy – which had allegedly not been discussed with medical leaders was causing 'major problems in terms of clinical safety as well as financial burden to the organisation;'
- Many other Health Boards across the NHS in Wales did not adopt such a policy;
- That the time delay built in as a result of the above 'policy' led to longer periods of time when BCUHB was paying 'agency locum rates almost 4 times higher than what we would have been paying for the NHS locum for several weeks before we progress to recruitment....'
- That on many occasions 'the quality of the agency locum doctors would be very poor;'
- That currently (July 2012) the Older Persons Mental Health service did not have 'sufficient number of doctors to hold the bleep in Ablett.'
- There had previously been a problem with lack of medical cover described as 'an emergency in Flintshire' where the service paid for an 'agency locum for 6 weeks before we progressed with NHS locum recruitment and for a couple of days there was no cover as we struggled to get agency cover.'

*“The quality of the agency locum doctors would be very poor.”*

The problem with locum usage at BCUHB continued into 2013 and beyond into 2017. Such was the concern around the high use and high cost of locum use in BCUHB in 2013/14 that the BCUHB Audit Committee were required to respond to the Welsh Audit Office (WAO) 'Use of Locums' report in 2013/14. Issues with continued medical locum use and high levels of consultant vacancies have been raised in multiple HIW inspections over the last 7 years and were also commented on extensively in the service user 'Listening and Engagement' events in the spring and summer of 2017. This is further discussed in Part 2 of this report.

## 12.7 BCUHB's strategic vision and the subsequent lack of service reconfiguration associated with 'Healthcare in North Wales is Changing'

BCUHB underwent challenging public consultation in the latter part of 2012. This was based on the consultation paper 'Healthcare in North Wales is Changing' which closed at the end of October 2012. The changes within the community localities were for a significant proposed reduction in community beds for older person's mental health. The BCUHB Board held an extraordinary meeting on the 19th July 2012 to receive the findings in public of the projects board that had

been established following the approval by the BCUHB Board of the case for change across service areas. The Ockenden review has been informed that there had been extensive involvement of stakeholders including the Alzheimer's Society, carers, local authorities and the public.

The Board minutes<sup>110</sup> show the attendance of senior staff representing Older Persons Mental Health to present the findings from the public consultation. The notes of the meeting refer to a report to the Board of 'currently significant variances across the organisation.' (see link below) There was a report of 'low bed occupancy in many inpatient units, compounded with difficulties in staffing the units.....an increasing number(s) of people with dementia and the associated need to provide support and care for their carers.'

The minutes of the meeting show that further information was sought at this meeting by an Independent Member (IM) on how carers would be supported and the response given was provision of 'diagnostic counselling for carers would be utilised and additional support provided through working with partners and voluntary organisations.' No detail was provided in the Board minutes as to who those proposed partners or voluntary organisations would be. The poor experiences described by service user representatives and carers of patients using older persons mental health services across North Wales at the 'Listening and Engagement Events' held throughout the Spring and Summer of 2017 suggest that the recommendations from the public consultation presented to the BCUHB Board in July 2012 had simply not been worked through into a form that could be described as deliverable.

Discussing behaviours around the presentation of key issues to the Board around that time staff number 20 said 'I think people wanted to give you reassurance... not assurance ...' Staff number 55 in interview in April 2017 agreed and told the Ockenden team that the senior management team within the CPG received feedback from 'yes people, [who] told them what they wanted to hear, everything's alright, everything's alright, well no it's not, you lift the lid and it's not.'

BCUHB Board papers from 2013 show a further attendance by members of the Older Persons Mental Health team at a BCUHB 'extraordinary' Board meeting<sup>111</sup> in January 2013. This Board meeting was to receive a report on the outcome of the public consultation and recommendations to the Board as they pertained to Older Persons Mental Health. The Board paper (see link below and pages 12 and 13 note that 'The recommendations were approved in totality' by the Board.

These included recommendations to:

- Strengthen Older Persons Mental Health community teams (1)
- Strengthen nurse liaison services, including training and education in general hospitals and nursing homes (2)

*“The CPG received feedback from ‘yes people, (who) told them what they wanted to hear, everything’s alright, everything’s alright, well no it’s not, you lift the lid and it’s not..”*

*“The CPG received feedback from ‘yes people, [who] told them what they wanted to hear, everything’s alright, everything’s alright, well no it’s not, you lift the lid and it’s not..”*

*“‘The recommendations were approved in totality’ by the Board*

<sup>110</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%2019.7.12%20V1.0%20approved.pdf>

<sup>111</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20BCUHB%2018.1.13%20V1.0%20approvedx.pdf>



- Improve memory services and early diagnosis across North Wales, with a strong focus on recognising the symptoms of dementia and convey the message that it is possible to live well with dementia (3)
- Introduce a programme of accreditation for memory services
- Close mental health inpatient beds at Bryn Beryl and Dolgellau
- Reduce inpatient beds at Ysbyty Cefni and transfer beds to Ysbyty Gwynedd (4)
- Develop specialist beds in the North Denbighshire project with the closure of inpatient beds at Glan Traeth in Rhyl (5)
- Ensure that the service provided is based on need rather than age (6)

The Board was informed of opportunities to commission Elderly Mentally Infirm (EMI) beds in nursing homes, and also that 'support would be available to help families and carers look after people....' The Board was further informed that 'there was a strong degree of confidence in the proposals....' Information seen by the Ockenden review team shows that BCUHB implemented only partially the recommendations. The former clinical lead for OPMH has informed the Ockenden review that beds were closed before the supporting community infrastructure detailed in (1) to (6) above was developed. This has had long term and significant effects on care of older persons across North Wales which continues to the current time.

It is unclear to this review where the 'strong degree of confidence' at Board level came from. Emails between senior members of staff within the then MHL D CPG team and members of the BCUHB Executive team, starting on the day of the Board meeting above (18th January 2013) discuss the possible (then actual) closure of a large EMI nursing home in North Wales.

There is significant concern expressed by some senior members of the MHL D CPG team within those emails regarding the implications of closure of this large EMI nursing home on the then available bed capacity for older people across North Wales. On the 4th January 2013 (two weeks before the BCUHB Board meeting) members of the CPG team had been advised 'The view continues that closure of the home is inevitable.' Further internal emails seen from February 2013 highlight the lack of Board scrutiny for a plan that relied on the EMI nursing home sector providing beds, against a background of closing Older Persons Mental Health beds. The email from the lead consultant from OPMH to the CPG senior team and members of the Executive team describes five EMI nursing homes across North Wales either 'under escalating concerns' or considering closure. The email to members of the CPG senior leadership team and the Executive team says 'I am extremely worried about the impact it has...and the usage of NHS beds to accommodate vast numbers of patients...we need to have some urgent strategic thinking about the near future....' (Email sent 15th February 2013, @1654hrs.)

*"I am extremely worried about the impact it has...and the usage of NHS beds to accommodate vast numbers of patients...we need to have some urgent strategic thinking about the near future...."*



Finally the Board at the meeting of the 18th January 2013 were informed of 'a training the trainer programme which would be rolled out to care for people with dementia.' In the event inpatient bed closures happened. However the bed closures happened before an infrastructure of community support for older people and their carers had been adequately developed and delivered. This continues to affect the care pathway and care provision to people with dementia and older people with mental health needs to the current day.

### 12.8 Key point: Did the BCUHB Board scrutinise effectively the plans underpinning 'Healthcare in North Wales is changing'?

- No it did not.
- The presentations of feedback from public consultation to the BCUHB Board in July 2012 and January 2013 were aspirational and low on specific detail and the Board made very limited effort to seek that detail.
- The plans approved by the BCUHB Board went on to have far reaching and very serious consequences for the care of older people in North Wales for years to come and are still having a negative effect today; (at the end of 2017)

In April and May 2014 in a meeting titled 'Older Peoples Mental Health Review Steering Group' (part of the 2014 Flynn and Eley 'Strategic review of Older Peoples Mental Health Services' The minutes of the 3rd April 2014 discuss the provision of nursing home care, and say 'identified some ... complex patients are returning to wards, lack of capacity in homes in North Wales is influencing health care.' (BCUHB 2014, p3) This is very different from the commissioning 'opportunities' around nursing home beds presented to the BCUHB Board in 2012 and 2013.

### 12.9 Key points – what happened next with 'Healthcare in North Wales is Changing?'

- There was a lack of agreement between BCUHB and the North Wales Community Health Council. The changes were ultimately agreed with some monitoring requirements but significant delay occurred.
- The fragmented and slow approach to reconfiguration across North Wales made it difficult for BCUHB to enact a whole system redesign.
- The delays in the progress of the plans gave cause for concern against a background of recruitment/finance and sustainability challenges across BCUHB over a prolonged period of time.
- A number of staff in post at the time described at with the Ockenden governance review team challenging and significant Cost Improvement Programmes undertaken by BCUHB from 2013 onwards with values of between 6% and 8% aspired to.

*“However the bed closures happened before an infrastructure of community support for older people and their carers had been adequately developed and delivered. This continues to affect the care pathway and care provision provider to people with dementia and older people with mental health needs to the current day.”*

Evidence has been seen by the Ockenden review, (from consideration of a number of BCUHB Board and committee meetings throughout 2011, 2012 and 2013) that the Board, Executive team, Board of Directors and a range of senior managers grappled with the need to reduce costs, reconfigure services (and reduce the size of BCUHB's 'footprint') repeatedly.

The Ockenden review team has been advised that this subject was discussed at the BCUHB Board and a number of Committees and meetings including the BCUHB Board of Directors, the Finance and Performance Committee, the BCUHB Workforce and Organisational and Development Committee, and the BCUHB Board in July<sup>112</sup> and September<sup>113</sup> 2012 and in January 2014<sup>114</sup>.

Two examples – across a two year period are noted at the BCUHB Board by the then Director of Workforce and Organisational Development. These were that 'overall workforce had increased slightly due to needs to respond to emergency pressures' and that 'increased staff sickness levels were noted, and the Director of Workforce and Organisational Development reported this was an indication of pressures and stressors within the workforce.' 27/09/12 – see link 115 below and 12.92.7.1.2 and 12.92.7.1.3).

In January 2014 at the Board 14/011 there was discussion, led by the then Director of Workforce and OD on 'the indication of the need for additional staffing in the Hergest unit 'and 'the relevant CPG was already continually challenged to balance its budget.' (see link 11 below, page 15.)

These discussions continued and the Ockenden review has not seen evidence that the BCUHB Board have yet resolved the difficulties facing them in this area.

## 12.10 Joint review undertaken by HIW/WAO 2013

### 12.11 Key point: Why did HIW/WAO undertake a 'joint review' of governance arrangements at BCUHB in 2013?

This joint review and report was commissioned following 12 months of concerns (identified above) raised by the Healthcare Inspectorate Wales (HIW) and the Welsh Audit Office (WAO)

Concerns initially focused around the Board's financial performance and had resulted in independent reviews being conducted in April and December 2012.

The findings of both these 2012 reviews have been considered earlier in this report, as although their initial focus was on finance they did highlight many important issues for the BCUHB Board around the BCUHB structure and the consequences for the systems, structures and processes of governance in place

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<sup>112</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20BCUHB%2026.7.12%20v1.0%20Approved.pdf>

<sup>113</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20BCUHB%2027.9.12%20V2.0%20APPROVED%20PUBLIC%20VERSIONx.pdf>

<sup>114</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20Health%20Board%2023.1.14%20V1.0%20approved.pdf>

at BCUHB at that time. Staff member 16 recalled at interview that prior to the joint HIW/WAO review of 2013 two of the BCUHB Independent Members (IM's) had expressed concern to the Welsh Audit Office (or WAO) about the accuracy of financial reporting at BCUHB. Staff number 107, also provided contemporaneous evidence to the Ockenden review of concerns raised formally around a deteriorating financial performance in early January 2013 and:

A lack of 'accountability, structures and processes' and insufficient focus on cost control;

A lack of engagement 'in some of the organisation' with governance processes;

A lack of acceptance as to the true extent of the problem with a tendency to seek 'external solutions' rather than focusing on 'internal measures.'

Staff number 107 said at the time 'Good financial governance forms a coherent whole with good corporate governance and good clinical governance and this year we have experienced significant overspend accompanied by failure to achieve access targets and concerns raised on some aspects of the quality of our services...' (Staff number 107, written information submitted to the Ockenden review March 2018.)

Staff number 16 agreed with the findings of the 2013 HIW/WAO report and noted in interview that throughout BCUHB and the CPG structure 'There wasn't that thread of accountability...' Staff number 19 advised the Ockenden review in interview in November 2016 'There was a tension around accountability. On paper there was formal accountability between the Chiefs of Staff and nominated Executive Directors, but in practice the Chiefs of Staff also had a direct line to the Chief Executive...' Staff number 21 advised the Ockenden review in interview in March 2017 'Accountability was very light,'

The extent of the concerns at the time of the joint HIW/WAO review were very significant, however HIW and WAO were not aware that the concerns were replicated in any other Health Boards across Wales. Staff member 16, noted in interview in October 2016 that at the time BCU was 'good at presenting but there wasn't much under the surface. There was an absence of strategic plans, some services were not terribly safe at this point in time.' Staff number 21 told the Ockenden team at interview 'The emphasis was on good news.. So let's celebrate, lets....all have a clap and a cheer.'

Staff member 16 stated at interview 'The grip on the organisation wasn't there....' Staff number 19 noted at interview 'as we go through the years (what became clear) is that there were organisational design flaws in those, (the CPG) arrangements.'

*“There was a tension around accountability. On paper there was formal accountability between the Chiefs of Staff and nominated Executive Directors, but in practice the Chiefs of Staff also had a direct line to the Chief Executive....”*

*“Good financial governance forms a coherent whole with good corporate governance and good clinical governance and this year we have experienced significant overspend accompanied by failure to achieve access targets and concerns raised on some aspects of the quality of our services...”*

*“Good at presenting but there wasn't much under the surface. There was an absence of strategic plans, some services were not terribly safe at this point in time.”*

## 12.12 What were the objectives of the 2013 joint HIW/WAO report?

The objectives were said to be for other Health Boards across Wales to both review their own internal governance arrangements and to promote system wide learning (HIW/WAO 2013 page 5.)

The objective of the report for BCUHB was to provide a 'single consolidated overview of the corporate, clinical and financial challenges facing the Health Board and the potential impact of these on patients' (HIW/WAO 2013, page 7)

Staff number 47, discussed at interview the extensive amount of time and focus the first joint HIW/WAO review and report required of BCUHB and its Board. 'The...problem with the report is that, basically, it only told us what we already knew and were acting on but what it failed to say was that we were acting upon it..'

*"The emphasis was on good news.. So let's celebrate, lets.... all have a clap and a cheer.."*

*"The...problem with the report is that, basically, it only told us what we already knew and were acting on but what it failed to say was that we were acting upon it.."*

## 12.13 What were the outcomes?

The outcomes were grouped together into six key themes

1. Effectiveness of the BCUHB Board and its sub-committees;
2. Management and clinical leadership structures at BCUHB;
3. Quality and safety arrangements at BCUHB;
4. Financial management and sustainability at BCUHB;
5. Strategic vision and service reconfiguration at BCUHB;
6. The way forward: recommendations for driving improvement at BCUHB.

(HIW/WAO 2013, page 7.)

These themes formed the basis of the reporting of information for this joint review and subsequent joint reviews of BCUHB by HIW/WAO in 2014 and 2017.

## 12.14 Effectiveness of the Board and its Sub-Committees

In the 2013 joint review HIW and WAO identified that whilst BCUHB had provided some evidence that it was addressing the concerns previous reviews had brought to their attention the joint HIW/WAO review identified that a number of factors had combined to compromise the ongoing effectiveness of the Board. This included a breakdown of working relationships between senior leaders in the Health Board.

This is acknowledged and agreed by a number of current and former BCUHB Board members interviewed as part of this review. Staff member 16 in interview in October 2016 described BCUHB at the time of the joint HIW/WAO review as 'the organisation was a car crash...There was low trust between Independent Members and Directors. There was an 'us' and 'them' attitude. Directors weren't behaving as a team, they were very much as individuals....'

*"The organisation was a car crash... There was low trust between Independent Members and Directors. There was an us and them attitude. Directors weren't behaving as a team, they were very much as individuals...."*

Multiple interviewees at Board level recalled to the Ockenden team the tension between Executive roles and the CPGs and the long term concern from Independent Members regarding the level of autonomy given to CPGs. Executive members in post at the time described the difficulties where Board members were unable to get a common view on an issue because Clinical Programme Groups had been able to adopt different approaches to each other and had been able to structure themselves from a governance perspective in different ways. (This was discussed at length in multiple interviews by staff numbers including 1, 9, 14, 16, 20, 21, 47, 52, 78 and 90).

Staff member 16 also noted a lack of knowledge regarding the functioning of a Health Board in late 2013 by the senior leadership group. At this point BCUHB had been in existence for four years and Staff number 16 said of the Chiefs of Staff 'they had no idea what a Chair did or what a Chair does.....[and] the whole organisation had little sense of what a Board was there to do.'

Staff number 47, staff number 16 and the 2013 HIW/WAO report appear to be in agreement regarding considerable difficulties in Board relationships. Staff number 47 cites at interview the increasing dependence of the CEO on the CPG Chiefs of Staff role by the end of 2012 describing that the CEO 'saw the CPG, Chiefs of Staff as her powerbase within the organisation...she deployed them in ....to support her .....and she was increasingly .....dependent on them because... by this stage she didn't have much support on the Board.'

Staff numbers 100, 106, and 111 agree, stating in their written submission to the review that there was 'considerable variability in the leadership and management abilities of Chiefs of Staff and CPG Boards....' This was not a problem that was resolved by the multiple external reviews of 2012, 2013 and 2014.

Staff member 4 recalls the challenges for Board Directors working within a context where there was 'a clear expectation of autonomy for Chiefs of Staff and CPGs.....they were encouraged by the Chief Executive to work in a particular way and their accountability was straight to Committees...' [of the Board for example the Quality and Safety Committee.]

Staff numbers 100, 106 and 111 submitted a joint statement to this governance review in which they said 'We believe it to be accurate and fair to state that despite....mounting concerns, the CEO was totally committed to the CPG model and the group of clinical leaders (Chiefs of Staff) and to the autonomy of that group.' They continued 'One of the Board level 'battles' was an insistence..... [By IM's] that all CPG Board meeting minutes should be available to all BCUHB members to ensure proper governance (this was never delivered.) These concerns were compounded by the proliferation of 'Boards' with confusion, amongst many clinical staff throughout North Wales as to which Board was the responsible body.'

Staff number 47 described at interview the lack of capacity and capability at Board level that was evident by the time of the 2013 HIW/WAO report. Staff number 47 advised the Ockenden review team 'I came to the conclusion that it

*"We believe it to be accurate and fair to state that despite.... mounting concerns, the CEO was totally committed to the CPG model and the group of clinical leaders (Chiefs of Staff) and to the autonomy of that group."*



was largely to do with capability.....there were not enough people.....too many things were getting stuck.....you needed 2 or 3 people to be doing those [roles].’ A further issue identified was the lack of a headquarters or base for the BCUHB Board with staff number 47 advising that the Board instead ‘we were all to drive constantly across North Wales.’

*“Some people, I think need to look to themselves about their roles....there no innocent bystanders in this process of governance....”*

## 12.15 Lack of cohesion, effectiveness and consensus amongst the Executive Members 2009 to 2013:

### Key points:

Information presented to this governance review demonstrated that the Executive Directors did not work cohesively as a team for a prolonged period of time after the creation of BCUHB. Views were also presented regarding the lack of consensus by the Executives during presentation of important issues to the Health Board.

Staff member 16 stated at interview in April 2017 ‘Directors weren’t behaving as a Team, they were very much as individuals....’ In a further discussion staff member 16 added ‘Some people, I think need to look to themselves about their roles....there no innocent bystanders in this process of governance....’ Staff number 48 described at interview the need to bring in new Board members ‘to try and lift the aspirations of those that were there....’ and describes a number of Executive members in 2013/14 ‘of the keep my head down, I don’t want to be in the line of fire....’ Staff number 48 further describes a number of long term Executive members of the Board in 2014 as ‘coasters.’

*“The papers weren’t well written...it would have been impossible to have actually read them all.... They weren’t concise, I don’t believe ... strategy was ever discussed.”*

## 12.16 Concerns regarding the way information was presented to the Board

The joint HIW/WAO review in 2013 stated that Board ‘discipline’ was not evident regarding preparation and presentation of papers. Staff number 47 informed the Ockenden review team that ‘receiving a coherent strategic executive response was problematic.’ Referring to the position more than a year later in 2014/15 Staff number 48 stated at interview ‘The papers weren’t well written...it would have been impossible to have actually read them all....They weren’t concise, I don’t believe ... strategy was ever discussed.’

*“We did end up with a dysfunctional Board.... It wouldn’t be the first time it would be called a dysfunctional Board...my concern is that the previous reports pointed out that it was dysfunctional but was not able to indicate that, actually, the Board was trying to do something about it...”*

## 12.17 A need for a greater mutual appreciation of the respective roles of Executive and Independent Board members

The 2013 joint HIW/WAO review stated there were frustrations from the Executive members regarding the Independent members as ‘managing the Executive’. Independent Members expressed concerns to HIW and believed they were not given the whole picture by Executive members. Staff number 16 noted in interview that ‘Independent Members ....were frustrated, they had raised concerns [but] .... had not followed these through formally enough’ In a joint written statement provided by staff numbers 100, 106 and 111 they disagree



with staff number 16 and state 'The Director of NHS Wales was kept fully informed of those concerns, agreements and developments.'

## 12.18 Did the Board function effectively in 2013?

**No**

The 2013 joint HIW/WAO review stated that in order to ensure that the Board at BCUHB functioned in an effective way there would need to be trust built between Board members. Staff number 47, discussed the situation in early 2013 noted at interview 'We did end up with a dysfunctional Board....It wouldn't be the first time it would be called a dysfunctional Board...my concern is that the previous reports pointed out that it was dysfunctional but was not able to indicate that, actually, the Board was trying to do something about it...' Staff number 19 noted at interview in June 2017 'Any Board that doesn't have a substantive Chair and Chief Executive or substantive Medical and Nursing Director is likely to be dysfunctional. The record shows very clearly there were serious issues in relation to the quality and safety of services, not only in Tawel Fan but things like C Diff and others.'

In the short-term, the 2013 Joint HIW/WAO review advised that additional external senior leadership support and capacity must be brought in to provide impetus and fresh perspectives. On reflection staff number 47 recalls that this fresh impetus was not achieved. Recalling the 'turmoil' that BCUHB was in at this time staff number 47 stated that meaningful activity in BCUHB stopped in early 2013. 'There is a stasis, and there's also ....a lack of focus on issues that needed to be addressed...when organisations are under this kind of pressure and turmoil it's the day to day stuff that suffers because you're spending all [y]our time on the telephone...'

Prior to the joint HIW/WAO review in 2013 a loyalty to historical structures and acceptance of inconsistent practices had been highlighted to the BCUHB Board with minimal if any change. Hurst (2012) had previously noted in a summary of his 2012 review provided to the Ockenden team by BCUHB 'the perceived longer-term 'tolerance of divergence in practice' (e.g. the multiple SUI processes still in use across BCUHB in early 2012 was quoted as an example by Hurst and staff number 14 and others.) This use of multiple legacy processes would undermine the work of the Directors to align staff to a common purpose, which was to 'deliver consistent and effective healthcare.' Hurst had 'asked the question' in April 2012, 'Are the Directors fully sighted on the areas where there is still variation of practice/procedures: and have you agree (d) a target date for standardising practice in each of these areas? (Hurst C 2012, page 4).

Staff numbers 100, 106, 111 recall that during this period of time BCUHB was heavily involved in 'clinical reconfiguration and modernising processes, with some centralisation of specialist services and some controversial services closures. ....These years were a time of developing and reinforcing an all North Wales identity, but at times it felt like we were driving against strongly held allegiances, particularly by senior clinical staff, for the old DGH model.' This

*"Any Board that doesn't have a substantive Chair and Chief Executive or substantive Medical and Nursing Director is likely to be dysfunctional. The record shows very clearly there were serious issues in relation to the quality and safety of services, not only in Tawel Fan but things like C Diff and others.."*

*"There is a stasis, and there's also ....a lack of focus on issues that needed to be addressed... when organisations are under this kind of pressure and turmoil it's the day to day stuff that suffers because you're spending all [y] our time on the telephone..."*

theme was found throughout the review undertaken by HIW of the Ysbyty Glan Clwyd site in February and March 2012. It was further discussed in the BCUHB Quality and Safety Committee<sup>115</sup> in April 2012. (see 12/37.4)

### 12.19 Insufficient accountability and performance management arrangements at BCUHB

Urgent work was required to improve the effectiveness of the Board and the processes supporting its work. The joint HIW/WAO report stated that 'Most significantly we have concerns that the Health Board's governance arrangements and organisational structures are compromising its ability to adequately identify problems that may arise with the quality and safety of patient care.' (HIW/WAO 2013, page 9.)

Staff number 47 in interview stated that 'the fundamental problem for the BCUHB Board was the CPG structure which .....prevented them from getting the sight from the Board to the Ward.....there was a long process to try and reduce the numbers of CPGs....' Staff numbers 100, 106 and 111 said in a joint statement to the Ockenden review. 'Concerns developed and intensified at Board level about the effectiveness of the CPG structure model fairly soon after its establishment.' They described that whilst the model devolved a great deal of authority and decision making to CPG Boards, 'there was the expectation from Independent Members of a far greater level of transparency and accountability to the Board than ever happened..'

Staff number 47, further described at interview how information from the CPGs would 'immediately clog up the system because there would be so many of them...' Staff number 4, stated at interview that it was often very difficult to assimilate information provided by the CPGs into BCUHB wide themes. 'Much of the information was presented in silos with a view of this is what's going on over here and this is what's going on there, they did try very hard to develop the information base that they were working with so they had a stronger and more in depth quality focus. Some of that worked well and was developing, some of it actually struggled, partly because of inconsistencies of approach and information gathering across the organisation and in some instances a difficulty in actually analysing and synthesising that information too. ....'

Staff numbers 100, 106 and 111 stated that following an informal meeting of the Chairman and IM's in October 2012 'there was unanimous agreement on the urgent need for change.' They subsequently described 'the discussions and agreements' of that meeting 'and the ultimate attempt by the CEO to over-ride those agreements....' They describe in written communication to the Ockenden review team that despite repeated requirements 'for improved sharing of CPG information' to IM's which it notes was 'a full Board decision approved in a public session..' this improved information sharing did not ever actually happen<sup>116</sup>.

*"Most significantly we have concerns that the Health Board's governance arrangements and organisational structures are compromising its ability to adequately identify problems that may arise with the quality and safety of patient care."*

*"Concerns developed and intensified at Board level about the effectiveness of the CPG structure model fairly soon after its establishment."*

*"Information from the CPGs would 'immediately clog up the system because there would be so many of them...'"*

<sup>115</sup> <http://www.wales.nhs.uk/sitesplus/861/page/60193>

<sup>116</sup> Written communication with Donna Ockenden January 2018

They further add 'The Director of NHS Wales was kept fully informed of those concerns, agreements and development....' Finally these staff members advised the Ockenden review that the IM's 'were entirely of single mind and united on this matter, despite the fact that we ultimately failed to oversee the progress we had hoped to achieve....'

## 12.20 The breakdown of the relationship between the then CEO and then Chair in early 2013 as described by HIW and others:

The concerns of IMs with the management and performance of the Board led to what the joint HIW/WAO report described as a 'breakdown' in the relationship between the relationship between the then Chair and the then CEO. This was described by HIW/WAO in their 2013 joint review as an issue of concern that 'presents real challenges for the Board..'

By early 2013 the relationship between the then CEO and then Chair was described as being broken beyond repair. This has been confirmed by staff number 47 and a significant number of others including 100, 107 and 111. Staff number 100 and 111 advised the Ockenden governance review that the relationship between the then CEO and the then Chair <sup>117</sup>appeared to be warm, friendly and cooperative' until early 2013.

A significant number of former Board members at the time have raised with the Ockenden review team their belief that Welsh Government did not intervene sufficiently swiftly when it was very clear to many colleagues and indeed to HIW/WAO in 2013 that working relationships between the CEO and the Chair had become irretrievably broken.

The former Board members described to the Ockenden governance review a 'sticking plaster' approach by Welsh Government to service continuity at BCUHB at this time. This 'sticking plaster approach' included other Board members asked to act as 'go between' between the then CEO and then Chair. A number of former BCUHB Board members raise the breakdown in the relationship between a CEO and Chair (as happened at BCUHB) as a concern of 'national governance' and one that therefore should have had national leadership from Welsh Government at the time. They note that the appointment of a 'go between' as was put in place at the time at BCUHB was not an appropriate solution since whilst it facilitated communication (to a degree) between the Chairman and CEO the 'go between' did not 'have the authority to drive improvement through the chaos that this partnership dysfunction [created.]' The Ockenden review has not seen evidence of any further input from Welsh Government at the time other than that shared by former Board members.

Staff number 47, a former Board member in interview discussed a formal letter which they had written to the then CEO in November 2012 raising concerns

*"The IM's 'were entirely of single mind and united on this matter, despite the fact that we ultimately failed to oversee the progress we had hoped to achieve....'"*

*"Following an informal meeting of the Chairman and IM's in October 2012 'there was unanimous agreement on the urgent need for change.'"*

*"The 'go between' did not 'have the authority to drive improvement through the chaos that this partnership dysfunction [created.]'"*

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<sup>117</sup> Written communication with Donna Ockenden January 2018

about the resilience and the cohesion of the Executive team at BCUHB and the weakness of the CPG management structure.

The letter (written after a very significant period of time of the Independent Members raising very serious concerns) said:

'The HIW report on Glan Clwyd highlights weaknesses in the operation of the CPG Management structure. This confirms the belief of Independent Members that there are fundamental problems in the management and governance implications of the CPG structure. In management terms the HIW report highlights the ineffectiveness of onsite CPG control. This is deeply worrying and needs to be addressed immediately....' The Ockenden review was advised by staff numbers 47, 100 and 111 that these formal written concerns on behalf of Independent Members regarding the ineffectiveness of the CPGs followed on from many discussions held between Independent Members and the CEO throughout 2011 and 2012.

Staff numbers 100, 106 and 111, all former Board members submitted a joint written statement to the Ockenden review team in November 2017. They said that the 'devolved structure' associated with the CPG model 'disempowered and subsequently divided (the BCUHB Executive team) and that across the CPGs 'there was a variable commitment to necessary cost improvement and efficiency plans throughout the organisation' Furthermore, the Ockenden review was advised that (the Board) 'was unable to aggregate CPG plans into corporate level strategic plans which were costed and deliverable..' They further advised the Ockenden review that following an 'informal meeting' between the Chairman and the then IM's in October 2012 'there was unanimous agreement on the urgent need for change...' This change did not subsequently happen for a number of years.

## 12.21 The need for Board Development in 2013

HIW and WAO (2013) stated that focused Board development was required to ensure that cohesive Board working was established. (HIW/WAO, 2013, page 10.) Staff member 16 agreed at interview and said that in 2013 the Board needed training and development to become an effective, high performing and well led Board..'). Staff member 16 said of the Board in interview 'It knew a hell of a lot, but it didn't have any overview so it would go into great detail...' Staff number 47 agreed and said at interview 'huge amounts of information came to the Board about all sorts of issues....'

Board development at the time was described as 'rubbish' by staff number 20. Staff number 20 described to the Ockenden review being given 'stickers if we had been very good in Board development sessions.....not everybody would turn up and the Execs...were constantly on...Blackberries because there was some other crisis all in all.' Staff number 20 reflected on the lack of Board induction and development available at this time and said 'I asked about Executive induction or an Executive pack or something that might help me, there was nothing....'

*“The ‘devolved structure’ associated with the CPG model ‘disempowered and subsequently divided (the BCUHB Executive team) and that across the CPGs ‘there was a variable commitment to necessary cost improvement and efficiency plans throughout the organisation’.”*

*“This confirms the belief of Independent Members that there are fundamental problems in the management and governance implications of the CPG structure. In management terms the HIW report highlights the ineffectiveness of onsite CPG control. This is deeply worrying and needs to be addressed immediately....”*

In a written statement submitted to the Ockenden review staff number 28, reflecting on the joint HIW/WAO review (2013) said 'The joint review of governance arrangements at the Health Board undertaken by WAO/HIW and reported during June 2013 represented an external perspective on the governance arrangements of the Health Board during this period. Its findings have not been contested....'

## 12.22 Key points: Final recommendations in the joint 2013/14 HIW/WAO review

Overall twenty four recommendations were identified by the joint HIW/WAO review in 2013 to address the concerns previously described above. Further detail can be found in the original report. (Pages 25 to 26.) There was a commitment by HIW/WAO to return to BCUHB for further review within 12 months.

## 12.23 Actions undertaken by BCUHB in response to the 2013 joint HIW/WAO review

Following on from the joint HIW/WAO review in June 2013 Staff number 28, refers to 'a work programme of activities' that were undertaken by BCUHB. These included the establishment of a 'Governance and Leadership Delivery Team' supported by an external to BCUHB NHS Wales CEO and the then interim CEO of BCUHB... Staff number 28 notes in a written statement 'The progress made..... was reported to the Health Board during September 2013....'

## 12.24 What assurance did the BCUHB Board have in 2013-14

The BCUHB Annual Governance Statement 2013-14 published in June 2014 stated the following on behalf of BCUHB's Head of Internal Audit; (HIA)

'The Board can take limited assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively..' and:

'The HIA has concluded reasonable assurance for the domains of corporate governance ... however the results of internal audit work offer only limited assurance across other domains and significantly amongst these is the primary assurance domain of clinical governance, quality and patient safety'. (BCUHB 2014, page 26.)

Subsequent to this BCUHB were further supported by the Good Governance Institute (or GGI) throughout 2014 and then by Mrs Ann Lloyd CBE. The work of the GGI and Mrs Lloyd in 2014 to support development of an effective governance system for BCUHB is described later in this report.

*"The joint review of governance arrangements at the Health Board undertaken by WAO/HIW and reported during June 2013 represented an external perspective on the governance arrangements of the Health Board during this period. Its findings have not been contested...."*

*"The Board can take limited assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.."*

Head of Internal Audit , BCUHB  
June 2014



## 12.25 The systems, structures and process of governance underpinning Infection Prevention and Control at BCUHB that are relevant to an overview of the systems, structures and processes of governance and as specified in the Ockenden review Terms of Reference

During May 2013 and prior to the commencement of the first joint HIW/WAO review an outbreak of Clostridium Difficile was reported at Ysbyty Glan Clwyd. The outbreak, how it was managed and the implications for the systems, structures and processes of governance across BCUHB was subject first to a review by Public Health Wales then to an external report by Professor Brian Duerden in 2013. The implications of the 2013 Duerden report for the systems, structures and processes of governance in the Mental Health and Learning Disabilities (MHL) CPG, Older Peoples Mental Health and ultimately Tawel Fan ward will be considered later in this report.

## 12.26 The following failings were reported by Public Health Wales prior to the Duerden review in 2013:

- Inconsistencies in incident reporting;
- Inconsistencies in receiving information;
- Inadequate infection control governance;
- Inadequate Board scrutiny.

The PHW review (2013) found that the Health Board placed too much reliance on the quality and safety arrangements within the CPG structures without having had sufficient assurance of its effectiveness. It was noted that the CPGs only reported to the Board annually and there was inconsistency in both the information brought and the assurance processes underpinning the acceptance of that information. This review has seen a similar arrangement for the scrutiny of the then MHL CPG by the Board

An overview of the recommendations from PHW (many of which have relevance to the systems, structures and processes of governance within the Mental Health and Learning Disabilities CPG at the same time) were:

- The Board must give greater priority to control of infection and **ensure that the safety of patients is not compromised**
- A **review of governance arrangements** must be undertaken as a matter of urgency
- The review must include the process of Executive and Board **'performance meetings and reviews' with the Clinical Programme Groups**
- The Board must be assured **that the Health Board wide policies** for all aspects of Infection Prevention and Control are implemented in full and understood by all healthcare staff.

*“The Health Board placed too much reliance on the quality and safety arrangements within the CPG structures without having had sufficient assurance of its effectiveness.”*



The lack of structures, systems and processes of governance found within infection prevention and control in 2013 had already been found in Maternity at YGC in 2012/13 and the BCUHB Board had been slow to take action over the course of three external reviews in Maternity.

Staff number 21, recalls 'Star Chamber meetings' held between the then CEO and Chiefs of Staff. In these meetings staff number 21 describes that the emphasis was on 'good news' and said at interview: 'The emphasis was very much on what have we got to celebrate rather than let's talk about your mortality, let's talk about your C –Diff rates, let's talk about your VTE rates..'

In consideration of the evidence this governance review has found that the governance failings that were evident within the C. Difficile outbreak could have been applied to and seen within any patient safety issue across BCUHB (i.e. staffing, lack of incident reporting, inadequate governance systems, structures and processes underpinning infection prevention). Staff number 21 said, 'If you were good at reassuring, that was good enough....'

By mid-2013, six months before the closure of Tawel Fan ward the systems, structures and processes of governance underpinning clinical care across BCUHB were clearly contributing to continuing and significant risks to patient safety. The BCUHB Board were far too slow to recognise this.

The BCUHB Board in 2013 was not analysing or scrutinising with sufficient rigour the gap between the Board and the ward(s) across the six counties of North Wales. There were fundamental issues relating to the inability of the Board in holding the CPG(s) to account and the mechanisms for escalating concerns from the individual CPGs to the Quality and Safety Committee to the BCUHB Board needed to be reviewed and strengthened.

There was an urgent and ongoing need to ensure effective lines of communication and accountability between the CPG(s) and the hospital management teams and then the Board in order that concerns which impacted on the quality and safety of patient care were identified and addressed.

## 12.27 The Duerden review (of Governance Arrangements, Structures and Systems for the Prevention and Control of Healthcare Associated Infections in the Betsi Cadwaladr University Health Board (2013))<sup>118</sup>

This review<sup>119</sup> of governance arrangements, structures, systems and processes for the prevention and control of healthcare associated infections, (or HCAI) was commissioned by BCUHB following an outbreak of Clostridium Difficile infection (CDI) at Ysbyty Glan Clwyd (YGC), in January – May 2013. It has relevance to a review of the governance arrangements relating to the care of patients on Tawel

*“The emphasis was very much on what have we got to celebrate rather than let's talk about your mortality, let's talk about your C –Diff rates, let's talk about your VTE rates..”*

*“The BCUHB Board in 2013 was not analysing or scrutinising with sufficient rigour the gap between the Board and the ward(s) across the six counties of North Wales. There were fundamental issues relating to the inability of the Board in holding the CPG(s) to account and the mechanisms for escalating concerns from the individual CPGs to the Quality and Safety Committee to the BCUHB Board needed to be reviewed and strengthened.”*

<sup>118</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/BCUHB%20Prof%20Duerden%20Report%20Final%20version%2011th%20August%202013.pdf>. (Link accessed July 22nd 2017.)

<sup>119</sup> Report by: Professor Brian I. Duerden CBE, BSc, MD, FRCPath, FRCPE Emeritus Professor of Medical Microbiology, Cardiff University)

Fan ward prior to its closure on 19th December 2013 for a number of reasons. The C. Difficile outbreak occurred on the YGC site where the Ablett unit containing Tawel Fan ward was found. Staff member 16 in interview described the consequence of the lack of hospital management team structure as part of the 'Clinical Programme Group' (or CPG) structure as 'the hospital down the road (YGC) that everybody and nobody was in charge of.....because every CPG had a finger in it, but there was no hospital management.'

Staff number 28, discussed the theme of governance and the C difficile outbreak both at interview and in a post-interview note said 'If the governance structures had not been deemed sufficient to identify the C Diff concerns, then it was probable that they wouldn't have been sufficient to identify the Tawel Fan issues if warning signs were there..' Staff number 28 continued 'If they [governance structures] did not work in one aspect of quality, is it reasonable to say the governance structures were not fit for purpose to ... pick up another quality aspect.'

The total number of Clostridium Difficile cases at YGC from January to May 2013 was 96 of which 15 were in January, 16 in February and 37 in March 2013. Later that year in December 2013 Tawel Fan ward closed. This was an outbreak of the utmost seriousness and combined with the joint HIW/WAO report into Governance at BCUHB also occurring in 2013 it consumed a considerable amount of Board time and focus at a time of Board personnel change, key vacancies, churn and turmoil.

Staff number 16 noted in interview the background to events at YGC in 2013. 'The weaknesses in BCU had gone back to the very beginning, they were not new. The infection control was.....a symptom of a much deeper systemic issue..... Little work had been done on creating an integrated organisation, so there were legacy systems, legacy approaches, legacy policies.....Insufficient work had been done to build the new organisation and to give it a distinctive .....culture, processes....' This view has been repeated by many staff working at a senior level at BCUHB throughout the interviews undertaken as part of this governance review including staff numbers 14, 15, 20, 22 and 78. Staff number 15 told the review at interview: 'I think in previous organisations there was a clear sense of direction of travel and you'd know what was expected of you and you would know that you'd be supported to do those things even if they were difficult and there would be [a] shared sense of values and everyone pulling in the same direction....I didn't get that feeling working within the BCU.'

The overall numbers and rates of C. Difficile cases at BCUHB were higher than in most other Welsh Health Boards in the years prior to this outbreak. There had been a 20% reduction in the number of cases in 2011 but this reduction had not been sustained in 2012.

Staff number 47 at interview acknowledged the lack of BCUHB Board knowledge around the C. Difficile outbreak in 2013 and said 'A, we had not been on top of it as we should have been, B it should never have happened and C we had no idea

*“If the governance structures had not been deemed sufficient to identify the C Diff concerns, then it was probable that they wouldn't have been sufficient to identify the Tawel Fan issues if warning signs were there..”*

*“If they (governance structures) did not work in one aspect of quality, is it reasonable to say the governance structures were not fit for purpose to ... pick up another quality aspect..”*

what the scale of it had been, it was clear that this [was] a much, much bigger problem than anybody had been told or understood it to be.'

The Chair and Vice Chair subsequently tendered their resignations from the Board in response to the HIW/WAO report published in June 2013; (although the Chair remained in post until October 2013.) Other Board members remained in post and did not resign because as stated by Staff number 52 'they wanted to be part of the solution, to put things right....' Staff number 52 continued 'I hope I would have acted differently ...they considered that the best course of action was to stay and be part of the solution.... the balancing issue was....if they had all resigned at the time, would they have destabilised the Health Board more?'

The subsequent independent external review by Professor Duerden in 2013 was commissioned as part of the BCUHB Board response to the PHW recommendations. The purpose of the Duerden (2013) report was to help advise the Board on the changes needed to improve the governance and delivery of the Board's infection prevention and control service. This report was not intended to repeat the earlier report presented by PHW but is an example of an external review of an aspect of the systems, structures and processes of governance within BCUHB building upon an earlier external review when the previous recommendations have yet to be met.

## 12.28 What did Duerden find?

Duerden (2013) found a lack of a single, BCUHB wide structure for infection prevention in 2013.

Following the establishment of the new BCUHB in October 2009, a single unified Infection Prevention and Control, (IP & C) service covering BCUHB's geographical area was developed. With the creation of a single service, the individual Infection Control Committees (ICC's) in the predecessor organisations were disbanded. However, the Duerden review (2013) found that this single unified service did not have a clear line of organisation and leadership. (See Duerden 2013, page 4) Duerden also found a lack of cohesion over management responsibilities, accountability and assurance lines. (Page 4). Duerden (2013) noted that the standing down of the local ICC committees in the three main sites after the merger which created BCUHB left a serious gap in the management of IP&C services.

This situation was found in and across the Mental Health and Learning Disabilities CPG at BCUHB where members of BCUHB staff also describe the dismantling of existing systems, structures, processes and relationships within legacy sites across the Mental Health and Learning Disabilities CPG. The dismantling of existing structures was described as occurring prior to the establishment of effective new structures pan BCUHB. Also described was the 'stretching' of existing structures from one former (smaller) Trust across the new larger BCUHB catchment area across North Wales. These systems, structures and processes were described as having worked effectively prior to the merger. Examples include the mental health 'bank' for temporary staff that needed

*“The weaknesses in BCU had gone back to the very beginning, they were not new. The infection control was.....a symptom of a much deeper systemic issue..... Little work had been done on creating an integrated organisation, so there were legacy systems, legacy approaches, legacy policies..... Insufficient work had been done to build the new organisation and to give it a distinctive .....culture, processes....”*

complete rebuilding after the new central BCUHB 'bank' failed to provide sufficient staff and as described by staff number 15 'the MH/LD governance team were not expanded to reflect new organisational challenges. For much of that time the governance personnel largely reflected the small department that existed within North East Wales NHS Trust MH/LD directorate who attempted to stretch themselves across North Wales to support governance activity.'

## 12.29 The impact of cost improvement plans on the systems, structures and processes of governance underpinning infection prevention and mirroring mental health

As with the experience described by multiple staff within mental health and Older People's Mental Health, (OPMH) specifically Duerden (2013) found that the Infection Control Nursing (ICN) team at YGC, in particular, had been subjected to very significant financial savings, vacant posts had been deleted and the number of ICNs had been reduced from 7 to 4. (Duerden 2013 page 5)

Staff member 16 agrees with Duerden. In interview staff number 16 said 'The organisation had also stripped out a lot of its support functions when it was first set up to save money....what it ended up doing, [was] it stripped out the wrong bits.' Staff 55 agrees and describes the atmosphere in Older Peoples Mental Health within the CPG in 2013 as 'very anxiety provoking, I was always, [I] felt quite scared, I thought God, what if I drop the ball, what if...' Staff number 55 told the Ockenden review team 'It didn't feel safe'.

Board members/senior managers in post at the time discussed at interview the expectation that at the merger creating BCUHB management costs would be significantly reduced. The review has been advised by a number of senior/Board level staff in post at/around merger that circa a 20% reduction in management costs was expected in the 'new' organisation, BCUHB when compared to the management costs in the multiple organisations prior to the creation of BCUHB. (These included staff numbers 11, 14, 22, 28, 63, and 78.)

The situation within the ICN teams identified by Duerden 2013 with vacant posts and key functions effectively 'stripped out' also mirrors the situation seen within the safeguarding adults team across BCUHB. The safeguarding adults function in BCUHB is central to the care of vulnerable older people. From 2009 at the creation of BCUHB until 2013 the review has been advised that the safeguarding adults team was made up of only 1.6WTE across the catchment area for BCUHB. This increased to 2.6WTE during 2013 but reduced again with long term sickness of 1WTE during 2014.

*“The organisation had also stripped out a lot of its support functions when it was first set up to save money.... what it ended up doing, [was] it stripped out the wrong bits..”*

*“It didn't feel safe”*

### 12.30 Findings from Duerden (2013) around the lack of an effective system, structure and process for medical leadership in infection prevention which mirrors the situation around safeguarding adults in BCUHB from 2013 onwards

Duerden (2013) described the difficulty in appointing a single Infection Control doctor, (or ICD) pan BCUHB which this governance review has found mirrored the difficulty in appointing a named doctor for safeguarding adults and appointment to an appropriately resourced safeguarding adults team pan BCUHB post merger and to the current time, (2018.) Duerden (2013) described that following the merger creating BCUHB the three ICDs for the three sites, each with responsibility for one main hospital, continued with their roles as pre-merger. Although the Executive Management team intended to appoint a single lead ICD for the BCUHB IP&C service, none of the existing ICDs wanted to be appointed to the role which would have been in addition to their existing responsibilities.

Instead, they attempted to work as a team of three ICD's pan BCUHB, but this did not provide an effective system, structure or process for medical leadership and management across BCUHB. Duerden (2013) described that the lack of a lead ICD for BCUHB led to a failure to establish effective systems, structures and processes for infection prevention and control within the CPGs.

A similar situation to that seen with the lack of an effective medical leadership structure and system across BCUHB ICD was seen with lack of medical leadership and lack of an appropriately resourced safeguarding adults structure across BCUHB from 2009 to the current time. The requirement for a 'named doctor' role to support the safeguarding adults function across BCUHB was noted in the BCUHB Safeguarding Children, Young People and Vulnerable Adults annual report for 2010-11 dated March 2011. BCUHB had intended that the provision of a 'named doctor' for safeguarding adults would mirror the provision found within safeguarding children at BCUHB. In 2011 the Annual Safeguarding Children, Young People and Vulnerable Adults report noted that two single safeguarding children's doctors, (in two of the three main BCUHB hospital sites) remained, following the retirement of one post-holder and that 'no agreement has been made regarding the revised structure for Betsi Cadwaladr University Health Board.' (BCUHB 2011 page 11.) There remained no progress in appointing a 'named doctor' for safeguarding adults as of May 2018. BCUHB advised<sup>120</sup> the Ockenden governance review that the appointment was supported by the Executive Director of Nursing and Midwifery and that work was underway on 'the development of the JD [job description] which will progress through recruitment. The JD will fulfil the safeguarding role and remit and support the legislative framework of the<sup>121</sup> SSWWA'.

*“The upward lines of management accountability and Board assurance were combined and somewhat confused in the way the organisation was set up. There was a lack of distinction between line management and accountability on the one hand and Board assurance on the other.”*

*“Things were sometimes blurred, sometimes disconnected, information didn't flow, it wasn't getting to the right place at the right time. It wasn't being looked at through the right lens at times...”*

<sup>120</sup> Correspondence from BCUHB May 2018

<sup>121</sup> Social Services and Wellbeing Wales Act 2014 <https://www.legislation.gov.uk/anaw/2014/4/contents>



Duerden (2013) stated that for infection prevention at BCUHB 'the upward lines of management accountability and Board assurance were combined and somewhat confused in the way the organisation was set up. There was a lack of distinction between line management and accountability on the one hand and Board assurance on the other.' (Duerden 2013 pages 5 to 6.)

Staff number 4, described at interview the Duerden report as 'very insightful' and describes 'the scenario....in the Board 'where those things were sometimes blurred, sometimes disconnected, information didn't flow, it wasn't getting to the right place at the right time. It wasn't being looked at through the right lens at times...' In a situation that echoed that found within infection prevention and control staff number 25 says of adult safeguarding from the creation of BCUHB to 2015: 'An immediate factor was the lack of organisational awareness regarding safeguarding adults, [the lack of] experienced personnel to undertake the corporate function, and lack of operational policies to support the agenda. This was further hindered by the lack of financial support to increase the workforce....' BCUHB Annual Safeguarding reports provided to this governance review by BCUHB show this position persisted from the creation of BCUHB in October 2009 until at least the end of 2016.

Duerden (2013) stated that neither the function of **management or assurance** appeared to have been fulfilled adequately in infection prevention and control in BCUHB in 2013. (Duerden 2013, page 6.) This mirrors the situation with Deprivation of Liberty (DoLS) across BCUHB in the Mental Health Act Committee at a similar timeframe where this review has found little discussion, challenge and ultimately minimal resolution of long term and serious issues of concern. The Ockenden governance review has noted parallels between the lack of information flow in infection prevention and control with events on Tawel Fan ward. Staff number 4 stated at interview: 'If I think about Tawel Fan in that context then, my recollection of that is.....a number of probably not interconnected systems, so there was work ongoing, so HIW did their things and came in and had a look, there was work like dementia mapping ongoing which was looking at it in a certain way. I think concerns and incidents and particularly safeguarding was not as visible as it might have been...there were systems to look at these things and.....I'm not aware the intelligence, such that it was, was pointing to flags or issues that might have said there is a difficulty in this area, one needs to be closer to it....' In discussion with the Ockenden team staff around the systems, structures and processes of governance and information flows that existed at the time staff number 4 noted the lack of 'an integrated governance strategy or a governance strategy' and stated 'If you could go to the shelf and say where's our governance strategy, no I don't recall documents of that nature..'

Staff number 52, also noted that 'information [was] gathered from.....the plethora of Healthcare Inspectorate Wales reports which .....tended to come in individually....' Staff number 52 stated in interview 'individual action plans were always developed so nobody was actually, .....looking at them in a thematic way and seeing, again, what the pan Betsi issues were and how they could be responded to, to make sure that what was happening in Cefni wasn't actually

*"If I think about Tawel Fan in that context then, my recollection of that is.....a number of probably not interconnected systems, so there was work ongoing, so HIW did their things and came in and had a look, there was work like dementia mapping ongoing which was looking at it in a certain way. I think concerns and incidents and particularly safeguarding was not as visible as it might have been...there were systems to look at these things and..... ..I'm not aware the intelligence, such that it was, was pointing to flags or issues that might have said there is a difficulty in this area, one needs to be closer to it...."*



happening over in the East as well, so some of the governance systems began to shift in the summer to autumn period of 2015..'. This was almost two years after the closure of Tawel Fan ward and highlights the limited success BCUHB had in putting in place effective systems, structures and processes of governance both more generally and underpinning older person's mental health for a number of years after Tawel Fan ward closed.

### 12.31 Creation of the clinical management structure in BCUHB and relevance to the adult safeguarding workforce/ establishment

With reference to the BCUHB clinical management structure in place in 2013 Duerden (2013) stated that which had already been said by a number of external reviews by mid-2013. At the creation of BCUHB in 2009 clinical leadership was provided through Clinical Programme Groups or CPGs. Each CPG had a part time Chief of Staff and was supported by two Assistant Chiefs of Staff (or ACoS) for both Nursing and Operations. The CPGs were responsible for the delivery and provision of clinical services in their speciality across BCUHB.

The structural reorganisation creating CPGs left a gap in the clinical management and co-ordination at local level, (i.e. for each main hospital site.) This was eventually addressed by the appointment of an Associate Medical Director and Assistant Director of Nursing for each main hospital site. Eventually, in April 2013, this structure was added to by the appointment of a senior site manager to complete the local team in each main hospital. The senior site manager post was however only established in April 2013 on a temporary basis, with a further delay until these posts were made substantive.

At the same time it was agreed that each main hospital site should re-establish its own Infection Prevention and Control (or IP&C) committee to deal with issues at local level and manage the local IP&C service. This recognised that local actions and co-ordination at each hospital site were required to deliver an effective IP&C agenda across BCUHB. A number of Board members in interview recalled how much time was spent dealing with the issues that came out of the C. Difficile outbreak in 2013, and the difficulty BCUHB had at the time with a largely interim senior leadership structure.

Board members have explained to the Ockenden review team that around the time of the outbreak (at various times) there was an acting Chief Executive, interim Medical Director, an interim Chief Operating Officer, an interim Finance Director and no Director of Therapies. Staff number 4 stated that the action required because of the outbreak 'was a massive, rightly a massive draw upon clinical and managerial resource....' The Executive Team are described as spending 'a huge amount of time' on the C. Difficile outbreak and staff number 4 describes the situation within the Executive team as 'the challenge was how many issues can you progress at one point in time with a very interim structure...it was very challenging to do some of those things.'

*“The structural reorganisation creating CPGs left a gap in the clinical management and co-ordination at local level, (i.e. for each main hospital site.)”*

*“The challenge was how many issues can you progress at one point in time with a very interim structure...it was very challenging to do some of those things.”*

## 12.32 Surveillance of key HCAI across Wales and subsequent surveillance of HCAI in BCUHB in 2013

Duerden (2013) describes that the national priorities for infection prevention and control across Wales are (and were) determined by the Welsh Government. The national programme required that Health Boards report their numbers of cases of certain HCAI through a system run by Public Health Wales; (PHW.) Boards are/were required to ensure that they had an effective programme of Ward to Board surveillance that would then feed into national statistics. This provided a system across Wales for real time measurement of cases in order to drive improvement.

Duerden described that HCAI Surveillance in BCUHB should have operated at four levels of escalation and then finally to Welsh Government (Level 5) (see Duerden 2013 page 8). Had these systems, structures and processes of governance been in place across BCUHB for infection prevention and control the BCUHB Board could have been assured that in place were the governance structures required for effective 'Ward to Board' oversight of infection prevention. The Ockenden governance review has found that had the structures described by Duerden been in place underpinning all aspects of clinical care the Board could have been assured of effective Ward to Board oversight across CPGs, main hospital sites and community care for a range of clinical specialities including Mental Health and Older Persons Mental Health specifically. The Board at the time in 2013 did not appear to understand the significance of the absence of these structures, systems and processes of governance until the Duerden report (2013) set it out as below:

Each **ward/unit (Level 1)** should have a regular (monthly) report showing what its numbers and rates of the key HCAIs are. The discussion of these figures and decisions on any actions required should be standing agenda items at ward/unit meetings alongside audit data on hand hygiene, environmental cleanliness, IV line care and antimicrobial stewardship

Each CPG needed the **same information** brought together for **each of the specialties within the CPG. (Level 2)** Robust discussion of these figures and any necessary actions should be standing agenda items at **CPG Board** meetings. Appropriate priority should be given to **CPG wide actions**

This information should then be **received and discussed. Actions for improvement** would be discussed with **Chiefs of Staff and senior leadership staff at the CPG**. Plans for improvement should be developed. This should be presented to an **expert operational group** to **lead the implementation of practice change and also to monitor success. (Level 3)**

Finally the **comprehensive and amalgamated data for the whole of BCUHB** would be **reported to the Board** through its Quality and Safety committee **(Level 4)** and be the **basis of the reports to Public Health Wales under the Welsh HCAI surveillance programme**

The **BCUHB IP&C committee** would also be **the route** through which the need to report outbreaks and deaths as required by the **Welsh Government** should be determined. (Level 5)

The terms highlighted above in **bold and italics** by the Ockenden governance review could reasonably be considered to be the building blocks of any system, structure and process of governance for any matter, and any clinical speciality not just infection prevention and control.

Duerden found that in 2013 the systems, structures and processes of governance then in place in BCUHB did not provide appropriate levels of action and assurance as described above. Monthly reports were produced but they were said to be 'complicated to follow' (Duerden 2013, page 8) and it was not clear at what levels they were reviewed and assessed for any necessary actions. (Duerden 2013, page 8). Staff number 21, a former Chief of Staff said 'there was unreliable connection between Board and Ward and there was a real lack of clarity about who was accountable for what and where.....and how the Board was given assurance....' Even post the comprehensive and clear Duerden (2013) report the Ockenden review team note that the Board at BCUHB were extremely slow in ensuring the necessary change for safe and effective systems, structures and processes of infection prevention and control. Neither did the Board extrapolate the lessons to be learned from the C. Difficile outbreak and the information they had been given by Duerden and apply them across other clinical specialities and services across BCUHB.

Evidence provided to the Ockenden review shows that the situation in Infection Prevention and Control in 2013 mirrored that of adult safeguarding at that time with interviewees outlining the challenges to the safe operation of the adult safeguarding due to the inconsistent availability of IT access across the organisation. This meant that as late as autumn 2017 there was a combination of (limited) IT records and multiple paper records held across all BCUHB sites. Interviewees have explained to the review that the lack of appropriate IT 'hindered the strategic direction required for the development of electronic databases for corporate safeguarding....' (Staff number 25, written statement, September 2017, page 12.)

Staff number 19 noted in interview 'it (the C. Difficile outbreak) highlighted significant flaws in our Governance and reporting arrangements....' Staff number 19 describes the presence of risk registers in 2013 prior to the C. Difficile outbreak but concludes 'We inherited a number of different systems which we were trying to migrate over a couple of years from paper based systems to an electronic system.....those systems were imperfect and immature at best...'. Staff number 19 adds 'I recall from about 2012 there was real disquiet emerging amongst Board members that our leadership and governance arrangements on a number of fronts were not as you would want them to be..'

*“There was unreliable connection between Board and Ward and there was a real lack of clarity about who was accountable for what and where.....and how the Board was given assurance....”*

*“The Board at BCUHB were extremely slow in ensuring the necessary change for safe and effective systems, structures and processes of infection prevention and control.”*

*“We inherited a number of different systems which we were trying to migrate over a couple of years from paper based systems to an electronic system.....those systems were imperfect and immature at best...”*

### 12.33 ICN establishment and comparison with the Adult Safeguarding workforce/establishment

In a detailed analysis of the BCUHB workforce available to meet the Infection Prevention and Control agenda within BCUHB Duerden states that the establishment numbers for the ICT had been eroded systematically since the organisation had merged to create BCUHB in 2009. Thus it fell below recognised benchmarked numbers of staff. In a situation that the Ockenden review has found mirrored Older People's Mental Health, (OPMH); the adult safeguarding function, which is a critically important aspect of keeping vulnerable older people safe Duerden says 'Staff who left were not replaced as part of an efficiency (cost cutting) programme aimed at bringing that part of the BCUHB into financial balance during a time of considerable financial pressures within the organisation..' (Duerden 2013 page 9).

Multiple interviewees for this governance review, including 3, 11, 14, 15, 22, 38, 57, 63, and 78, note delays in recruitment of clinical staff in mental health and specifically Older Persons Mental Health caused by a number of factors including slow and complex vacancy control factors, with the need for the Executive team to scrutinise clinically essential vacancies after the CPG had approved them. Examples of 'vacancy control' documentation has been shared with the Ockenden review team. An interviewee told the Ockenden review 'They [vacancies] were definitely signed off on high and it was a big industry....' Other interviewees told the review that nursing posts were held vacant whilst awaiting graduate appointments. There was some disagreement between staff as to whether delays occurred in approving vacancies whilst a lengthy staffing review took place. Some staff recollect that there was delay, others state not. The outcome was that, in a situation that mirrored infection prevention and control services within the Mental Health and Learning Disabilities CPG including Older Persons Mental Health frequently found themselves short of clinically essential staff.

### 12.34 Key point: What was the consequence of vacancy controls across the MHLD CPG until the end of 2013?

The consequence of the lengthy and many layered recruitment process in place in BCUHB means that multiple interviewees including staff numbers 3, 11, 14, 15, 22, 38, 57, 63 and 78 have told the Ockenden review that there was frequently insufficient staff in older peoples mental health at BCUHB from 2009 to 2013 both to provide direct clinical care but also a significant lack of senior staff to provide leadership, management and strategic planning across older peoples mental health care in BCUHB. Staff number 57 told the Ockenden review. 'It seemed that the vacancies were reviewed in isolation, even though the staffing complement and its impact were usually stated on the documentation. It did not feel that consideration was given to the long term consequences that may result.'

*"They [vacancies] were definitely signed off on high and it was a big industry..."*

*"It seemed that the vacancies were reviewed in isolation, even though the staffing complement and its impact were usually stated on the documentation. It did not feel that consideration was given to the long term consequences that may result."*

### 12.35 Training and Audit – a comparison between Infection Prevention and Control, Adult Safeguarding and Mental Health in BCUHB in 2013

Duerden states that the reduction in the IPC team prevented the delivery of training and providing ICT support and audit at both ward and organisational level. In a situation found by the Ockenden review to further mirror the Mental Health and Learning Disabilities CPG Duerden notes that failures in mandatory training 'was noted in several IP&C reports during 2012 but there was no indication of what was being done to rectify the situation..' (Duerden 2013 page 9). The situation with lack of mandatory training in Infection Prevention and Control as described by Duerden mirrors that within both Safeguarding Adults and Deprivation of Liberty (or DoLS). Staff number 25 notes 'The organisation in 2012 would not allow funding for an e-learning package...as they did for a similar Safeguarding Children Training Package in 2010. This was because a national programme was about to be developed. This package was considerably delayed and progress was only made in 2015....'

Staff number 57 describes an absence of training in dementia for support workers within Older Persons Mental Health at BCUHB and only a very basic level of training in dementia for registered nurses. This training was described as 'really very basic....' In addition staff number 38 described at interview the difficulty in releasing nursing and support worker staff to attend training and supervision. This was because of long term poor staffing levels across Older Persons Mental Health over a period of time described from 2009 to the current day.

Mirroring the difficulty in provision of mandatory training in infection prevention, adult safeguarding, dementia and DoLS, (despite the lack of training being well documented and frequently discussed across BCUHB). Staff number 25 described how from 2012 onwards practical steps could not seemingly be taken to increase the ability of clinical staff to attend planned training in adult safeguarding. Rather, BCUHB as an organisation made it very difficult for ward staff to be released at appropriate notice 'The organisation in 2012 would not support the pre-booking of venues to enable planned events to increase attendance and pre-book external speakers, on occasion training was cancelled as the organisation held [an] urgent or unscheduled Board meeting and required the venue. The clinical centre in YGC Hospital would only allow a pre booking of 2 weeks, this caused continued difficulties .....[in arranging training and releasing staff...] The annual report 2017/18 for safeguarding cites this as a continuing problem in 2017.



## 12.36 Concerns with Root Cause Analysis (RCA) and Serious Untoward Incident (SUI) reporting and review with reference to infection prevention, and relevance to Mental Health specifically and BCUHB overall in 2012-13

Duerden stated that BCUHB had in place a system for Root Cause Analysis, (RCA) following outbreaks or serious incidents and/or deaths relating to HCAI. (Duerden 2013, page 11) In a situation that the Ockenden review found mirrored a consistent lack of appropriate review of serious incidents in Older Persons Mental Health, the wider Mental Health and Learning Disabilities CPG and BCUHB overall Duerden (2013) found the RCA process related to HCAI was not consistent with best practice guidance on conducting RCAs. Duerden stated that the RCAs associated with infection prevention and control appeared to have been an exercise led by the nursing staff with limited medical involvement. The outcome of the RCAs did result in recommendations for improved practice over most of the period reviewed by Duerden, but these were not always acted upon within or across the CPGs. Therefore there was no investigative vehicle for improvement. Duerden notes the result of a report reviewing the results of RCAs conducted between April and December 2013. Duerden states that only 63% of RCAs that **should** have been completed were **actually** completed and Duerden describes 'numerous gaps' in the material recorded. (Duerden 2013, page 11.

The discrepancy found by Duerden (2013) between the numbers of RCAs that should have been completed and those that actually were completed was part of a wider failure in the systems, structures and processes of governance underpinning identification of and management of serious incidents in BCUHB at the time. Correspondence in the form of a letter from BCUHB to Welsh Government in December 2013 has been seen by the Ockenden governance review team. The letter dated 6th December 2013 describes a quality assurance process of serious incidents at BCUHB following the appointment of an interim Director of Quality Assurance by the then new Executive Director of Nursing and Midwifery. Some of the incidents which were subject to additional validation had already been submitted by BCUHB to Welsh Government for closure. The letter describes the need to 'recall 17 closure forms' for serious incidents previously submitted to Welsh Government and reject a further 15 serious incidents that CPG management teams within BCUHB had previously considered to have been of sufficient quality to submit to Welsh Government for closure.

The review has also been provided with an internal BCUHB report created for the handover of the concerns, (serious incidents, claims and complaints) process dated December 2014. ('Legacy/handover document for 'Putting Things Right' portfolio.) In this document is found:

- The history of the 'concerns' process at BCUHB with a detailed overview of the situation within BCUHB in the summer of 2013:
- The performance of 'concerns' at that time was described as 'of grave concern.' (BCUHB 2014, page 1.)

*“Some of the incidents which were subject to additional validation had already been submitted by BCUHB to Welsh Government for closure. The letter describes the need to ‘recall 17 closure forms’ for serious incidents previously submitted to Welsh Government and reject a further 15 serious incidents that CPG management teams within BCUHB had considered to be of sufficient quality to submit to Welsh Government for closure.”*



- Information regarding the 'significant variance in the resources within each CPG from which to manage 'concerns.' (BCUHB 2014, page 2.)
- Information regarding 'the poor management of concerns and governance arrangements prior to the review in late 2013.) (BCUHB 2014, page 5)

### 12.37 Key point: What did the Poole report (2012) into SUIs in mental health explain?

An analysis of SUIs in the MHLD CPG had been undertaken by Poole (2012) This was predominantly an analysis of SUIs to address concerns about the level of SUIs in the MHLD CPG compared with other CPGs in BCUHB.

Poole examined the 'sharp rise in the number [of SUIs in mental health ] in December 2011 and January 2012..' In this process Poole identified 'achievable improvements in the *relevant* SUI surveillance systems..'

Professor Poole has subsequently advised the Ockenden review team that his report was 'making a distinction between severity thresholds and levels of reporting. Professor Poole advised the Ockenden review: 'Mental health practice is in many ways different from other forms of healthcare and there are bound to be major differences in criteria for SUIs, including severity thresholds<sup>122</sup>.'

Professor Poole subsequently advised the Ockenden review that in his opinion 'the NHS Wales criteria generated far too many full investigations. Professor Poole continued that 'a more targeted approach, with a different method of deciding the intensity of the investigation, would be more effective. It would lead to better investigation of the incidents of greatest concern, and would avoid great effort being expended on incidents that could not be prevented and thus generated no learning for the service..'

Poole also noted that mental health services typically remain in contact with service users for a prolonged period of time and treat a large number of people in the community. Therefore comparisons between the numbers of SUIs in mental health and comparisons between (for example) SUI numbers in medical and surgical services were not appropriate, where 'clinical relationships' were generally much shorter. (Poole 2012, page 2.)

Poole suggested that the concern regarding the higher than usual level of incidents in late 2011 and early 2012 was 'due to a combination of changes in reporting practice, and chance variation.' (Poole R 2012, page 3.) Poole concluded that 'the difficulty in making sense of the information illustrates a real problem with the SUI reporting system in general....' (Poole 2012, page 11.) In correspondence with Donna Ockenden in 2018 Poole stated that reference to 'the SUI reporting system in general....' was intended to mean the SUI reporting system determined at Welsh Government and Health Board levels. It was not intended to indicate that there were flaws specific to the mental health CPG SUI reporting system...' (Poole 2018, page 3.)

*"A more targeted approach, with a different method of deciding the intensity of the investigation, would be more effective. It would lead to better investigation of the incidents of greatest concern, and would avoid great effort being expended on incidents that could not be prevented and thus generated no learning for the service.."*

<sup>122</sup> Communication to Donna Ockenden from Prof R. Poole April 2018

**Poole (2012) also noted the following requiring further work:**

- There was a trend for higher reporting of SUIs to occur on Fridays and Saturdays and around Bank Holidays. This might indicate a problem with difficulty accessing services after 5pm on a Friday or be related to increased alcohol use during weekends and Bank Holidays. Further work was required to understand this
- Poole stated that SUI surveillance in Mental Health and Learning Disabilities creates 'real challenges with regard to the accurate identification of events of concern, the analysis of findings and the implementation of necessary service changes.' (Poole 2012, page 11). Poole states that there are intrinsic challenges in SUI surveillance in mental health and learning disabilities in general, not that there were particular challenges in the MHLDP CPG at the time. Poole stated that 'these challenges could be met more effectively without an enormous investment of resources.' Poole did not believe that local improvements were impossible, but 'that these would require changes at Health Board and Welsh [Government] levels, as the necessary changes were beyond the authority of the CPG managers.' (Poole 2018, page 4.)
- Poole noted that he had not systematically investigated the implementation of action plans from SUI reviews as part of this work' but was aware of the 'limitations in the system of action planning' associated with SUIs in mental health in BCUHB. Poole states in recent correspondence with Donna Ockenden that 'at the time ... there was a major problem in the Chair of the SUI panel being a different non-executive director of the Health Board for each review.' Poole states that this was because 'they had minimal training in investigation and very little knowledge of mental health..' (Poole 2018, page 4.) This viewpoint was also held by a number of other colleagues involved in SUI processes at the time who have also contributed to the Ockenden review.
- Poole states there was a 'de facto BCUHB policy that there should always be recommendations and actions, irrespective of findings, which meant that co-ordinated and coherent action planning was impossible. The system was simply generating too many recommendations, with little or no prioritisation.....This was an example of why improvement would require changes that could only be authorised at Health Board level.' (Poole 2018, page 4.)
- As recommended by Poole (2012) follow up work was subsequently carried out by Dr Robert Higgo covering the period February 2012 to January 2014 and this evidence has been seen by the Ockenden review team.

*"At the time ... there was a major problem in the Chair of the SUI panel being a different non-executive director of the Health Board for each review.' Poole states that this was because 'they had minimal training in investigation and very little knowledge of mental health.."*

*"De facto BCUHB policy that there should always be recommendations and actions, irrespective of findings, which meant that co-ordinated and coherent action planning was impossible. The system was simply generating too many recommendations, with little or no prioritisation..... This was an example of why improvement would require changes that could only be authorised at Health Board level."*

### **12.38 Key point: What did the BCUHB Annual Governance Statement tell us about the 'state of governance' in 2013/14?**

In the BCUHB Annual Governance Statement 2013/14 – published in June 2014 the following was said:

'The following internal audits received limited assurance (including):

Governance arrangements: Mental Health and Learning Disabilities Clinical Programme Group (CPG)



(BCUHB 2014, page 27.)

And:

'During the year internal audit conducted the following draft audit report with a conclusion of no assurance: Serious Incident Reporting.' (BCUHB 2014, page 28.)

The purpose of this audit as described by BCUHB (2014) had been to 'establish the system in place to report and manage serious incidents that fall under the criteria set out by the Welsh government...in respect of patient services under the responsibility of the Health Board...'

### 12.39 Issues identified with estates, facilities and accommodation in the 2013 Duerden report which resonate with issues found within the review of the governance arrangements relating to the care of patients on Tawel Fan ward

Duerden (2013) highlights issues with limited single room accommodation in all of the BCUHB hospitals but with considerable concern regarding single/cohort accommodation at YGC where the Clostridium Difficile outbreak occurred. The lack of single rooms had been exacerbated by two factors – the extensive re-building ongoing at the YGC site over many years, and the change of use of some former single clinical rooms to non-clinical use.

The lack of fit for purpose estate that was a key feature of the C. Difficile outbreak is also a significant factor in any review of events leading to the closure of Tawel Fan ward in December 2013 and a review of the current systems, structures and processes of governance underpinning older persons mental health care. At interview staff number 65, stated that concerns had been raised about the environment for in patient care of older persons with mental health problems to the MHL D CPG leadership team, the Ysbyty Glan Clwyd medical leadership team and the Executive team for more than a year before the closure of Tawel Fan ward. Evidence has been seen by the Ockenden review confirming this is correct.

Many current and former staff including staff numbers 57 and 65 also provided extensive evidence to the Ockenden governance review showing long term

*“Concerns had been raised about the environment for in patient care of older persons with mental health problems to the MHL D CPG leadership team, the Ysbyty Glan Clwyd medical leadership team and the Executive team for more than a year before the closure of Tawel Fan ward.”*

concerns with the poor quality of the older person's inpatient environment, specifically Tawel Fan ward and Tegid ward on the Ablett unit. A range of internal emails from these staff members, has been provided to the Ockenden review team including one titled 'Formal complaint re furnishings, décor and garden (Tawel Fan) dated March 27th 2012 @0858hrs. This email says 'I am mindful that we responded to a similar complaint last year but there does not appear to have been any progress made despite our reassurances to the complainant at that time..' The email details that 'issues concerning the carpets/flooring have been raised with the Estates Dept. since early 2011 (and 2010 in the case of the uneven paving in the garden courtyard) I understand the courtyard still remains' out of bounds to patients'. Staff number 5, a former senior nurse within Older Peoples Mental Health described at interview in October 2016 how when an adult ward got new furniture Tawel Fan ward 'got all their crummy cast offs.' Overall, in mental health, staff number 5 told the Ockenden review 'you couldn't get stuff seen to, beds were broken.....I said where's the furniture.....ordered twenty months ago – where is it?'

*"I am mindful that we responded to a similar complaint last year but there does not appear to have been any progress made despite our reassurances to the complainant at that time.."*

A letter from The Alzheimer's Society to the then CEO of BCUHB, dated 22nd July 2011 raises concerns regarding the poor state of the courtyard in Tawel Fan ward and that the courtyard in Tawel Fan had 'recently been closed due to health and safety precautions as a result of uneven flags.' A handwritten note on the top of the letter, presumably by the then CEO says '> X cc Y, need draft' presumably meaning that the letter needs to go to the then Chief of Staff, copied to the Director for Primary Care, Community and Mental Health and then a letter of response needs to be drafted for the CEO. The response has not been provided but the letter of July 2011 and the concern raised that no progress has been made in restoring the courtyard to use in March 2012 despite previous reassurance to a complainant may well be linked.

*"When an adult ward got new furniture Tawel Fan ward 'got all their crummy cast offs.'"*

An email dated 24th February 2012 (timed at 11:18hrs), from the lead consultant for OPMH to the then site Medical Director and the BCUHB Executive Director of Nursing around the poor state of Tawel Fan ward. This is clearly described as both a 'dignity' and 'safety' issue. Emails have also been seen requesting the Executive team visit Tawel Fan and Tegid wards for their next Executive 'health and safety' walkabout. The email from the lead consultant makes it clear that both wards are not fit for purpose and that significant modifications are required to make these wards safer for older people. The outcome of this request to the Executive team to attend a health and safety walkabout on Tawel Fan ward is not known.

*"You couldn't get stuff seen to, beds were broken.....I said where's the furniture..... ordered twenty months ago – where is it?"*

Overall the Ockenden review has seen and heard evidence from a variety of sources that the Ablett unit had at least the following problems for a number of years leading up to (and for a long time after) the closure of Tawel Fan ward:

- Broken and shabby furniture and difficulty in getting broken furniture taken for disposal;
- Stained, torn and urine soaked carpets;

- Poorly maintained and unsafe gardens that were 'out of bounds' to patients for long periods;
- Ant infestations;
- A boiler that broke down leading to interruption in hot water supplies;
- Paintwork that was reported as peeling with mould and rust apparent
- Unsuitable bathroom facilities;
- Insufficient signage.

*“Broken and shabby furniture and difficulty in getting broken furniture taken for disposal”*

*“Stained, torn and urine soaked carpets”*

Evidence for these concerns were found in a range of internal BCUHB reports, family and carer complaints and internal emails. All of these issues were escalated within the MHLD CPG and importantly outside the CPG to the Executive team via personal contact from within the MHLD CPG and via a series of external reviews that were very clear about the lack of facilities available on Tawel fan and other units. There was very limited response seen from the Executive team from 2009 onwards.

*“Poorly maintained and unsafe gardens that were 'out of bounds' to patients for long periods”*

Further internal emails from January 2013 show difficulties with the ward layout at Tawel Fan ward including the need for patients to share rooms. The purpose of one email is to 'escalate a concern ...at present on the bed situation on Tawel Fan. They have 12 very complex, all of whom have differing challenging presentations and none of whom....are suitable to share a room. They did try last night and it did not work. A gentleman walked in on another gentleman this afternoon and was punched. The problem is that there is a 4 bedded room and 2 x 2 bedded rooms thus making 5 beds unusable at present. We are trying to manage the situation as best we can, but pressure on beds is growing....' (Email from staff number 57 sent 29th January 2013 @1650 hrs.) The bed situation across Older Persons Mental Health is described in the email as:

*“A boiler that broke down leading to interruption in hot water supplies”*

'Wrexham 0 beds

Glan Traeth 1 bed

Cefni 1 bed + closed ward

Bryn Hesketh 8 beds, but concerns over lack of medical cover.'

*“Paintwork that was reported as peeling with mould and rust apparent”*

Further emails from the lead consultant for older peoples mental health (OPMH) provided to the Ockenden review escalate concerns around beds and inappropriate admissions to Tawel Fan ward include one email expressing concerns about an out of hours admission to Tawel Fan from Bryn Beryl Hospital, (Pwllheli). The email says 'I am not convinced about the indication of admission to a dementia ward as he is still physically unwell and recovering from a stroke.' The out of hours and inappropriate admissions to Tawel Fan ward at the time are described as 'causing huge safety concerns....' (Email sent 1st March 2013 @1549hrs.)

*“The out of hours and inappropriate admissions to Tawel Fan ward at the time are described as 'causing huge safety concerns....”*

Evidence has been seen by the Ockenden review team that the unsuitability of and safety of Bryn Hesketh as a stand-alone unit for inpatient Older Persons

(Email sent 1st March 2013 @1549hrs.)



Mental Health care was raised within the CPG senior management team as early as July 2010. An email stated the need to consider 'a robust plan to strengthen the framework in the stand alone units and enhancement of the structure in old age psychiatry service in Conwy and Denbighshire....' The email describes the transfer of a patient from Bryn Hesketh to Tawel Fan 'early this morning, hand cuffed by the police as he was extremely aggressive and was a danger to other patients.' The email raised concerns regarding: 'the lack of support in the stand alone units' and describes the event as 'an adverse event and a huge risk management issue, as there could be ... complaints, potential for legal action....'

At the time the following information regarding estates was known to the Executive team at BCUHB following HIW visits to specific units providing care to older persons with mental health.

#### 12.40 Bryn Hesketh Unit and Glan Traeth Unit (2010)

The Ockenden review team has been provided with a letter to the then CEO of BCUHB from HIW (17 June 2010) following an unannounced 'Dignity and Respect Spot Check' visit to Bryn Hesketh and Glan Traeth EMI wards on 18-19 November 2009. Of note is that the letter to the CEO took seven months to be sent from HIW to BCUHB despite there being issues of significant concern including a lack of understanding of capacity and consent on Glan Traeth ward and a lack of consistent recording of capacity and consent on both Glan Traeth and Bryn Hesketh wards.

'Staff at Glan Traeth had a general view of what was meant by capacity and consent however we felt that there was a lack of understanding as to the precise meanings of these terms. If staff are not confident that they fully understand what is meant by capacity and consent then they are less likely to challenge any inappropriate behaviour of colleagues..... (HIW 2011, pages 2 and 3). Staff in Bryn Hesketh were said to have 'demonstrated a good understanding of consent and capacity.' (HIW 2011, page 3.) Both units were identified as having deficits in the way these decisions were recorded within patients notes.

In Bryn Hesketh ward the environment was 'very clinical and lacked personal items such as pictures of family, flowers, clocks etc.' The letter stated that 'patients, relatives and carers should be encouraged to make the patient's room as comfortable and individual as possible....' (HIW 2011 page 4). There was concern expressed by HIW that 'Protected mealtimes are rigidly enforced at Glan Traeth and it is legitimately believed by staff that this is of considerable benefit to the well-being of patients....this could lead to an inflexible approach which might dissuade relatives from offering their services to help at mealtimes.' (HIW 2011, page 3)

Patient records were described as 'inconsistent in terms of layout, content and the lack of formal documentation from social care which indicates a lack of integration.....because of the inconsistency of the patient records deriving relevant information can be a non-trivial task..' (HIW 2011, page 5). Evidence of clinical audit activity was described as 'sparse' (HIW 2011, page 5).

*"Staff at Glan Traeth had a general view of what was meant by capacity and consent however we felt that there was a lack of understanding as to the precise meanings of these terms. If staff are not confident that they fully understand what is meant by capacity and consent then they are less likely to challenge any inappropriate behaviour of colleagues....."*

*"Patients, relatives and carers should be encouraged to make the patient's room as comfortable and individual as possible...."*



### **Action Plan from this visit**

The action plan suggests a number of reasonable interventions to the issues raised by HIW but without any detail on how these interventions would be implemented or monitored by either the CPG or BCUHB governance structures. From as early as 2009 onwards, from the 'birth' of BCUHB there was a lost opportunity in response to HIW visits to ensure that the same issues did not occur over and over again throughout both Older Persons Mental Health and the wider Mental Health and Learning Disabilities CPG (subsequently Division.)

At the HIW visit to Bryn Hesketh in 2010 HIW found there was limited awareness of the Fundamentals of Care initiative-standards of which were published in 2003, with a revised audit tool<sup>123</sup> available from June 2010. (NHS Wales 2010)

### **12.41 Review of the Fundamentals of Care audit across Wales (2012) with specific reference to BCUHB and Older Peoples Mental Health**

The 2012 Fundamentals of Care<sup>124</sup> audit results for Wales are available via the link below. The report states that individual Health Boards were required to collate and submit data from every ward across their Health Board during October to December 2012. Whilst BCUHB attained a number of amber scores (51-84%), they also scored significantly high numbers of green (85%-100 %) in areas where HIW and others had highlighted significant problems subsequently. These included areas such as:

Communication and Information, (page 26)

Ensuring safety, (page 27)

Preventing pressure sores and ulcers, (page 31)

Sleep, rest and activity, (page 28)

#### **Areas that BCUHB received an amber score for were:**

Personal hygiene, appearance and foot care, (page 29)

Oral health and hygiene, (page 30)

The report states that the feedback from a patient perspective 'reflects only the responses of those patients who were audited..' (Welsh Government 2013, page 5.)

However the Ockenden team notes with concern the significant differences in feedback about BCUHB from a range of sources within the period of two years (2012 to 2013) including the NHS Delivery Unit, NHS Wales Shared Services

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<sup>123</sup> <http://www.wales.nhs.uk/sitesplus/documents/1064/Care%20Audit%20Tool.pdf>

<sup>124</sup> <https://www.wales.nhs.uk/documents/All-Wales-FOC-audit-Report-English.pdf>

Partnership, HIW and WAO, (all 2013) the Duerden report and Public Health Wales, (both 2013.) Reports from HIW's earlier visits to older persons mental health units, as above also seem to point to significant concern that was highlighted to the then CEO. However these concerns are not present in the Fundamentals of Care Audit of 2012/13.

The apparent difference between the positivity presented to the 'world outside' BCUHB when compared to the reality of what was happening within it was mentioned by multiple current and former members of staff during interviews with the Ockenden team. Former staff members described the presence of 'almost a rah rah band' at BCUHB creating a noisily positive atmosphere and the inference given to external partners as 'we're doing marvellously well.' Internally at key meetings former staff described a 'looking down at papers' and an 'embarrassed silence' when 'bad news' or potential issues of concern were raised with the then CEO (2009 to 2013.) The culture was universally described as 'bring me good news.'

*“Former staff members described the presence of ‘almost a rah rah band’ at BCUHB creating a noisily positive atmosphere and the inference given to external partners as ‘we’re doing marvellously well.’”*

#### 12.42 Key point: Are problems with Estates across Older Persons Mental Health still a significant governance risk?

**Yes**

From the perspective of a review of current governance arrangements across Older People's Mental Health in BCUHB lack of beds and the poor quality of the estate has been (and remains) a key governance concern and is raised as a concern in a number of HIW reports over a prolonged period of time until late 2017. There is a continuing lack of action by BCUHB to resolve estates concerns when raised as a governance, quality and patient safety concern by HIW and others over many years and to the current time.

*“‘Looking down at papers’ and an ‘embarrassed silence’ when ‘bad news’ or potential issues of concern were raised with the then CEO.”*

The CEO of HIW wrote to Donna Ockenden, (HIW 2017) and noted that an unpublished management letter was sent to BCUHB from HIW regarding a visit to Bryn Hesketh on the 18th June 2013. The action plan, dated September 2013 has been seen and it is also included on the 'Divisional action plan of action plans.'

HIW do not appear to have visited the Bryn Hesketh unit from 2010 to 2013 and then after the 2013 visit not until the end of 2017, with the report being published 2018. There had been significant issues raised both by BCUHB and the North Wales Community Health Council (NWCHC) in the intervening time.

#### 12.43 Summary: The C. Difficile Outbreak at YGC – What went wrong with the systems, structures and processes of governance underpinning infection prevention and control and to what extent, (if any) did these failures mirror events leading to the closure of Tawel Fan ward?

The key failures of the systems, structures and processes of governance in the management of the C. Difficile outbreak was that a higher than comparable

incidence of healthcare acquired infection was not recognised. The BCUHB Board failed to recognise itself as an outlier.

*“The BCUHB Board failed to recognise itself as an outlier.”*

This resonated with the lack of action BCUHB took following the Healthcare Inspectorate Wales (HIW) Mental Health Act visit to Tawel Fan ward in July 2013. Those involved in providing the feedback, (the HIW reviewer) and those receiving the feedback from the visit on the day failed to realise the seriousness of the issues raised. A member of the Board was not present for feedback, there has been no evidence seen by the review that the feedback was shared with either the CPG Chief of Staff or the Executive team. Finally, there was a significant failing in the systems, structures and processes within HIW at the time in that communication from HIW to the then interim CEO at BCUHB was also significantly delayed from July 2013 to October 2013. When Dementia Care Mapping, (BCUHB 2013) equally serious concerns on Tawel Fan ward three months after the HIW visit there was again little (if any) evidence of prompt or effective action by BCUHB.

*“A lack of leadership and action on key issues over a prolonged period of time.”*

## 12.44 Key points: Where do concerns within Duerden 2013 resonate with those seen in OPMH?

- Duerden (2013) found a grossly insufficient IP&C management structure at BCUHB leading to a lack of leadership and action on key issues over a prolonged period of time. Both the Mental Health and Learning Disabilities CPG, (and specifically Older Persons Mental Health, safeguarding and DoLS) suffered with this lack of management structure and therefore from a lack of management and leadership over a prolonged period of time.
- As with OPMH there was a lack of adequate training provided for ward staff in key areas of practice.
- As with OPMH there were considerable estates issues (and a failure to respond to concerns around estates provision for both IP&C and OPMH for many years until the current time (the end of 2017.)
- As with OPMH the way in which HCAI matters were reported to (or understood by) the Board led to false assurance and complacency. For OPMH this can be seen in the two Board presentations by the OPMH team around 'Healthcare in North Wales is Changing' (July 2012 and January 2013) and the two visits by the MHLTD CPG team to the BCUHB Quality and Safety Committee in October 2010 and then not until March 2012. All four of these meetings on critical issues affecting Older Persons Mental Health care provided the Board and its Quality and Safety Committee with untested and unchallenged assurances.
- The Ockenden review notes that other external reviews completed at/ around the same time found significant issues of concern in the systems, structures and processes of governance underpinning the provision of mental health care at BCUHB.
- As advised by multiple staff including staff numbers 3, 5, 11, 14, 15, 22, 25, 31, 54, 55, 57, 65 and others, (who are representative of a wide range of BCUHB staff members at the time including nursing, consultant medical

*“Safeguarding adults at the time appeared to have had a low priority at Executive level and in the clinical management system through the CPGs.”*

colleagues and 'support functions' to OPMH mental health in general and most specifically safeguarding adults and older persons mental health) safeguarding adults at the time appeared to have had a low priority at Executive level and in the clinical management system through the CPGs. This was the same situation faced by infection prevention and control at the time according to Duerden (2013). Staff number 57 told the Ockenden review 'Adult mental health wards across BCUHB were able to access funding and accreditation much easier than older persons.' Staff number 57 states that Older Persons wards were only able to start the process of applying for any accreditation 'once the acute wards had completed theirs....'

*“Adult mental health wards across BCUHB were able to access funding and accreditation much easier than older persons.”*

#### 12.45 Issues within Maternity services at Ysbyty Glan Clwyd (YGC) 2012-13 which resonate with issues found within the review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013

There were a number of external reviews of Maternity services at YGC in 2012-13 including a review by Wallace Walker (2012) and two external reviews by the Royal College of Obstetrics and Gynaecology (both in 2013.) This report will only summarise a brief overview of the issues identified with relevance to a review of the systems, structures and processes of governance in older people's mental health as set out in the Terms of Reference underpinning this governance review.

#### 12.46 The Wallace Walker<sup>125</sup> review of Maternity services at Ysbyty Glan Clwyd (YGC) in 2012 noted the following:

There had been a long history of concerns with the maternity service at YGC, and Wallace Walker (2012) noted a number of previous external reviews with lack of resolution of the issues raised, including 2005/6 and 2009. The Ockenden review of governance has been provided with an internal document by BCUHB titled 'Diagnostic Exercise: O and G, YGC, BCUHB, (July 2012.)

*“A clinically led leadership and management structure significantly underperforming – top to bottom.”*

The document provided appears to be a feedback document to the Executive team at the time and states that many of the cultural and behavioural issues seen in Maternity services in 2012-13 had been subject to 'a lack of follow through under the new BCUHB clinically –led organisation.' (Wallace Walker, 2012, page 15). The Wallace Walker review noted 'significant discipline issues outside of women's services/within other CPGs at YGC/other hospitals within BCUHB.' (page 11) and found 'a clinically led leadership and management structure significantly underperforming – top to bottom.' (page 13). Wallace Walker (2012) described a lack of engagement with clinical governance processes (page 14) and 'a culture of no consequence for non-compliance (Wallace Walker 2012, page 21) the question is asked – is this 'restricted to O and G or site – wide?' (page 21.)

<sup>125</sup> Internal to BCUHB Wallace Walker document seen

Echoing the findings around the lack of time and development given to the Chief of Staff for the Mental Health and Learning Disability CPG, the Wallace Walker review of Maternity services at YGC found a similar issue within the Chief of Staff role for Women's Services responsible for Obstetrics at YGC. (Wallace Walker 2012 page 23). The Wallace Walker review resonated with feedback from multiple interviewees and other external reviews of governance more generally and stated that at that time in BCUHB there was 'confusion regarding roles and responsibilities within all leadership roles – both at Executive and CPG levels, and a failure to 'act as a consequence'. (Wallace Walker 2012, page 23.)

*“Confusion regarding roles and responsibilities within all leadership roles – both at Executive and CPG levels, and a failure to act as a consequence.”*

## 12.47 RCOG reviews of Maternity services at YGC 2013

In the summer and autumn of 2013, two reviews by the Royal College of Obstetrics and Gynaecology (RCOG) took place into Maternity services at YGC. There were multiple findings and a lengthy action plan from the second review. The report of the first RCOG review has not been seen by the Ockenden review team. One of the key findings of the second RCOG review/report was the inability to find any evidence of a BCUHB organisational response to the Wallace Walker Report (completed May 2012; with issues first in escalated November 2011), and previous reports dating back to 2004. The RCOG review stated that this reflected a failure by the then BCUHB Executive team and its predecessors to take an adequate account of any of the reviews and recommendations made over the last decade. (RCOG 2013.)

Throughout 2012 and 2013 there was clear feedback to the BCUHB Executive team on three occasions from two respected sources that Maternity services at YGC had significant problems. The reviews stated clearly that were significant issues around clinical leadership and managerial oversight, confusion around roles and responsibilities and a lack of engagement with the systems, structures and processes of governance within the service at YGC. There was no evidence of any BCUHB response to the recommendations within the 2012 Wallace Walker review and report, which had pointed to lack of action on reports going back as far as 2004. The Ockenden review team has been advised that the then Executive Medical Director took updates regarding the Wallace Walker review first to the Workforce and Organisational Development (WOD) Committee and then to the Quality and Safety Committee. However this did not appear to have resulted in any actions that were easily identifiable by the RCOG team in 2013.

Following the three external reviews, (all highlighting the same issues) there appeared to be limited understanding by the BCUHB Board that the problems outlined in one clinical speciality on one main site could be found more widely across BCUHB as proved to be the case.

## 13 Chapter 5

**The Francis Report<sup>126</sup> (2013) – the findings of the Public Inquiry into events at Mid Staffordshire NHS Foundation Trust between 2005 and 2008 and its relevance to a review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013.**

### 13.1 The Francis Report<sup>127</sup> (2013)

The Ockenden review team considered and discussed twelve papers presented at the BCUHB Board and various BCUHB committees and meetings throughout 2013 concerning the Francis Report published in February 2013.

The purpose of the Ockenden review team considering the papers arising from multiple BCUHB discussions regarding the Francis report was to assess the action taken by BCUHB following the publication of the Francis report in 2013.

### 13.2 Key point: What was the relevance of the Francis report to care of older people with mental health problems in BCUHB in 2013?

It was hugely significant.

The publication of the Francis Report (2013) was some ten months before the closure of Tawel Fan ward in December 2013 and thrust the care of vulnerable elderly people into a national (UK wide and Wales wide) spotlight. It would have been reasonably expected that:

- All NHS bodies would have undergone a thorough review of their systems, structures and processes of governance to ensure that the systems they had in place, specifically around the care of vulnerable older people were robust enough to have accurately captured concerns from staff, patients and families in a timely manner.
- Secondly, and with reference to the Francis Report (2013), that all NHS bodies were able to provide evidence of organisation wide learning.

### 13.3 What did the Ockenden team review?

The first paper considered by this review was a BCUHB Board paper dated 28.3.13 (Item 13/046.4.)

This Board paper and all subsequent papers and minutes were reviewed in full by the Ockenden governance review team.

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<sup>126</sup> <http://www.midstaffpublicinquiry.com/report>. (Link accessed 17.11.17).

<sup>127</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/13\\_046.4%20francis%20report\\_findings%20of%20public%20enquiry%20mid%20staffs%20nhs%20foundation%20trust%20final.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/13_046.4%20francis%20report_findings%20of%20public%20enquiry%20mid%20staffs%20nhs%20foundation%20trust%20final.pdf) (accessed on 28th January 2018)



### What does the Board paper<sup>128</sup> of the 28th March 2013 do?

The Board paper provides an overview of the report into the Francis Inquiry (The Francis Report – the findings of the Public Inquiry into events at Mid Staffordshire NHS Foundation Trust between 2005 and 2008) The purpose of the paper was to bring to the BCUHB Board's attention:

The publication of the Francis Inquiry;

Outline BCUHB's response;

Provide opportunity for a wider Board discussion.

The BCUHB Board paper provided a summary of themes from the Francis reports which had 290 recommendations. Francis (2013) had identified a collective failure by the Stafford Trust Board and others to respond to a number of warning signs which are summarised within the Board report.

The BCUHB Board report stated that many of the themes and issues identified by Francis were already receiving focused attention within BCUHB as they were consistent with concerns which had already been raised in other reports received by the Board following external review from a number of organisations including Healthcare Inspectorate Wales, (HIW) the Ombudsman, the Older People's Commissioner for Wales and the Wales Audit Office, (WAO).

The Board report then goes on to expand on each theme within Francis (2013) and the action said to have been completed to date, (March 2013) within BCUHB. Of note is that this is just prior to the seriousness of the Clostridium Difficile outbreak becoming apparent to the BCUHB Board, post the Hurst (2012) review, post the Allegra (2012) review and post the HIW (2012) review into Ysbyty Glan Clwyd.

As cited in the Allegra review (2012, page 10) the decision to undertake the first joint HIW/WAO review (2013) had already been taken at this point and relevant information was said to have been passed from Allegra (2012) to that review. A summary of the themes outlined by Francis and the progress said to have been made by BCUHB by March 2013 are found within the Board report.

*“The BCUHB Board report stated that many of the themes and issues identified by Francis were already receiving focused attention within BCUHB as they were consistent with concerns which had already been raised in other reports received by the Board following external review from a number of organisations.”*

<sup>128</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20BCUHB%2028.3.13%20PUBLIC%20VERSION%20V1.0x.pdf> Item 13/046.4 pages 3 to 5).

## 13.4 Themes found within the Francis report (2013) and the BCUHB response at the time

### Theme 1: Common Values

#### BCUHB response

The Board report stated that extensive work had already been progressed, working with staff, to generate and describe the values<sup>129</sup> of BCUHB. See the link below for further information on the values of BCUHB.

The Board report at the end of March 2013 stated that these values had been shared widely, were included in induction, in annual appraisals, were visibly displayed across BCUHB and were said to be routinely referred to at many levels. However, the Board report noted that there were times when these values were not put into practice and patient experience at BCUHB was poor as a consequence. The Board report stated that the BCUHB values would be reviewed to ensure they remained relevant and would be reinforced through ongoing training at every level, as well as being modelled by all, in particular, senior staff.

Staff number 20, advised the Ockenden review that there was no Executive induction in 2013. 'When I asked about Executive induction.....there was nothing.' Staff number 57 also advised the Ockenden review of no induction on taking up a new role within BCUHB in late 2012/early 2013. Staff 57 confirmed, 'there was an X, (specific role stated) development programme started but after two or three sessions it ceased and nothing recommenced after that...' The same situation arose with appointments of the Chiefs of Staff.

The review has heard from many members of current and former staff and been provided with significant amounts of evidence that at the time of this Board paper reviewing the Francis report in March 2013 annual appraisal rates were low, and training and development opportunities were limited. In the absence of Executive and 'new role' induction for a number of roles within BCUHB, staff, with low annual appraisal rates and poor mandatory training and development opportunities, as described by interviewees for this review it is difficult to understand how extensive work can be said to have been progressed on common BCUHB values at this point in time. Whilst the Ockenden review was subsequently advised that 'there is and has [always] been a system of corporate induction the actual experience of former and current BCUHB staff means that there were a number of occasions when this simply did not happen in reality.

*“Values had been shared widely, were included in induction, in annual appraisals, were visibly displayed across BCUHB and were said to be routinely referred to at many levels. However, the Board report noted that there were times when these values were not put into practice and patient experience at BCUHB was poor as a consequence.”*

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<sup>129</sup> <http://www.wales.nhs.uk/bcuhbwelcome/page/62114>. (Link accessed on 15.11.2017)

## Theme 2: Fundamental Standards – provision of equipment and basic care

### What staff told this governance review

Referring to the time around the publication of the Francis report a senior nurse working within Older Persons Mental Health told this review that the wards in one BCUHB inpatient unit lacked basic equipment. The interviewee said [The wards] 'didn't have things/they didn't have a blood pressure machine, they didn't have weighing scales.....the staff used to come and take the equipment [from one ward to another] 'and then we wouldn't have the equipment and the equipment would go missing, we wouldn't know if it was on (ward X) or if it was on our ward....' Staff number 38 in interview confirmed that there was 'one blood pressure machine between two wards...'

The lack of a blood pressure machine said by a number of staff to have been raised over a twelve month period and the Ockenden governance review was told that to acquire one per ward took '2 years really' and happened 'after Tawel Fan.' Staff number 57 agreed and described at interview the use of the 'Patient Amenity Fund' to purchase basic ward equipment, such as an electric sphygmomanometer, (blood pressure apparatus.) Staff number 57 explained that the Patient Amenity Funds held money donated by relatives or patients to a specific ward for patient enjoyment or enrichment. Staff number 57, in a written account submitted to the Ockenden governance review told the review of objection to using the Patient Amenity Fund 'for basic essential items such as a sphygmomanometer'.

Emails provided to the Ockenden review by staff number 65 show further long term problems with lack of availability of basic equipment in some Older Peoples Mental Health wards across BCUHB. One example is the lack of a working ECG machine in Cefni Hospital, (Cemlyn ward) in February 2011. The email provided describes a request for a new ECG machine 'several months ago, I have not heard that we are any closer to getting one.' (Email dated 23rd February 2011@ 1106hrs). The email says 'This is having an impact on inpatient and outpatient care.' The issue of the ECG machine is said to have been discussed 'several times' in meetings 'to prioritise it as an urgent safety issue.' The same email titled 'Confidential – basic care needs – OPMH (Urgent) says 'Carers and patients are writing letters to me about their difficulties particularly around the inpatient environment in Tegid, (heating, mixed sex etc.) And I have asked that the last complaint that I have received, to be registered as a formal one.'

The combination of evidence from staff interviews, minutes of CPG meetings, and internal BCUHB documents suggested to this governance review chronic and unaddressed problems with estates and a lack of basic equipment across Older Persons Mental Health care provision in BCUHB from at least 2009 until after the closure of Tawel Fan ward. The information provided to this review also suggests a number of informal complaints from service users and their representatives (which have not been provided to the Ockenden governance review.) An email was provided to the review dated February 2011 where these

*“The wards didn't have things/they didn't have a blood pressure machine, they didn't have weighing scales.....the staff used to come and take the equipment (from one ward to another) 'and then we wouldn't have the equipment and the equipment would go missing, we wouldn't know if it was on (ward X) or if it was on our ward....'”*

*“Carers and patients are writing letters to me about their difficulties particularly around the inpatient environment in Tegid, (heating, mixed sex etc.) And I have asked that the last complaint that I have received, to be registered as a formal one.”*

informal complaints appear to start to become formal complaints. These examples have not been provided to the review team for verification.

### BCUHB response

The Board paper (28th March 2013) advised that fundamentals of care processes were embedded within BCUHB as an organisation and provided a platform from which BCUHB could measure the effectiveness of the care provided. The report stated that BCUHB had 'recently', (no date provided) started to code all concerns raised in a way which would identify any breaches in the fundamental standards of care. (BCUHB 2013, page 6) These standards were said to be focused on nursing care and consideration may be required as to whether or not amendments needed to be made to include the actions expected of other members of the multi professional team. If basic standards were not met, BCUHB needed to be clear about what happens. (All BCUHB 2013, page 6.)

The Board paper said that a failure to meet basic standards of care should always be reported and patients and their families told whether or not they ask. If death or serious harm results from failure to meet basic standards this should automatically result in a defined process for the staff and service involved. This defined process (BCUHB 2013, page 6.) was not elaborated upon in the Board paper. Later in 2013, following the arrival of the then new Executive Director of Nursing of Midwifery comprehensive external reviews of the concerns process (which included complaints and serious untoward incidents) was carried out. Unfortunately the assurance given to the Board in March 2013 on 'fundamentals of care' as set out by Francis (2013) and any process regarding the understanding of the content of complaints proved to be incorrect since the reviews found limited assurance around the systems structures and processes utilised within BCUHB for the management of and learning from concerns.

### Theme 3: Openness, Transparency and Candour

#### BCUHB response

The Health Board stated it had made progress in implementing the nationally agreed 'Putting Things Right Regulations for Managing Concerns' See:<sup>130</sup> which reflected the themes arising within the Francis Report. However, there were said to be areas for improvement locally with regards to the timeliness and quality of responses. (BCUHB 2013, page 6.) Unfortunately the comprehensive review of 'concerns' undertaken by the incoming Executive Director of Nursing and Midwifery from June 2013 onwards proved that the bland assurances around 'progress' given to the BCUHB Board were overly optimistic. The external reviews of concerns later in 2013 found a range of issues including repeated 'Never Events' and a lack of appropriate investigation techniques in serious untoward incidents such that many serious incidents, even those that were previously declared closed by BCUHB required reopening and reinvestigating. The Board report stated that 'Patients should always be informed if they have or may have

*"The reviews found limited assurance around the systems structures and processes utilised within BCUHB for the management of and learning from concerns."*

*"The external reviews of concerns later in 2013 found a range of issues including repeated 'Never Events' and a lack of appropriate investigation techniques in serious untoward incidents such that many serious incidents, even those that were previously declared closed by BCUHB required reopening and reinvestigating."*

<sup>130</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20BCUHB%2028.3.13%20PUBLIC%20VERSION%20V1.0x.pdf>

been unavoidably harmed, whether or not they ask.' In the circumstances outlined in the reviews of the concerns process from the summer of 2013 to December 2013 it was clear that BCUHB did not have an effective system, structure and process in place to be able to inform patients of all cases of unavoidable harm.

#### **Theme 4: Compassionate, Caring, Committed Nursing**

##### **BCUHB response**

The Health Board and Welsh Government had set out an agenda to ensure that all wards had safe staffing levels, this included a Wales wide approach to identifying acuity of patients as well as working towards a common dependency tool. The Board report stated that nurse staffing must always be triangulated with professional judgement and benchmarking. This review has been provided with extensive evidence of chronic problems with staffing within mental health and most specifically older peoples mental health from the formation of BCUHB in 2009. A complex and lengthy Executive led vacancy control process was described by a number of interviewees and examples of the documentation utilised has been seen by the Ockenden review. Examples of inpatient wards across older persons mental health trying to assist and share from a depleted pool of staff have been provided to the Ockenden review. Inpatient wards in the MHL D CPG also undertook a detailed nursing establishment review using the Hurst methodology<sup>131</sup>, details of which are found below. Staff working within the service at the time described that in the medium term whilst this review was underway, staffing levels were very poor, since substantive recruitment to vacant posts did not occur.

*“A complex and lengthy Executive led vacancy control process was described by a number of interviewees.”*

This followed on from a recognition that historic staffing establishments were not appropriate to mental health care provision in BCUHB at the time.

#### **Theme 5: Strong Patient Centred Healthcare Leadership**

##### **BCUHB response**

Staff in NHS Wales are expected to behave in accordance with a code of conduct.<sup>132</sup>

The Board report stated that BCUHB recruitment, training and development programmes need to be tested to ensure that they reflect these expectations and the systems and processes that support this work must ensure that when patient safety, well-being and candour is not put first then this is challenged and dealt with and is not tolerated.

This summary for the Board was in the future tense using phrases such as 'should be' 'need to be,' (BCUHB 2013, page 7.) 'will ensure' 'will result.' (BCUHB 2013, page 8.) There was no specific, measureable or timed plan with no named ownership as to how this would be achieved.

<sup>131</sup> <https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf>

<sup>132</sup> <http://www.wales.nhs.uk/governance-emanual/values-and-standards-of-behaviour-framew>



## **Theme 6: Accurate, Useful and Relevant Information**

### **BCUHB response**

The Health Board stated it had made 'substantial progress' (BCUHB 2013, page 8.) in developing its website and social media arrangements including Facebook and Twitter. Board meetings were open to the public and papers from the Committees of the Board were published. More work was said to be needed to ensure that the data presented, (particularly as it related to indicators of quality and safety) was available to the public in an accurate, useful and relevant format. There was no detail provided as to how this would be achieved, by whom (and when).

In 2013 the Health Board produced an Annual Quality Statement which was described as 'first and foremost for the public.' It was intended to summarize how BCUHB as an organisation was 'continuously improving the quality of all the services it plans and provides for its local citizens, in order to drive both improvements in population health and the provision of healthcare services.' (BCUHB 2013, page 8.)

## **Theme 7: Culture Change Not Dependent on Government**

### **BCUHB response**

The Board report stated that BCUHB will ensure that the actions already underway to address the issues raised in previous reports and within the Francis Report are addressed. (BCUHB 2013, page 8.) BCUHB needed to continue to work to create a climate which supported staff and patients to speak up when things go wrong in a way in which they feel supported, listened to and appropriate responses are put in place. (BCUHB 2013, page 8.)

## **Theme 8: Improving Services for Older People**

### **Francis Recommendations**

The Francis Report made a number of specific recommendations that related to care of older people. These covered teamwork, communication, hygiene, and provision of food, water, medicines and the recording of observations. (BCUHB 2013, page 9.)

### **BCUHB actions stated to be in place as of March 2013**

BCUHB stated that The Health Board had already committed to a programme of improvement, building on the reviews undertaken by the Older Peoples Commissioner. As with the BCUHB response to the previous Francis recommendations this response gave no indication of the responsible person, the timeline for meeting the recommendation, and how BCUHB would assess for itself that the recommendation had been met. Again the response is in the future tense, with no responsible individual identified, no defined and specific timeline for achievement and no discussion on how the Board would measure progress or success. (BCUHB 2013, page 9.)

*“The response gave no indication of the responsible person, the timeline for meeting the recommendation, and how BCUHB would assess for itself that the recommendation had been met.”*



## 13.5 Overview of various BCUHB documents concerning implementation of the Francis Report in BCUHB

### 28th March 2013

The Ockenden team undertaking this governance review found that all the responses in the March 2013 Board paper associated with the Francis Report are narrative in nature and have no key performance indicators or detail on how improvement or success would be measured or described by BCUHB. The report did not identify how any learning would be shared organisation wide across BCUHB. There were no indicators that would link to any organisational performance matrix or dashboard. Finally, the BCUHB Board was asked to support a six month update to the Board with 'regular' updates to the Quality and Safety Committee. There is no indication what format the report will take and the time line of 'regular' is not explicit.

*“All the responses in the March 2013 Board paper associated with the Francis Report are narrative in nature and have no key performance indicators or detail on how improvement or success would be measured or described by BCUHB.”*

## 13.6 Overview of BCUHB and the BCUHB Community Health Council Board (BCHCB) 16 May 2013 discussion on The Francis Report

The May 2013 joint Board report provides an overview of the report Francis Inquiry (The Francis Report 2013) to the Board of the North Wales Community Health Council. There is a great deal of repetition to the previous report and the report is almost identical to the previous Board paper some two months earlier. The only additional information related to an update on the progress of Executive implementation.

It was noted that a national approach from Welsh Government (BCUHB 2013, page 5) to Francis was beginning to evolve. This was known as **'Safe Care, Compassionate Care.'** (2013) This document was explicit that everyone who worked in, or for the NHS in Wales had an absolute responsibility to serve the public. Therefore, everyone, at every level had a part to play in driving up standards of safe, effective, patient centred care. Patients and patient safety was central to decision making. This document required the publication of an Annual Quality Framework by each Health Board which focused the provision of care to the people of Wales from a compassionate and qualitative perspective.

Learning for Wales<sup>133</sup> from 'the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' published by the Welsh Government in July 2013 set out the all Wales response to the Robert Francis Report into events in the Mid Staffordshire NHS Foundation Trust. It demonstrated an all Wales commitment to deliver safe and compassionate care to all who used health services in Wales. The response was broken down into key action areas with supportive Executive leads, a timeline and delivery expectations. NHS Wales were very clear that this response would not be a traditional action plan, this was in order to ensure that there is a culture which focuses, at all times, on the needs and rights of patients.

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<sup>133</sup> <http://www.wales.nhs.uk/governance-emanual/document/219549>

The minutes of the joint Board meeting show a degree of challenge from the CHC members present around what was described as lapses in basic standards of care in BCUHB. This included concerns around 'provision of food and water,' (BCUHB 2013, page 5) and failures around courtesy, suggested in the minutes to be medical staff (BCUHB 2013, page 5)

### 13.7 Continuing overview of Betsi Cadwaladr University Health Board's response to the 2013 Francis Report

(See The Quality and Safety Committee Paper 5.9.13 Item QS13/160 for further reference). This report in September 2013 from the Quality and Safety Committee (a sub-committee of the Board) provided a summary of progress to date. Again, there is a great deal of repetition from previous reports. Additionally the Health Board had been in receipt of specific reports regarding dignity and the care of the elderly particularly at Glan Clwyd Hospital and this had led to formation of Older Peoples Commissioner and Ombudsman Report Working Group. An early output from this group was the creation of dignity ambassadors at ward level.

*“There is a great deal of repetition from previous reports.”*

The paper concluded that:

Responding to Francis (2013) specifically was increasingly complex for BCUHB as chronologically the report had almost been superseded or duplicated by the 2013 Joint HIW/WAO report into the Health Board, and the Duerden (2013) report into the C. Difficile outbreak at Ysbyty Glan Clwyd (and more recently the 2013 Keogh Report into concerns raised within 14 English NHS Trusts.) External reviews into BCUHB's ability to manage and learn from concerns were underway.

It was evident that all three national reports; Francis, Berwick<sup>134</sup> and Keogh<sup>135</sup> and the multiple BCUHB external reviews of 2012, plus those of 2013 focused on (or considered) many of the same themes particularly the systems, structures and processes of governance, safety, care and candour.

### 13.8 Key point: what do the external reviews into BCUHB of 2012-13 tell us?

- There was evidence as early as mid-2013 of a series of multiple external reviews, both specific and individual to BCUHB and those external to BCUHB containing recommendations of relevance to the systems, structures and processes of governance at BCUHB.
- There was already a real risk that work to meet key recommendations either in those reports individual to BCUHB, as in the reviews concerning maternity services (2012 and 2013), specific HIW reports of 2012 and 2013 and the Public Health Wales and Duerden reports of 2013 or reports concerning the wider NHS in England and Wales could be either be duplicated or 'lost' in

<sup>134</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/226703/Berwick\\_Report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf)

<sup>135</sup> <https://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

the multiple recommendations around the systems, structures and processes of governance at BCUHB now becoming apparent.

### 13.9 Key point: How much progress had the BCUHB Board made with responding to Francis by September 2013?

Very limited

The September 2013 report was consistent with the previous BCUHB reports on the Francis (2013) Inquiry in that it was highly narrative with a lack of specific and/or measureable progress or clear identification of issues.

BCUHB had no evidence of:

- A reconciliation of the actions still required;
- Board scrutiny of the effectiveness of the plans that the CPGs had produced;
- Triangulation of the organisational learning across BCUHB achieved to date.

### 13.10 Key point

Whilst the evidence outlined above showed little progress as of September 2013 report, the Ockenden review team also undertook a search on the BCUHB website and could also not find any further evidence of organisational learning at the time.

### 13.11 Key point: How much progress had the BCUHB Board made with responding to Francis by November 2013?

Again limited, the Quality and Safety Committee paper of the 7th November 2013 (see item: QS13/214.2); provided an almost identical overview of information previously discussed.

The report described the associated Director line of responsibility and accountability and identified the requirements needed by the Quality and Safety Committee in order that that the Committee was able to provide assurance to the Health Board or raise concerns to prevent a repeat of the issues raised within the Francis report.

Some of the recommendations had been progressed with further work required to strengthen the focus on the quality of care and safeguards to protect patients from harm.

The Quality and Safety Committee would need to build into its annual work programme a process for aligning the themes of the Francis review with those of Keogh (2013) and Berwick (2013).

*“The September 2013 report was consistent with the previous BCUHB reports on the Francis (2013) Inquiry in that it was highly narrative with a lack of specific and/or measureable progress or clear identification of issues.”*

### 13.12 Key point:

- The report is dated November 2013, and eight months have passed since the publication of The Francis Report.
- The language still focuses on 'analysis' in the future tense i.e. the Director 'will need' rather than a plan focused on current action and measurement of progress. This is against a history of two previous reports to the Quality and Safety Committee and many months following the publication of the Francis Inquiry.
- The previous reports were consistent with the presentation of this one with a complete absence of robust and measureable data.

*“The language still focuses on ‘analysis’ in the future tense i.e. the Director ‘will need’ rather than a plan focused on current action and measurement of progress. This is against a history of two previous reports to the Quality and Safety Committee and many months following the publication of the Francis Inquiry.”*

### 13.13 Conclusion

Overall, the lack of systems, structures and processes of governance within BCUHB to drive forward in a timely manner the recommendations of Francis (2013) were further evidenced within the three reviews into maternity services in YGC in 2012 and 2013, the Public Health Wales Report, (2013) the Duerden report, (2013), the external reviews of the 'concerns' process throughout 2013, the Good Governance Institute review (2014), the Ann Lloyd Report<sup>136</sup> (2014) and both the first (2013) and second Joint HIW/WAO review (2014). All of these reports had significant relevance to the delivery of Mental Health care and specifically Older Peoples Mental Health care as provided by BCUHB.

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<sup>136</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Ann%20Lloyd%20Report.pdf>

## 14 Chapter 6

### 14.1 Progress in the implementation of systems, structures and processes of governance as explained in the 2012/13 Annual Governance Statement and from the perspective of current and former members of BCUHB staff

The Annual Governance<sup>137</sup> statement for 2012/13 is dated June 2013.

There was an interim CEO in post at BCUHB at the time. In the section titled 'Scope of Responsibility' (BCUHB 2013, page 1) the statement describes 'particular attention to patient safety and the reconfiguration of service (s) to ensure they are safe, sustainable and affordable now and in the future.' The statement also says that in the time period under review BCUHB had worked 'closely with partner organisations such as local authorities and the third sector to discuss and address health inequalities and promote community engagement.' (BCUHB 2013, page 1.)

Board responsibilities were stated to include:

- Maintaining high standards of corporate governance;
- Ensuring effective communication between the organisation and the community regarding plans and performance and that these arrangements are responsive to the locality's health needs.

Board member responsibilities and those described as 'Champion roles' are clearly set out on pages 2-8.

#### **The BCUHB Governance Framework in 2012-13 as set out in the Annual Governance Statement<sup>138</sup> (see BCUHB 2013, page 11.)**

A range of BCUHB quality, governance and annual reports from 2012-13 onwards are available on the BCUHB website. These have been reviewed from 2012-13 to the current day. To avoid repetition or consideration of those issues already known only those issues that the review team consider have relevance to care of patients on Tawel Fan ward prior to closure in December 2013 have been considered in any detail.

At the time of publishing the Annual Governance statement BCUHB was in the midst of the C. Difficile outbreak. The statement said that BCUHB had 'strived to deliver improved performance in challenging circumstances, as well as to improve quality and safety and achieve financial balance'. (BCUHB 2013, page 11.) The statement refers to the setting up of a 'Recovery/Delivery Board' in existence from May 2012, chaired by the then substantive CEO. The Annual

*“BCUHB had worked ‘closely with partner organisations such as local authorities and the third sector to discuss and address health inequalities and promote community engagement.’”*

<sup>137</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Annual%20Governance%20Statement%20v2%207%206%2013%20FINAL%20APPROVED%20%28%29.pdf>

<sup>138</sup> <http://www.wales.nhs.uk/sitesplus/861/page/87716>

Governance statement describes the 'Recovery/Delivery Board as leading a 'strategic approach to 'Turnaround' (BCUHB 2013, page 12.) Subsequent and multiple external reviews and this governance review have all found very limited evidence of a strategic review to 'turnaround' at the time. Instead 2012/13 marks a period of time when BCUHB begins a process of multiple external reviews over an extended period of time, (to the current day) with limited evidence of meeting the recommendations and requirements of one external review before embarking on another. This is one of a significant number of examples of the 'outward facing' BCUHB presenting an altogether more positive image than that which was the reality.

The 2012/13 Governance Statement acknowledges the difficulties experienced by CPGs including '...significant differences in the CPGs' span of responsibilities which required review alongside concerted effort being needed to embed effective models of clinical leadership and engagement'. The solution is described as a revision and refinement of the 'performance and accountability framework between corporate and CPG areas during 2012-13.' This was said to ensure that a 'Director is accountable for each CPG and that regular meetings are held between the Director and Chief of Staff and Senior CPG management teams.' Former Board members including 47, 20 and 91 have described to this review the 'impossibility' of making this initiative work across 11 CPGs, since it relied upon only a small number of Executive Directors taking responsibility for those CPGs in addition to their existing responsibilities. This is not acknowledged in the 2012-13 Annual Governance statement.

The Governance Statement acknowledged the need to both 'build upon the strengths of the clinical leadership model, whilst addressing the current challenges in governance and operational delivery.' The Board had agreed to progress changes to the Executive structure, including moving the Executive Lead for Quality and Safety within BCUHB to the Executive Director of Nursing, Midwifery and Patient Services.

There were a number of changes to the Executive Director of Nursing, Midwifery and Patient Services role that took place in 2013. The substantive post holder left BCUHB in March 2013, having been in post in a legacy site pre-merger, during the merger creating BCUHB and post-merger in the 'new' BCUHB from October 2009 to March 2013. An acting Executive Director of Nursing, Midwifery and Patient Services held the role for twelve weeks from March 2013 awaiting the start of the new substantive Executive Director of Nursing, Midwifery and Patient Services who took up post from June 1st 2013. The Ockenden review has also been advised of a change in the seniority of the nursing hierarchy in 2012. The Deputy Director of Nursing role was removed from the senior nursing structure by the then Executive Director of Nursing, Midwifery and Patient Services in 2012 and replaced with four 'Assistant Nurse Directors' with responsibility for discreet functions, e.g. professional regulation, safeguarding.

At this stage an external review of maternity services at YGC has already been completed. That review raised significant concerns regarding the leadership and

*“2012/13 marks a period of time when BCUHB begins a process of multiple external reviews over an extended period of time, (to the current day) with limited evidence of meeting the recommendations and requirements of one external review before embarking on another.”*

*“...Significant differences in the CPGs' span of responsibilities which required review alongside concerted effort being needed to embed effective models of clinical leadership and engagement.”*

*“Whilst in theory at least BCUHB had a system where it should have been able to capture and analyse information and ensure the timely investigation of incidents from 2011 onwards this did not occur.”*



management abilities and capacity within the then CPG structure. The authors questioned whether the problems seen within maternity at YGC were wider than one individual CPG and affected the whole of YGC. No measurable, visible and definitive action was taken by the Board and the RCOG undertook two further external reviews in August and September 2013, which were similarly critical.

## 14.2 Implementation of Datix at BCUHB and within OPMH

The Annual Governance Statement of 2012/13 discussed Datix as 'an integrated risk management solution [that] has been 'embedded' in 2012/13. (BCUHB 2013, page 14.) Following on from the use of the phrase 'embedded' the AGS acknowledges 'variation in progress reported as an issue of significance'. (BCUHB 2013 page 14). However the use of the word 'embedded' to describe progress when Datix was anything but 'embedded' will have been unintentionally misleading. Whilst **in theory** at least BCUHB had a system where it should have been able to capture and analyse information and ensure the timely investigation of incidents from 2011 onwards this did not occur.

External reviews of the 'concerns' systems later in 2013 found issues within the Mental Health and Learning Disabilities CPG such as introduction of the Datix system without prior training. Issues with the utilisation of the Datix system proved to be a long term problem for BCUHB generally and the Mental Health Division and Older Persons Mental Health more specifically for a number of years from 2009 until into the spring of 2017. This was presented to the Ockenden review team via a number of interviewees working across BCUHB's Older Persons Mental Health service:

- Pressure and the amount of time ward staff spend to staff wards safely meant that ward managers were unable to spend the time required to review Datix appropriately and in a timely way, (Staff number 38, nursing, describing the position in February 2017.)
- Feedback from Datix at ward level was 'nil' until 2015. (Staff number 53)
- Submitting Datix and getting no feedback 'not....anything closing the loop to come back' (Staff number 40, describing the position with Datix until September 2016.)
- Lack of engagement by some medical colleagues as recently as the summer of 2017. One colleague, number 79, told the Ockenden review 'Datix, I don't do it personally, the nurses do it.....At the moment I have not had any reason to do that but if I had, I would learn how to do it.'
- 'I was shocked.....I had no idea Datix was as broken as it was broken...there were literally thousands being reviewed, with no timescale.....all they'd actually done was just moved the problem from holding to being reviewed, as opposed to actually reviewing and closing them down..' (Staff number 68, describing the position with Datix across mental health in summer 2015.)

*"Pressure and the amount of time ward staff spend to staff wards safely meant that ward managers were unable to spend the time required to review Datix appropriately and in a timely way."*

*"I was shocked.....I had no idea Datix was as broken as it was broken...there were literally thousands being reviewed, with no timescale.....all they'd actually done was just moved the problem from holding to being reviewed, as opposed to actually reviewing and closing them down.."*

- Staff number 4 told the Ockenden review team 'the systems and reporting and the intelligence was not as streamlined and focused and rigorous as it might have been.....If that had been there it may well have detected issues that would have manifested themselves in earlier intervention...'
- Referring to a situation that persisted in BCUHB for several years after the closure of Tawel Fan ward staff number 25 noted the lack of 'automatic flag or alert system' on Datix to identify the number of referrals against any individual 'by name or by ward or department..'
- 'Performance on Datix is dramatically better and has improved considerably over the last twelve months' (Staff number 68, describing the position with Datix across Mental Health in June 2017)

*"Performance on Datix is dramatically better and has improved considerably over the last twelve months – June 2017"*

### 14.3 In conclusion:

Implementation of Datix at BCUHB remained a considerable problem for several years until 2017 after its launch in 2011/12 within Mental Health.

### 14.4 Key clinical risks identified within the BCUHB Annual Governance Statement the Annual Governance Statement or AGS (as at May 2013) included:

- Failure to manage concerns effectively and learn lessons to improve patient safety; The AGS noted that more work is required to ensure that all incidents are being reviewed in a 'timely way'.
- Failure to create a climate and culture that puts the patient first;
- Failure to ensure that BCUHB had the right staff, with the rights skills at the right time;
- Failure to provide information which supports effective governance, assurance and decision making;
- Failure to locate and provide patient and corporate records to underpin the delivery of safe patient care in a timely manner. (See page 15.)

*"Failure to create a climate and culture that puts the patient first"*

*"Failure to ensure that BCUHB had the right staff, with the rights skills at the right time"*

The Annual Governance Statement said that 'Measures are in place to address these risks, which are reported to and monitored by the Board and its Committees.' (BCUHB 2013, page 16.) The Annual Governance Statement<sup>139</sup> described the development of the BCUHB Risk Management Policy (2012) – the link to access this via the BCUHB website is found below.

*"Failure to locate and provide patient and corporate records to underpin the delivery of safe patient care in a timely manner."*

The BCUHB Risk Management Policy (2012) included the objectives of:

- Creating a culture at BCUHB that puts citizens at the centre of everything we do;
- Creating a fully 'risk aware' approach at BCUHB;

<sup>139</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/12\\_106\\_3%20risk%20mgt%20policy%20and%20strategy.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/12_106_3%20risk%20mgt%20policy%20and%20strategy.pdf) (accessed March 22nd 2018,)

- Clarifying that risk management at BCUHB was everyone's responsibility.

The 2012/13 Annual Governance Statement said that the BCUHB Risk Management Policy and Strategy included the development of 'a robust governance framework to achieve the highest standards of patient safety and public service delivery.' (BCUHB 2013, page 17) and that 'there are mechanisms in place to learn lessons from any incidents or untoward occurrences and that corrective action is taken where required' (BCUHB 2013, page 17)

The 2012/13 BCUHB Annual Governance Statement or AGS appears to paint an altogether more positive picture of the success of managing 'concerns' than any of the subsequent external reviews found. The Statement within the AGS said that 'The Director of Governance and Communications and the 3 clinical Executive Directors together with the Director of Primary, Community and Mental Health meet regularly to discuss clinical issues and trends in concerns and incidents to ensure that the organisation learns from patient' experiences.' (BCUHB 2013, page 22.) Whilst the Ockenden team would not dispute that meetings happened 'regularly' as cited in the AGS – the effectiveness of the systems, structures and processes of governance around the management of concerns as a result of these meetings and other processes were in place at the time were clearly questionable.

Staff number 25 advised the Ockenden review of a long term lack of sharing of information across SI's, HIW action plans or complaints across BCUHB. Staff number 25 further noted the lack of any 'intelligence to inform or provision to benchmark service risk or improvement or organisational briefing to enhance awareness of service risk. Staff 25 concluded that as of September 2017 that the only way of finding 'any work to determine risk' within BCUHB 'was done by personal research..'

*“The lack of any ‘intelligence to inform or provision to benchmark service risk or improvement or organisational briefing to enhance awareness of service risk.’”*

## 15 Chapter 7

### Key events across BCUHB leading up to the closure of Tawel Fan ward on 19th December 2013

#### 15.1 The Heddfan Unit

##### The Action Plan – following the unannounced 'Dignity and Respect' Spot Checks at the Heddfan unit, Wrexham Maelor Hospital in February 2010

Many positives are included in the action plan as a result of the move to the new Heddfan unit at Wrexham Maelor Hospital. Actions are mainly 'to ensure' (in the future tense) that certain things happen and there are some changes to documentation to facilitate this but how this is monitored and the timescale over which it is monitored is not included. Training programmes are said to be put in place.

##### Action Plan following HIW Inspection of the new Heddfan unit 16.5.2011.

This is found in the Divisional 'action plan of action plans' dated August 2015 and updated December 2015 as provided by BCUHB. (see BCUHB 2015, MH 0029 to 0036.) The action plan, (see excerpt overleaf) draws attention to problems with Mental Health Act documentation and a number of systems and processes underpinning this particularly 'Second Opinion'<sup>140</sup> and capacity assessments. In addition there are concerns about the levels of activities and provision of interpreting services. Staff training remains an issue despite the earlier assurances and the actions to remedy this are reported as 'ongoing with no defined timescale for improvement to be delivered. Levels of pharmacy support are reported as 'improved.' (as of August 2015, four years after the visit)

*“The inspectors noted many positive aspects of the service, including good team working at ward level, with strong leadership and supportive management on the acute and PICU wards. Patients were generally very complimentary about staff attitudes and approach.”*

#### 15.2 HIW Inspection report: Wrexham Maelor Hospital, The Heddfan Unit on the 15-16 April 2015

#### 15.3 What had changed in the Heddfan unit since the last HIW visit?

The inspectors noted many positive aspects of the service, including good team working at ward level, with strong leadership and supportive management on the acute and PICU wards. Patients were generally very complimentary about staff attitudes and approach. The Inspection team noted 'We were pleased to learn of the good links the unit had with third sector organisations and the advocacy service was proactive to assist with patient needs.' (HIW 2015, page 5)

As with many HIW inspections in the six years leading up to this HIW inspection there were major issues with Estates management on all the wards and the garden areas including the presence of ligature points. (HIW 2015, pages 9 and

*“As with many HIW inspections in the six years leading up to this HIW inspection there were major issues with Estates management on all the wards and the garden areas including the presence of ligature points.”*  
(HIW 2015, pages 9 and 10).

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<sup>140</sup> See glossary

10). Concerns were also raised by the HIW team about the time nurses spent completing non-nursing tasks such as undertaking the role of porter. (HIW 2015, page 11). Work in open areas led to concerns about breach of patient confidentiality on Gwanwyn ward. (HIW 2015, page 9). Issues of cleanliness, medication recording and of poor completion of mandatory training were raised as concerns by the HIW team. (HIW 2015, page 17). The shortage of medical staff was also noted. (HIW 2015, page 19).

#### 15.4 Did the attention, focus and time spent on the Hergest unit in 2012-13 reduce the opportunities for attention, focus and time to be spent on Tawel Fan ward?

#### 15.5 What is the Hergest Unit?

The Hergest Unit is based at Ysbyty Gwynedd, Bangor and was built in the early 1990s. Initially there were three wards, each with 18 beds. These were Aneurin, Cynan and Gwalchmai wards. In addition there is a Psychiatric intensive care unit, (or PICU), known as Taliesin ward. Gwalchmai ward was closed in 2011, as part of a move towards creating a 'Home Treatment Team'; based within the community. From 2009 onwards there was extensive scrutiny of the Hergest unit. These include:

- Multiple HIW reviews and reports;
- An 'Invited review' by the Royal College of Psychiatrists – December 2013
- The Royal College of Psychiatrists (Accreditation for Inpatient Mental Health Services), or AIMS;
- An external review, which was halted before completion, at the end of 2012;
- The Robin Holden investigation (the investigation taking place at the end of 2013, being reported to BCUHB January 2014.)

Multiple interviewees and an extensive review of internal BCUHB and external documentation highlight a long history of inspection, reviews and concerns regarding the Hergest unit in Bangor.

One family raised very significant concerns regarding care in the Hergest unit, at the 'Listening and Engagement' exercises in the spring of 2017 – although these concerns were from a 'historic' perspective in 2013. Those concerns have yet to be investigated appropriately by BCUHB as of the end of 2017, which has caused the family very significant distress. This example of very serious potential concerns around poor care and poor systems, structures and processes of governance underpinning clinical care and the failure of the concerns system within BCUHB to have responded appropriately to this family over a four year period (to the current day) is presented as an anonymised case study within the report with the permission of the family, family number 21. In addition the review considered a number of other internal pieces of BCUHB evidence, (as provided by BCUHB), including Serious Untoward Incident (SUI) reports and feedback from staff working within the CPG from 2009 onwards which highlighted

*“Issues of cleanliness, medication recording and of poor completion of mandatory training were raised as concerns by the HIW team.”*  
(HIW 2015, page 17).

*“This example of very serious potential concerns around poor care and poor systems, structures and processes of governance underpinning clinical care and the failure of the concerns system within BCUHB to have responded appropriately to this family over a four year period (to the current day) is presented as an anonymised case study within the report with the permission of the family”*



to the review team the lack of systems, structures and processes of governance underpinning investigation of concerns into older peoples mental health care within the Hergest unit. The Ockenden governance review team further considered a range of correspondence between HIW and BCUHB and reports regarding the Hergest unit from 2009 to the current day.

The Ockenden team found that interviewees, (both current and former BCUHB staff) in 2017 appear to see the issues around the Hergest unit from completely opposing viewpoints. Those who were working within or had worked within the Hergest unit remained angry at how they believed they were treated by the then management team from 2009 onwards, with particular reference to the time periods of 2010 onwards. An external review of the Hergest unit (Holden 2014) appears to validate that viewpoint. Those managing the situation within the Hergest unit (and across all other mental health services in North Wales) saw and still see the situation differently. They described a unit with concerns raised about it by HIW, The Royal College of Psychiatrists and within SUI reports from 2009-2016. They describe extensive work over a prolonged period of time to try and improve upon these many concerns and then describe being subsequently unsupported by the BCUHB Executive team, when they made difficult decisions.

*“Lack of occupational therapy and activity programmes, with staff informing HIW that service reductions had been ‘made for financial reasons.’”*

(HIW 2009, page 1.)

Overall each of the reviews and reports seen have much positive feedback regarding the staff working within the Hergest team. However, over a number of years, the HIW reports particularly are characterised by repeated recommendations for improvement (particularly around estates and staffing) that BCUHB do little if anything to resolve.

## 15.6 HIW visits to the Hergest unit from 2009 onwards

The earliest records seen by the Ockenden team were from the HIW Inspection of the Hergest Unit dated 30 and 31st July 2009. The letter to the then CEO of the North West Wales NHS Trust is dated 1st September 2009, just a month before the creation of BCUHB. The letter from HIW is sent promptly by HIW to BCUHB within a month of the HIW visit. There is minor redaction of the letter, which was previously unpublished.

It should be noted that practice over much of the period covered, (from 2009 to 2014) was for HIW to feedback verbally to the local management team immediately following a visit and then to feedback more formally in a letter to the Health Board Executive team. The personal nature of information in these reports was such that they were not published for wider scrutiny. This practice has now changed with formal reports being posted on the HIW website (Letter CEO HIW to Donna Ockenden 28th February 2017). An extensive range of unpublished HIW reports from 2009 onwards, with some limited prior redaction by HIW to ensure that personal data, (patient information) was not disclosed have now been shared with the governance review by HIW. The Ockenden review team agreed with HIW that the redaction by HIW was very limited and appeared to be completely appropriate. (Letter to Donna Ockenden from HIW, dated 30th October 2017.)



Four HIW visit reports were reviewed covering the period September 2009 to August 2012.

The following were the main issues identified, and said by HIW to be requiring action and improvement in the Hergest unit as of September 2009:

- Inappropriate admission of adolescent patients to the wards;
- The lack of a Section 17<sup>141</sup> leave policy, which still required development 'despite several audits having been carried out previously by the MHA administrator.' (HIW 2009, page 2)
- Lack of occupational therapy and activity programmes, with staff informing HIW that service reductions had been 'made for financial reasons.' (HIW 2009, page 1.)
- 'Dormitory rooms, which offer little privacy or dignity to patients' (HIW 2009, page 1)
- Concern around staffing levels, 'it was reported and observed that staff resources appeared to be stretched whilst trying to meet both the needs of all patients and the duties of the staff, given the levels of acuity and challenging behaviour of patients. (HIW 2009, page 4.)

*"It was reported and observed that staff resources appeared to be stretched whilst trying to meet both the needs of all patients and the duties of the staff, given the levels of acuity and challenging behaviour of patients."*

(HIW 2009, page 4.)

### 15.7 The significant positive comment made by HIW included

- Describing staff being 'supportive to each other.'
- The ward manager as sensitive to their [staff] needs;
- Staff training and development was described as a 'high priority with mandatory training and Mental Health Act training up to date.' (All, HIW 2009, page 2.).
- 'Staff were observed to treat the patients with respect and dignity;' (HIW 2009, page 3.)
- Mental Health Act documentation was found to be in good order throughout the visit.

*"Staff were observed to treat the patients with respect and dignity."*

(HIW 2009, page 3.)

There is a further visit to the Hergest unit just over a year later in October 2010 and again HIW write promptly to the then CEO of BCUHB, within a month of the visit. There is much positive feedback of the Hergest unit again, specifically around:

- Appropriate training in 'Control and Restraint' and 'De-escalation techniques'
- Positive interactions between staff and patients, 'with patients being treated with dignity and respect' and 'very evident' interaction between patients and staff that was 'caring and respectful;' (HIW 2010 pages 1 and 2)
- Good patient access to advocacy services

*"Positive interactions between staff and patients, 'with patients being treated with dignity and respect' and 'very evident' interaction between patients and staff that was 'caring and respectful.'"*

(HIW 2010 pages 1 and 2)

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<sup>141</sup> See glossary

- Mental Health Act documentation was found to be in good order (All – HIW 2010, page 1)

## 15.8 Concerns raised by the HIW team regarding the Hergest unit in 2010:

- Poor staffing levels, particularly on Aneurin ward, leading to 'limited patient attention' and patients raising 'concerns of boredom,' this was said to be made worse by the loss of vacant posts (HIW, 2010, page 1)
- Staff described a 'remote management style' with staff reporting that whilst they 'are flexible to make appropriate changes....they feel they are not sufficiently informed at present....'
- Closures of other EMI units had increased pressure particularly on Aneurin ward, resulting in 'the placement of vulnerable elderly patients onto an acute admission ward for working age adults.' (HIW 2010, pages 1 and 2)
- Concerns with ligature points were mentioned as an issue with fixed rather than collapsible rails in patient wardrobes; (HIW 2010, page 1 and 2)
- A lack of patient activities particularly on Aneurin ward;
- Inappropriate admission of an adolescent onto Gwalchmai ward for 8 days due to the CAMHS ward being shut due to staff shortages; (HIW 2010, page 3)
- A serious incident had occurred involving patient violence, aggression and property damage in Taliesin. Staff had described issues around the 'lead consultant role' which had led to an alleged lack of involvement of other consultants. This had been escalated to the CPG senior management team but had not been resolved.

*“Staff described a ‘remote management style’ with staff reporting that whilst they ‘are flexible to make appropriate changes....they feel they are not sufficiently informed at present....’”*

*“Closures of other EMI units had increased pressure particularly on Aneurin ward, resulting in ‘the placement of vulnerable elderly patients onto an acute admission ward for working age adults.’”*

(HIW 2010, pages 1 and 2)

## 15.9 HIW visit to the Taliesin ward in Hergest unit (April 2011)

The Taliesin ward was visited by HIW because two wards were said to be closed due to an outbreak of Norovirus and one ward closed in order to develop a new Home Treatment team. There was a delay in HIW writing to BCUHB with the letter to the then CEO being sent 10 weeks after the visit. Despite the outbreak of Norovirus, the domestic ward cover (due to sickness of the regular domestic) was said to be only 20 minutes a day. There had been no deep cleaning and general standards of cleaning had not been maintained. (HIW 2011, page 1.)

Concerns within the HIW letter to BCUHB were around staffing and most importantly the lack of Responsible Clinicians<sup>142</sup> for some patients detained under sections of the Mental Health Act. Lack of activities on the ward is also highlighted. A combined Divisional action plan dated December 2014 and updated August 2015 on a sixty two (62) page spread sheet refers to an HIW visit to the Hergest Unit on this date. The August 2015 update, (more than four years after the HIW visit) describes a locum Responsible Clinician in place, with a failure to appoint after interview in June 2015. The post is said to be re-advertised but

*“Despite the outbreak of Norovirus, the domestic ward cover (due to sickness of the regular domestic) was said to be only 20 minutes a day. There had been no deep cleaning and general standards of cleaning had not been maintained.”*

(HIW 2011, page 1.)

<sup>142</sup> See glossary

'interview dates unknown' (BCUHB 2015, page 1.) There is also an August 2015 update regarding the situation with domestic staffing. The Divisional action plan describes a meeting with the domestic manager in June 2015, as 'MH0011' (4 years after the visit) and the comment is 'This situation has improved.'

The divisional action plan, provided to the review by BCUHB which covers HIW inspections and other visit and external reviews concerning Mental Health services at BCUHB is of concern. It is sixty two pages long and has 411 separate actions within it. It appears to have been collated in August 2015 and updated December 2015 and contains incomplete actions from February 2011. (See BCUHB 2015, pages 1&2 (excerpts below).

MH0011	HIW visit	12/04/2011	Hergest	West	Taliesin	Staffing	The regular domestic staff member was currently on sick leave and the ward had been given cover of only 20 minutes per day. It was reported to our reviewer that as a result, there had been no deep cleaning and general cleaning standards had not been maintained. The Health Board are requested to ensure a full cleaning rota for the ward can be maintained and advise HIW of the actions taken	not started	11/08/2015
MH0012	HIW visit	12/04/2011	Hergest	West	Taliesin	Staffing	It was highlighted to our reviewer that there was a significant issue regarding the lack of responsible Clinician on the ward. The previous Responsible Clinician had moved to a new job and a new RC was currently on maternity leave. Cover was by a consultant based in Wrexham for one day a week, who had reportedly made one visit since February. The role of the RC is integral to the care of detained patients, as they have responsibilities around areas such as:	not started	11/08/2015
MH0014	HIW visit	12/04/2011	Hergest	West	Taliesin	MH Act	The Mental Health Act Office identified four detained patients in the Hergest Unit and three patients without a responsible Clinician. Ward staff raised concerns regarding the effects on both patients and staff of what they feel is insufficient RC cover. In addition, during an interview with our reviewer, a patient also raised concerns that they felt they were unable to take leave because there was no RC to authorise it. The Health Board is requested to inform HIW when those patients identified as not having a RC have been allocated one.	in progress	11/08/2015

## 15.10 HIW Inspection of the Hergest unit 21-23rd August 2012

Workforce and workforce related issues are cited as a particular concern within this report (HIW 2012, page 26) including problems with recruitment, staffing levels, medical cover, supervision, preceptorship support for newly qualified nurses and appraisal being raised. This report (HIW 2012 page 20) highlights again issues with staffing and says 'there was limited time for staff – patient interaction. Staff acknowledged that due to pressures on their time that occasionally they were required to prioritise patients and felt that they may respond to patients that were more demanding rather than those patients that required the assistance..' (HIW, 2012 page 20.) The report note that teamwork was good with staff supporting each other across professions and taking pride in their work. However due to gaps in the rota caused by vacancies and sickness staff acknowledged that 'they survived on the goodwill of colleagues....' (HIW 2012, page 20.)

The report highlights bed pressures and that due to this the beds that were allocated to patients on overnight leave were then used for admissions. BCUHB were told by HIW that they must review and monitor admissions and bed capacity to ensure that there were available beds should someone return from leave earlier than planned. (HIW, 2012, page 24.)

*“Staff acknowledged that due to pressures on their time that occasionally they were required to prioritise patients and felt that they may respond to patients that were more demanding rather than those patients that required the assistance..”*  
(HIW, 2012 page 20.)

The report highlights continuing problems within patient records, particularly with finding relevant documentation in relation to the Mental Health Act, (HIW 2012, pages 23 and 24) and appropriate recording of medication administration. (HIW 2012, page 23.) Concern is expressed by HIW around the lack of patient therapies, activities and an inability for patients to undertake escorted leave. (HIW 2012 page 27) The review has been provided with a blank copy of an 'action plan' which is undated. (See HIW 2012, pages 33 to 41.) This report identified many of the issues that arose in previous visits to the Hergest unit, starting in 2009 and continued to arise within the Hergest unit over subsequent years. There is little evidence of BCUHB taking any effective action to meet any of these recommendations from 2009 to 2012.

**The undated action plan developed following the August 2012 HIW visit covered the following issues:**

1. Application of the Mental Health Act – largely the onus for this appeared to be placed on the Mental Health Act managers to ensure all appropriate processes were completed in a full and timely manner.
2. For management of beds the action plan has few constructive proposals beyond the need to commission further reports.
3. The concerns regarding the ward environment – most problems are placed under the auspices of a 'Hergest Improvement Programme' (later known as the HIP) but with little concrete information about specific actions and timescales.
4. Privacy and Dignity – little is said other than 'options are being explored.'
5. The multi-disciplinary Team – staffing levels, ward reviews and supervision are all being 'looked at.' (No information was provided either in the action plan or to the Ockenden governance review regarding specific actions or a timescale against which these would be delivered.)
6. A letter was shared with the Ockenden review sent to the then CEO by a consultant (Letter to CEO, dated 5th November 2012.) The letter raises a number of specific concerns about the action of individuals which is not the remit of this governance review. Importantly, however the letter highlights an apparent difference in vision between the CPG management team and some clinicians working with in the unit. There is a divergence of views on the philosophy of care and the actions required to resolve staffing issues and a range of other issues. HIW had been raising staff concerns regarding the 'remote management style' in the Mental Health CPG since November 2010. It appears little has been done to resolve the concerns which appear to be growing rather than reducing.
7. Patient therapies and activities – the only detail contained within the action plan is that a timetable has been 'drawn up.'

*“BCUHB were told by HIW that they must review and monitor admissions and bed capacity to ensure that there were available beds should someone return from leave earlier than planned.”*

(HIW, 2012 page 24.)

*“Due to gaps in the rota caused by vacancies and sickness staff acknowledged that ‘they survived on the goodwill of colleagues....’”*

(HIW 2012, page 20.)

*“For management of beds the action plan has few constructive proposals beyond the need to commission further reports.”*

## 15.11 Hergest update (Quality and Safety Log) September 2012

An internal BCUHB document 'Update for the Quality and Safety Log' dated 7th September 2012 has been provided to the governance review. This was prepared by the then ACOS Nursing and the Chief of Staff at the request of the then Executive Director of Nursing and Midwifery. The report says that 'issues have been noted through a number of serious untoward incident reviews, ranging from escalation procedures, reporting arrangements, clinical processes and MDT working..' (BCUHB, 2012, page 1.)

The update paper refers to the CPG having already commissioned an external review of the Hergest unit. The review was to commence in November 2012, with a report due in December 2012. (BCUHB, 2012, page 1.) An undated Terms of Reference for that review has been provided to the Ockenden governance review team. Staff number 4, advised the review of concerns regarding teamwork, a number of quality indicators around the Hergest unit, concerns with service user experience, and a number of adverse incidents and events. Therefore staff number 4 advised the review 'it was felt some external support would be helpful...'

*"It was felt some external support would be helpful..."*

Also provided to the review was a letter from the lead of the review team to the then interim CEO dated 15th December 2012 outlining a number of very serious concerns with the Hergest unit. These are described as having been 'drawn to our attention in the initial listening and gathering of information stage of the review.' (Letter dated 15th December 2012, to then CEO.) Staff number 4 advised this review that the initial work had found a 'range of issues....around relationships between medical staff and others.....issues about the environment.....issues about service user experience and some of the feedback [they] picked up from service users.....pointed to an environment and a culture that was not conducive to positive care and good mental health and wellbeing..'

*"The judgement that was formed was that the issues identified could not be ignored, there needed to be a very detailed response plan around that....."*

Staff number 11 advised the Ockenden governance review via a written statement that 'staff members in the Hergest Unit expressed opposition with the review.' Staff number 4 advised the review 'the judgement that was formed was that the issues identified could not be ignored, there needed to be a very detailed response plan around that..... Staff number 4 described to the Ockenden team a desire for a 'positive co-creative way of working with staff to improve things..... and a plan was developed that was termed the Hergest Improvement Plan.....'

*"The ever increasing and complex role within the Hergest unit demanded considerable amounts of time and energy .... between January 2013 and September 2014."*

## 15.12 The Hergest Improvement Programme (HIP)

The HIP commenced in January 2013, and was in place until September 2014. This process is described as an 'intense period of leadership and operational management Staff number 11 said of the HIP 'the ever increasing and complex role within the Hergest unit demanded considerable amounts of time and energy ....between January 2013 and September 2014.'

The HIP was made up of eight work streams, (see the minutes of the Hergest Improvement Group meetings dated 4th and 27th February 2013.) The progress



of these 8 work streams were fed back to the Quality and Safety Committee.<sup>143</sup> The feedback is grouped under four headings:

- a) Service user/carer experience;
- b) Management & Leadership;
- c) Learning lessons;
- d) Acute Care and Home Treatment.

Progress and priorities are noted. There is little discussion of any of the difficulties experienced in the delivery of the HIP and the Committee is invited to receive the report.

In May 2013 The Delivery Unit of Welsh Government were invited to undertake a review of the Mental Health Measure Compliance. This was delivered in June 2013 with the findings prioritised for the HIP. Applying the Royal College of Psychiatrists (2011) 'Do the right thing: How to judge a good ward' standards<sup>144</sup> the NHS Delivery Unit noted that only one standard was met in full, 8 partially and one not at all. Concerns were again raised about activities, access to psychology, 1:1 protected time and the lack of a therapeutic environment. The report concluded that the requirements of the Mental Health Measure were not being met.

### 15.13 HIW visit to the Hergest Unit 2013

#### **Letter dated 26th July 2013 from the Director of Governance and Communications at BCUHB, in response to HIW. (Letter from HIW dated the 5th July 2013)**

This letter is sent out with an accompanying eleven page action plan. Issues that have been raised by HIW in previous inspections since 2009 and had been found in multiple action plans on a number of occasions are found repeated once again within this action plan.

1. Application of the Mental Health Act – again the onus is placed on Mental Health Act Managers to provide greater assurances around processes. A project group to improve clinical recordkeeping is expected to report in September 2013.(BCUHB 2013, pages 1-4)
2. The wards – the action plan states that 'reports' concerning patient flow are awaited as are 'discussions' with estates. These issues are said to fall under the HIP (BCUHB 2013, pages 4-7)
3. Privacy and dignity – The action plan states that patient flows are being 'reviewed' as is patient privacy on the telephone. (BCUHB page 7.)
4. Safety – Ligature risk assessment has been undertaken and the seclusion policy and associated monitoring is now in place (BCUHB page 7.)

*“The NHS Delivery Unit noted that only one standard was met in full, 8 partially and one not at all.”*

(NHS Delivery Unit, May 2013)

*“Issues that have been raised by HIW in previous inspections since 2009 and had been found in multiple action plans on a number of occasions are found repeated once again within this action plan.”*

*“The action plan states that ‘reports’ concerning patient flow are awaited as are ‘discussions’ with estates. These issues are said to fall under the HIP”*

(BCUHB 2013, pages 4-7)

<sup>143</sup> see Committee Paper 7.11.13 Item QS13/216.1 as an example

<sup>144</sup> [https://www.rcpsych.ac.uk/pdf/OP79\\_forweb.pdf](https://www.rcpsych.ac.uk/pdf/OP79_forweb.pdf)



5. The multi-disciplinary team, (BCUHB 2013, pages 8-10) The action plan states that recruitment remains an issue, ward review timetables, supervision and appraisal are 'to be monitored.'
6. Patient therapies – The action plan states that 'proposals are in place.' There is no detail as to what these proposals are or the timescale for delivering them. (BCUHB 2013, pages 10-11.)

*“The action plan states that ‘proposals are in place.’ There is no detail as to what these proposals are or the timescale for delivering them.”*

(BCUHB 2013, pages 10-11.)

#### 15.14 Other sources of information on the Hergest Unit considered by the Ockenden review team:

1. The Senior Management 'Team Minutes' of a meeting held on the 26th July 2013 state that:

'Hergest & Dryll y Car HIW action plans – 'been agreed and to go to Corporate today.' (BCUHB 2013 page 2) The Senior Management Team Minutes of the 2nd August 2013 note that 'Y responses gone to Corporate.'

2. There is further discussion around the Hergest Unit at the Senior Management Team dated September 13th 2013. See 'Item 6. Healthcare Inspectorate Wales

X – Normal procedure would be to ask Matrons to work through action plans with Y to collate. The minutes say 'procedure for Hergest outside this standard practice' (BCUHB 2013, page 3.) In having a different process for the Hergest unit this suggests that there is a greater concern for the Hergest Unit at this time (BCUHB 2013, page 3)

*“The day to day running of the Hergest unit does not appear to be posing immediate concerns in relation to patient safety. However a key issue is that staff including consultant staff need to acknowledge that there is room for improvement at the Hergest unit as in all services....”*

(RCP 2013, page 14.)

#### 15.15 The Royal College of Psychiatrists Report into the Hergest Unit (2013)

This report was commissioned by BCUHB in October 2013 and reported in December 2013. The Royal College of Psychiatrists report stated 'The day to day running of the Hergest unit does not appear to be posing immediate concerns in relation to patient safety. However a key issue is that staff, including consultant staff need to acknowledge that there is room for improvement at the Hergest unit as in all services....' (RCP 2013, page 14.) There were a number of recommendations.

##### Key Recommendations included the following:

- A review of the management structure to develop a locality based senior management team (RCP 2013, page 15.) HIW had been raising similar concerns regarding the remote nature of the CPG management team since 2010.
- A development programme for managers and nursing staff including support for ward managers to be able to manage their defined areas;
- A training programmes for nurses involved in urgent assessment, also involving peer support and mentoring; (RCP 2013, page 16 and 17.)

- Engagement by staff in quality improvement initiatives;
- A revision of the nursing establishment;
- Urgent consideration to the provision of care for patients with physical dependency needs;
- Electro Convulsive Therapy (ECT) should be provided in a neighbouring approved unit. (RCP 2013, pages 15-17.)

## 15.16 MHLDP CPG Senior Management Team Meeting 17th January 2014

'Hergest Action Plan' – X updated meeting. 'Unannounced visit from HIW on 2nd December 2013 raised a number of concerns regarding poor professional relationships, lack of staff engagement with the change process, low staff morale, concerns regarding availability of staff to meet a variable patient group, dignity of care issues with the mix of frail elderly patients with other mental health patients. Estates issues. HB now approved an action plan to meet HIW recommendations' (BCUHB 2014, page 2).

### **Letter dated 17th December 2013 to the then CEO following an HIW inspection of the Hergest Unit on the 2nd, 3rd and 4th of December 2013**

The letter, (HIW 2013) cites a number of positive findings including staff co-operation with the visit, unit refurbishment, patient activities, and patient experience. (HIW 2013, page 1) They also note that Taliesin Ward (the Psychiatric Intensive Ward (PICU)) is functioning reasonably well. Twenty one (21) significant concerns are enumerated, (HIW 2013 pages 2-4.) highlighting the relationships between some 'Responsible Clinicians' and some nursing staff as being poor, lack of engagement in change, poor morale, lack of training, poor supervision and managers not being empowered to initiate change (identified in previous visits).

*"Twenty one (21) significant concerns are enumerated."*

(HIW 2013 pages 2-4.)

Also identified by HIW in a previous visit in August 2012 was the wide variety of patients (both frail older adults, working aged adults and adolescents) on the wards and a need to review the admission criteria, as was the state of the seclusion room. There were significant environmental concerns. Care documentation was often poor in relation to risk. Patient information was visible to all on a white board and the ECT suite remained in only very occasional use with concerns about competence. (HIW 2013, page 4.). This letter to the interim CEO of BCUHB was sent from HIW within two weeks of the visit, sent to the Chair of BCUHB and circulated also to the Delivery Unit at Welsh Government. (HIW 2013, page 5.) HIW have advised the Ockenden governance review team that the speed of sending the letter should not be considered per se as a reflection of the seriousness of the issues within it, rather that 'this was a period when we were specifically seeking improvement to the timeliness of our reporting.' (HIW 2018 to Donna Ockenden.)

*"This was a period when we were specifically seeking improvement to the timeliness of our reporting."*

(HIW 2018 to Donna Ockenden.)

## Response from BCUHB to HIW

The then interim CEO responded to HIW in a letter dated 10th January 2013 (probably 2014). The combined letter and action plan is lengthy at 22 pages and responds with the steps taken to mitigate the concerns under several headings. Much of the content of the 2013 action plan has been seen in previous action plans.

*“Much of the content of the 2013 action plan has been seen in previous action plans.”*

- **Engagement**

An external consultant has been engaged to advise and facilitate engagement with the nursing staff with weekly senior nurse meetings and a leadership ‘away day.’

A ‘Hergest Medical Group’ is being established and the local management team is being supported with links to other areas of the Health Board.

- **Staffing.**

Basic Life Support and Fire training has taken place with ‘a plan’ to improve appraisal and supervision rates.

An assurance framework to monitor training and a ‘range of quality metrics’ are reported to the Clinical Programme Group governance arrangements.

Recruitment ‘has taken place’.

*“Basic Life Support and Fire training has taken place with ‘a plan’ to improve appraisal and supervision rates.”*  
(BCUHB 2013)

- **Bed Usage and Dignity of Care**

Reconfiguration of the beds has occurred to allow for reduction in beds and a specific frailty area.

ECT is not currently provided at the Hergest Unit.

- **Estate.**

The Board will take further guidance on the changes required for the seclusion room whilst changes have been made to protect confidential patient information.

*“Low staff morale, with members of staff experiencing upset and concern that they are unable to complete their duties adequately, by the end of their shift; often phoning in worried they may have omitted something.”*  
(Holden 2014, page, 11)

## 15.17 ‘The Holden Investigation.’

**Author Robin Holden**

**Report date: January 2014**

This investigation and the subsequent report was commissioned under the BCUHB Raising Staff Concern/Whistleblowing Policy (WP4). The Holden investigation was also informed by previous recommendations made by HIW, the NHS Wales Delivery and Support Unit (DSU). The report describes liaison with the Royal College of Psychiatrists who were undertaking an ‘Invited review’ in the Hergest unit at a similar time, at the request of BCUHB. HIW also undertook a further unannounced inspection at the beginning of December 2013. (See Holden 2014, page 1)

## Summary of Content

There were said to be thirty one staff concerns, (Holden 2014, pages 3 and 4,) which are organized in the Holden (2014) report into five main themes.

- Weaknesses in communication (Holden 2014, pages 5 and 6)
- A top down management style taking little or no notice of the views of staff. (Holden 2014, pages 7 and 8)
- A culture of bullying and intimidation from senior managers (Holden 2014, pages 8 and 9)
- High levels of bed occupancy and inadequate staffing to meet the needs of the patients in the Hergest Unit, which is described as being 'chaotic'; with managers being unresponsive to the situation. (Holden 2014, pages 9, 10, 11)
- Low staff morale, with members of staff experiencing upset and concern that they are unable to complete their duties adequately, by the end of their shift; often phoning in worried they may have omitted something. (Holden 2014, page, 11)

Each of these five themes is then examined in some depth in the Holden investigation (2014) following interviews with ward staff and managers. In each theme significant problems are identified. Holden states 'With the exception of Taliesin Ward, the Hergest Unit is in serious trouble. Relationships between staff and management at matron level and above have broken down to a degree where patient care is in undoubtedly being compromised.' (Holden R 2014, page 11)

'The lines of communication are critically weak and although regular management returns are received from the wards one has to question whether these adequately reflect the worrying standards of the care being provided and the inherent level of clinical risk. These systemic communication weaknesses have been brought about, to a large degree, by a lack of presence on the wards by senior managers.' Holden acknowledges the lack of presence by senior managers on the Hergest unit thus 'To be fair, this lack of presence is understandable to a degree, bearing in mind the geography of the BCUHB, the complexity of the CPG and the distances that the senior management team have to travel to discharge their duties..' (Holden 2014, page 12)

Staff number 4 told the Ockenden review 'I think there's no doubt, that looking back, there are examples of where the management style adopted and the approach adopted was probably less than it might have been in dealing with some issues ... or tensions within the unit ... and that tension continued and elements of that tension remain today and have been there for a long while. A staff member working within Older Peoples Mental Health (but outside the Hergest unit) told the Ockenden review team 'There seemed to be a lot of feeding up (of concerns) ... but not necessarily coming down..'

*"With the exception of Taliesin Ward, the Hergest Unit is in serious trouble. Relationships between staff and management at matron level and above have broken down to a degree where patient care is in undoubtedly being compromised."*

(Holden R 2014, page 11)

*"The lines of communication are critically weak and although regular management returns are received from the wards one has to question whether these adequately reflect the worrying standards of the care being provided and the inherent level of clinical risk. These systemic communication weaknesses have been brought about, to a large degree, by a lack of presence on the wards by senior managers."*

(Holden R 2014, page 12)

Another staff member, number 54 working within the CPG at the time told the Ockenden review team 'It's critical that the information comes the other way because otherwise the staff don't know what's happening and how can you work within an organisation if you don't know where your organisation is going and changing...' . Staff number 54 continued: 'So there was a great communication gap ... I don't know whether they were trying to communicate but nothing bridged that gap...'

*“So there was a great communication gap ... I don't know whether they were trying to communicate but nothing bridged that gap...”*

Whilst acknowledging the usefulness of the Hergest Improvement Plan, (HIP), which includes multiple HIW recommendations, alongside the recommendations from the previous DSU report, Holden states: 'There is no agreed vision or shared values to underpin the HIP. All eight work streams are being implemented concurrently and at pace. The process of change is seen as bewildering at the ward level. The HIP, consequently, has little ownership at the ward level and is seen as a top down, distant document of low priority on a day to day basis.' (Holden R 2014, page 12)

Describing the situation regarding the lack of staff training and development Holden says: 'There has been a critical underestimation of the training and personal development required by qualified and unqualified ward staff in order to prepare them for the journey ahead.' (Holden R 2014, page 12). On staff morale Holden says: 'Staff morale has plummeted. Staff feel unheard and powerless. There is no trust in the managers above ward level. Consequently any management interventions, even if well intentioned, are open to misinterpretation, further reinforcing the belief system that has become established.' (Holden R 2014, page 12). Nineteen recommendations are made by Holden. (See Holden 2014, pages 12 and 13.) Many of them, can be seen to have developed and become greater problems for the Hergest unit over time, largely due to the continued non-compliance and lack of progress seen by BCUHB in the presence of repeated HIW recommendations from 2009 onwards.

*“There has been a critical underestimation of the training and personal development required by qualified and unqualified ward staff in order to prepare them for the journey ahead.”*

(Holden R 2014, page 12).

### 15.18 HIW Inspection of the Hergest Unit 12th, 13th and 14th of May 2014

The letter dated 2nd June 2014 from HIW to the interim CEO, was sent within two weeks of the visit. Verbal feedback had been provided to the Executive team on the 14th May 2014. Overall, some positive aspects were noted. These included staff engagement with the HIW inspection, rapport between patients and staff, patient reports, the involvement of the Mental Health Act (MHA) administrator and development initiatives such as AIMS (Accreditation for Inpatient Mental Health Services). Again Taliesin ward (the PICU) on the Hergest Unit is noted to function more effectively than the other wards – perhaps because they have a single 'Responsible Clinician.' (HIW 2014, page 1.)

The report stated that improvements had been made in staff numbers and governance with a number of groups taking place weekly or monthly. There had been an improvement in staff morale. However the issue of the seclusion room



remained with its lack of privacy and dignity. (HIW, 2014, page 2.) This had been previously highlighted by HIW in December 2013 and August 2012.

The 'frailty rooms' were a step forward but had not progressed far enough. A consultant psychiatrist was still recommending the ECT suite be used and it required decommissioning. Care documentation remained poor in five sets of notes reviewed by HIW and multiple issues were cited. (HIW 2014 pages 3 and 4)

Transfers between wards were undertaken in inappropriate ways and training in Restrictive Physical Intervention<sup>145</sup>, was not complete. (Page 4) Supervision and appraisal for medical staff needed to be embedded in professional development and there was little assurance this was the case. The level of concern was such that the Health Board was required to submit a detailed action plan to HIW by the 23rd June 2014. (HIW 2014, page 5)

A fourteen (14) page action plan resulted from this visit which was then updated in August 2015. The Ockenden review has been provided with a copy of the 2015 action plan by HIW.

- a) The seclusion room – A review took place on the 16th June 2014 with 'a report pending' and an 'intention to review seclusion policy' The work was described as complete in May 2015. (BCUHB 2015 pages 1 and 2)
- b) Frailty – A final paper was to be agreed setting out a short term plan for frail patients. A further meeting was arranged for July 2015.
- c) The ECT suite had been decommissioned. (BCUHB 2015, page 4.)
- d) Patient information – Completed in August 2015
- e) Poor documentation – Memos sent out re general points (including Mental Health Act issues) and the specific patient records reviewed. Task and Finish groups were set up by September 2014.
- f) Training – dedicated resource to update this information and 'ensure monthly reports are scrutinised at senior nurses meeting.'
- g) Restrictive Physical Intervention – between 48 and 92% in June 2014 and 64% (Cynan) and 100% (Aneurin) and 75% in Taliesin in August 2015 (BCUHB 2015, page 8.)

#### **Board Paper 3.6.14 Item 14/118.1 and 14/118.2 (BCUHB 2014, page 7)**

This update presented by the then interim CEO updates the BCUHB Board on the progress in Hergest to include the HIW visit) and the Royal College of Psychiatrists (RCP) report of December 2013. The update does not mention the Robin Holden investigation and report of January 2014. It invites the Health Board to note the progress in addressing the issues of the HIW and RCP action plans. It does not ask the Board to recognise the challenges still facing the Hergest unit or ask the Board to become involved in addressing those challenges. The BCUHB Annual Governance statement notes that: 'A number of new risks have been identified

*“There is no agreed vision or shared values to underpin the HIP. All eight work streams are being implemented concurrently and at pace. The process of change is seen as bewildering at the ward level. The HIP, consequently, has little ownership at the ward level and is seen as a top down, distant document of low priority on a day to day basis.”*

(Holden R 2014, page 12)

*“It invites the Health Board to note the progress in addressing the issues of the HIW and RCP action plans. It does not ask the Board to recognise the challenges still facing the Hergest unit or ask the Board to become involved in addressing those challenges.”*

(BCUHB 2014)

<sup>145</sup> See glossary



during 2013/14 which are part of the corporate risk register. They included the following:

- Inability to attract and train qualified staff with appropriate skills and competencies;
- Failure to locate, provide and modernise patient medical records;
- Failure to provide safe patient care at the Hergest Unit. (BCUHB 2014 page 14)

#### **Quality, Safety & Experience Sub Committee (see Item 15/25 Date of meeting 17.2.15.)**

This February 2015 paper to the Q, S and E Sub Committee provides an update on continued progress within the Hergest unit following previous briefings made to the BCUHB Quality & Safety Committee in May and July 2014. This paper describes the work that has been progressed in the Hergest unit since the HIW visit of May 2014 which has been significant and is beginning to show results. However there are some areas that have been very difficult to resolve including the seclusion facility and job planning and appraisal for consultant staff. The seclusion facility is described as completed in May 2015 in the action plan arising from the HIW visit, updated August 2015. No further details were available on consultant job planning in that action plan.

Whilst there is a recognition that there remain problems within the Hergest unit the Committee is not asked to assist with these issues and they are not clearly articulated in the body of the report. Minutes of this meeting suggest that despite this report and the positive aspects, members were still not convinced that the level of assurance was sufficient to allow the frequency of reports to be reduced. BCUHB 17.2.15, pages 3 and 4). The minutes also record the need for a 'more robust' tracker system for the actions plans following HIW visits. (BCUHB 17.2.15, page 6 and 7). This had been and remains an ongoing concern in BCUHB to the current day, (end of December 2017.)

The Senior Management Team minutes dated the 24th April 2015 note the following (see 2015 04.10.7.1, page 3) 'HIW Letter – A letter has been received in respect of matters which the HIW wish to have us take immediate action.'

- a) Action plan to resolve estates issues;
- b) For us to demonstrate that the instruction regarding nursing staff and cleaning is altered in order that the nurses are spending time caring for patients;
- c) Action plan for improvement in the mandatory training levels as seen on wards'.

*“Whilst there is a recognition that there remain problems within the Hergest unit the Committee is not asked to assist with these issues and they are not clearly articulated in the body of the report.”*

*“HIW Letter – A letter has been received in respect of matters which the HIW wish to have us take immediate action.”*

(Senior Management Team minutes, 24th April 2015)

*“For us to demonstrate that the instruction regarding nursing staff and cleaning is altered in order that the nurses are spending time caring for patients.”*

(Senior Management Team minutes, 24th April 2015)

## 15.19 HIW Inspection of the Hergest Unit 6-8th January 2016

This HIW inspection found a number of improvements.

- a) The seclusion room (now the Intensive Care Suite or ICS) had been appropriately modified;
- b) Patient information was now covered when not in use;
- c) Mandatory training had significantly improved across the wards in the Hergest unit;
- d) Supervision was now documented;
- e) The achievement of AIMS reflected these improvements as did staff morale;
- f) Advocacy had improved.

*“Ligature assessment revealed continuing risks and this required urgent attention.”*

(HIW, January 2016)

However there were a number of continuing and long term concerns

- a) Issues remained about the management of beds;
- b) The levels of staffing reflecting a number of vacancies across the wards within the Hergest unit;
- c) Ligature assessment revealed continuing risks and this required urgent attention.

## 15.20 NHS Wales Delivery Unit ‘Assurance review’ May 2016

Field work for this assurance review took place between the 16th and 20th May 2016. (NHS Delivery Unit 2016, page 3.) A wide range of recommendations resulted around:

### **The safeguarding of patients**

This included concerns around the use of the PICU for older adults and particularly those with dementia needs. Where such an admission was unavoidable, additional safeguards would need to be ensured.

### **The provision of quality care and treatment**

There was a need to improve care and treatment planning, to ensure that care plans were developed in partnership with patients and their carers and were person centred and outcome focused. Positive practice seen in a number of units should be shared across BCUHB.

*“There was a need to improve care and treatment planning, to ensure that care plans were developed in partnership with patients and their carers and were person centred and outcome focused. Positive practice seen in a number of units should be shared across BCUHB.”*

### **The creation of a dementia and older person friendly environment**

BCUHB needed to do more to improve access to activities on the wards, and ensure equitable access to OT and psychology. There needed to be continuing environmental reviews with specific reference to anti ligature work. Good practice seen in a number of units should be shared across BCUHB.

## The involvement of carers and families

Carers should be involved to ensure that a patient's life history was known. The continued roll out of Johns Campaign and 'Care to Talk' should be ensured. BCUHB needed to ensure that there was an increase in carers receiving a carer assessment in line with The 2014 Social Services and Wellbeing Act (Wales). Concerns around the continued use of Tegid ward as expressed by some carers should be built into an ongoing strategic review of estates by BCUHB.

## Leadership and oversight

The work underway to revise the MHLD Divisions organisational structure needed completion. The new governance structures must be kept under review to ensure they continued to deliver effective channels of communication throughout the service and that strategic planning translated into operational delivery and improvement. There needed to be continued use of annual reviews and the appraisal process to continue to develop staff.

## Learning lessons from concerns

There needed to be a greater focus on the delivery of action plans, ensuring that the actions from within action plans were implemented. There needed to be further development and embedding of the systems, structures and processes around learning from serious incidents, claims and complaints.

## Workforce development

The original work undertaken on the Hurst<sup>146</sup> benchmarking, needed to be revisited and there needed to be a clear strategy to deal with nursing vacancies across the service. There needed to be robust workforce plans developed to ensure sustainability of the multi-disciplinary team and appropriate skill mix. (NHS Delivery Unit 2016, pages 4-6)

## 15.21 NHS Delivery Unit: Follow-up visits to Mental Health inpatient units serving Older People

Following the May 2016 NHS Delivery Unit report it was agreed that a revisit to the three (3) mental health units of greatest concern during the initial assurance review would be undertaken. The wards visited were; Taliesin (Psychiatric Intensive Care Unit), Cynan (male ward) and Aneurin (female ward) on the Hergest unit, Cemlyn ward at Ysbyty Cefni and Tegid ward on the Ablett Unit Ysbyty Glan Clwyd. The visits took place on the 2/3 February 2017. The report concluded that:

- Progress has been made in all of the units since the initial assurance visits.
- Work has commenced to improve the ward environments with some of the developments being of a significant scale.

*“BCUHB needed to ensure that there was an increase in carers receiving a carer assessment in line with The 2014 Social Services and Wellbeing Act (Wales).”*  
(NHS Delivery Unit 2016)

*“There needed to be a greater focus on the delivery of action plans, ensuring that the actions from within action plans were implemented. There needed to be further development and embedding of the systems, structures and processes around learning from serious incidents, claims and complaints.”*  
(NHS Delivery Unit 2016)

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<sup>146</sup> See footnote 56

- A capital programme has been developed to further improve the overall estate which will, if completed, significantly enhance older adult mental health provision. The speed of progress with the environmental improvements achieved to date was welcomed but it will be important to sustain this progress in the coming months.
- A number of the concerns identified at the time of the initial visit related to the case mix on a number of the wards, in particular those within the Hergest unit remain. Whilst steps have been taken to try to mitigate these difficulties the case mix remains a challenge on a number of the wards. This needs to be kept under continuous audit with further steps taken to reduce the necessity for adults of working age and older age adults being admitted into the same wards. This had been a long term concern in multiple HIW reports.
- Work was underway to improve the culture on the wards and continued with a well-structured programme of Dementia Care Mapping being rolled out across BCUHB and training initiatives being used to develop staff skills.
- The recent implementation of a service management structure within the Division appeared positive, with staff in some areas commenting that this has improved relationships and familiarity and support from senior management.
- Staffing and recruitment was a continuing barrier to progress impacting on the availability of multi-disciplinary input and a continuing reliance on bank staff and in some cases agency nursing staff.
- Additional Occupational Therapy (OT) input and OT technician support was described as impacting positively upon the quality and culture on a number of the wards. Service user representative feedback in May 2017 emphasised the fragility of the changes being made to the OT structure within some of the wards. Service user representative 11 told the Ockenden review team 'When I was I was visiting the Hergest Unit at Ysbyty Gwynedd recently I was told that the 2 activities co-ordinators were off on sick leave for a month each. They had not been replaced and no activities had been arranged for the patients – except for a bit of gardening'. (Service user representative feedback 8th May 2017, Bangor)
- Whilst efforts have been made to improve the way language is used to describe patients in the case notes this had not led to a wide ranging improvement in the quality of Care and Treatment Plans. This remained a concern at the time of the NHS Delivery Unit visit in February 2017. Attendees at the May 2017 Pwllheli 'Listening and Engagement event also spoke of limited involvement in care planning with families and a lack of choice when planning care for elderly relatives. Discussion also followed regarding the little understanding BCUHB had of county wide services in Gwynedd for elderly people/patients following discharge from units such as the Hergest Unit.

*“Staffing and recruitment was a continuing barrier to progress impacting on the availability of multi-disciplinary input and a continuing reliance on bank staff and in some cases agency nursing staff.”*

*“Whilst efforts have been made to improve the way language is used to describe patients in the case notes this had not led to a wide ranging improvement in the quality of Care and Treatment Plans.”*

## 15.22 Summary and conclusions of the Ockenden team around the systems, structures and processes of governance in the Hergest Unit to the current day:

The reports of Healthcare Inspectorate Wales (HIW) from 2009 to 2017 and other independent reviews including the Royal College of Psychiatrists (2013), the Holden review (2014) and a partially complete external review of the Hergest at the end of 2012 reveal a unit with significant problems over the period from late 2009 to 2016 when it appears that improvements are starting to be made. A number of continuing themes and concerns run throughout this period including staffing issues, both medical and nursing, poor compliance with training, significant problems with estates, clinical records, Mental Health Act administration, bed usage, lack of support services such as occupational therapy, and poor relationships with the senior management team. Many of these issues start being noted by HIW in 2010. Not surprisingly there are long term problems noted with staff morale with staff being described as under significant pressure and the wards within the Hergest unit running on 'staff goodwill' for many of those years. Throughout these years, many of the recommendations made by HIW were repeated over and over again, with limited success by BCUHB in resolving the issues. Multiple action plans, often repetitive have been considered by the Ockenden review team.

There were attempts throughout 2013 using the Hergest Improvement Plan (the HIP) to make improvements in the unit for the benefit of patient care and staff wellbeing. This initiative is noted positively by the Holden investigation, (Holden 2014, page 12.) However, the delivery of the multiple work streams, concurrently, at pace and with limited ward staff engagement proved ineffective. (Holden 2014, page 12.)

Some information regarding the Hergest unit and its long term issues is fed upwards through the then Health Board governance structures. This does not appear to have had a positive impact upon the process to support the Hergest unit. The reports presented to the Health Board governance structure, both Committees and the Board outline the work done in a very bland way but do not accurately represent any of the significant difficulties experienced in making the changes required over many years. Staff number 4 told the Ockenden review team at interview 'I think to caricature it, you know, that actually we were doing alright in the West until we became part of this organisation...' Whilst this was not entirely true, in that some issues of concern were identified at the Hergest unit by HIW as early as September 2009 it is correct that review of extensive HIW and other external reports showed the failure of the BCUHB Board to support the Hergest unit in meeting multiple and repeating recommendations as was clearly required over many years from 2010 to 2016. In addition staff number 22, in a senior role within the then CPG advised the Ockenden report of an externally commissioned review that was halted, (by the Executive team) at the end of December 2013 prior to its completion. This then led to the creation of the Hergest Improvement Plan (or HIP) which is discussed further in this report.

*"A number of continuing themes and concerns run throughout this period including staffing issues, both medical and nursing, poor compliance with training, significant problems with estates, clinical records, Mental Health Act administration, bed usage, lack of support services such as occupational therapy, and poor relationships with the senior management team."*

*"The reports presented to the Health Board governance structure, both Committees and the Board outline the work done in a very bland way but do not accurately represent any of the significant difficulties experienced in making the changes required over many years."*



The multiple HIW reports also appear to have little impact within the Clinical Programme Group to judge by the minimal details around the Hergest unit found within minutes of the senior management team meetings, the Operational Group or the later Senior Leadership Group, from 2010 to 2016. Comments on the repeated HIW visits are minimal sometimes just acknowledging the reports, and that responses had been made. Whilst many of the recommendations are of central importance to themes that run throughout these meetings including training, staffing levels, estates, clinical notes, psychology and activities, the recommendations and action plans do not appear to have been scrutinised in any detail by these groups and there is no structured follow up to ensure that actions have been completed. The shortcomings in progress are clearly recognised in the Quality, Safety & Experience Sub Committee (BCUHB February 2015) but there is little evidence over the coming year that this has any impact on local management. In discussing whether a response would be received to concerns raised within the CPG staff number 54 stated that these were escalated to the then senior leadership team in the CPG. In responding to whether a response would be received Staff number 54 stated 'Occasionally. Sometimes the response was a bit unclear, you'd get a response but it wasn't always clear what it meant..'

It is of concern that HIW continually raised these issues with the Health Board often in a timely manner and very clear manner. HIW subsequently received multiple action plans from BCUHB but changes did not happen. The period of time covered by these reports was one in which the HIW was under scrutiny from the Welsh Government which recognised some of these concerns and significant changes to the organisation have been made (see National Assembly for Wales Health and Social Services Committee Inquiry into the work of HIW (2013) and Marks (2014) An Independent review of the work of Healthcare Inspectorate Wales; The way ahead to become an Inspection and Improvement Body<sup>147</sup>.

The case study below is reproduced with the permission of the family and shows an attempt to resolve concerns with the care of an elderly relative in BCUHB over more than 3 years, (The case is still ongoing as of the end of May 2018).

The chronology was prepared by the family and was submitted to the Ockenden review team by them. The chronology was then edited by the Ockenden review team to ensure that any material identifying either the patient or family or BCUHB staff has been amended. The final version has been approved by the family. The concerns of the family have **not yet** been investigated by BCUHB, so the Ockenden team makes no judgement as to the accuracy of the family's concern.

The lack of support to gain basic nutrition on the Hergest unit is an issue that has been raised by both Hergest unit staff and HIW on numerous occasions. Both HIW and staff have told the BCUHB Board repeatedly and over many years that staffing levels are of a concern and staff have stated on many occasions that they were continually only able to support those in greatest need whilst other needs went unmet.

*“Whilst many of the recommendations are of central importance to themes that run throughout these meetings including training, staffing levels, estates, clinical notes, psychology and activities, the recommendations and action plans do not appear to have been scrutinised in any detail by these groups and there is no structured follow up to ensure that actions have been completed.”*

*“It is of concern that HIW continually raised these issues with the Health Board often in a timely manner and very clear manner. HIW subsequently received multiple action plans from BCUHB but changes did not happen.”*

<sup>147</sup> [http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board\\_Item\\_5.1a\\_Independent%20Review%20of%20HIW\\_Appendix%201\\_EXECUTIVE%20SUMMARY.pdf](http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board_Item_5.1a_Independent%20Review%20of%20HIW_Appendix%201_EXECUTIVE%20SUMMARY.pdf)



### 15.23 Case study 1 Summary highlighting existing family concerns with the 'Concerns' process at BCUHB 2013 to the current day – Family 21

#### 15.24 Why is Case study 1 of importance?

Case study 1 highlights:

- Long term problems with the concerns process in BCUHB, still occurring to the current day, (beyond the end of December 2017.) These have been highlighted in external reviews since 2013 but were known about before then
- Difficulty and discrepancies with the management of Continuing Health Care<sup>148</sup> funding
- Issues with the provision of basic care on the Hergest unit – which Hergest unit staff and HIW have raised as a concern since 2009
- Potential issues with ligature risks which HIW had been raising as a concern with BCUHB for a number of years before the incident reported.

#### 15.25 What happened?

The family describe the patient became ill in 2011 and was admitted to Dryll y Car. In July 2013 Dryll y Car closed and the patient returned home for less than two weeks. The patient was hearing voices and self-harming and becoming a danger to both themselves and their spouse and so was admitted to the Hergest Unit.

Whilst on Hergest Unit the family reported the patient did not eat well as they believed food would burn their throat or cause choking. Eating at mealtimes on the Hergest unit did not appear to be assisted or monitored as the family would often find the patient's food untouched when visiting. Staff told the family that the patient was not weighed whilst in the Hergest Unit. However, following this statement, at a later date, weight records were given to the family, which indicated that the patient had lost considerable weight over a very short period of time. Although the family were aware the patient did not eat well, the figures in the records did not appear either possible (28lbs in ten days) or to match the patient's actual weight loss, and as staff had told the family the patient was not weighed during their stay in the Hergest Unit, the family believed these records were falsified.

On one occasion, other patients on the Hergest Unit informed the family that the patient had attempted suicide by hanging, using cords on the blinds in the dining room. This incident was later confirmed as correct, but the family had not been informed of this incident at the time.

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<sup>148</sup> See glossary

The family state that appropriate procedures were not correctly followed during the discharge from the Hergest Unit on 27th November 2013. This resulted in the patient becoming self-funded, as the patient was effectively discharged as having dementia and not acutely mentally ill, or under Section 117 of the Mental Health Act, and therefore was ineligible for funding. This caused the patient's spouse considerable financial pressure and extreme distress. This was not resolved prior to the spouses death. Following discharge from the Hergest Unit, the patient was admitted to X Elderly Mentally Infirm (EMI) Home.

On querying the patient's self-funding status, the family stated to the Ockenden review that they were told by numerous BCUHB staff that the patient could not receive any funding for X EMI Home. The family also state they were told if they pursued funding, there was a possibility that the patient would be returned to the Hergest Unit or a similar unit. Due to their poor experiences during the patient's stay on the Hergest Unit, they did not wish to happen.

17 months later during a multi-disciplinary Team, (MDT) Meeting in March 2015, staff AA. gave the patient's diagnosis as 'dementia', which was previously unknown to the other MDT members or the staff and manager at X EMI, who stated they believed the patient had frontal lobe damage. The patient's family did not consider the patient to have dementia prior to this diagnosis. Care was then transferred from the Mental Health Team to the Older Persons Team and the patient's medication was changed.

The patient died on 19th June 2016, and the patient's spouse continued to worry about their financial situation, developing dementia, and dying in the summer of 2017 without the investigation into the family concerns ever being resolved.

The patient's family have asked for details on:

- The treatment the patient received whilst on the Hergest Unit;
- Whether the patients discharge was appropriately handled, if the patient should have been discharged under Section 117 of the Mental Health Act and if therefore the patient should have been eligible for funding;
- If it is confirmed that patient was eligible for funding, the family request the return of the money paid by the patient's spouse for the patient's care in X EMI.

15.26 Please see the appendices for the detailed timeline, it is recommended that this is read to understand the length of time involved in resolving this issue

## 16 Chapter 8

### 16.1 Tawel Fan Ward: Significant issues concerning governance arrangements in the Ablett unit and Tawel Fan ward prior to its closure on 19th December 2013

#### Healthcare Inspectorate Wales (HIW) reports on The Ablett Unit, Ysbyty Glan Clwyd at BCUHB

The Ablett Unit made up of Tawel Fan, Cynydd, Dinas, and Tegid wards had received significantly less attention from HIW, than the Hergest from 2009 to the end of 2013.

The following HIW visits to the Ablett unit were confirmed in communication between HIW and Donna Ockenden dated 30th October 2017.

- Tegid and Tawel Fan wards October 2009
- Dinas ward – February 2011
- Tegid ward – July 2013
- Tawel Fan ward July 2013

### 16.2 What is the earliest communication from HIW seen regarding the Ablett unit?

The earliest communication seen by the Ockenden review team between HIW and BCUHB is a letter to the then CEO, from HIW dated December 2009 following a visit to both Tegid and Tawel Fan wards in October 2009.

There are a number of positive comments. On Tegid ward patient documentation was described as 'in good order, accurate and easy to assess' and all patients having access to 'therapeutic groups and one to one activities.' Staff training and development was found to be 'up to date and encouraged by managers' on Tegid ward and similarly up to date on Tawel Fan ward (HIW 2009, page 1.) Discussions with staff number 55 (who had worked within a legacy site prior to the formation of BCUHB) also commented at interview in April 2017 on the positive attitude to staff training and development and the effective structure for delivering mandatory training prior to the creation of BCUHB concurred with the HIW findings and told the Ockenden team 'I found some records and we were....98% compliant with safeguarding training.'

A concern was raised regarding staffing on Tawel Fan ward in the letter to the CEO with reviewers observing staff difficulties in providing all the care necessary for their patients and staff confirming their concerns. (HIW 2009, page 1.)

*“On Tegid ward patient documentation was described as ‘in good order, accurate and easy to assess’”*  
(HIW December 2009)

*“Staff training and development was found to be ‘up to date and encouraged by managers’ on Tegid ward and similarly up to date on Tawel Fan ward.”*  
(HIW 2009, page 1.)

### 16.3 Letter from HIW dated 21st April 2011 to the CEO and action plan following the HIW visit to Dinas Ward in the Ablett Unit on February 28th 2011

The action plan is found within a 'Precis of Action Plans' Excel spreadsheet provided to the Ockenden review by BCUHB. The spreadsheet was undated but was compiled in August 2015 and updated in December 2015. The following issues are recorded in the letter to the CEO, (HIW 2011) and the combined Divisional action plan created in August 2015:

- Insufficient bed capacity – with beds for patients on leave being utilised in their absence, (a similar problem had been described in the Hergest unit.) Some patients were having to be transferred to Wrexham and Bangor due to a lack of bed capacity in the Ablett unit. (HIW 2011, page 1.)
- Patients fearful of taking leave, 'losing' their bed and having their clothes and possessions put into store due to bed shortages'. (HIW 2011, page 2.)
- Problems with Mental Health Act documentation and relevant staff training. (HIW 2011, page 3.)
- Insufficient staffing and resources to meet the increased acuity of patients, (HIW 2011, page 2.)
- Adolescents being inappropriately admitted to the Ablett unit (HIW 2011, page 2.)
- Issues with the privacy, dignity and safety of female patients, particularly at night. (HIW 2011, page 3.)

There are a number of positive comments regarding the staff including positive feedback from patients, their commitment to patient privacy and dignity in difficult circumstances and success in achieving a number of awards. (HIW 2011, pages 1 and 2.)

HIW undertook visits to both Tawel Fan ward and Tegid ward in July 2013. The letter to the then acting CEO of BCUHB regarding Tegid ward was sent in August 2013, written feedback from the Tawel Fan ward visit was not sent until the 10th October 2013.

Since HIW's last visit, Tegid had become a ward for older persons aged 65 and above. (HIW 2013, page 1.)

A number of significant concerns were raised about the infrastructure in Tegid ward including:

- Lack of nurse call systems in some bedrooms;
- Lack of space in the ward communal areas, making them too small for patients in wheel chairs and using walking aids;

*“Patients fearful of taking leave, ‘losing’ their bed and having their clothes and possessions put into store due to bed shortages.”*  
(HIW 2011, page 2.)

*“Insufficient staffing and resources to meet the increased acuity of patients”*  
(HIW 2011, page 2.)

*“Issues with the privacy, dignity and safety of female patients, particularly at night.”*  
(HIW 2011, page 3.)

*“There are a number of positive comments regarding the staff including positive feedback from patients, their commitment to patient privacy and dignity in difficult circumstances and success in achieving a number of awards.”*  
(HIW 2011, pages 1 and 2.)

- Lack of bathroom facilities, (only one bathroom) with no hoist, access to the shower was via a high step. Ward staff told the HIW reviewers that this meant that some patients required bed baths rather than accessing a bath or a shower;
- There was no sluice – body fluids were being disposed of using the toilet;
- The garden area was unkempt, littered with debris and cigarette ends, with no ramp to allow access by wheel chair users.

There were significant concerns expressed by HIW regarding staffing and lack of patient activities. An action plan was provided to the Ockenden review team with timescales for completion of the concerns raised by HIW by November 2013.

A second 'master action plan' created in August 2015 and updated in December 2015 records the same actions arising from the 2013 HIW visit to Tegid ward as 'MH0095 to MH0105.' Of the 11 actions six are described as still being 'in progress' as of August 2015, two years after the HIW visit.

*“Lack of bathroom facilities, (only one bathroom) with no hoist, access to the shower was via a high step. Ward staff told the HIW reviewers that this meant that some patients required bed baths rather than accessing a bath or a shower.”*

MH0096	HIW visit	18/07/2013	Ablett	Centre	Tegid Ward	Environment	Physical environment of ward – does not meet the needs of current patient group, e.g. mobility issues.. The Health Board should urgently review the environment and its facilities at Tegid Ward and take appropriate action to ensure it meets the mental and physical needs of the patient group.	in progress	11/08/2015
MH0097	HIW visit	18/07/2013	Ablett	Centre	Tegid Ward	Environment	Bathroom – only one bathroom – no hoist, no support aids. The Health Board should urgently review the environment and its facilities at Tegid Ward and take appropriate action to ensure it meets the mental and physical needs of the patient group.	in progress	11/08/2015
MH0098	HIW visit	18/07/2013	Ablett	Centre	Tegid Ward	Environment	Shower Room – via high step, assistance from ward staff required, therefore bed baths given.. The Health Board should urgently review the environment and its facilities at Tegid Ward and take appropriate action to ensure it meets the mental and physical needs of the patient group.	in progress	11/08/2015

MH0265	HIW visit	Ablett	centre	Environment	The external grounds of the Ablett unit could have a tremendous therapeutic value for the patients, however with the exception of Cynnydd ward, where the external grounds were maintained by staff and patients, the other outside areas were extremely neglected.	in progress
MH0266	HIW visit	Ablett	centre	Environment	General maintenance of the environment was required and entries requesting repairs and replacements, made in the maintenance diary, had not been completed, some entries dated back to April 2014.	in progress

There is supplementary text to MH 0265 that says 'The grounds outside Tegid ward were overgrown with brambles and weeds and patients had difficulty accessing the gardens because of the steps. A ramp is required so this patient group can access the grounds and regular maintenance of the grounds is required to ensure accessibility and maximum therapeutic benefit for the patient group.' This had been highlighted over a number of years with limited action occurring by BCUHB.

*“The garden area was unkempt, littered with debris and cigarette ends, with no ramp to allow access by wheel chair users.”*

## 16.4 The Ablett unit – Tawel Fan ward

A visit to Tawel Fan ward was also undertaken on the 17th July 2013 (more than five months before closure of the ward on the 20th December 2013) HIW wrote to the then Acting CEO on October 10th 2013:

'As part of our visit we met with patients and staff, reviewed patient records and other supporting documentation and observed the ward environment and the interactions between staff and patients, focusing on:

- The Environment of Care
- The Administration of the Mental Health Act (The Act)
- Patient Care

HIW's initial findings and recommendations were fed-back to staff throughout the visit and more formally at the feedback meeting with BCUHB held at the end of the day. 'Any urgent concerns were notified to the Health Board and immediate action taken.' One interviewee, staff number 4 told the governance review how HIW reports were dealt with at this time: 'The HIW reports went in two directions, they were, first and foremost ... managed ... through the Clinical Programme Group ... were received within the Clinical Programme Group ... by the Chief of Staff and the Associate Chiefs of Staff, ... the process was that they ... with the local team, review the issues identified, identify a response plan and that would be ... submitted back to HIW'.

Staff number 38, a nurse told the Ockenden team: 'After the merger they would be talking about the reports and yet, I wouldn't see them. I would have to keep asking for them, I didn't feel a part of it.' (Staff number 38.) Staff number 38 continued: 'I used to struggle to get the feedback and ... action plans would be made and ... When I would see an action plan would be in one of the managers meetings and it would already be underway and things would be ticked off and I hadn't even seen the action plan or the initial report.....' Staff number 38 added 'I didn't feel they were deliberately withholding it, but it was like they were doing all the work in the background but not including me or the team..'

Staff number 4 told the review team: 'If I think about Tawel Fan..... my recollection of that is.....a number of probably not interconnected systems, so there was work ongoing, so HIW did their things and came in and had a look, there was work like dementia mapping ongoing which was looking at it in a certain way. I think concerns and incidents and particularly safeguarding was not as visible as it might have been...there were systems to look at these things and.....I'm not aware the intelligence, such that it was, was pointing to flags or issues that might have said there is a difficulty in this area, one needs to be closer to it....'

There was no record in the letter sent to the acting CEO who HIW had met with for feedback on the day of the visit to Tawel Fan ward in July 2013. HIW have subsequently confirmed it was two members of the CPG management team, at ward level and Associate Chief of Staff level, (the level below Chief of Staff). It is

*"After the merger they would be talking about the reports and yet, I wouldn't see them. I would have to keep asking for them, I didn't feel a part of it."*

*"I used to struggle to get the feedback and ... action plans would be made and ... When I would see an action plan would be in one of the managers meetings and it would already be underway and things would be ticked off and I hadn't even seen the action plan or the initial report....."*



unclear what route was then followed in escalating the immediate feedback from HIW to the Chief of Staff or the Executive team. It has been confirmed by a number of sources that no members of the Executive team directly received feedback on the day of the visit to Tawel Fan ward.

Tawel Fan ward was described by HIW as 'a mixed-gender ward providing care for patients aged 65 and above diagnosed with organic mental illness.' (HIW 2013, page 1) The HIW letter describes 'a mixture of single occupancy bedrooms and shared bedrooms. Within the shared bedrooms patient beds were separated by curtains which only provided the most basic form of privacy and dignity. This dormitory style area needs to be reviewed for its appropriateness and the risks of patients falling and disorientation. The patients' dignity is also put at risk in this dormitory style ward.' (HIW letter to BCUHB October 10th 2013 page 1)

### Action Required by HIW

**The Health Board must review the provision of dormitory accommodation. (HIW 2013, page 1.)**

HIW (2013, page 2) stated that 'The ward, [Tawel Fan] was bright, with a good amount of space available for patients. However, on entering the ward there was a smell of urine, which pervaded around the ward....' This was a feature of family feedback in the first Ockenden report into Tawel Fan ward where families reported the ward smelling of urine on entry and other families stating soiled or wet clothes (following incontinence) were sent home from Tawel Fan ward mixed in with other dry clothes. A third family also added to the feedback around the smell within the ward describing a refusal for their relative to have a daily shower following episodes of double incontinence. In finding an explanation for the smell of urine pervading the ward as stated by HIW in July 2013 a fourth family supported other families and told the original Ockenden review that they frequently found their relative smelling badly with dirty hair and nails. This family reported to the original Ockenden review that they requested a daily bath in light of their relative's incontinence and reported being told the ward had too many patients to allow a daily bath. A fifth family also told the original Ockenden review that their relative was always unkempt, dirty and smelly despite multiple requests to the ward staff for their relative to be bathed/washed. They informed the original Ockenden review that the smell on occasions was so bad as to prevent them from sitting next to their relative.

HIW further stated 'Patients had access to a communal garden, however the garden area was unkempt and there was little evidence that this had been regularly maintained because the garden and flower beds were full of weeds.' (HIW 2013, page 2.)

*"Within the shared bedrooms patient beds were separated by curtains which only provided the most basic form of privacy and dignity. This dormitory style area needs to be reviewed for its appropriateness and the risks of patients falling and disorientation. The patients' dignity is also put at risk in this dormitory style ward."*

(HIW letter to BCUHB October 10th 2013 page 1)

*"The ward, (Tawel Fan) was bright, with a good amount of space available for patients. However, on entering the ward there was a smell of urine, which pervaded around the ward...."*

### Action Required by HIW

#### The Health Board must ensure that the garden area is maintained.

This review of governance has found that the concerns around the garden area had been raised with BCUHB on a number of occasions since at least 2010. Staff number 57 and others also provided extensive evidence to the review showing long term concerns with the poor quality of the older person's inpatient environment, specifically Tawel Fan ward and Tegid ward on the Ablett unit. A range of internal BCUHB emails has been provided to the review including one titled 'Formal complaint re furnishings, décor and garden (Tawel Fan) dated March 27th 2012 @0858hrs. This email says 'I am mindful that we responded to a similar complaint last year but there does not appear to have been any progress made despite our reassurances to the complainant at that time..' The email details that 'issues concerning the carpets/flooring have been raised with the Estates Dept. since early 2011 (and 2010 in the case of the uneven paving in the garden courtyard) I understand the courtyard still remains 'out of bounds to patients'. Communication has been seen by the Ockenden review complaining about the Tawel Fan garden dating from the summer of 2011 from the local Alzheimer's Society to the then CEO.

*“Patients had access to a communal garden, however the garden area was unkempt and there was little evidence that this had been regularly maintained because the garden and flower beds were full of weeds.”*  
(HIW 2013, page 2.).

#### The Administration of the Mental Health Act

HIW stated in their letter to BCUHB (HIW 2013, page 2) that they reviewed the statutory detention documents of three of the detained patients being cared for on the ward at the time of the visit. They found that all patients' legal papers were available, but one patient's papers were spread over three files. HIW noted that copies of legal papers should be kept in patients' current notes and in date sequence. HIW found that there was evidence of completed assessment of capacity forms for all patients and assessments had been completed by approved doctors within the set time limits. However, they found one patient who had a CO3<sup>149</sup> in place who had been prescribed and given medication that had not been authorised. Medicines must not be given without authority on the CO3 form, urgent treatment may be provided once authorised under section 62<sup>150</sup> of the Act.

*“I am mindful that we responded to a similar complaint last year but there does not appear to have been any progress made despite our reassurances to the complainant at that time..”*

### Action Required by HIW

#### The Health Board should ensure a regular programme of ward based Mental Health Act documentation audits take place to ensure ward staff have a full set of up-to-date patient documentation.

As found on Tegid ward, HIW found on Tawel Fan ward that no activities were taking place. 'During the visit we saw no evidence of group or individual activities being undertaken.' (HIW 2013 page 3)

*“During the visit we saw no evidence of group or individual activities being undertaken.”*  
(HIW 2013 page 3)

<sup>149</sup> See glossary

<sup>150</sup> See glossary

### Action Required by HIW

#### **The Health Board must ensure that there is a suitable programme of group and individual activities available for the patient group.**

HIW noted that staff were committed to providing good care for the patients and there was good interaction between staff and patients as they carried out their assessments and care needs.' (See page 2, letter, HIW to BCUHB October 2013). HIW continued that 'Staff reported morale to be reasonable and said they were spending long periods of time completing documentation. As a result there was some concern amongst staff that they were unable to provide as much time interacting with patients as they would wish. 'Sickness levels on Tawel Fan ward for staff were reported as high across the unit, however there was said to be evidence that this was reducing.

During the visit HIW found two patients were on their own in their bedrooms. One of these patients was sitting in a bucket chair<sup>151</sup>, doubly incontinent. HIW found that as the nurse's station was 'away from the patient areas, staff need to ensure patients are checked upon on a regular basis. Patient safety and dignity had been compromised in this situation. (See pages 2 and 3 letter, HIW to BCUHB October 2013).

### Action Required by HIW

#### **The Health Board should review the staffing levels to ensure they meet the needs for patient care.**

BCUHB were required by HIW to submit a detailed action plan to be received by HIW by the 1st November 2013, (three and a half months after the visit) clarifying the action taken (or BCUHB intended to take) to address the issues raised. The action plan was required to set out timescales and details of whom will be responsible for taking the action forward. Of note is that HIW itself did not set timescales for resolution of some of the critical issues outlined above. These included a ward where:

- a) Two patients were on their own in their bedrooms. One of these patients was sitting in a bucket chair, doubly incontinent (Letter to BCUHB from HIW dated 10th October 2013, page 2)
- b) There was no evidence of group or individual activities being undertaken;
- c) Medicines management under the Mental Health Act did not meet required standards;
- d) A smell of urine 'pervaded around the ward;'
- e) The garden area was unkempt and there was little evidence that this had been regularly maintained;

*“Staff reported morale to be reasonable and said they were spending long periods of time completing documentation. As a result there was some concern amongst staff that they were unable to provide as much time interacting with patients as they would wish.”*

*“During the visit HIW found two patients were on their own in their bedrooms. One of these patients was sitting in a bucket chair, doubly incontinent. HIW found that as the nurse's station was 'away from the patient areas, staff need to ensure patients are checked upon on a regular basis. Patient safety and dignity had been compromised in this situation.”*

*(See pages 2 and 3 letter, HIW to BCUHB October 2013).*

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<sup>151</sup> See glossary

- f) Patients' dignity was being put at risk in a dormitory style ward patient where beds were separated by curtains (which only provided the most basic form of privacy and dignity.)

BCUHB did produce an action plan which has been provided to the review by BCUHB. The response by BCUHB to the concerns as set out by HIW does not appear to mitigate those concerns. Some of the timescales are nonspecific and lengthy. Issues a) and b) above were conflated into one issue. Quarterly reviews of privacy and dignity were to be carried out by the 'Corporate Team' and 'toileting of patients occurs 2 – 3 hourly currently. The plan is for 'intentional rounding to be introduced.' (Timescale 3 months). A Singing with Dementia project was due to commence at the end of November and within '3 months' the action plan stated that 'The Activities Process will be reviewed looking at options of the possibility of dedicated hours for an Activities Coordinator.

Clearly provision of a dedicated Activities Coordinator would be an action with a long 'lead time' since first the need would be identified, then the funding sought then the recruitment process undertaken. Despite asking for a 'detailed' action plan, some three months after the visit HIW do not appear to have been unduly concerned as to the lack of detail, rigour or pace within the plan provided by BCUHB at this time. Staff number 4 notes 'In terms of when the written report came in, it did not seek any sort of immediate response...'

It is of particular concern to the Ockenden governance review team that from the end of 2009 onwards and up until and after the closure of Tawel Fan ward HIW made numerous visits to mental health units across BCUHB. With reference to the Ablett unit and the Hergest unit repeated concerns from HIW led to development of multiple action plans over several years. All of the action plans seen by the Ockenden review team were similar in nature, with many important issues unresolved over several years and over many action plans.

At this time Mental Health Act Monitoring Visits were carried out by a single HIW inspector. (Letter from CEO HIW to D Ockenden, February 2017). The letter states that although there was a delay in issuing the management letter to BCUHB verbal feedback had been given on the day to senior BCUHB staff. The CEO HIW noted that the action plan created by BCUHB failed to give the kind of reassurance that would be expected. (HIW 2017, page 3.) Finally the letter (2017) also notes that HIW has made significant changes to its processes, integrating the Mental Health Act inspections with broader inspections. Donna Ockenden was advised that inspectors are now part of a team, timeliness of feedback to Health Boards has improved and challenge to inadequate reassurance is more robust. (HIW 2017, page 2.)

*“A smell of urine ‘pervaded around the ward.”*

(HIW October 2013)

*“The garden area was unkempt and there was little evidence that this had been regularly maintained.”*

(HIW, October 2013)

*“Patients’ dignity was being put at risk in a dormitory style ward patient where beds were separated by curtains (which only provided the most basic form of privacy and dignity.)”*

(HIW, October 2013)

*“Despite asking for a ‘detailed’ action plan, some three months after the visit HIW do not appear to have been unduly concerned as to the lack of detail, rigour or pace within the plan provided by BCUHB at this time.”*

## 16.5 Summary and conclusions: what does review of HIW visits (and the subsequent communication and action plans) tell us about governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 20th December 2013

As in the case of Hergest Unit HIW had visited the Ablett Unit a number of times between 2009 and 2013 without seeing significant and positive changes in the way that the wards functioned. The inspection following shortly after the closure of Tawel Fan in December 2013 is particularly pertinent as one would expect that the management team and senior clinicians would be working incredibly hard to ensure that the area was functioning at a high level. Whilst accepting that the physical environment of the ward takes significant time to improve many of the processes underpinning care could have been improved upon quickly and reliable assurance therefore provided by the CPG senior management team to the BCUHB Board.

As with the Hergest unit there appears to be a lack of meaningful discussion of the reports at the CPG senior management team level and the absence of any formal review of the action plans coming out of HIW visits. Many of the issues identified in multiple HIW visits are concerns seen across Mental Health care provision in the CPG so they could have been brought together as one single 'action' e.g. improvement in documentation across all inpatient units with little additional work.

The Mental Health Act review<sup>152</sup> on July 17th 2013 requires particular attention as it specifically visited Tawel Fan ward. Mental Health Act reviews are limited in scope, but given the nature of the client group on the ward the majority would be either subject to the Mental Health Act or to Deprivation of Liberty Safeguard procedures and processes and would therefore come under the remit of the inspection. The issues raised by the inspection, the smell of urine and a patient in a 'bucket' seat doubly incontinent should have raised significant and urgent concerns. The very presence of bucket seats, designed to restrict the movement of individuals, suggests practice that was outdated for 2013 and that lacked an understanding of the basic principles of human rights enshrined in a number of laws and clinical guidelines. There is no specific recommendation in the HIW report concerning this practice. Whilst HIW have confirmed (HIW to Ockenden D, letter February 2017) the recommendations post the July 17th 2013 visit were conveyed orally to CPG representatives at the end of the day there was then a significant delay in the letter to the CEO dated the 10th October 2013.

Staff number 4 says 'I recall conversations with the Nurse Director at the time .....who was looking specifically at some of the issues around there, about that being an alarm for them ....their clear view was that bucket chairs should not have been in use...' Staff number 4 continued 'there were a number of concerns that were coming through...my recollection is that their response, when they

*“The smell of urine and a patient in a 'bucket' seat doubly incontinent should have raised significant and urgent concerns.”*

(referring to the HIW visit to Tawel Fan ward, July 2013)

*“There were a number of concerns that were coming through...my recollection is that their response, when they were party to the information, was that that was very clearly not a practice that should be followed, those bucket chairs needed to be removed..”*

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<sup>152</sup> See glossary



were party to the information, was that that was very clearly not a practice that should be followed, those bucket chairs needed to be removed..’ Staff number 25 a senior colleague within mental health at the time said of bucket chairs ‘I can’t recall when I saw one in any hospital in England.....[but] they were still piled up on the closed ward’ [Tawel Fan ward.]. Explaining what a bucket chair was staff number 25 advised the Ockenden review ‘the bucket chair is one that’s got a high back, sides, so you can plonk a tray in the front of it and you can push it back.....’ Staff 25 continued ‘It’s a restraining chair,..... it’s not meant as a restraining chair.’

The BCUHB response to the HIW letter was wholly inadequate and changes such as ‘intentional rounding’ were still only proposed many months after the visit and subsequent report. In conclusion, the July 2013 HIW inspection appears to represent a lost opportunity for HIW to escalate the need for changes within Tawel Fan ward. HIW states they have recognised these issues and has made significant changes to its practice to reduce the likelihood that such delays will happen again. (HIW to Ockenden D, letter February 2017)

## 16.6 Internal review of Tawel Fan ward on the 17th October 2013

A review of Tawel Fan ward was undertaken on the 17th October 2013 in response to a number of complaints made about care on the ward. The review was undertaken by a senior team of eight colleagues including the Nurse Consultant for Dementia, the Matron, the interim Deputy Associate Chief of Staff and a member of the BCUHB ‘Transforming Care’ team. The team were both senior and experienced and large in number. In summary the following was found:

- On the day bed occupancy was 12 out of the 17 beds occupied. There were 3 registered nurses on duty, with four healthcare support workers, two of whom were ‘bank’ staff;
- The ward environment was described as having ‘bright furnishings’ that were ‘in good repair; The garden area was found to be ‘attractive’ and in ‘good order’;
- The ward staff told the review they found patient acuity difficult to manage and that activity sessions could not always be provided;
- The review noted that bank and agency staff were regularly used, this led to difficulties in building a therapeutic relationship between patients and staff they were unfamiliar with;
- Patients were noted to be clean, well cared for and dressed in their own clothes. Personal hygiene was said to be carried out behind closed doors in bathroom and bedroom areas;
- Staff were observed to provide appropriate and kindly support to patients in taking food and drink.

*“The July 2013 HIW inspection appears to represent a lost opportunity for HIW to escalate the need for changes within Tawel Fan ward. HIW states they have recognised these issues and has made significant changes to its practice to reduce the likelihood that such delays will happen again.”*

(HIW to Ockenden D, letter February 2017)

*“The ward environment was described as having ‘bright furnishings’ that were ‘in good repair; The garden area was found to be ‘attractive’ and in ‘good order’.”*

[internal review of Tawel Fan ward October 2013]

*“The review noted that bank and agency staff were regularly used, this led to difficulties in building a therapeutic relationship between patients and staff they were unfamiliar with.”*

[internal review of Tawel Fan ward October 2013]



## 16.7 Dementia Care Mapping<sup>153</sup> in Tawel Fan ward in October 2013 – what did it tell us about governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013?

The Ockenden review team has been provided with an October 2013 internal BCUHB document describing Dementia Care Mapping being undertaken on Tawel Fan ward. Dementia Care Mapping or DCM is an observational framework that records quality of life and quality of care from the perspective of the person with dementia.

DCM is regarded as an objective independent observational method of patient behaviours and indicators of well-being. The methodology for the mapping exercise and the consent gained prior to the exercise being undertaken is described within the report.

DCM was completed in Tawel Fan ward at the end of October 2013. This was three and a half months after the HIW visit of July 17th 2013. The Dementia Care Mapping Report, (BCUHB 2013, page 3) found that 'over the total mapping period of 12 patient hours', no patient experienced 'a state of wellbeing.' The report states that 'each patient's day from their perspective could be described as uneventful, mundane and lacking in stimulation.' The report states that this pattern remains the same even when the analysis is 'broken down into morning and afternoon sessions. The report notes the use of agency staff on Tawel Fan ward on the day and a number of missed opportunities for engagement with patients due to lack of staff presence. (Page 3.) It is of particular concern that the Dementia Care Mapping, (or DCM) process was carried out three and a half months after the HIW visit and seemingly found no improvement. (The report from HIW to BCUHB after the July 2013 visit was significantly delayed until the 10th October 2013 but verbal feedback had been given to senior members of the CPG on the day.)

In agreement with a number of families interviewed for the first Ockenden report and the July 2013 HIW visit (with October report) the Tawel Fan DCM report found that the patients observed on Tawel Fan at the end of October 2013 existed in a 'neutral' environment overall with 'episodic periods of ill being, reflecting the lack of engagement and stimulation.' (Page 6.)

One family who visited their relative on Tawel Fan ward several times a week over a period of time in 2013 provided feedback to the first Ockenden review that agreed with the findings of the July 2013 HIW visit and the October 2013 DCM report. They noted a lack of activities for patients and a television that was switched on continuously in the lounge, even when no one was watching it. They also reported lack of staff engagement with patients. The DCM report described 'the lived experience' of a group of three patients as 'characterised predominantly by inactivity or self-stimulation.' (BCUHB 2013, page 8.) Where engagement occurred it was described as 'a consequence of task related activities ...rather

*"Staff were observed to provide appropriate and kindly support to patients in taking food and drink."*

*"Over the total mapping period of 12 patient hours', no patient experienced 'a state of wellbeing."*

*"Each patient's day from their perspective could be described as uneventful, mundane and lacking in stimulation."*

*"The patients observed on Tawel Fan at the end of October 2013 existed in a 'neutral' environment overall with 'episodic periods of ill being, reflecting the lack of engagement and stimulation.'" (Page 6.)*

*"'The lived experience' of a group of three patients as 'characterised predominantly by inactivity or self-stimulation.'" (BCUHB 2013, page 8.)*

<sup>153</sup> See glossary

than an attempt at meaningful or human interaction....' (BCUHB 2013, page 8.) The report described a patient spending 'long periods of time talking to herself and receiving limited opportunities to engage with others...' When staff known to this patient engaged with her the patient experienced 'heightened levels of well-being....' (BCUHB 2013, page 8.)

Other patients were described as:

'Sat in a communal lounge disengaged' (page 13)

Having 'interactions with staff' that were 'brief' (page 13.)

Spending the 'majority of the morning sleeping.' (page 13.)

In a neutral and inactive state for the majority of the mapping period. (page 11)

**The Dementia Care Mapping Report for Tawel Fan ward (October 2013) recommended that:**

- The ward manager increase staff awareness of the benefit that their interactions with patients can have on their well-being.
- Orientation cues and signage should be available in every area; that written orientation should be bilingual and that 'orientation regarding day, date, time, place should also be available.'
- There should be a review of the clinical usefulness of daily blood pressure checks which the DCM team considered was leading to a reduction in the time that ward staff were able to spend with patients.
- All case notes should contain a completed copy of 'This is Me'<sup>154</sup>

Activities should be considered to support patients in response to faecal smearing since it is considered that 'faecal smearing may be a response to a lack of activity and engagement.' (Page 15) The report noted that in one instance a patient who subsequently did smear faeces during the DCM exercise 'was keen to engage with others but had limited opportunities to do so.' (Page 15)

All of the recommendations found within the DCM report would be considered to be at or below the most basic level of care expected. The requirement of assessors to recommend the ward team 'consider' these issues should have led the senior leadership team within the CPG to have followed up this report with a specific and measureable action plan that had a planned, effective and timely journey throughout the governance processes within the CPG. In addition there should have been an immediate review of all other older people's inpatient areas within the CPG to assess those areas against the measures and recommendations within the report. (There should have been no requirement to await the next cycle of DCM for this to occur.)

On receipt of this report there should have been a very clear message from the CPG senior leadership team shared throughout the entire CPG at every shift

*"The report described a patient spending 'long periods of time talking to herself and receiving limited opportunities to engage with others...' When staff known to this patient engaged with her the patient experienced 'heightened levels of well-being....'"*  
(BCUHB 2013, page 8.)

*"Activities should be considered to support patients in response to faecal smearing since it is considered that 'faecal smearing may be a response to a lack of activity and engagement.'" (Page 15) The report noted that in one instance a patient who subsequently did smear faeces during the DCM exercise 'was keen to engage with others but had limited opportunities to do so.'" (Page 15)*

<sup>154</sup> [https://www.alzheimers.org.uk/download/downloads/id/3423/this\\_is\\_me.pdf](https://www.alzheimers.org.uk/download/downloads/id/3423/this_is_me.pdf).

handover for a period of several weeks saying 'The standards of care found in Tawel Fan ward as evidenced by the Dementia Care Mapping process are not good enough.' Despite review of all available governance, Senior Management Team and operational minutes in the year prior to this Dementia Care Mapping exercise and up to the middle of 2014 the original Ockenden report into Tawel Fan ward found no evidence that this occurred. The recommendations and findings within the Dementia Care Mapping report were validated (BCUHB 2013, page 8.) by the HIW visit three months earlier.

*"The ward manager increase staff awareness of the benefit that their interactions with patients can have on their well-being."*

The results of the DCM exercise clearly show a ward and an older persons mental health team under considerable pressure. Within eight weeks internal BCUHB documents prepared for the BCUHB Board and shared with the Ockenden team by BCUHB describe six mental health services 'in escalation.' In reality, taking into account all we now know everyone involved in the provision of older persons mental health care is likely to have been working way beyond capacity.

DCM is referred to in internal emails describing the need to reduce beds in Tawel Fan ward in early December 2013. An internal email provided to this review says 'I feel we have no option but to reduce the bed capacity [on Tawel Fan ward] for the next couple of months.' The email between members of the CPG management structure describes insufficient staffing levels across all grades of nursing staff, bank staff that are difficult to obtain, agency nurses who have not turned up and are 'unreliable.' In the email staff morale is described as 'low and stress levels are rising amongst staff.' The email also states that Dementia Care Mapping has found that 'patient wellbeing is lower when staff cared for by bank/agency.' (Email dated 9th December 2013 @0940hrs.)

*"Dementia Care Mapping has found that 'patient wellbeing is lower when staff cared for by bank/agency.'"*

(Email dated 9th December 2013 @0940hrs.)

Overall four reviews of Tawel Fan ward were carried out in the space of three months, one in July 2013 by HIW, one of older adults ward generally – including Bryn Hesketh, Cefni and the Ablett unit which reported in October 2013 and two in October 2013, by different teams internally to BCUHB.

The findings of all four reviews, two external and two internal have both similarities and differences. All describe difficulties with staffing, all describe an increase in acuity of patients all describe a lack of activities for patients. The NHS Delivery Unit stated that the lack of activities provision on older adults wards generally failed to meet the Royal College of Psychiatrists standards<sup>155</sup>. Only one describes the ward smelling strongly of urine – the HIW visit in July 2013, this resonated with family experiences of taking home bags of mixed and unsorted wet and dirty washing and patients said by families to have been found dirty and wet on a regular basis. The NHS Delivery Unit report of October 2013 specifically criticised the sharing of bedrooms on Tawel Fan ward, unsafe garden areas and a lack of a reliable hot water supply, (which had not been mentioned elsewhere.) A number of the reviews noted the bureaucracy associated with nursing documentation. Overall the concerns around estates issues raised in a number of the reviews resonated with multiple HIW visits across inpatient units across North Wales.

<sup>155</sup> [https://www.rcpsych.ac.uk/pdf/RCPsych\\_Standards\\_In\\_2016.pdf](https://www.rcpsych.ac.uk/pdf/RCPsych_Standards_In_2016.pdf) (see page 11)

## 16.8 Shortage of staff on Tawel Fan ward

In the first Tawel Fan report families told Donna Ockenden how shortage of staff on Tawel Fan ward affected the experience of their family members. Staff shortage usually manifested itself as lack of supervision of very vulnerable patients on the ward and (as observed by HIW in their July 2013 visit) a lack of any meaningful activities for patients on the ward, (many of whom had long stays on Tawel Fan ward.). Family members confirmed that when they visited patients would be found wandering around corridors unsupervised and that fights frequently broke out between unsupervised patients. At least one family wrote to BCUHB expressing concerns around shortage of staff on the ward and this evidence has been seen by the Ockenden governance review team.

*“Families stated that ward staff spent most of their time in the office on Tawel Fan ward, rather than supporting patients in the communal areas or providing activities.”*

A number of families told the first Ockenden review that unsupervised patients on Tawel Fan ward walked continuously around the ward. Families observed patients walking around the ward in a state of undress. Families also described disinhibited behaviour between female and male patients and rarely saw staff intervene to support, distract or assist these patients. Families stated that ward staff spent most of their time in the office on Tawel Fan ward, rather than supporting patients in the communal areas or providing activities. In the July 2013 HIW visit Tawel Fan ward staff fed back to the HIW inspector their concern ‘that they were spending long periods of time completing documentation.’ (HIW 2013, page 2). Staff number 57 described at interview that the computers necessary to complete mandatory documentation were based within the office. Requests were made for the purchase of laptops so that staff could work more flexibly within the clinical area but still complete the required documentation. Staff 57 told the Ockenden review ‘I tried for Bryn Hesketh as well, for them to have laptops ...and Tegid, but the answer was that computers had to be condemned before we could apply for a laptop.....the computers were always in the office, and.....it did take staff away because they were moving more and more towards electronic records...’

*“Staff number 57 described at interview that the computers necessary to complete mandatory documentation were based within the office. Requests were made for the purchase of laptops so that staff could work more flexibly within the clinical area but still complete the required documentation.”*

## 16.9 If warning signs or ‘red flags’ existed prior to the closure of Tawel Fan ward what action did BCUHB take?

### 16.10 Finding

**Red flags did exist** for a number of years prior to the closure of Tawel Fan ward and the BCUHB Board took very little meaningful action. Evidence seen from multiple external reviews from 2012 show that the BCUHB Board had not established systems, structures and processes of governance that provided them with a clear ‘line of sight’ from the ‘Ward to the Board.’ Concerns originally expressed by Independent Members of the BCUHB Board regarding the overall CPG structure from at least 2011 had not been acted upon, or acted upon very partially. Instead the BCUHB Board relied upon a long series of external reviews, the action plans of which were rarely completed before the next external review took place.



The HIW visit to Tawel Fan ward in July 2013 (where the verbal feedback was attended by senior staff from within the CPG) and BCUHBs failure or inability to react in a timely manner to that feedback was a lost opportunity to insist on change in Tawel Fan ward many months before ward closure.

Throughout 2012 and 2013, there were a number of other external reviews of services at BCUHB outside Older Persons Mental Health that the Board were fully sighted upon. Three reviews of maternity services at Ysbyty Glan Clwyd in 2012 and 2013, (all before the closure of Tawel Fan ward) describe a clinical leadership structure through the CPG that was ineffective and in feedback the 2012 report authors (Wallace Walker 2012) asked the Board to consider whether this problem was wider than maternity at YGC. Public Health Wales and Duerden (both 2013) highlighted to the BCUHB Board that the systems, structures and processes of governance underpinning infection and prevention at BCUHB were not fit for purpose. This led to a highly publicised and catastrophic C. Difficile outbreak at YGC

Two reviews of the 'concerns' process in 2013 highlighted similar issues to the Board. Independent members have also explained to this review their long term concerns that the CPG structure was ineffective. They have provided evidence to this review that they were vocal in this regard and 'The Director of NHS Wales was kept fully informed of those concerns, agreements and developments.' Staff numbers 100, 106 and 111 told this review 'Concerns developed and intensified at Board level about the effectiveness of the CPG structure model fairly soon after its establishment.' (All, staff numbers 100, 106 and 111, written statement November 2017, page 2). They describe 'major differences of opinion between the CEO and the group of non –officers with what felt like a very divided and dispirited group of Executive Directors looking on.....' (Staff numbers 100, 106 and 111, written statement November 2017, and page 2)

A post Tawel Fan ward closure and retrospective internal review of events leading to the closure of Tawel Fan ward has been provided by BCUHB to the Ockenden team. This is known as the 'Merged Chronology Regarding Tawel Fan.' The Ockenden review team has been advised that this was prepared after the closure of Tawel Fan ward at the request of the BCUHB Chairman. This retrospective review shows that concerns were first raised by a family member directly to the then Chief Executive of BCUHB on the 6th November 2012. At this stage the concerns were said to be around a lack of adequate bathing facilities on Tawel Fan ward. The letter of response is stated to have been sent on the 28th February 2013 by which time a POVA<sup>156</sup>, (described in the merged chronology as POVA 1) concerning a head injury and a further complaint regarding staffing levels had been sent to BCUHB. By the time of the HIW visit on the 17th July 2013 the 'Merged Chronology Regarding Tawel Fan' as provided to the Ockenden team describes 6 POVAs and several complaints (from at least four different families). By the time of the closure of Tawel Fan ward this had increased to at least 11 POVAs.

*“Red flags did exist for a number of years prior to the closure of Tawel Fan ward and the BCUHB Board took very little meaningful action. Evidence seen from multiple external reviews from 2012 show that the BCUHB Board had not established systems, structures and processes of governance that provided them with a clear ‘line of sight’ from the ‘Ward to the Board.’”*

*“Concerns developed and intensified at Board level about the effectiveness of the CPG structure model fairly soon after its establishment.”*

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<sup>156</sup> See glossary



The Ockenden governance review team has not seen any evidence of the ability of BCUHB to successfully share critical information across POVAs, Serious Incidents (SI's), complaints and Datix both up to and after the closure of Tawel Fan ward. In a statement dated September 2017 referring to the position up until September 2015, therefore including the time leading up to and after the closure of Tawel Fan ward Staff number 25 outlines the challenges within the CPG and across BCUHB of sharing any information across SI's, complaints, Datix and POVA's. Staff number 25 states: 'Challenges remained due to the inconsistent availability of IT access across the organisation....' Staff number 25 continued: 'The sporadic implementation of Datix by the organisation and individual and inconsistent CPG management of identified reporting caused inconsistency [in] escalation. There was no automatic flag or alert system on Datix to identify the number of incidents against each individual by name or by ward or department....'

In addition this review has seen extensive documentation of visits by HIW from 2009 onwards to both the Ablett unit and the Hergest unit where recommendations and concerns from HIW inspections were transferred to an action plan and little if any action took place by BCUHB. All of these HIW visits were lost opportunities for change and each one had multiple red flags of a mental health service under severe pressure.

### 16.11 HIW visit to Glan Clwyd Hospital (YGC) Ablett Unit – and feedback to BCUHB in June 2014

This letter from HIW to the new CEO dated 14th July 2014 describes an HIW inspection in June 2014 that came after the closure of Tawel Fan ward in December 2013. Some positive features are noted by HIW including the up to and after the closure of Tawel Fan ward evidence of working between inpatient services and the home treatment team, cleanliness and ECT accreditation. (HIW 2014, pages 1 and 2).

However numerous issues of concern are raised. Many of these related to estates and the wards not being fit for purpose. Many of these concerns had been raised over a number of years by HIW with no or limited action by BCUHB. Concerns included:

- Care planning and documentation, (HIW 2014, page 3.)
- Controlled drug administration, recording and storage, (HIW 2014, page 3.)
- Poor levels of mandatory staff training 'On Tegid and Dinas wards there was 0% compliance in Mental Capacity Act 2005 training. The Mental Health Act 1983 and Deprivation of Liberty Safeguards (DoLS) training on Dinas ward had 0% compliance.', (HIW 2014, page 4) Staff number 55 said of safeguarding training within the CPG 'It just plummeted..... It was diluted' [training and compliance in safeguarding across BCUHB immediately post-merger] 'When it [BCUHB] became one, and people were all getting into place, that was all totally watered down and training sessions became like a two hour blitz..' Staff number 25 stated at interview 'Mandatory training was.... not seen as a priority for CPGs and staff shortages were blamed for poor attendance at

*“The sporadic implementation of Datix by the organisation and individual and inconsistent CPG management of identified reporting caused inconsistency (in) escalation. There was no automatic flag or alert system on Datix to identify the number of incidents against each individual by name or by ward or department....”*

*“On Tegid and Dinas wards there was 0% compliance in Mental Capacity Act 2005 training. The Mental Health Act 1983 and Deprivation of Liberty Safeguards (DoLS) training on Dinas ward had 0% compliance.”*  
(HIW 2014, page 4)

training events'. Training events were said to be cancelled due to poor attendance.

## Glan Clwyd Hospital (YGC) The Ablett Unit HIW inspection of June 2014 and the resulting action plan Version 10 provided, updated 30th June 2015

MH0271	HIW visit		Ablett	centre		Training	There was a lack of mandatory training in the following areas:  A – on Tegid and Dinas wards there was 0% compliance in Mental Capacity Act 2005 training.  B – The Mental Health Act 1983 and Deprivation of Liberty Safeguards (DoLS) training on Dinas ward had 0% compliance.  Training in the areas identified above must be facilitated.	in progress
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MH0273	HIW visit		Ablett	centre		Staff Files	Staff training was recorded differently across all wards. A comprehensive system that is used by all wards should be introduced to ensure consistency across Ablett Unit and to enable an effective overall audit of training at the unit.	in progress
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A lack of references, medical checks and Disclosure and Barring Service (DBS) documentation in a number of staff files were noted by HIW. (HIW 2014, pages 3 and 4). The excerpt below shows a divisional action plan dated August 2015 with limited progress. At this stage the division had yet to establish a Task and Finish group to agree what should be placed in personal files and yet to put in place a system to maintain this appropriately.

MH0269	HIW visit		Ablett	centre		Staff Files	We reviewed a sample of staff files and the following observations were made: A – There was a lack of references on the files examined 4/10 files had no references.  B – 4/10 files had no evidence that a Disclosure and Barring Service (DBS) check had been undertaken.	in progress
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## 16.12 Correspondence to Welsh Government regarding Mental Health services including Older Persons Mental Health services in 2014

A letter dated 31st October 2014 from the then CEO of BCUHB to the CEO of NHS Wales has been provided to the Ockenden review team by the author, (the then CEO), It is 7 pages in length and provides a response to issues in:

- The Hergest unit
- 'Issues relating to Tawel Fan ward'
- 'Emerging concerns which have been noted in relation to Cefni Hospital.' The letter states that there is to be an update to the BCUHB Board in December 2014. The discussion at the Board regarding Mental Health is found at 14/267 and 14/268. The Board minutes<sup>157</sup> are found via the link

The Board minutes show discussion on:

- Depression in older people
- The need to 'involve service users and listen to them' and the need to 'improve coordination of services for users and their families'

<sup>157</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Minutes%20BCUHB%202.12.14%20Public%20v1.0%20Approved.pdf>.

The interim Director of Mental Health services described 'steps already taken to improve the quality of care and family involvement.' (Board minutes December 2014, 14/268.2 page 3.) and discussed an HIW report<sup>158</sup> into the homicide committed by Mr M, a former patient of BCUHB, available via the link below.

*“Notes, which remained an issue, and he was unable to give full assurance until the electronic system was in place....”*

The interim Director of Mental Health services raised concerns about the 'notes, which remained an issue, and he was unable to give full assurance until the electronic system was in place....' There were discussions by Board members around a stated 'lack of understanding of equality and diversity.' The interim Director of Mental Health services 'stated it was not simply about training; listening to service users and carers was also crucial.'

The paper discussing a 'Strategic review<sup>159</sup>' of Older Peoples Mental Health Services by Margaret Flynn and Ruth Eley presented at the BCUHB Board on 2nd December 2014 can be found at 14/267.1 in the Board documents or via the the link below.

*“The interim Director of Mental Health services 'stated it was not simply about training; listening to service users and carers was also crucial.'”*

The letter of the 31st October 2014 from the CEO at BCUHB to the CEO of NHS Wales details:

- The appointment of an interim Director of Mental Health services;
- The standing down of the 'former construct of the Clinical Programme Group;'
- A review of the operational arrangements within Mental Health by the new interim Director with implementation of recommendations made being actioned;
- The interim Director of Mental Health services 'personally oversees the Divisions clinical governance arrangements.'

*“The commitment, effectiveness and ability of the BCUHB Board to deliver upon the action plan arising from the visit a year earlier was called into question by this unannounced HIW visit a year later.”*

### 16.13 Glan Clwyd Hospital (YGC) – Ablett Unit – Inspection – 6-8 July 2015 and report

A further HIW visit took place to the Ablett unit in July 2015. The commitment, effectiveness and ability of the BCUHB Board to deliver upon the action plan arising from the visit a year earlier was called into question by this unannounced HIW visit a year later. In some respects little had changed. There were significant concerns around staffing (HIW 2015, page 3). The environment on Tegid ward remained unsuitable to meet the needs of the patients who were admitted, 'Tegid ward does not provide an adequate environment for the elderly patient group.' (HIW 2015, pages 4)

*“Tegid ward does not provide an adequate environment for the elderly patient group.” (HIW 2015, pages 4)*

There were a number of estates issues that were unresolved e.g. bathrooms, communal space and lack of space for nursing care. Issues remained around, staffing levels and training. '...on Tegid and Dinas wards there was still 0% compliance in Mental Capacity Act 2005 training.' (HIW 2015, pages 16).

<sup>158</sup> <http://hiw.org.uk/docs/hiw/reports/141120mrhmhomicidereporten.pdf>

<sup>159</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/Item%2014\\_267.1%20OPMH%20Strategic%20Review.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/Item%2014_267.1%20OPMH%20Strategic%20Review.pdf)

The excerpt below is found within a divisional action plan dated August 2015 showing limited progress over a number of years. The position in August 2015 is described as 'there is currently no training programme in place, apart from two e-learning packages... Staff are being encouraged to undertake this e-learning in the interim'.

MH0271	HIW visit		Ablett	centre		Training	There was a lack of mandatory training in the following areas:  A – on Tegid and Dinas wards there was 0% compliance in Mental Capacity Act 2005 training.  B – The Mental Health Act 1983 and Deprivation of Liberty Safeguards (DoLS) training on Dinas ward had 0% compliance.  Training in the areas identified above must be facilitated.	In progress
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Care planning also remained a significant issue of concern. HIW stated 'The Health Board should address issues around care plans lacking depth and detail, DoLS assessment and status, patient involvement in care planning and management of UTIs, falls, wounds and diabetes/blood glucose testing'. (HIW 2015, page 20.) The Quality, Safety and Experience Sub-committee on the 15th September 2015 (see QS15/145) notes the receipt of the above report and that a response was made to HIW in the timescales required but there is little meaningful discussion amid an otherwise very long agenda.

Of particular note and concern to the Ockenden review team is that Committee members do not make reference to the repeated concerns (and lack of BCUHB action) found within HIW inspections and reports which are very clear to the Ockenden team over a period of time from 2009 onwards. This questions the effectiveness of the scrutiny carried out by QSE Committee members as of 2015.

Overall, in considering the feedback from HIW to BCUHB over a number of reports spanning many years there are some positives but also many and consistent failings in terms of staffing levels, mandatory training, medicines management, leadership, audit and governance.

The positives largely appear to come from a dedicated staff group who are struggling to maintain good levels of care in very difficult circumstances. That some of these problems can still be found consistently in HIW reports in some cases a number of years after the Tawel Fan closure in December 2013 suggests both the size of the task that faced the Board at BCUHB and the capabilities and capacity within the organisation to address the issues. The latest reports suggest that change is slowly and sporadically underway but there is still very significant work to do.

The Ockenden governance review team consider that there are questions to be asked of HIW that would place decisions not to visit some of the smaller peripheral units in the context of their broader workload and alongside inspections in the well-known 'hot spot' areas that are considered to problematic within BCUHB. Apart from the 2009 and 2010 letters regarding Bryn Hesketh, following unannounced 'Dignity and Respect Spot Checks' (HIW 2010) there were no other available reports until 2014. This may have been a follow up visit as a consequence of the 2013 Joint HIW/WAO review and report on governance

*“The Health Board should address issues around care plans lacking depth and detail, DoLS assessment and status, patient involvement in care planning and management of UTIs, falls, wounds and diabetes/blood glucose testing.”*  
(HIW 2015, page 20.)

arrangements in BCUHB. In the 2015/16 Annual HIW report on BCUHB only three community hospitals are reported as being visited. (HIW 2016, page 5.)

#### 16.14 What have staff told the Ockenden review team about governance arrangements at the time?

Staff in post within the CPG were asked to describe the governance arrangements within the CPG from 2009 until before the closure of Tawel Fan ward. One relatively senior member of staff working within older people's mental health stated that governance arrangements within predecessor Trusts for specific professions 'were fairly sophisticated already, before the join up,' (before the merger creating BCUHB.) Post the merger, staff number 54 was unable to describe the development of any CPG wide governance arrangements and said 'I would have no idea, to be fair, I wasn't included..'. Instead legacy governance arrangements based around individual professions continued within mental health. Describing an individual governance structure within a profession within the CPG: 'Nobody really would know not to let us continue.....there wasn't anybody overseeing it...there was no integrated governance.' Describing the existence of individual risk registers within a profession within the Mental Health and Learning Disabilities CPG Staff number 54 said: 'I don't know whether they did (exist) outside XX (named profession) I mean in XX we had our own as part of the governance process but we had no links really..... that was a major issue, we had no links outside, (named profession) It was very much within the profession.... we were just sort of left to get on with that...'

*"Nobody really would know not to let us continue.....there wasn't anybody overseeing it...there was no integrated governance.."*

*"We were just sort of left to get on with that..."*

#### 16.15 A summary of governance issues identified within the Mental Health and Learning Disabilities CPG (subsequently known as the Division) but outside Older Persons Mental Health which all have relevance to understanding of current governance arrangements in Older Peoples Mental Health at BCUHB

The reports arising from a number of HIW visits to inpatient units other than those providing mental health care for older people have been considered by the Ockenden team where they have relevance and similarity to consideration of current governance issues within older people's mental health.

##### **HIW visits to Bryn y Neuadd Hospital – Ty Llywelyn Unit**

Two letters from HIW to BCUHB have been seen. The first is a letter dated 22nd August 2013 to the then interim CEO, the second a letter to the then CEO dated 15th November 2014 following a visit on the 4th, 5th and 6th November 2014 to Ty Llewellyn unit at Bryn Y Neuadd Hospital. A number of themes relevant to those seen within HIW inspections of older people's mental health and current governance issues are noted.

The letter dated 22nd August 2013 to the then interim CEO noted a previous visit undertaken by HIW in June 2010. HIW say 'It was disappointing to note a number

*"It was disappointing to note a number of issues identified during our last visit were reoccurring, such as lack of patient activities due to insufficient staffing and limited availability of physical healthcare."*  
(HIW 2013, page 1.)



of issues identified during our last visit were reoccurring, such as lack of patient activities due to insufficient staffing and limited availability of physical healthcare.' (HIW 2013, page 1.) The HIW report notes a reduction in staffing levels and the seniority of post holders, high sickness levels and a cancellation of patient leave as a consequence of insufficient staffing levels. (HIW 2013, pages 3 and 4.) HIW plan required BCUHB to submit a detailed action plan within three weeks. (12th September 2013.)

A number of issues raised within the letter written following the November 2014 HIW visit mirrored or were very similar to those raised a year earlier in 2013 and four years earlier in 2010. The issues raised were also similar to those raised in a number of older person's inpatient mental health units and from concerns expressed to the Ockenden review team by both former and current BCUHB staff. These common or frequently found issues included the following:

**Staffing** where poor rostering of nurses 'indicated a lack of a structured approach to effectively staff the unit. (HIW 2014, page 2).

**Poor availability of equipment.** The HIW team found that there 'were no individual printers available on the wards (HIW, 2014, page 2.) As a result there were therefore significant issues with IT and record keeping (which needed to be addressed as a matter of urgency.)

**Poor compliance with mandatory training,** (HIW 2014, page 3.) around the Mental Health Act and Mental Capacity Act, with staff compliance with Restraint and Physical Intervention training said to be at 26% (Staff within the unit were said to have informed HIW that figure this was not accurate but there were no systems available to show what the correct figures were)

**Lack of staff supervision with staff files found to be out of date.** (HIW 2014, page 3)

Staff morale was described to be low. (HIW 2014, page 3)

Concerns were also raised regarding GP cover and food.

A number of wider issues, seen in a number of other HIW reports were also identified including the vacancies within the 'Responsible Clinicians' group. (See Glossary – HIW 2014, page 4) There needed to be greater focus overall on staff retention. The policy for rapid tranquilisation had been found as out of date by a number of years. (HIW, 2014, page 4.)

HIW stated that 'A review of the robustness of audit and governance processes' were required 'to ensure issues are addressed.' (HIW 2014, page 4) A further HIW visit took place to Ty Llewellyn unit at Bryn y Neuadd Hospital in December 2016 The publication date of the HIW report was 8 March 2017.

A number of issues raised within previous HIW inspections were raised again by HIW on this visit. Many of the issues raised were found across a number of

*“A reduction in staffing levels and the seniority of post holders, high sickness levels and a cancellation of patient leave as a consequence of insufficient staffing levels.”*

(HIW 2013, pages 3 and 4.)

*“The policy for rapid tranquilisation had been found as out of date by a number of years.”*

(HIW, 2014, page 4.)

*“A review of the robustness of audit and governance processes' were required 'to ensure issues are addressed.”*

(HIW 2014, page 4)

mental health inpatient units, including those providing older persons mental health. Concerns were expressed around the provision of occupational therapy support to allow off ward and community activities. There were also concerns raised by HIW that BCUHB must ensure that records of pre-employment checks are filed in accordance with BCUHB policy. There continued to be concerns around the completion and organisation of Mental Health Act documentation and care and treatment plans and again HIW reminded BCUHB of the need to have effective systems of governance to promote timely identification and escalation of any quality and safety issues identified.

### 16.16 HIW visits to units outside the MHL D but to services providing care for vulnerable older people where issues raised resonate previous HIW visits to OPMH

### 16.17 HIW visit to Llandudno General Hospital – September 2014

HIW carried out an unannounced Dignity, Essential Care Inspection, (also known as DECI) at Llandudno Hospital on the 2nd and 3rd of September 2014. The resultant report<sup>160</sup> was published on the 13/02/2015.

The HIW inspection team concluded that the fundamentals of care were being delivered at a basic level. However, the team also concluded that there were staffing issues on the ward in terms of numbers, resilience and skill mix. (HIW 2015 Page 4) Further concerns were raised around documentation to support the delivery of safe and effective care and treatment. This was considered to be generally poor in terms of its quality and completeness (HIW 2015 Page 4)

The HIW inspection team found that there was a lack of effective management and leadership to help and support staff to deal with the day to day challenges and pressures they were experiencing. (HIW 2015 Page 4) Overall, the inspection team concluded that given the number of concerns they identified during this inspection, patients could not be assured that they would routinely receive a safe and effective service. (HIW 2015 Page 4) The inspection team concluded that patients with cognitive impairment did not have any specific support to meet their particular cognitive needs. (HIW 2015 Page 6). With reference to medicines management the report stated that BCUHB should provide HIW with a statement on whether its current arrangements for monitoring the effectiveness of its service are sufficiently robust. (HIW 2014 Page 12). HIW found evidence of non-compliance with BCUHB policy and procedures with regard to the safe storage, administration and recording of patient medication.

A number of issues were raised with BCUHB via a letter requiring immediate assurance from BCUHB to HIW, (HIW 2015, and page 6.) HIW advised in the report that BCUHB responded to these requests for assurance in a timely manner.

*“The inspection team concluded that patients with cognitive impairment did not have any specific support to meet their particular cognitive needs.”*

(HIW 2015 Page 6)

*“Overall, the inspection team concluded that given the number of concerns they identified during this inspection, patients could not be assured that they would routinely receive a safe and effective service.”*

(HIW 2015 Page 4)

<sup>160</sup> <http://gov.wales/docs/hiw/inspectionreports/DECI%20Inspection%20Report%20-%20BCHB%20-%20Llandudno%20General%20Hospital%20-%20202%20and%203%20September%202015.pdf>

## 16.18 HIW Inspection Eryri Hospital – Peblig and Padarn Wards December 2014

The HIW report published following this visit in December 2014 was published on 12/3/2015.

This report concerns care of the vulnerable elderly outside the MHL Division, however the issues are very similar which suggested to the Ockenden governance review team that there were systemic issues at the time, more than a year after the closure of Tawel Fan ward.

Once again, a number of issues were raised in this report that resonated with elsewhere in BCUHB and within the Mental Health and Learning Disabilities Division, specifically within Older Persons Mental Health. Issues that were raised by HIW throughout these visits included staffing levels, the low levels of mandatory training achieved including POVA and dementia awareness. There were concerns regarding medicines management, organisational learning from Serious Incidents (SI's) and access to the BCUHB complaints procedure for those who wished to raise concerns. (HIW 2014, Immediate Assurance Letter to BCUHB pages 3-5). Further correspondence from HIW seeking greater assurance was sent to BCUHB in January 2015. This was subsequently provided by BCUHB in a follow-up letter which was promptly provided.

## 16.19 HIW visit to Denbigh, Penrhos Stanley and Mold Community Hospitals November 2015

A further HIW visit that caused concern to the Ockenden review team was that to Denbigh Community Hospital. The concern was raised by members of the Ockenden review team because of the similarity of many of the issues found in some HIW inspections of older persons mental health inpatient units across BCUHB from 2009 to the current day. The HIW inspection occurred in November 2015 with publication of the report in February 2016. As part of this HIW review the community hospitals – Penrhos Stanley, Mold and Denbigh were reviewed. These had just over 120 beds in total broken down into the following formations.

Penrhos Stanley – Cybi and Fali Wards – 43 Care of the Elderly beds

Mold – Delyn and Clwyd Wards – 40 Care of the Elderly Beds and GP beds

Denbigh – Llweni and Famau Wards – 40 Care of the Elderly, GP and Palliative care beds

This report raised very serious concerns about practice particularly on Fali ward.

HIW found that staff practices fell well below expected standards in several areas. In particular, there were significant shortfalls in record keeping and medication practices. Due to the potential risks to patient safety, HIW sought immediate written assurance from BCUHB in relation to these matters. As a

*“Issues that were raised by HIW throughout these visits included staffing levels, the low levels of mandatory training achieved including POVA and dementia awareness. There were concerns regarding medicines management, organisational learning from Serious Incidents (SI's) and access to the BCUHB complaints procedure for those who wished to raise concerns.”*

(HIW 2014, Immediate Assurance Letter to BCUHB pages 3-5)

*“HIW found that staff practices fell well below expected standards in several areas. In particular, there were significant shortfalls in record keeping and medication practices.”*

(HIW February 2016)

result of HIW findings, HIW took the decision to refer one patient to the local authority under the POVA procedures.

The Ockenden governance team have been provided with significant correspondence between HIW and BCUHB highlighting the efforts made by BCUHB to ensure standards were brought up to a level that was expected by HIW. The correspondence from HIW to BCUHB requiring 'immediate assurance' commenced on the 27th November 2015, just two days after the visit took place with confirmation as of 12th January 2016 that HIW were not yet satisfied that sufficient assurance had been provided by BCUHB. (HIW 2016, page 1.)

Following a meeting between HIW and BCUHB on the 19th January 2016 HIW confirmed that a further updated action plan specifically around Fali ward in Penrhos Stanley Hospital was required since the earlier action plans had provided HIW with sufficient assurance regarding Cybi and Delyn wards. This was provided promptly by BCUHB and further correspondence between HIW and BCUHB seen by the Ockenden review team indicate that the action plan arising from the visits to Penrhos Stanley Hospital was considered a 'live issue' with regular updating of the BCUHB action plan seen in correspondence between BCUHB and HIW until the end of October 2016. (letter from BCUHB to HIW dated 27th October 2016.)

## 16.20 HIW visit to Deeside Hospital 2016

An example of an HIW inspection occurring outside of the Mental Health and Learning Disabilities Division but providing care for vulnerable elderly patients undergoing rehabilitation and palliative care is Deeside Community Hospital. Review by the Ockenden team noted there are both Consultant led and GP beds on the units at Deeside Community Hospital.

The HIW inspection dates were from the 15th to the 17th November 2016 and the publication date of the report was the 27 February 2017. Again, common themes from previous HIW inspections in mental health units and specifically inpatient older person's mental health units were found. This suggested to the Ockenden governance review team that the concerns raised around older persons mental health inpatient units were frequently found across a range of mental health units and as recently as early 2017 in a number of other wards across BCUHB providing health care to vulnerable older people. The HIW report states that Deprivation of Liberty (DoLS) issues were found to be of such significant severity that the team were required immediate reassurance from BCUHB that improvements would be put in place. Medication management required significant improvement and those records reviewed as part of the visit did not reflect personalised care planning. There was further comment on the poor level of staff appraisals achieved and significant environmental issues and concerns. All of these issues had been commented on in HIW inspections of older people's mental health inpatient units since 2009, suggesting that very limited, if any, organisational learning took place across BCUHB as a result of HIW visits.

*“The HIW report states that Deprivation of Liberty (DoLS) issues were found to be of such significant severity that the team were required immediate reassurance from BCUHB that improvements would be put in place.”*

*(HIW February 2017)*

The Ockenden governance review team has noted that there remains as of 2017 a significant challenge around locum medical staff use within the Mental Health and Learning Disabilities (MHLDD) Division to the current time, (at the end of 2017.) This has stretched back to the formation of BCUHB. Staff number 55 described parts of the service, in April 2017 particularly the 'West' as 'existing on locums' and that this was the 'biggest risk' to the service. A further risk associated with the use of locum staff was identified by staff number 68 in interview in June 2017. Staff number 68 discussed the issue of inductions currently with the Ockenden team and described that 'substantive consultants have always had inductions but locums didn't..'. Staff number 68 went on to describe a conversation with a locum consultant colleague in June 2017. Staff number 68 described the conversation as the locum colleague 'not had an induction, been here for months..'

*“Substantive consultants have always had inductions but locums didn't..”*

Further issues around induction were described by other new staff joining BCUHB recently. A new member of staff joining BCUHB at a senior level as recently as the end of 2016 was interviewed by the Ockenden team in June 2017. This member of staff, previously employed outside of BCUHB stated at interview that on joining BCUHB 'the standard of ... mandatory training was very low .. very wishy washy.....it's just a tick box. Only safeguarding training and equality and diversity training was described as 'comprehensive.'

*“Training was an issue (both mandatory and non-mandatory), there was a lack of understanding of the issues of capacity, consent and POVA or the Fundamentals of Care (FOC) audits. There was little recording in individual notes of capacity or consent to treatment. Levels of bed occupancy were recorded as a concern.”*  
(HIW 2010)

## 16.21 2010 HIW visit to Wrexham Maelor Hospital and feedback to BCUHB via 'Management Letter'

### Unannounced 'Dignity and Respect' Spot Checks Wrexham Maelor Hospital – Visit 22nd and 23rd February 2010

The letter to BCUHB regarding this visit is dated 10th June 2010 (which is circa 15 weeks post the visit.) This inspection took place immediately after the move to the new unit. Many positives concerning the care given to patients were noted but the systems, structures and processes underpinning the care raised concerns. Training was an issue (both mandatory and non-mandatory), there was a lack of understanding of the issues of capacity, consent and POVA or the Fundamentals of Care (FOC) audits. There was little recording in individual notes of capacity or consent to treatment. Levels of bed occupancy were recorded as a concern.

The BCUHB action plan following this HIW visit is published with the report. The action plan is detailed and specific and notes both responsible people for delivery of actions and the associated time lines for delivery. There are plans to address each of the issues that have been raised by the inspection.

However, whilst some of the actions included methods of monitoring the individual plans to be put in place as a result of this HIW visit to the Heddfan unit (See HIW 2010, pages 23-30.) there is no indication as to how these issues will be addressed by the wider governance structure of the Mental Health and Learning Disabilities Division and across BCUHB to ensure these issues do not come up repeatedly across Mental Health, Older Persons Mental Health and in Care of the



Elderly wards across BCUHB. Consideration of numerous HIW reports alongside other external reviews show the same issues coming up repeatedly in different clinical settings over many years from 2009 to 2017

## 16.22 HIW visit<sup>161</sup> to the Heddfan unit June 2017

This was an unannounced inspection by HIW 12th to 14th June 2017, this report was published in September 2017.

The Heddfan Unit has five wards including Gwanwyn ward with 13 beds and Hydref with 14 beds. These two wards are the wards designated for the care of older adults.

Of particular note is the conclusion that 'Staff at Heddfan provided safe and effective care for the patients. There were good processes in place to maintain patients' safety whilst receiving a high standard of care on the wards' (HIW 2017, page 15.) and also that 'Legal documentation to detain patients under the Mental Health Act or restrict patients leaving the hospital by Deprivation of Liberty Safeguards were compliant with the relevant legislation.' (HIW 2017, page 15.)

The report stated that 'we observed that ward staff and senior management at the hospital interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke to were enthusiastic about how they supported and cared for the patients. (HIW 2017, page 9.) In addition HIW noted in the report that patient and relative/carer feedback was also positive.

However, a number of issues remain.

Considering the problems BCUHB has experienced with infection prevention and control it is disappointing that completion rates in 'Infection Prevention and Control – Level 2' training require improvement. (HIW 2017, page 18.) This should however, be viewed in conjunction with the positive comments regarding the process to monitor staff training, the levels of mandatory training, and regime of annual appraisals and regular supervision, which have much improved, although further progress is still required.

With regard to record-keeping, particularly on the Older Adults wards where records were found to be disorganised, improvement was recommended. All the wards were at full occupancy, and this creates many pressures on the mental health services as a whole. This has been recorded in a number of previous reports with recommendations to review the bed numbers, and service provision. The inspectors also raised the issue of 'out of hours' mental health assessments of young people under the age of 18, as these were not being undertaken by staff with appropriate Child and Adolescent Mental Health Service (CAMHS) experience.

*“Staff at Heddfan provided safe and effective care for the patients. There were good processes in place to maintain patients' safety whilst receiving a high standard of care on the wards”*  
(HIW 2017, page 15.)

*“We observed that ward staff and senior management at the hospital interacted and engaged with patients appropriately and treated patients with dignity and respect. The staff we spoke to were enthusiastic about how they supported and cared for the patients.”*  
(HIW 2017, page 9.)

<sup>161</sup> <http://hiw.org.uk/docs/hiw/inspectionreports/170913heddfanen.pdf>

Perhaps the greatest cause for concern was the medication management issues, HIW said 'we found inconsistencies in the safe and effective management of medicines across Heddfan.' (HIW 2017, page 18.) This ranged from problems with storage (medication fridge temperatures and unlocked storage) to prescriptions not correctly written. This included not indicating the route of administration for some medication (oral or intra-muscular) or stating maximum daily dose. (HIW 2017, page 18.) One set of notes did not include a regular medication review and also cited in the report were occasions when the use of controlled drugs had not been signed by two registered staff.

The HIW inspectors record their view that no immediate causes for concern were identified on the inspection. On consideration of the information regarding medicines management at Heddfan the governance review team was concerned about the medication management issues and would have been seeking ongoing reassurance regarding these matters. HIW noted to the Ockenden review team that this ongoing reassurance is gained by the immediate verbal feedback on the day, the receipt by BCUHB of a draft report from HIW for factual accuracy checking and the opportunity for the Health Board to commence actions where concerns have been raised long before publication of the HIW report. (HIW to Ockenden D, April 2018.)

### **Heddfan – Immediate Improvement Plan**

The report contains the BCUHB detailed 'Immediate Improvement Plan' at Appendix B (pages 29-45.) which addresses the concerns raised by the HIW inspectors with timelines and identified staff roles responsible for each action.

Some immediate interventions regarding estates were reported to have been made, whilst other issues such as managing the open nursing stations form part of a larger estates programme. (HIW 2017, page 32.)

Addressing the issues of bed numbers and the CAMHS assessments were described as part of longer term service redesign within mental health services. It is stated that CAMHS staff are available for telephone consultation 24 hours a day, seven days a week. As with other inpatient mental health units bed pressures are an ongoing concern. On the day of the visit HIW described that all five wards were at full occupancy. (HIW 2017, page 12.) The report described when all beds were full the following options might be utilised:

- Out of 'own area' admissions – where patients are cared for within BCUHB beds but away from their own place of residence;
- Admissions to other Welsh Health Boards;
- Admissions to NHS Trusts or independent providers in England.

This feedback on bed pressures and the steps taken were described as a concern in all the 'Listening and Engagement' events undertaken as part of this governance review across the six counties of North Wales from April to July 2017.

*“We found inconsistencies in the safe and effective management of medicines across Heddfan.’ (HIW 2017, page 18.) This ranged from problems with storage (medication fridge temperatures and unlocked storage) to prescriptions not correctly written. This included not indicating the route of administration for some medication (oral or intra-muscular) or stating maximum daily dose.”*  
(HIW 2017, page 18.)

In line with feedback on the 'sofa system' described by staff numbers that include 68 and 38 and service user number 7 the HIW report records that 'patients would be admitted on to wards and the patient was accommodated overnight in ward communal areas that were made private for that persons sole use.' (HIW 2017, page 12.) This required the authorisation of the 'on call manager.' HIW state it is 'not appropriate for patients to be temporarily accommodated outside of a designated bedroom.'

*“Patients would be admitted on to wards and the patient was accommodated overnight in ward communal areas that were made private for that persons sole use.”*

*(HIW 2017, page 12.)*

Service user 7, described sleeping a communal ward area and how it was impossible for the communal areas in Dinas ward at the Ablett unit to be made private. They asked ward staff to 'watch the door' of the TV lounge to ensure no one came in overnight. Staff had told service user 7 at the time this was not possible. Service user number 7 also described to the Ockenden review team how it was not possible to gain adequate sleep and rest on a sofa and that the choice of late night television watching in the communal lounge by other patients meant that service user number 7 had to remain awake longer than they would have wished whilst the communal lounge was in use. This system was clearly still in use in June 2017, a number of months after service user 7 met with the CEO and Chairman of BCUHB to raise concerns about their experience of treatment in BCUHBs mental health services.

The action plan arising from the HIW visit describes:

Current compliance percentages for Infection Prevention and Control are:

Level 1: OPMH – 90%, AMH – 92%

Level 2: OPMH – 60%, AMH – 60% with an aim to get level 2 to 90% by the end of 2017.

(HIW 2017, page 38)

Issues associated with medication storage, administration and documentation are being addressed through a series of reminders to staff regarding the issues and the importance of maintaining standards. A series of audits are being established to ensure that these standards are being met. Reference is made to monthly pharmacy audits, but is not clear from the action plan if these were already in existence and were not covering the areas identified by HIW, or if these are being introduced in order to cover those areas. There are plans to ensure that some issues are addressed in the trainee doctor induction which will include a session from the pharmacy team and also stated is that staff have received specific training in rapid tranquillisation from the ward Consultant, and the Pharmacist. (HIW 2017, page 38-39.)

The Ockenden governance review team was concerned that these issues had not already been identified by the ward pharmacy service prior to the HIW visit. How this pharmacy support is provided, and the role of pharmacist on the ward was not clear from the HIW report. It would be expected that each ward would have a dedicated pharmacist who would regularly review practices on the ward, and

would very rapidly identify any issues that required attention. It would not be expected that this would be picked up upon by an HIW inspection, rather that the ward pharmacist would have been proactively managing this issue before HIW noted it. Ward pharmacist input is of particular importance on Older Persons wards where the levels of poly pharmacy are potentially high as one is managing the combination of physical and mental health problems. The issue of managing the side-effect profiles against effective dosages is an area that requires discussion between pharmacist and clinician to ensure the best outcome for the patient on an ongoing basis.

In conclusion, there are many examples of positive progress in this report indicating that some systems have improved within the provision of mental health services within BCUHB. Some of the themes cited in HIW reports since 2009 remain unresolved. Issues around outstanding estates work, medicines management, induction and training of Bank staff and utilisation of the staff bank have all been raised in multiple HIW inspections.

### 16.23 HIW and Cefni Hospital 2010-2017

HIW identified two unpublished management letters concerning this unit dated 02/11/2010 & 10/12/2012. The most recent inspection by HIW was on the 14th, 15th, 16th February 2017 with a report publication date of the 16th May 2017. The report shows a positive and committed team who are working together to provide good quality care. (HIW 2017, page 5) The staff are engaged with training, the environment has improved and there are clear attempts being made to develop the ward further. Staff commented positively on the senior management structure and told HIW that communication between senior management and staff was effective. (HIW 2017, page 21)

One significant concern is that of the Health Board failing to undertake DoLS assessments in a timely way, thus leading to 'unlawful detention'. (HIW 2017 Page 30)

The action plan published with this report with many of the required actions either making significant progress or already complete reflects the aspirations of the staff to develop the ward further. This is the first of the action plans reviewed that refer to the wider governance structure of the MHL Division and also the wider governance structures within BCUHB. (HIW 2017 Page 30) The positive nature of change on the ward is also reflected in the recent NWCHC report dated June 2017.

*“One significant concern is that of the Health Board failing to undertake DoLS assessments in a timely way, thus leading to ‘unlawful detention’”*

(HIW 2017 Page 30)

### 16.24 Bryn Hesketh 2016-2017

#### 16.25 What is Bryn Hesketh?

Bryn Hesketh is a stand-alone unit in Colwyn Bay, approximately eight miles, and a 14 minute journey time from the Ablett unit based in Ysbyty Glan Clwyd. It was

opened in 1995 to provide community based mental health care including 'respite care' beds and day hospital facilities for the local population.

## 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.)

## 16.27 External review of Bryn Hesketh October 2016

An external investigation by senior staff at Aneurin Bevan University Health Board was undertaken into Bryn Hesketh ward in October 2016 following a number of serious concerns raised on Bryn Hesketh in September 2016. The report from the Aneurin Bevan team was shared with the Ockenden governance

*"The hospital staffing levels are now in a desperate state."*

(NWCHC page 1.)

*"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 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.)



review team by BCUHB. A considerable number of issues were raised as part of this external investigation. The external investigation team found the following which they described as 'further issues'. (ABUH 2016, pages 20 and 21.)

- a) A closed culture at Bryn Hesketh demonstrated by some, (not all);
- b) Care and treatment plans 'are not informing the delivery of care on Bryn Hesketh;'
- c) There was a lack of multi-disciplinary involvement in the decision making regarding management of aggressive behaviours. The use of restraint was viewed as a nursing decision, the use of restraint was not recorded in patient care plans and not discussed in multi-disciplinary ward rounds;
- d) Staff on Bryn Hesketh were not clear about the definition of restraint and were referring to restraint as 'safe hold' and believed this was different from restraint;
- e) There was a lack of visible clinical leadership on the ward. This was particularly noted around untoward incidents occurring at a specified time in September 2016;
- f) Debriefing of staff and/or patients was not undertaken on Bryn Hesketh ward;
- g) There was a lack of clarity around the nursing hierarchy/structure in Bryn Hesketh at the time, with a divide found between the ward staff team
- h) The ward roster was not effectively managed, with some shifts being described as having up to 10 staff on duty, others having only 5;
- i) The process for sharing information during handovers varies – with handover reports not being completed for every shift;
- j) Patient information and documentation was inconsistent in the patient notes.

#### 16.28 Nineteen recommendations were made by the external team regarding Bryn Hesketh. These included the following that concern the 'governance' underpinning older persons care in the 'current' time

Many of the issues raised in these recommendations resonate with those found in multiple prior inspections and reports in other inpatient mental health units at BCUHB over a number of years.

- a) There needs to be a wider review of care provided to patients at Bryn Hesketh ward to determine if the issues highlighted in this report are evident in other areas of practice. The Ockenden governance review has not been provided with any follow up documentation subsequent to the October 2016 report.

*“There was a lack of multi-disciplinary involvement in the decision making regarding management of aggressive behaviours. The use of restraint was viewed as a nursing decision, the use of restraint was not recorded in patient care plans and not discussed in multi-disciplinary ward rounds.”*

(External review into Bryn Hesketh, October 2016)

*“Staff on Bryn Hesketh were not clear about the definition of restraint and were referring to restraint as 'safe hold' and believed this was different from restraint.”*

(External review into Bryn Hesketh, October 2016)

*“Debriefing of staff and/or patients was not undertaken on Bryn Hesketh ward.”*

(External review into Bryn Hesketh, October 2016)

- b) There needs to be multi-disciplinary involvement in the development of care and treatment plans and these plans need to reflect the current context of care that is being delivered to patients on Bryn Hesketh ward;
- c) There needs to be clear and visible leadership on Bryn Hesketh ward;
- d) A clear message should be communicated to all staff about the appropriate use of reclining chairs and that their use is care planned if the benefit of them has therapeutic value;
- e) Staff would benefit from training in wound care;
- f) 'This is Me' should be completed for every patient who requires one;
- g) Training and clarity regarding the use of physical interventions/restrictive practices needs to be delivered to ensure common understanding across the service;
- h) There should be a process to ensure all equipment, including wheel chairs is for purpose;
- i) There needs to be clear guidance and boundaries regarding staff behaviour towards each other in the workplace and these should be implemented;
- j) There needs to be robust induction processes for all staff, (including students.)
- k) Staff should have regular access to supervision;
- l) A regular audit of record keeping should be undertaken on Bryn Hesketh to monitor the standards of record keeping;
- m) Handover reports should be completed for every shift;
- n) The systems and processes in place should encourage the development of a 'whole team' approach rather than a divided or fragmented team.

*“There needs to be multi-disciplinary involvement in the development of care and treatment plans and these plans need to reflect the current context of care that is being delivered to patients on Bryn Hesketh ward.”*  
(ABUH 2016)

*“A clear message should be communicated to all staff about the appropriate use of reclining chairs and that their use is care planned if the benefit of them has therapeutic value.”*  
(External review of Bryn Hesketh, ABUH 2016)

### 16.29 HIW visit<sup>162</sup> to Bryn Hesketh 8th to the 10th November 2017

This report was published on the 12th February 2018 and there were a number of positive issues identified at this HIW inspection. HIW commented positively on the new ward manager who was providing 'strong leadership' and 'was in the process of building a committed ward team with clear focus on maximising patient experience.' (HIW 2017, pages 6 and 8.) HIW noted with positivity the refurbishment of the unit, which NWCHC had also commented upon and that legal documentation under the Mental Health Act and DoLS was appropriate and compliant.

As with previous visits by NWCHC, HIW expressed concerns regarding staffing and the stability of the workforce with a number of interim posts and significant

*“HIW commented positively on the new ward manager who was providing 'strong leadership' and 'was in the process of building a committed ward team with clear focus on maximising patient experience.'”*  
(HIW 2017, pages 6 and 8.)

<sup>162</sup> <http://hiw.org.uk/docs/hiw/inspectionreports/180212brynheskethen.pdf>

use of bank and agency staff. (HIW 2018 pages 7 and 16.) Staff described being able to provide only 'basic care for patients.' (HIW 2018, page 9.) Concerns around training of temporary staff that had been found by HIW in the Heddfan unit in June 2017 were also highlighted at this visit to Bryn Hesketh. (HIW 2018, page 26.) Care and Treatment plans were described as 'brief,[and] lacked specific detail' (HIW 2018, page 22).

*“Staff described being able to provide only ‘basic care for patients.’”*

(HIW 2018, page 9.)

Concerns were expressed around the medical support at Bryn Hesketh taking into account the 'standalone' nature of Bryn Hesketh ward. This had been raised by staff and HIW since 2010. (HIW 2018, page 16.) Staff described feeling 'isolated and anxious' due to the stand alone nature of Bryn Hesketh (HIW 2018, page 17.)

*“Treatment plans were described as ‘brief,[and] lacked specific detail’.”*

(HIW 2018, page 22.)

Medicines management continued to be a concern as did completion of clinical records. (HIW 2018, pages 19 and 20.)

There remained issues with 'estates' at Bryn Hesketh even following the refurbishment, examples cited are the lack of observation panels on bedroom doors which meant that in order to observe patients rest and sleep would be disturbed. Equipment such as the tumble dryer was found to be broken. (HIW 2018, page 10.) There needed to be appropriate availability of equipment for dementia care. (HIW 2018, pages 12 and 18.)

*“Staff described feeling ‘isolated and anxious’ due to the stand alone nature of Bryn Hesketh.”*

(HIW 2018, page 17.)

*“There remained issues with ‘estates’ at Bryn Hesketh even following the refurbishment, examples cited are the lack of observation panels on bedroom doors which meant that in order to observe patients rest and sleep would be disturbed.”*

## 17 PART 2

**Current Governance Arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB.) from December 2013 to the 'current' day.**

### 17.1 Key points: What do we know from a review of a range of HIW and other visits to Mental Health facilities at BCUHB caring for older people from 2009 to 2017

HIW reviews and inspections happen over a period of time in excess of seven years. There are some clear examples of good practice over the period of these reviews. Staff are frequently commented on in a positive way. The good practice seen is often despite (rather than because of) any specific interventions by either the CPG management team or the BCUHB Board over the timescale, particularly from 2009 to 2016. Throughout these reports and over this prolonged period of time there are a long catalogue of issues that are similar across many of the HIW inspection reports. These are repeated across multiple units with very little assurance that the situation is improving. these include:

- Estates that are neither fit for purpose, maintained adequately or addressing risks to patients – e.g. ligature risks left in place for several years following on from HIW raising concerns about them in multiple visits;
- 'Too many patients with too few beds' and a lack of availability of alternative models of care;
- Inadequate numbers of staff and staff not engaged in the appropriate work for their skillset;
- Long term concerns over senior medical staff numbers and ways of working;
- Lack of staff training (both mandatory and developmental;)
- Concerns regarding record keeping and formats – These concerns are found at all levels from Mental Health Act documentation to risk assessment, care planning and documentation of physical care provision;
- Lack of psychology and occupational therapy interventions;
- Poor standards of cleanliness;
- Staff who demonstrate a lack of understanding of concepts of consent and capacity.

Action plans following on from HIW visits over the period of seven years have varied from the perfunctory to the more recent detailed action plans from 2017 that start to link to the wider governance systems within the Division and BCUHB.

There is frequently no description of how the interventions are to be monitored nor do the local management systems within the CPG or the Division give any convincing evidence that the reports are given much time, consideration or review. Response to HIW visits, reports and action plans appear to be largely

*“The good practice seen is often despite (rather than because of) any specific interventions by either the CPG management team or the BCUHB Board over the timescale, particularly from 2009 to 2016. Throughout these reports and over this prolonged period of time there are a long catalogue of issues that are similar across many of the HIW inspection reports.”*

*“Estates that are neither fit for purpose, maintained adequately or addressing risks to patients – e.g. ligature risks left in place for several years following on from HIW raising concerns about them in multiple visits.”*

*“‘Too many patients with too few beds’ and a lack of availability of alternative models of care.”*

thought of and treated as a necessary task to be completed after one visit. Action plans seem to be developed in isolation. There is no evidence to the current time that lessons learnt from an HIW inspection visit in one unit are transferred to other units or care settings although many problems found by HIW are repeated across many units e.g. training, documentation, estates, lack of patient activities and medical and nursing staffing.

Significant opportunities were lost to achieve change with the HIW Mental Health Act visit (HIW 2013) to Tawel Fan ward on the 17th July 2013 and the subsequent delay by HIW in writing to BCUHB on the 10th October 2013. However, even on receipt of the letter the very basic action plan developed by the CPG team showed a lack of understanding of the very serious issues identified by the July 2013 visit. In addition, verbal feedback had been given on the day to relatively senior members of the CPG team and the review has not found any evidence that this was fed up through any CPG governance structures to the Chief of Staff and onwards to the Executive team/Board. HIW (2017) noted that significant changes have been made to HIW processes that will mitigate this issue in the future. (Letter HIW to Ockenden D, February 2017)

In conclusion, all of the wards visited by HIW across BCUHB providing care to vulnerable elderly people have experienced very significant problems in the period of time reviewed (from 2009 to the current day.) There was little evidence found by the Ockenden team of any significant 'lessons learned' from events on Tawel Fan ward. Had lessons been learnt across the provision of elderly mental health care in the CPG as these visits and their subsequent action plans occurred many of the ongoing and recurring problems seen are likely to have been preventable. The role of HIW in ensuring that basic processes are in place to keep vulnerable elderly people safe has been strengthened to a degree over time but the resource implications and level of attention still required of HIW in monitoring the older persons mental health services at BCUHB at the level which still appears to be necessary in late 2017 are significant.

## 17.2 Chapter 9

Consideration of the systems, structures and processes of governance at **BCUHB** following the closure of Tawel Fan ward.

What did the following external reviews and scrutiny have the potential to tell the Board about current governance arrangements in BCUHB and Older Peoples Mental Health at BCUHB from 2014 onwards?

- a) 'An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board – A summary of progress against recommendations made in June 2013 by HIW/WAO, (July 2014);
- b) A review of the governance systems at Betsi Cadwaladr University Health Board by the Good Governance Institute (September 2014.)

*“There is no evidence to the current time that lessons learnt from an HIW inspection visit in one unit are transferred to other units or care settings although many problems found by HIW are repeated across many units e.g. training, documentation, estates, lack of patient activities and medical and nursing staffing.”*

*“All of the wards visited by HIW across BCUHB providing care to vulnerable elderly people have experienced very significant problems in the period of time reviewed.”*

(From 2009 to the current day.)



- c) Trusted to Care (2014) by Professor June Andrews, (The Dementia Services Development Centre) and Mr Mark Butler, (Director of the People Organisation);
- d) 'Targeted Intervention' A report by Mrs Ann Lloyd CBE (January 2015);
- e) Imposition of 'Special Measures' in June 2015;
- f) 'Wider issues emanating from the governance review of Betsi Cadwaladr University Health Board, Public Accounts Committee, National Assembly for Wales, (February 2016);
- g) An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board – A Summary of Progress by HIW/WAO (June 2017);
- h) HIW visits across the Mental Health and Learning Disabilities Division and Older Persons Mental Health and their significance to a review of current governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB.) from December 2013 to the 'current' day;
- i) Annual Governance statements by the BCUHB Board – what they tell us about current governance arrangements in BCUHB and Older People's Mental Health at BCUHB from December 2013 to the 'current' day;
- j) Consideration of BCUHB Board minutes throughout 2017, what they tell us about what do they tell us about current governance arrangements in BCUHB and Older People's Mental Health at BCUHB.

### 17.3 An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board<sup>163</sup>

#### **A Summary of Progress against Recommendations made in June 2013 by HIW/WAO**

**Date of publication:** July 2014 by HIW/WAO

A review of key issues which have relevance to a review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013 and relevance to a review of the systems, structures and processes of governance in Older Persons Mental Health to the current time.

#### **Introduction**

This report focused on the progress made by BCUHB against the 24 recommendations within the original and first joint Health Inspectorate for Wales (HIW) and Welsh Audit Office (WAO) review in 2013. The original report had made 24 recommendations.

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<sup>163</sup> <http://www.audit.wales/publication/overview-governance-arrangements-betsi-Cadwaladr-university-health-board>

The recommendations had been focused around six key areas of the systems, structures and processes of governance underpinning care provision across BCUHB:

- **Effectiveness of the Board and its sub-committees**
- **Management and clinical leadership structures**
- **Quality and safety arrangements**
- **Financial management and sustainability**
- **Strategic vision and service reconfiguration**
- **The way forward: recommendations for driving improvement**

This 2014 review highlighted that which many other external reviews (including multiple reports from HIW inspections across mental health and older peoples mental health) had advised the BCUHB Board. Whilst there was some evidence of progress a number of significant issues and concerns still existed. In 2014, now aged five years old BCUHB had a considerable amount of work to do before its systems, structures and processes of governance and management arrangements could be regarded as fully fit for purpose. (HIW/WAO 2014, page 4.)

Staff number 52 said the following in April 2017 of some members of the Board in role at the time: 'some were in denial at how bad things were, I think some people actually said they wanted to remain part of the Board because they wanted to be part of the solution. There were new Execs who'd come in but had.....been part of the organisation in the past.....so although they were seen to be new they weren't completely new or completely out with the culture within the Health Board...'

### **Effectiveness of the BCUHB Board and its subcommittees**

The 2014 Joint HIW/WAO review found that Board meetings were operating in a more professional manner and Board members now felt supported. Board development work was said to be underway in order to clarify roles, to foster cohesive working and establish sound working practices in terms of governance. (HIW/WAO 2014, page 4.)

Following the external review regarding infection prevention and control by Professor Brian Duerden in 2013, there had been significant improvement in the management of infection prevention and control. There had been a number of new Board posts appointed to including the Chairman, Vice Chairman, Executive Medical and Nurse Director roles. The primary concern had been the delayed appointment of the new Chief Executive – only commencing post in June 2014. There was also no Executive Director of Therapies and Health Sciences – (either interim or substantive) from October 2013 to August 2016, (with the then Executive Director of Nursing and Midwifery adding this to an already substantial executive portfolio from mid-2014 onwards.) A substantive Chief Operating Officer was appointed to the Board from September 2014 onwards

*“In 2014, now aged five years old BCUHB had a considerable amount of work to do before its systems, structures and processes of governance and management arrangements could be regarded as fully fit for purpose.”  
(HIW/WAO 2014, page 4.)*

*“Some were in denial at how bad things were, I think some people actually said they wanted to remain part of the Board because they wanted to be part of the solution. There were new Execs who'd come in but had.....been part of the organisation in the past.....so although they were seen to be new they weren't completely new or completely out with the culture within the Health Board...”*

Staff number 4 stated at interview with the Ockenden team that in 2013 there had been 'discussion live with the Board and the Independent Members about changing the management structure, about changing the approach to clinical programme groups, and that also involved a discussion about changing the executive structure.' Staff number 4 continued given the complexities of the WAO Report and the HIW report it was felt that a wholesale change of structure at that point in time, with the impending appointment of a new Chief Executive may well be more disruptive than it would be beneficial.. Therefore, the Ockenden team noted that further significant delay in the much needed change that was required in BCUHB occurred once again.

The major area of concern in 2014 remained BCUHB's failure to develop their integrated 3 year plan in line with the requirements of the Welsh Government. (HIW/WAO 2014, page 5.) In order to ensure both ownership and engagement BCUHB needed to ensure that it consulted fully with all clinical staff during any future service development. This was an area of continuing concern in the many staff interviews undertaken as part of this governance review throughout 2016 and 2017.

#### 17.4 Brief overview of outstanding actions required of BCUHB against the 24 recommendations from the 2013 HIW/ WAO review that have relevance to a review of the current systems, structures and processes of governance in Older Persons Mental Health

(Source: The 2014 Joint HIW/WAO report: see pages 6 to 21 for further detail.)

**R1** Further work was required to develop cohesive working relationships between Board members (page 6)

**R2/R14/R21/R22/R23** Following the additional short term capacity to support BCUHB the challenge remained to maintain the impetus, progress and the momentum generated by the support (page 7). Whilst additional turnaround support was secured, the challenge remained in a number of areas including financial sustainability and short and medium term planning. The BCUHB Board had not yet developed its integrated workforce and financial plan. There were a number of key roles filled by interim post-holders (see pages 7, 13, 18, 19, 20).

**R3** Risk management processes still required development as Board members were not believed to be sighted on the totality of the risks across BCUHB (page 8). Staff number 52, stated at interview in April 2017 'Corporate risks would come to the Board meetings but there were pages and pages of information which made it extremely difficult, ..... to play your part in the governance of that risk..'

*"In order to ensure both ownership and engagement BCUHB needed to ensure that it consulted fully with all clinical staff during any future service development. This was an area of continuing concern in the many staff interviews undertaken as part of this governance review throughout 2016 and 2017."*

*"Corporate risks would come to the Board meetings but there were pages and pages of information which made it extremely difficult, ..... to play your part in the governance of that risk.."*

Staff number 52 continued 'The methodology for rating them, and the methodology by which they appeared on the corporate risk register, probably left a lot to be desired..'

**R4/R7/R8/R9/R10/R12** An improvement had been noted in Board papers presentation and timeliness. Improvement was still required in the quality, breadth, depth and focus of Board papers was still required in order that the Board was fully equipped to focus on decision making processes. (See pages 9, 10, 11)

**R9/R12 R11** An evaluation of independent members perception of their ability to discharge their role effectively was required (see pages 10 and 11)

**R13 and R15** Organisational restructuring was currently on hold pending the arrival of the new Chief Executive, (see page 12.) The operational challenges of the CPG still remained, pending organisational restructure (see page 13)

**R16** Even though the formal reorganisation had not taken place the new Nurse and Medical Directors had actively and positively engaged with their clinical colleagues to clarify professional accountabilities, (see page 14)

**R17** The role of the Hospital Site Manager still remained unclear and job descriptions and roles and authorities required further attention (see page 14)

**R18** Whilst the Executive team had been strengthened further ongoing support would be required to support the clinical leadership functions (see page 15)

**R19** The Health Board had completed an urgent review of the monitoring and reporting of quality and safety issues. Subsequent revised arrangements had been put in place which had seen positive reporting. Ongoing work was required to ensure timely and effective 'Board to Ward' reporting on issues relating to quality and safety (see page 16)

**R20** The Health Board had strengthened the incident reporting system (including the escalation of concerns.) The number of unresolved concerns, complaints and serious untoward incidents continued to be substantial (see page 17). Board members in post at the time acknowledged this feedback and have acknowledged to this governance review that the Board still had significant work to do to improve its management of quality, safety and risk as well as the timeliness and quality of responses to complaints and serious incidents. This had been previously advised to the Board in two in-depth external reviews completed on 'concerns' in August and December 2013 by the NHS Wales Delivery Unit and the NHSWSSP.

**R24** There was no progression at the time of the 2014 Joint HIW/WAO review on the delivery of the North Wales Clinical Services review. This had significant impact on the delivery of older people's mental health services across North Wales.

*“Even though the formal reorganisation had not taken place the new Nurse and Medical Directors had actively and positively engaged with their clinical colleagues to clarify professional accountabilities.”*

*(see HIW/ WAO 2014, page 14 for further detail)*

*“Ongoing work was required to ensure timely and effective 'Board to Ward' reporting on issues relating to quality and safety.”*

*(see HIW/ WAO 2014, page 16 for further detail)*

## 17.5 Conclusion

Overall the 2014 Joint HIW/WAO review found that the Health Board had made significant progress regarding some key issues. However the pace of change was slower than expected and there remained many outstanding issues to resolve. The commencement of the new Chief Executive in role would be key to ensuring the embedding of change across BCUHB. This appointment commenced in June 2014.

At this time the Health Board's financial position was known to be precarious and the future shape of health services across North Wales required urgent attention in order to enable the delivery of a sustainable financial and workforce plan. Staff number 52, recalled at interview in April 2017 the time that the then CEO, was in place (June 2014 to early June 2015) said 'There were lots of good things happening, so you could feel the green shoots in certain places and you could feel things beginning to bed in, certainly around the structures.....I don't think all of the detail had been worked out ...there were bits of operational stuff that needed to be resolved, and I think when Y came in one of the great contributions he made was to just de-escalate everything and to put in the final bits of what needed to be done. That's probably a reflection of how X left and he wasn't here that long...'

The most concerning area in the joint 2014 HIW/WAO review which resonated with feedback from both the NHS Delivery Unit and the NHS Wales Shared Services Partnership in their separate 2013 reports around the concerns process was with regard to improving the timeliness and accuracy of response to complaints and serious incidents. HIW/WAO (2014) found that there was limited evidence across BCUHB of learning from complaints and SUIs. (HIW/WAO 2014 page 17.)

The joint HIW and WAO Report (2014) concluded that they would continue to monitor the Health Board to ensure the momentum was maintained. A review of progress was timetabled within 12 months.

### The Good Governance Institute (or GGI)

## 17.6 A review of the governance systems at Betsi Cadwaladr University Health Board (BCU) Draft\* Final Report (September 2014)

(\*The Ockenden review team has been informed by BCUHB that this is the final report with nothing further said to have been received in BCUHB after the 'Draft Final' version.)

*“The pace of change was slower than expected and there remained many outstanding issues to resolve.”*

*“There were lots of good things happening, so you could feel the green shoots in certain places and you could feel things beginning to bed in, certainly around the structures...”*

(Staff number 52 describing the position at BCUHB 2014 to 2015)



**Key Elements of the GGI review and its relevance to a review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013 – and current governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board.**

The report provides a high level overview of BCUHB and a brief insight into the history surrounding the 2014 Good Governance Institute (or GGI) review. This summary focuses on those issues relevant to an understanding of events leading to the closure of Tawel Fan ward. Staff number 52 described the lack of systems, structures and processes of governance within the CPG structure in early 2014, and told the Ockenden review team of a meeting with the senior management team of the CPG: 'I asked for some of the basic architecture of a...CPG as it was, business plan, a strategy etc, and none of that existed.....I found that quite a sobering moment.'

Staff number 52 continued at interview 'It was just the apparent lack of grip.... around operational issues...there appeared to be a gap between the senior management team of the clinical programme group and the Executive..

**17.7 What had happened before the 2014 GGI review? What had the BCUHB Board already been told?**

The GGI review followed on from the Hurst review and the Allegra review (both in 2012). There had also been an analysis of SUIs in the MHL D CPG by Professor Robert Poole to address concerns about the level of SUIs MHL D CPG compared with others in BCUHB. Poole (2012) examined the sharp rise in the number of SUIs in December 2011 and January 2012. Poole has subsequently advised the Ockenden review team that the work 'identified achievable improvements in the relevant SUI surveillance systems..' (Poole 2018 to Ockenden D). Poole concluded that 'although...improvement in the CPG could be achieved.....[it was] concluded that the main problems were due to the NHS Wales requirements and systems, and BCUHB wide issues.' Poole stated that 'improvement in the SUI surveillance system in the CPG would require significant staff time and changes in the management of SUIs at Health Board and Welsh Government levels..'

In addition to Poole (2012) the first (2013) and second (2014) joint review by HIW/WAO of BCUHB had taken place prior to the GGI commencing work in 2014.. There had also been the Public Health Wales and then Duerden reviews, (both 2013) following the C. Difficile outbreak at Ysbyty Glan Clwyd in 2013. There were further reviews on the management of complaints and concerns across BCUHB in 2013 with reviews by the NHS Wales Delivery Unit and the Welsh Risk Pool both focusing on the management of concerns – a 'Learning Lessons Assurance review' in the summer of 2013 and a further review of the management of claims and concerns completed in December 2013. In addition this governance review has considered a large number of reports arising from HIW inspections from 2009 to 2014 where recommendations and action plans remained unresolved over many years, despite assurances from BCUHB to HIW that changes would be made in a timely manner.

*"I asked for some of the basic architecture of a...CPG as it was, business plan, a strategy etc, and none of that existed..... I found that quite a sobering moment.."*

*"It was just the apparent lack of grip.... around operational issues...there appeared to be a gap between the senior management team of the clinical programme group and the Executive.."*

Many of the external reviews from 2012 onwards were commissioned by BCUHB and can be seen as a proactive response to the multiple problems facing the organisation. However there was little evidence of timely and effective pan BCUHB responses to the findings of these reviews with many recommendations carried forward from review to review and action plan to action plan.

## 17.8 What did the GGI find initially?

Following on from the reviews of 2012 and 2013 The Good Governance Institute (GGI) was appointed by BCUHB to carry out a further review of its governance systems. The GGI stated that there was a clear need to establish new systems of management and clinical leadership as well as the need to 'rebuild the Board around sound governance principles.' (GGI 2014, page 1.) These issues had all been recognised in a number of the previous reviews. Therefore the GGI were requested to support the development of sound and robust systems, structures and processes of governance at BCUHB.

Staff number 48, noted at interview that as late as 2014 – almost five years after the creation of BCUHB there was an absence of an integrated governance structure at BCUHB and that in the absence of that it was 'difficult for the Board to carry out some of its function..'. In addition and in the same year (2014) as the GGI review staff number 48 noted the concerns echoed in the 2014/2015 BCUHB Annual Governance Report which said that management of capital spend had been a further area where the Board had been subject to intervention from Welsh Government. (Following specific concerns raised with regards to the management of capital relating to the redevelopment of Ysbyty Glan Clwyd a number of changes had needed to be made to the way capital expenditure was managed by the Board at BCUHB.) These changes were supported by review from NHS Wales Specialist Services Internal Audit and a further external review from Capita.

Although not an external review concerning the systems, structures and processes of governance underpinning clinical issues such as C. Difficile or Safeguarding Adults, Deprivation of Liberty (DoLS) or the concerns process at BCUHB staff number 48 expressed concerns that this was another indication that the Board at BCUHB as late as 2014 had failed to have sufficient oversight and understanding of the systems, structures and processes underpinning the governance of capital spend involving millions of pounds of public money. (Staff number 48, at interview and the BCUHB Annual Governance Statement 2014/15, page 2.)

*“The need to ‘rebuild the Board around sound governance principles.’”*  
(GGI 2014, page 1.)

*“Board meetings that became so bogged down in the detail..... Lost the focus on strategy and holding the organisation to account.....They overly obsessed about detail. Some BCUHB Board members were described as being ‘more comfortable in detail than .... in their role of strategic leaders and being assured that the organisation is fulfilling its objectives....”*

## 17.9 Summary of key findings by the GGI in 2014 and from interviews carried out by the Ockenden team that have relevance to a review of current governance arrangements in Older People's Mental Health at BCUHB

### 17.10 The lack of a clear strategy and BCUHB objectives had continued to prevent the timely development of robust governance systems across BCUHB

The GGI found that in 2014 risk management and governance structures (e.g. Board committees and Executive management) 'floated' within BCUHB and did not work together to achieve common goals (GGI 2014, page 3.) It was said to be difficult for Board members to be assured on the key priorities facing BCUHB in a planned and structured way. Competing issues facing BCUHB could not be prioritised in respect of their impact on the organisation. Board and committee papers were found to still lack focus and were often repeated in a number of places. This led to lengthy, discursive and ineffective meetings. Staff number 20 described at interview 'the lack of anything strategic being done at the Board..... you would be in the Board for 9/10 hours....' Staff number 49 noted a lack of team working within the BCUHB Board with some new Board members bringing in new ideas and a new perspective.

Staff number 48, described at interview with the Ockenden team in March 2017 'Board meetings that became so bogged down in the detail..... Lost the focus on strategy and holding the organisation to account.....They overly obsessed about detail. Some BCUHB Board members were described as being 'more comfortable in detail than .... .... in their role of strategic leaders and being assured that the organisation is fulfilling its objectives....'

Other Board behaviours were said to remain a concern in a number of interviews held by the Ockenden team. At interview in March 2017 staff number 48 described Board behaviours in place in 2014 as ineffective and says: 'There were some who were passive and would wring their hands with despair that things had happened on their watch.....But did virtually nothing about it...there were those who were highly critical and wanted heads to roll with immediate effect despite what the process may say...And then there were those who were constructive....I have to say the constructive ones were in the minority.'

Staff 48 described some Board meetings as 'aggressive' and that there were 'quite upset both non-Execs or Execs who felt they had been bullied harassed, talked down or just completely ignored and embarrassed..' Staff number 20, agreed and described 'swearing at individuals' and some Board members 'being so demeaning (to individual members of the Board) in public Board meetings. Staff number 20 told the Ockenden review that on occasions behaviour at Board meetings was so bad that arrangements to allow staff to attend Board meetings for professional development 'to see the things that are discussed and see how a Board operates' had to be stopped.

*"The GGI found that in 2014 risk management and governance structures (e.g. Board committees and Executive management) 'floated' within BCUHB and did not work together to achieve common goals (GGI 2014, page 3.)"*

*"There were some who were passive and would wring their hands with despair that things had happened on their watch..... But did virtually nothing about it...there were those who were highly critical and wanted heads to roll with immediate effect despite what the process may say...And then there were those who were constructive....I have to say the constructive ones were in the minority.."*

The GGI found that development of the Executives, both as individuals and as a team, needed to be a priority. At interview a number of Board members acknowledged that in 2014, with BCUHB now approaching five years of age the BCUHB Board still did not function as a Board. Board members have acknowledged different groupings of Independent members 'old' and 'new' and different groupings of Executives, again 'old' and 'new'. Along with the then CEO and the Chair and Vice Chair these 'old' and 'new' groupings across Independent members and Executive members had yet to form a cohesive and effective Board team.

### **1. The GGI found that lack of Executive cohesion had resulted in defensive and ineffective responses to previous external reviews.**

This combined with the Executive team not provided with the authority to act over a prolonged period had resulted in a failure to implement remedial action plans arising from multiple previous external reviews. This has been seen on numerous occasions by the Ockenden review team in considering actions taken by the BCUHB Board following HIW and other inspections at a number of mental health inpatient units. A document shared with the Ockenden governance review team, and developed within the then MHL Division in August 2015 collates feedback from HIW reviews (some stretching back to February 2011.) Some of those historic recommendations remained 'not started' or still 'in progress' in some cases four years after the original HIW recommendations. 463 recommendations relating to the delivery of mental health care at BCUHB are listed within the document. The document is updated for the last time on 31st December 2015 with all the actions from the Holden investigation (2014) onwards remaining blank at that time.

While the GGI found there were action plans in place to respond to each of the previous external reviews, (and action plans arising from multiple HIW inspections as seen by the Ockenden team) there did not appear to have been sufficient agreement at Executive team level to give the plans authority and credibility across BCUHB. Ultimately the GGI review found no evidence of ownership at a corporate level and no responsibility and accountability for follow through of these action plans until completion. Staff number 52 stated in interview 'individual action plans were always developed so nobody was actually, up until this period in the Health Board, looking at them in a thematic way and seeing, again, what the pan Betsi issues were and how they could be responded to, to make sure that what was happening in Cefni wasn't actually happening over in the East as well, so some of the governance systems began to shift in the summer to autumn period of 2015..'

Staff number 4, stated at interview with the Ockenden team 'I've observed ... areas where yes action plans were perhaps not as rigorous or as thought through as they might be and some of those ... were then not followed through with the rigour that they perhaps should have been.' Staff number 4 stated 'I recognise the scenario of action plans not often getting finished.' Staff number 4 also reflected in interview with the Ockenden team upon 'delays in getting responses

*“Individual action plans were always developed so nobody was actually, up until this period in the Health Board, looking at them in a thematic way and seeing, again, what the pan Betsi issues were and how they could be responded to, to make sure that what was happening in Cefni wasn't actually happening over in the East as well, so some of the governance systems began to shift in the summer to autumn period of 2015..”*

*“Action plans were perhaps not as rigorous or as thought through as they might be and some of those ... were then not followed through with the rigor that they perhaps should have been.”*



to complaints' but also stated at interview there were 'a number of mechanisms that were used within the Board ... at times used to good effect in terms of learning lessons ... patient stories and safety bulletins which were regularly produced that focused on lessons learnt and implications for practice..'

## **2. The GGI (2014) found at BCUHB a historical practice of reducing risks which had prevented risks being escalated appropriately to the Board.**

The BCUHB Corporate Risk Register (CRR) and the BCUHB Board Assurance Framework (BAF) were said by the GGI to be unconnected to the corporate strategic view of the overall organization. The Board still lacked understanding of the real risks across BCUHB that could compromise achievement of objectives. The GGI described 'top down pressure' to reduce scores or to 'escalate fewer risks.' GGI described BCUHB as an organisation with an 'understandably strong' desire to 'recover from past difficulties' but stated that the message from the Board to the wider organisation had to be one of 'welcoming concerns and encouraging analysis and discussion of threats to the improvement of quality, safety and stability for BCUHB..' (GGI 2014, page 2.)

## **3. Structural concerns continued at BCUHB with ongoing difficulty in effective working across Hospital Management Teams (HMTs) and CPGs. (GGI 2014, page 2)**

The GGI Report, (2014) found that the CPGs still had different ways of managing risk. The corporate team therefore spent considerable time and effort in tracking progress across the multiple CPGs. The GGI said that this 'indicates that tracking the problem of inconsistency may be consuming more effort than the harder task of supporting CPGs to standardise...their local systems..' (GGI 2014, page 11) Communications between CPGs were also reportedly difficult. There was a group for Chiefs of Staff from CPGs to meet together but it was reported to be ineffective due to poor attendance. There was also a meeting held between the Chiefs of Staff and the previous CEO. This review has been informed by attendees at these meetings, (staff number 14 and staff number 21) that no minutes were kept (or are available) of these meetings for consideration by the Ockenden review team.

Issues with the CPG structure had been highlighted over many years by Independent Members at BCUHB (as advised by staff numbers including 16, 47 90, 100, 106 and 111.) This had also previously been highlighted by the joint HIW/WAO review of June 2013, which stated:

'The Health Board's organisational structure, based around Clinical Programme Groups (CPGs), is designed to support the aim of being a clinically-led organisation. However, problems have been evident for some time as a result of the imbalance in size of different CPGs and the shortcomings in connectivity between CPGs, geographical hospital sites and the Executive team. These have been exacerbated by weaknesses in the arrangements to hold CPGs to account on key aspects of financial and clinical governance'. (Quoted in GGI, 2014, page 14).

*“The Health Board's organisational structure, based around Clinical Programme Groups (CPGs), is designed to support the aim of being a clinically-led organisation. However, problems have been evident for some time as a result of the imbalance in size of different CPGs and the shortcomings in connectivity between CPGs, geographical hospital sites and the Executive team. These have been exacerbated by weaknesses in the arrangements to hold CPGs to account on key aspects of financial and clinical governance”*

(Quoted in GGI, 2014, page 14).



**4. It was essential to understand, describe and then enhance the capacity of the corporate and governance teams at BCUHB to deliver to frontline services at BCUHB.**

A model for how effective support to the CPGs could be delivered by the corporate teams and functions should be developed, to include the capability and capacity required and identification of priority areas.

The guidance on the Well-Led Framework for Governance reviews, (2014) was cited by GGI as being able to provide the BCUHB Board with a benchmark for good governance, and additionally provided for external review every three years. It also provided a range of Key Performance Indicators (KPIs) on good governance that would provide BCUHB with its own action plan for Board development needs. Further, if aligned with the Welsh Governance and Accountability Module<sup>164</sup>, (2012) then it could be rolled out as a useful tool for the other Welsh Health Boards enabling those Boards and the Welsh Government to benchmark Board effectiveness across Wales.

There was already a recognised need to strengthen the governance underpinning contracting processes at BCUHB and BCUHB was receiving support in this. GGI advised that this needed to include contracts for care delivered outside North Wales.

### 17.11 Next Steps for BCUHB following the 2014 GGI review and its Report

BCUHB was then undergoing a further year of transition. A new Chief Executive, had been appointed in June 2014. He had undertaken a programme of analysis of the Executive needs of the organisation which had happened in parallel with the GGI review/report which had been previously commissioned. This led to a consultation to implement a new organisational structure across BCUHB accompanied with a supporting strategic development programme.

As noted in previous external reviews throughout 2012, 2013 and 2014 in order that BCUHB was able to continue to perform and deliver at an appropriate level, GGI recommended a consistent configuration of governance systems, structures and processes throughout the entirety of BCUHB. This needed to be considered and developed from the ward(s) to the Board taking into account what was described by GGI as the 3 'tiers' in the BCUHB structure, (GGI 2014, pages 19 and 20):

The organisation (providing hospital, community and primary care across the six counties of North Wales)

The Executive team

The Board (see GGI 2014, page 19 and 20)

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<sup>164</sup> <http://www.wales.nhs.uk/sitesplus/documents/1064/Governance%20and%20Accountability%20Module.pdf>. Link accessed 13.11.17.

## 17.12 Overview of the Trusted to Care<sup>165</sup> Report June 2014 – Professor June Andrews and Mr Mark Butler – 2014

Following the publication of the independent review of care provided at the Princess of Wales Hospital and Neath and Port Talbot Hospital at Abertawe Bro Morgannwg Health Board (ABMU) by Professor Andrews the then Minister for Health and Social Care wrote to all Health Boards seeking assurance that the failings identified in the report, in particular those relating to the care of older patients were not to be found across NHS Wales. The Minister requested specific assurance in four areas where the care of older people was said to be compromised in ABMU these being:

- In giving patients their medication;
- In ensuring patients are kept hydrated;
- In the over-use of night-time sedation;
- In basic continence care.

BCUHB provided assurance to the Minister that there were no concerns regarding the quality of care received within the Health Board as part of the Health Board paper 29th July 2014. Staff number 52, stated at interview that a Task and Finish Group 'was convened by the then acting Chief Executive to develop a response to that report, and I think that was the first time that I'd seen the organisation actually do a piece of work that was rigorous in terms of quality assuring around the four elements of the Andrews Report..'

Staff number 28, in a written statement provided for the review described the BCUHB approach to providing that assurance as 'a series of unannounced visits to a significant number of inpatient areas across acute, community and mental health settings, to assess the culture, application of high quality standards and to listen to patients, carers and staff.' A BCUHB Board statement submitted jointly to the HASCAS review and the Ockenden review of Governance in March 2017 describes the process of assurance across BCUHB around the 'Trusted to Care' report as 'comprehensive and intensive.' (BCUHB 2017, page 15.) The BCUHB Board statement described that a number of actions were undertaken immediately as a result of these visits including monthly quality and safety audits at ward level and implementation of the All Wales Medication Safety Monitoring Tool. (BCUHB 2017, page 15)

## 17.13 Explanation of the NHS Wales Escalation and Intervention Framework

An escalation and intervention framework for the NHS in Wales was launched by the Welsh Government in March 2014 following a recommendation in the Welsh

*“A Task and Finish Group ‘was convened by the then acting Chief Executive to develop a response to that report, and I think that was the first time that I’d seen the organisation actually do a piece of work that was rigorous in terms of quality assuring around the four elements of the Andrews Report..”*

<sup>165</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Trusted%20to%20Care%20-%20An%20Independent%20Review%20of%20the%20Princess%20of%20Wales%20Hospital%20and%20Neath%20Port%20Talbot%20Hospitals%20at%20ABMU.pdf> (Link accessed 5th April 2018.)

Government Public Accounts Committee's report of December 2013 on Governance Arrangements at BCUHB.

Within the NHS Wales 'Escalation and Intervention Arrangements there are three levels of escalation above 'Routine Arrangements' (or 'business as usual.')

These levels are: Enhanced Monitoring, Targeted Intervention and Special Measures.

### 17.14 Targeted Intervention at BCUHB June 2014 onwards

Only five months after the arrival of the new CEO, in June 2014 Welsh Government made the decision in November 2014 to escalate BCUHB to a level of 'targeted intervention' as specified under the NHS Wales Escalation and Intervention Arrangements Protocol (March 2014). See the link<sup>166</sup> below for further information.

This decision was said to be based upon discussions held between the Welsh Government, the WAO and HIW. The aim of targeted intervention is to identify potentially serious issues affecting an NHS body in Wales and to ensure that appropriate and timely action is taken. Targeted intervention is designed to strengthen the capacity and capability of the NHS body to drive improvements in a timely way. Prior to the decision being taken BCUHB had previously been subject to multiple external reviews, stretching back to 2012, many of which have been considered within this report.

### 17.15 What was already known about BCUHB before targeted intervention?

Staff number 48, a former Board member summarised the position of BCUHB in late 2014 following multiple external reviews 'It was known the governance structures were needing to be reviewed, it was known the organisational structures needed to be reviewed. There was a dearth of quality leadership within the organisation and the clinical staffing groups were seen to be too focused on protection rather than on redesign and improving quality and outcomes....'

The Ockenden review team has been provided with correspondence between the CEO at BCUHB and the CEO of Welsh Government in October and November 2014. This correspondence has been provided to the Ockenden review team by the then CEO of BCUHB.

The correspondence between the two CEOs (Welsh Government and BCUHB) is dated from the 14th October 2014 when the then CEO had been in post at BCUHB just over four months. The letter dated 14th October 2014 from BCUHBs CEO described that BCUHBs 'forecast year end deficit at that time was £62.5 million, which is £27.5 million above the initial forecast of £35 million....'

*“Within the NHS Wales ‘Escalation and Intervention Arrangements there are three levels of escalation above ‘Routine Arrangements’ (or ‘business as usual.’) These levels are: Enhanced Monitoring, Targeted Intervention and Special Measures.”*

*“It was known the governance structures were needing to be reviewed, it was known the organisational structures needed to be reviewed. There was a dearth of quality leadership within the organisation and the clinical staffing groups were seen to be too focused on protection rather than on redesign and improving quality and outcomes....”*

<sup>166</sup> <http://www.wales.nhs.uk/sitesplus/documents/862/Att21iNHSWalesEscalationandInterventionArrangementsReportMarch2014.pdf>

The letter also describes that at 'initial review' of BCUHB [since the CEO took up post] had shown 'clear deficiencies' in a number of key areas' These are described in the correspondence as:

- Planning processes – described as 'cumbersome and insufficient to deliver the real structural change required';
- Management structures as 'not fit for purpose' with 'a lack of management focus, grip, skill set and capacity';
- Service delivery 'not embedded as a culture in the organisation.'

The letter provided to the Ockenden review a number of actions already underway including:

- 'Replacing interim Executive arrangements with a robust team;'
- Consulted upon the organisational structure with implementation now imminent;
- Commissioning of [named] external support 'to develop a robust three year plan to achieve sustainable service delivery and financial recovery...'
- Work from the Good Governance Institute, led by the Chairman was being progressed;
- Review of the financial reporting systems within BCUHB by the new Director of Finance.

The letter to Welsh Government requested that the then CEO of BCUHB was seeking 'to agree any support arrangements with [Welsh Government] such that they 'take assurance from rather than duplicate work currently in place' and also how any such support would pick up 'the themes from the previous Welsh Government Allegra review in October 2012 and the headlines from the WAO/ HIW review.' [Of 2013]

The response dated 17th October 2014 from Welsh Government to the then CEO described Welsh Government 'seeking to change [BCUHB's] escalation level and the actions and support that comes along with this..' This was described as happening 'within the revised escalation framework.' A number of letters following this have been provided to the Ockenden review team by the former CEO of BCUHB.

A letter dated 3rd November 2014 from the Deputy Chief Executive NHS Wales to the then CEO confirms that the status of BCUHB is changed from 'Enhanced Monitoring' to 'Targeted Intervention.' The reasons stated are:

- Concerns regarding the ability of BCUHB to deliver a revised financial plan;
- Significant concerns around the safety and quality of Mental Health services across BCUHB;
- The management and control of capital schemes, capital planning and capital financial control.

*“The aim of targeted intervention is to identify potentially serious issues affecting an NHS body in Wales and to ensure that appropriate and timely action is taken.”*

*“The letter to Welsh Government requested that the then CEO of BCUHB was seeking 'to agree any support arrangements with [Welsh Government] such that they 'take assurance from rather than duplicate work currently in place' and also how any such support would pick up 'the themes from the previous Welsh Government Allegra review in October 2012 and the headlines from the WAO/HIW review.'”*  
[Of 2013]

## 17.16 BCUHB, Targeted Intervention and support from Mrs Ann Lloyd CBE

The link to the Lloyd report<sup>167</sup> is found below.

The Lloyd report outlined the first stage of the targeted intervention – described in the report as the diagnostic review. This work was undertaken in December 2014/January 2015 and led by Mrs Ann Lloyd CBE. This 'diagnostic' review was just two months after completion of the 2014 GGI review. Mrs Lloyd presented her report to the BCUHB Board in March 2015. Staff number 48 summarised to the Ockenden review team the position of BCUHB in mid to late 2014 as 'It was a basket case, the whole of Wales knew it was a basket case....' Staff number 26 recalled being told by colleagues outside BCUHB, when considering a position with BCUHB in early 2016: 'You're having a laugh aren't you? It's a basket case?'

A number of former Board members described the culture underpinning governance at BCUHB as 'fractured' at the time in 2015. There was a variable understanding of good governance at Executive level. Former Board members explained to the Ockenden review that some Board colleagues had gained their experience in a limited number of organisations, meaning they had less exposure to different approaches than some of their colleagues.

*"It was a basket case, the whole of Wales knew it was a basket case...."*

*"You're having a laugh aren't you? It's a basket case?"*

## 17.17 Ann Lloyd on Financial Control at BCUHB

The independent review previously undertaken by Allegra (2012) identified significant financial failings and provided BCUHB with a plan for action and is commented upon within the Lloyd Report. Staff number 107, provided contemporaneous written evidence to the Ockenden review that in 2012/2013 there had been 'clear financial advice to the Health Board and its Committees on the seriousness of the situation and advice on how this should be addressed; this advice has not been fully supported by actions.'

In December 2014, the Board presented a range of potential cost savings in order to mitigate the increasing escalation of the BCUHB year-end deficit. Even with a challenging new savings plan (which had a risk of non-achievement in some areas) the forecast deficit at the end of the 2014/15 financial year remained at £27.5m. For the plans to deliver would require a robust Project Management Office (or PMO) approach, combined with effective partnership working with BCUHB's wider health and social care community. The PMO commenced its work in November 2014 and a new and substantive Chief Operating Officer had commenced in post in September 2014 with a new Director of Finance in post from August 2014.

In addition it was based on the assumption that there would not be requirement to repay the previous year's assistance from Welsh Government. It was imperative to ensure that the financial shortfall at BCUHB did not become a regular occurrence. A key theme from the Lloyd report (2014) was to prevent the culture

*"In 2012/2013 there had been 'clear financial advice to the Health Board and its Committees on the seriousness of the situation and advice on how this should be addressed; this advice has not been fully supported by actions.'"*

<sup>167</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Ann%20Lloyd%20Report.pdf>



of a Welsh Government 'bailout'. This was against the background that the new CEO believed that the resources within the organisation were sufficient to serve the population in BCUHB's catchment area. (BCUHB 2015, page 6).

It was noted by Mrs Lloyd (BCUHB 2015 page 6) that 'the new FD has exercised a grip on the management of money and reports the issues to the Board and the Finance Committee in a clear and concise way but ... cannot achieve success alone.....It is of concern that within the Board there is a sense of inevitability about the results'. The report goes on to state 'There is... a real need to ensure that the executive team and senior staff are very clear about the priorities they need to pursue, priority setting having been seen to be very variable in the recent past.' (BCUHB 2015, page 6). It continues 'To date all the action and responsibility seems to be vested in the FD<sup>168</sup> and the COO; action appears not to be regarded as a responsibility for the whole of the Executive team (excluding the MD<sup>169</sup> and ND who are wrestling with the safety and sustainability of services...' (BCUHB page 6.)

*“There is... a real need to ensure that the executive team and senior staff are very clear about the priorities they need to pursue, priority setting having been seen to be very variable in the recent past..”*

### 17.18 Key point: What actions did Lloyd require of the BCUHB Board? How many of these actions had they been told about before the Lloyd (2015) recommendations?

Most of what Lloyd set out clearly for the BCUHB Board was not new. The following summarises the recommendations made by Lloyd (2015).

1. Agreement of a pan BCUHB 'Clinical Services Strategy;'
2. The production of a 3 year plan, which demonstrates accountability for delivery and the road map to BCUHB's financial and service delivery recovery;
3. All financial plans presented to the Board committees to be fully worked up and have a full risk assessment;
4. The Board only to adopt financial plans when they are assured that the plans are fully aligned with agreed strategies;
5. BCUHB financial plans should in essence be SMART –Specific, (and practical), measureable (and realistic) and achievable. They must be supported by timescales, action plans and are supported by appropriately robust risk analysis;
6. The zero based budget approach can only be accepted if it is supported by clear and accurate clinical workforce performance and estates plans. The Board must assure itself that these are in place and are deliverable.
7. The recommendations from the Capita review regarding management of capital schemes was commended by the Lloyd review (2015).

<sup>168</sup> FD = Finance director, COO =Chief Operating Officer

<sup>169</sup> ND= Executive Director of Nursing, MD = Executive Medical Director

### 17.19 What did Lloyd (2015) find that was already underway in developing systems, structures and processes of governance?

The BCUHB Board was said to be in the process of developing a suite of local indicators including:

- Nursing quality measures which included 'I Want Great Care;'
- PMO efficiency;
- Caesarean Section rates;
- Staff turnover;
- Hand hygiene;
- Appraisal rates for medical staff. This approach was required as a result of continued deterioration of performance against a number of key performance measures resulting in safety concerns.
- The new Nursing and Medical Directors had made significant efforts to improve the quality of the care delivered across BCUHB;
- The Director of Nursing and Midwifery had made progress in resolving the poor response time and quality of responses regarding complaints and concerns. In January 2015, responsibility for Putting Things Right (PTR) regulations did transfer from the Executive Director of Nursing and Midwifery to the Director of Corporate Services.
- The new Medical Director had undertaken a 'Red Amber' Green' (or RAG) rating of clinical services in order to prioritise actions to further improve clinical care and reduce patient safety risks.

At December 2014 the organisation remained at escalation 4 on a number of high priority delivery areas (reflecting a continued failure to improve performance or to engage with the national process across the NHS in Wales in the following areas):

- **Staying healthy** – smoking cessation;
- **Safe care** – tissue viability/C. Difficile/MRSA/serious incidents
- **Dignified care** – postponed procedures;
- **Timely care** – RTT diagnostic waits/Emergency Department/ambulance response times/cancer/stroke.

All of these reflected a deteriorating position across BCUHB but with appropriate actions said to be in place to address the issues.

## 17.20 Summary of key points from the Ann Lloyd (2015) report

The Ann Lloyd Report (2015) followed on from a number of other external reviews from 2012 onwards that all highlighted the enormity of the effort that would be required by the whole of the Executive and leadership teams to enable BCUHB as an organisation to achieve the required improvement in its performance. This was in addition to a picture of repeated concerns found within HIW reports from 2009 onwards. Failure by BCUHB to achieve a significant improvement in performance across a number of fronts would continue to have a detrimental effect on patient care across North Wales.

## 17.21 Overview of Mental Health Services at BCUHB as described in external Reports and reviews and considered by Lloyd (2015)

There had been a wide range and large number of reports and reviews within adult and older people's mental health services reported since 2009. These both individually and collectively gave cause for concern about the quality and safety of care provided to patients across the service. (BCUHB 2015, page 12)

Reports from Healthcare Inspectorate Wales (HIW) seen by the Ockenden team regarding adult and older person's mental health services identified a significant number of areas for improvement. A number of these issues were raised by HIW to BCUHB over a prolonged period of time-sometimes many years before improvement took place. Examples included record keeping, fundamentals of care, staff supervision and training and development for staff, medicines management and clinical relationships in some units. Where the Royal College of Psychiatrists had reviewed some services it was said that their findings 'complemented the reports of HIW' (BCUHB, 2015 page 13). The Ockenden team agrees with this finding.

An interim Director of Mental Health had been seconded into the Health Board for one year to provide leadership and direction. One concern was that the performance measures used in Wales had rated the services as 'green'. (BCUHB 2015, page 13.) The evaluation of the quality indicators relating to mental health across Wales required review in order to enable Health Boards to detect areas of concern at the earliest possible time.

## 17.22 Action required in mental health services in BCUHB as of 2015

1. The new interim Director of Mental Health was required to make a full report against the existing action plans in response to the critical reports in order to provide assurance to the Board, its patients and their carers. This was presented to the BCUHB Board in March 2015.

2. To maintain the momentum of long term improvement, a senior nurse and Medical Director required appointment, dedicated solely to mental health services including CAMHS.<sup>170</sup>
3. The lack of clarity regarding the position of the Mental Health and Learning Disabilities CPG, (subsequently the Division) and its relationship to the BCUHB Board needed to be resolved.
4. The new Mental Health Director should be accountable to the CEO.
5. BCUHB was still required to develop its Clinical Services Strategy and a current 3 Year Plan.

Two further documents, pertaining to the 2015 Ann Lloyd report were provided by BCUHB to this governance review. These were notes (described as 'Draft') of an 'In Committee' session of the Board with Mrs Lloyd dated 23.10.15 and a lengthy action plan of 33 pages dated 29.1.16 described as a 'closedown report.'

The 'closedown' report titled 'Action Plan from Governance reviews and Ann Lloyd workshops: Closedown Report, January 2016.' is commented upon by staff number 28, in a written statement submitted for the Ockenden review. Staff number 28 describes that the 'closedown report' was 'collated and signed off by BCUHB and the Wales Audit Office in January 2016. It is important to note that a number of the recommendations made had now been superseded and were covered by the special measures improvement framework tracking of the progress of special measures.' Staff number 28 notes that this 'progress tracking' 'is reported monthly to public Board meetings and is overseen by a special measures improvement group chaired by the Vice Chair...' This process is described in the 'closedown report' as one of 'cleanse and transfer to special measures improvement plan.' (BCUHB 2016, pages 1 to 33)

The Ockenden review team has considered the 'closedown report' as an important element in assessing the progress made by BCUHB from 2012 following the large number of external reviews concerning BCUHB as described within this report.

Of the 24 recommendations arising from the Joint HIW/WAO reviews of 2013 and 2014 (pages 1-21) in January 2016 the BCUHB document describes that there were 14 risks rated as 'green' and there remained 7 rated as 'amber' and 3 as 'red.' This means that the recommendations from the original 2013 HIW/WAO report which had significant work still to progress as of January 2016 – (e.g. those graded amber or red) number 10 in total. In percentage terms this means that 42% of the recommendations made by HIW/WAO had significant work outstanding in January 2016 at a time of 'cleanse and transfer' to the Special Measures Improvement Plan.

Of the six recommendations from the Structured Assessment of 2015, (pages 22-24) there were 3 risks rated as 'green' and there remained 2 rated as 'amber' and 1 as 'red' in January 2016. This means that in percentage terms 50% of the 6 recommendations had significant work outstanding as of January 2016.

*“Of the 24 recommendations arising from the Joint HIW/WAO reviews of 2013 and 2014 (pages 1-21) in January 2016 the BCUHB document describes that there were 14 risks rated as 'green' and there remained 7 rated as 'amber' and 3 as 'red.' This means that the recommendations from the original 2013 HIW/WAO report which had significant work still to progress as of January 2016 – (e.g. those graded amber or red) number 10 in total.”*

<sup>170</sup> See Glossary

Of the 32 recommendations from the 2015 Ann Lloyd 'Targeted Intervention Report' (pages 25-33.) there were 11 risks rated as 'green' and there remained 17 rated as 'amber' and 4 as 'red' in January 2016. This means that in percentage terms 65% of the 32 recommendations had significant work outstanding as of January 2016, a year after delivery of the Ann Lloyd Report.

In addition to the significant actions outstanding from the number of external reviews above the Ockenden review team was provided by BCUHB with a separate lengthy action plan of nineteen pages in length, dated February 2016 for the outstanding actions still to be met from the Duerden review (2013.) Overall, the picture is of very slow progress on a number of areas of significant concern over a very prolonged period of time – now approaching six years since the first external review known to, this governance review – namely Hurst of April 2012. In addition there remained many outstanding actions from a range of HIW reports concerning the delivery of mental health services across North Wales stretching back to 2009.

By the end of October 2015 Mrs Lloyd is still describing the Health Board model as 'problematic.' The notes of the meeting state 'The Board is too big and the corporate objectives too woolly....' (BCUHB 2015, page 3). There was still ongoing discussion regarding the contribution of Independent Members to the Board.

It was further acknowledged that 'The Board operates in a difficult environment. This makes decisive action difficult....' (BCUHB 2015, page 4.) Echoing previous feedback from the HIW/WAO (2013) and the GGI (2014) the feedback from Mrs Lloyd states 'contributions (at Board) from Board members were reflective rather than developmental. Individuals must take collective responsibility.....the presentation of information outweighed discussion and decision making...' (BCUHB 2015, page 4). A number of Board members agreed and described lengthy conversations and contributions from some members with others contributing very little. A number of Board members referred in interview to repetition from Board members with an approach that could be described as 'round the table, everyone have a say' rather than a thoughtful, timely and appropriate consideration of the very significant issues facing the BCUHB Board at that time.

The Committee structure underpinning the Board which had been the subject of much discussion in the GGI report early in 2014 was further discussed. The notes of the meeting state 'There is much indiscipline in the running of meetings generally – some overrun by hours and practices such as having presentations and discussions on papers to note are a waste of time... (BCUHB 2015, page 5.)

### 17.23 A summary of key themes from the HIW Annual report 2014/15 that have relevance to a review of current governance arrangements in Older People's Mental Health at BCUHB

During the year HIW was engaged with an extensive level of activity within BCUHB. The annual report confirmed that HIW had conducted 72 visits to BCUHB

*“Of the 32 recommendations from the 2015 Ann Lloyd 'Targeted Intervention Report' (pages 25-33.) there were 11 risks rated as 'green' and there remained 17 rated as 'amber' and 4 as 'red' in January 2016. This means that in percentage terms 65% of the 32 recommendations had significant work outstanding as of January 2016, a year after delivery of the Ann Lloyd Report.”*

*“‘The Board is too big and the corporate objectives too woolly....' (BCUHB 2015, page 3).”*

*“‘There is much indiscipline in the running of meetings generally – some overrun by hours and practices such as having presentations and discussions on papers to note are a waste of time... (BCUHB 2015, page 5.)”*



plus a Special review. These visits were made up of 7 Dignity and Essential Care Inspections, (or DECI) 22 Mental Health Act inspections and a further 11 visits to BCUHB mental health units. (HIW 2015, page 1.)

There were a number of key themes that were apparent across all of the work undertaken by HIW at BCUHB, both inside and outside mental health. These are considered below as they have significant relevance to an understanding of the current governance arrangements in older people's mental health at BCUHB.

DECI inspections which HIW describe as a 'snapshot of the standards of care patients were receiving at that point in time.' (HIW 2015, page 2) said the following:

- The 'majority of patients were positive about the standards of care and treatment that they received.' (HIW 2015, page 2.)
- There was a recurring theme around 'patient documentation and care planning.' HIW found these issues were consistently found to be poor, both in terms of quality and its completeness. Nursing care records greatly varied. 'HIW could not always be confident that patients were receiving the necessary treatment in a timely way.' (HIW 2015, page 2)
- HIW stated that BCUHB staff were 'committed to delivering good quality care and they were kind and caring.' However in line with feedback from HIW reports in older person's mental health and feedback from interviews with front line clinical staff and managers as part of the Ockenden review HIW found issues with staff numbers, vacancies, resilience and skill mix. HIW found a high number of temporary bank and agency staff and overall 'a lack of effective management and leadership to help and support staff to deal with the day to day challenges and pressures they were experiencing.' (HIW 2015, page 2.)
- Staff members had very limited opportunities, such as team meetings and formal supervision meetings, to raise issues that affect them on a day to day basis;
- 'Staff were not routinely receiving feedback in relation to any concerns they raised or incidents that they may have reported. HIW were concerned by this 'as it could portray to staff that reporting incidents is not an important aspect of their role and that the Health Board may not be learning from incidents that occur'
- Patients did not have easy access to the complaints procedures and the leaflets seen by HIW were often out of date 'up to seven years in some instances.' (HIW 2015, pages 2 and 3.)
- HIW were concerned regarding staff access to training and noted 'difficulty in staff being afforded the time to complete mandatory training or training that was pertinent to their role in the provision of care for the client group.' (HIW 2015, page 3.)

*"The 'majority of patients were positive about the standards of care and treatment that they received.'"*  
(HIW 2015, page 2.)

*"HIW could not always be confident that patients were receiving the necessary treatment in a timely way."*  
(HIW 2015, page 2)

*"Staff were not routinely receiving feedback in relation to any concerns they raised or incidents that they may have reported. HIW were concerned by this 'as it could portray to staff that reporting incidents is not an important aspect of their role and that the Health Board may not be learning from incidents that occur.'"*

Across the provision of mental health in BCUHB HIW (2015) described 'several significant issues'.

- Inconsistency in the recording of staff training – with Deprivation of Liberty Safeguards (DoLS), Mental Capacity Act and Mental Health Act awareness training of significant concern. (HIW 2015, page 3.)

An excerpt from a divisional action plan dated August 2015 shows this as an issue raised as a concern by HIW in 2011.

MH0273	HIW visit		Ablett	centre		Staff Files	Staff training was recorded differently across all wards. A comprehensive system that is used by all wards should be introduced to ensure consistency across Ablett Unit and to enable an effective overall audit of training at the unit.	in progress	
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- 'Little evidence of any regular staff supervision meetings taking place within mental health services' This issue was of greater significance in relation to medical staff, with HIW finding that 'some medical staff had not received any performance management reviews.' (HIW 2015, page 3.)
- Deficiencies in relation to documentation. HIW said 'Mental Health Act documentation was not always completed, care plans were limited in nature and did not reflect the current treatment plans/observation levels and there were gaps in the medication administration records.' (HIW 2015, page 3.)
- Concerns in relation to the adequacy and relevance of some of the documented policies and procedures used by mental health services... lack of process in place to review policies and procedures to ensure that they were up to date and reflected the most recent best practice. HIW described an out of date policy in 'Rapid Tranquilisation' which was due for review in 2010, had a revised draft only in 2013, with no further work completed. Hence the policy was four years out of date.
- HIW recommended that a strategic review of the mental health services be undertaken by BCUHB to consider the range of services provided, the environment, and address the lack of adequate intensive care suite facilities for dealing with particularly challenging patients (HIW 2015, page 4.)
- Recruitment within mental health services was a concern with a significant number of Consultant and junior doctor vacancies. Concerns were raised by HIW around the lack of 'Responsible Clinicians'<sup>171</sup> in place.
- HIW found that ward staffing levels were inadequate in some instances which had the potential to affect safe patient care. (HIW 2015, page 4.)

*“Concerns in relation to the adequacy and relevance of some of the documented policies and procedures used by mental health services... lack of process in place to review policies and procedures to ensure that they were up to date and reflected the most recent best practice. HIW described an out of date policy in ‘Rapid Tranquilisation’ which was due for review in 2010, had a revised draft only in 2013, with no further work completed. Hence the policy was four years out of date.”*

<sup>171</sup> See glossary

## 17.24 Immediate assurance required of BCUHB by HIW in 2014/15

'Six immediate assurance letters were issued to BCUHB following DECI inspections. HIW noted that this equalled one immediate assurance letter for each DECI inspection undertaken – more than any other Health Board in Wales at the time. Two themes emerged which were also seen repeatedly in HIW visits to mental health units:

- Medicine Management – which includes the safe storage and recording of medicines given to patients;
- Staffing levels not being adequate for the acuity level of the ward.

*“HIW found that ward staffing levels were inadequate in some instances which had the potential to affect safe patient care.”*

(HIW 2015, page 4.)

## 17.25 BCUHB and 'Special Measures' and the relevance of 'Special Measures' to a review of current governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board

On 8 June 2015, the Minister for Health and Social Services indicated that he was placing the Health Board in 'Special Measures' (Welsh Government Written Statement 8 June 2015) The decision was taken following a meeting between senior Welsh Government officials, and staff from the Wales Audit Office and Healthcare Inspectorate Wales as part of the escalation and intervention framework within NHS Wales.

Correspondence between the then CEO and the Chairman of BCUHB dated 27th February 2015 has been provided to the review by the then CEO, (the recipient of the letter). The letter says 'The Health Board requires a complete rebuild and there is a need to tackle and resolve long standing and systemic problems with the Health Board and the services we commission and provide....' The letter describes the need for 'proper management and grip' and 'an increased pace of change and renewal.' The letter states 'I believe we make a strong and effective team that will lead BCUHB from the wilderness.'

*“The Health Board requires a complete rebuild and there is a need to tackle and resolve long standing and systemic problems with the Health Board and the services we commission and provide....”*

(Letter to CEO 27th February 2015)

At interview in March 2017 Staff number 49, described the situation regarding governance at BCUHB as 'special measures' was introduced. Staff number 49 described at interview that the standards of governance were variable with a culture of a lack of effective governance and new people coming into the organisation appeared not always to have been inducted effectively.

*“I believe we make a strong and effective team that will lead BCUHB from the wilderness.”*

## 17.26 Five key areas at BCUHB were cited as requiring demonstrable improvements as part of special measures

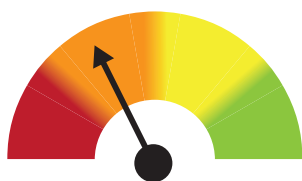
- a) On-going concerns about the governance, leadership and oversight of the Health Board, as highlighted in a number of joint reports in 2013 and 2014 by the Welsh Audit Office and Healthcare Inspectorate Wales, and in the subsequent work undertaken by Ann Lloyd CBE.

- b) Concerns relating to mental health services, most notably the serious care failings that occurred in the Tawel Fan Ward on the Ablett Unit of Ysbyty Glan Clwyd;
- c) The need to resolve the issue of consultant-led maternity services at Ysbyty Glan Clwyd, acknowledging the significant challenges associated with quality, safety and sustainability of these services;
- d) GP and primary care services, and in particular the need to address the concerns identified in a report on 'Out of Hours GP services that was commissioned by the Health Board; and:
- e) The need to reconnect and engage with the public, listening to the views of the local population in North Wales.

Staff number 49, described at interview that the BCUHB Board in 2015 was not functioning effectively, that there were varying levels of engagement by Board members, that the Executive team was of mixed ability with some individuals in particularly challenging roles. This viewpoint was replicated by a number of other interviewees and found within multiple external reviews already undertaken involving BCUHB and its Board. The external reviews stretch back to at least 2012, many with their findings and recommendations replicated multiple times. The Ockenden governance review team has considered all of these external reviews and considered carefully the feedback from multiple interviewees and conclude that by the time BCUHB entered 'special measures' in June 2015 there had been long term and well known failure at Board level at BCUHB for several years.

*“By the time BCUHB entered ‘special measures’ in June 2015 there had been long term and well known failure at Board level at BCUHB for several years.”*

This ongoing failure was further evidenced by the assessment undertaken by the Head of Internal Audit at BCUHB in 2014/15. This assessment concluded that the Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.



**This was regarded as an 'amber' risk for BCUHB. (See BCUHB 2015, page 30.)**

A further 'structured assessment' of the systems, structures and processes of governance at BCUHB took place in 2014 and is described in the Annual Governance Statement (BCUHB 2015, page 33.) This was undertaken on behalf of the Auditor General for Wales, by the Welsh Audit Office. (WAO) The results were presented to the Audit Committee in December 2014 and the conclusions of relevance to a review of the systems, structures and processes of governance within mental health and specifically older persons mental health are: The Board

has taken steps to strengthen governance arrangements, but the scale of the challenge remains significant and the pace of change needs to further increase:

- BCUHB recognises it has had issues with planning, change management and wider stakeholder engagement, although there were indications of positive progress;
- BCUHB continued to face a number of significant challenges and still needed to tackle issues relating to internal capacity, capability and culture in order to secure the improvements which were required;
- There was still an absence of clear plans for the reconfiguration of health services in North Wales, (with very limited progress since 'Healthcare in North Wales is changing' had been consulted upon in 2012;)
- There were significant barriers to progress and change in a number of areas including cultural, quality and safety issues absorbing senior leadership time but limiting the Health Board's capacity to drive necessary changes with sufficient pace. (BCUHB 2015, page 33.)
- The Annual Governance statement acknowledged that 'simultaneous change against a background of historic poor performance – and crucially limited capacity – increases risk of failing to prioritise and drive improvement' (BCUHB 2015, page 33.)
- Key areas for improvement still remained the need to focus on building public trust through openness, transparency and engagement, strengthening and standardising arrangements for staff to raise concerns and finalising and implementing the new clinical management structure.

*“Simultaneous change against a background of historic poor performance – and crucially limited capacity – increases risk of failing to prioritise and drive improvement”*  
(BCUHB 2015, page 33.)

## 17.27 The National Assembly for Wales – Public Accounts Committee 2016

- Consideration of the document 'Wider issues emanating from the Governance review of Betsi Cadwaladr University Health Board' (February 2016) and its relevance to a review of current governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board:

### What is the National Assembly for Wales<sup>172</sup>?

The National Assembly for Wales is the democratically elected body that represents the interests of Wales and its people, makes laws for Wales and holds the Welsh Government to account. (National Assembly for Wales 2016)

### Who are the Public Accounts Committee?

The role of the Public Accounts Committee, (also known as 'PAC') is to ensure that proper and thorough scrutiny is given to Welsh Government expenditure. The Committee will consider reports on the accounts of the Welsh Government

<sup>172</sup> <http://www.assembly.wales/en/abthome/role-of-assembly-how-it-works/Pages/role-of-assembly-how-it-works.aspx>



and other public bodies and on the economy, efficiency and effectiveness with which resources are employed in the delivery of public functions.

Following publication of the HIW/WAO reports into governance arrangements at Betsi Cadwaladr University Health Board (BCUHB) in 2013 and 2014, the Public Accounts Committee, (PAC) had closely monitored the implementation of the recommendations contained within the reports by receiving regular written and oral updates from both BCUHB and the Welsh Government. This monitoring by PAC had also provided an opportunity to consider how BCUHB had responded to being placed in 'Special Measures' in June 2015

Subsequently, the Committee decided to look more generally at governance arrangements for Health Boards across Wales and followed up issues arising from the independent review of the Princess of Wales and Neath and Port Talbot Hospitals, 'Trusted to Care'<sup>173</sup> by Professor June Andrews and published in May 2014.

This report summarised the work and findings of the Public Accounts Committee, and made a number of recommendations. The purpose of the recommendations made by the Committee was stated as to improve Health Board governance and strengthen performance management at both BCUHB and more widely across Wales. (National Assembly for Wales, 2016, page 5)

**Recommendations from the PAC that had significant relevance to the current systems, structures and processes of governance at BCUHB included recommendations on:**

1. Board leadership, Board development, the use of Board advisers and attendance at Board meetings;
2. Management of concerns and when it was appropriate for a Health Board to escalate concerns to Welsh Government;
3. The sharing of multiple sources of information across a health care system, in building 'intelligence' around a Health Board (e.g. sharing of information held by HIW and the Community Health Council). Arrangements for information sharing between HIW and the CHCs should be formalised;
4. The sharing of good practice across Health Boards in Wales.

The Public Accounts Committee also asked specific questions around the HASCAS investigation, the Ockenden governance review and concerns around Gwanwyn ward, (in the Heddfan unit).

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<sup>173</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/Trusted%20to%20Care%20-%20An%20Independent%20Review%20of%20the%20Princess%20of%20Wales%20Hospital%20and%20Neath%20Port%20Talbot%20Hospitals%20at%20ABMU.pdf>

## 17.28 The HIW Annual report for BCUHB 2015/16

The HIW Annual Report for BCUHB covering the period 2015/16 was published in August 2016. A summary of key themes with relevance to a review of the systems, structures and processes of governance in mental health and specifically older person's mental health were included within the report.

During the year HIW had conducted 48 visits to BCUHB of which 7 were Mental Health Act visits and 3 were Mental Health unit inspections. (HIW 2016, page 5.)

In BCUHB Mental Health services HIW said that patients were generally 'very complimentary about staff attitudes and approach and we observed a caring approach and a good rapport between staff and patients.' (HIW 2016, page 7.) However continuing long held concerns that the Ockenden review team first saw evidence of in HIW inspections of late 2009, HIW described that 'staffing levels ....found as inadequate on some of our inspections.' (HIW 2016, page 7.) Another long standing concern of HIW and expressed over a long period of time by former and current BCUHB staff was concern regarding 'the amount of time nursing staff were spending performing non-nursing tasks that was taking them away from patient care and the ward.' (HIW 2016, page 7.)

HIW also expressed concerns around the 'many maintenance and estates issues across our inspections....' (HIW 2016, page 8) and 'staff members who had not received any training or supervision for some time....' Staff number 13 told the Ockenden review team at interview in October 2016: 'it is so important around estates because if you don't look after the estates then it makes people feel they don't matter and that makes the patients feel they don't matter so it's really important how we do that.....where you see gardens overgrown, it's just not right. It's not right the staff are feeling that they have to come in and I've seen staff come in on the weekends doing the gardening....'

HIW (2016) found 'gaps in mandatory training..... supervision and appraisals needed attention.' Another long term issue found by the Ockenden review team in HIW inspections going back to 2011 was HIW's finding that 'considerable pressure on in-patient beds and during our inspections .... 100% occupancy on the wards. This prevented patients being able to return from home leave.' (HIW 2016, page 8.)

HIW stated that they had been 'provided with assurance' that BCUHB had 'taken the action necessary to address the improvements we identified in 2014-15'. BCUHB were said to have 'provided evidence to demonstrate this in the majority of matters.' (HIW 2016, page 12.)

*“Patients were generally ‘very complimentary about staff attitudes and approach and we observed a caring approach and a good rapport between staff and patients.’”*  
(HIW 2016, page 7.)

*“The amount of time nursing staff were spending performing non-nursing tasks that was taking them away from patient care and the ward.”*  
(HIW 2016, page 7.)

## 17.29 A Summary of Progress – Joint review<sup>174</sup> undertaken by Healthcare Inspectorate Wales and the Wales Audit Office' with recommendations that had significant relevance to a review of the current systems, structures and processes of governance at BCUHB. (June 2017)

### Introduction

This was the third joint report by HIW and WAO, and was published in June 2017 (previous reports were in 2013 and 2014 and are covered earlier in this report.) following the concerns raised regarding BCUHB. The 2014 joint review by HIW/WAO considering progress made by BCUHB since the original 2013 report in 2014 acknowledged that there had been significant improvements.

However in considering progress made since the 2014 joint review many of the proposals identified as necessary in 2014 had not been implemented and the pace of change had not been maintained. HIW said 'Several of the most pressing challenges that we identified in 2013 continue to remain evident, some four years after our original report.' (HIW/WAO 2017, page 4.)

The financial challenges faced by BCUHB combined with the lack of strategic plans for the development of clinical services across North Wales, (HIW 2017 page 4.) and the continuing concerns regarding leadership, governance and progress in BCUHB resulted in the Minister for Health and Social Services placing the Health Board in 'Special Measures' in June 2015.

As part of the special measures programme announced in June 2015 five key improvement areas were required of BCUHB:

1. Governance leadership and oversight;
2. Mental health Services;
3. Maternity services at Ysbyty Glan Clwyd;
4. GP and primary care services including 'Out of hours' services';
5. Reconnecting with the public and regaining public confidence.

(HIW/WAO 2017, page 5.)

The report was clearly stated not to be a review or assessment against Welsh Government's special measures assessment framework. The report followed the previous format of consideration of the four original themes from the 2013 and 2014 joint reviews:

1. Effectiveness of the Board and its committees;
2. Strategic planning and development of sustainable services;

*"It is so important around estates because if you don't look after the estates then it makes people feel they don't matter and that makes the patients feel they don't matter so it's really important how we do that.....where you see gardens overgrown, it's just not right. It's not right the staff are feeling that they have to come in and I've seen staff come in on the weekends doing the gardening...."*

*"Several of the most pressing challenges that we identified in 2013 continue to remain evident, some four years after our original report."*  
(HIW/WAO 2017, page 4.)

<sup>174</sup> <https://www.wao.gov.uk/system/files/publications/An%20Overview%20of%20Governance%20Arrangements%20-%20Eng.pdf>

3. Management and organisational structures;
4. Quality and safety arrangements.

### 17.30 Effectiveness of the Board and its Committees

HIW and WAO recognised the 'visible improvements' in the effectiveness of the Board and its Committees that had taken place since the 2014 review. (HIW/ WAO 2017, page 8.) The concerns relating to Board behaviour and Board cohesion were no longer apparent. The Executive were providing a stronger collective lead that was assisting BCUHB to progress a resolution of ongoing concerns:

- Communication with the whole Board had improved with the addition of the daily briefing circulated to the Independent Members;
- Board development sessions were described as well attended and they had been used constructively as part of individual development;
- Both Board administration and discipline had improved in line with timeliness, Board behaviour and etiquette and the content of Board papers;
- There were positive improvements with regard to Committee working however further work was still required to ensure that sufficient detail was provided without stepping into operational management function.

In interview staff number 52, told the Ockenden governance review team 'It now feels like a much more active team of Independent Members, it's a much more balanced skillset.....we have very open transparent conversations....and there's much more sharing of information and peer mentoring....so it is a lot healthier state than when I first came in...' In interview (April 2017), Staff member 16, noted the improvement in Board papers 'they are a lot better, because the message has got through about what we want..' Staff number 16 continued and discussed the current discipline around Board papers that still requires improvement 'You'll find that some people are saying oh, it's not ready today, we'll have to take it,.....so it's still getting people.... into that discipline.'

*"It now feels like a much more active team of Independent Members, it's a much more balanced skillset.....we have very open transparent conversations.... and there's much more sharing of information and peer mentoring....so it is a lot healthier state than when I first came in..."*

In interview  
(April 2017)

### 17.31 Performance management

Was found to be improving. (HIW 2017, page 8.) As BCUHB further developed its strategy this would need be an area requiring ongoing review and development. Staff number 4, said of the progress made to date 'I think there is a discernible difference. I think it is still work in progress and it's something the Board needs to be very mindful of over the next couple of years in terms of moving things forward, but I think there are some positive things there...' Asked at interview where BCUHB would score out of a possible ten staff number 4 replied 'Where would I put the organisation? Probably in the six or seven domain....' Staff number 16 also reflected on the situation as found in early 2014 and asked to 'score' governance out of ten, with ten being excellent and zero being extremely poor. Staff number 16 responds 'Probably about a three...' Reflecting on the situation in April 2017 staff number 16 responded 'about a seven....'

Reflecting on the progress made at BCUHB as of April 2017 at BCUHB Staff number 16 stated at interview with the Ockenden review team that 'on every indicator we're in a better place but we're nowhere near where we should be but there's been no deterioration in some of the performances, the staff survey results were all improved in terms of scores on the staff survey, across the board, but again not where they should be.....a Board that had in the past got used to mediocrity and its baseline was a bad baseline.....this (April 2017) is where we should have been then and it's not where we should be, but at least we're not getting worse....the Board has got itself now where it is a bit more confident, a bit more prepared for real change...the firefighting isn't as prevalent now....so we've got the platform...now is the era of real progress and change...'

In summarising the position within BCUHB in June 2017 staff number 19 was asked if the views of some colleagues describing BCUHB's progress as 'green shoots' was accurate. Staff number 19 responded to the Ockenden team 'I think it would be naïve and arrogant to think there is not significant further work to be done despite early "green shoots." We still have major challenges in relation to our financial position and do not yet have an approved 3 year plan. There is much to be done to rebuild the confidence of the public and our partners and all of that has an impact on the quality, safety and experience of care provided..'

Staff number 52 reflected on the composition of the Board in April 2017 and their ability to be able to move BCUHB forwards at appropriate pace and with appropriate rigour. 'The same people were around the table when I came into my role as had been there, certainly in the previous year and it creates an amount of difficulty. I think it's and it's just not around governance, there's an issue of capacity and capability in other key roles around the Board table, even today...'

### 17.32 HIW/WAO (2017) on strategic planning and the development of sustainable services at BCUHB

The Health Board was required as part of the NHS Wales Finance Act to prepare an Integrated Medium Term Plan. (IMTP) This was a statutory requirement. However, for a range of reasons (previously identified) BCUHB had not been able to approve an IMTP. In line with the special measures improvement framework, the Board had agreement from the Welsh Government that it could continue to operate on the Annual Operating Plan arrangements.

The 2017 joint HIW/WAO review found that positive steps had been taken as regards improving risk management at BCUHB. However there remained a requirement for continued focus on the balance of detail and content and ensuring the correct risks are identified, described, acted upon and escalated.

The WAO had noted that the Board in the absence of the IMTP have developed a Corporate Risk and Assurance Framework (CRAF). Whilst this was a pragmatic, 'workaround' solution, the lack of clarity around BCUHB's objectives could be a barrier to the development of a robust Board Assurance Framework. The review

*"On every indicator we're in a better place but we're nowhere near where we should be but there's been no deterioration in some of the performances, the staff survey results were all improved in terms of scores on the staff survey, across the board, but again not where they should be.....a Board that had in the past got used to mediocrity and its baseline was a bad baseline.....this (April 2017) is where we should have been then and it's not where we should be, but at least we're not getting worse....the Board has got itself now where it is a bit more confident, a bit more prepared for real change...the firefighting isn't as prevalent now....so we've got the platform...now is the era of real progress and change..."*



found that strategic development had not progressed in the short term. This needed to be an area for continuing future development.

Staff number 16 told the Ockenden review at interview 'it's a frustration that the organisation can't move forward more quickly.....because it doesn't have a plan...' Staff number 16 continued at interview 'The organisation's come from a place where it never had a clear strategic direction. It had 'Healthcare in North Wales is Changing' but that was almost like a picking bits of services rather than taking that overview'.

The Board's overarching strategic approach had been set out in 'Living Healthier, Staying Well'<sup>175</sup>.

There had been opportunities for the local population to become involved in the future direction of BCUHB via this initiative. (See link below for further information.) The 2017 joint HIW/WAO review cited a positive change in BCUHB's level of public engagement process and the current progress was found by the review<sup>176</sup> to be both comprehensive and continuing to develop.

HIW/WAO (2017) stated that they did not have clarity that BCUHB had 'the capacity and capability to deliver the complex change agenda that is needed.' (HIW/WAO 2017, page 20.) The original 2013 joint HIW/WAO joint review cited medical recruitment and financial sustainability of current services as an issue of considerable concern. There was little evidence of long term solutions identified in these two critical areas and without clear direction potential financial instability would impact on the ability of BCUHB to deliver the requirement of an IMTP

The delivery of this was critical to allow BCUHB to return to sustainable financial balance. Staff number 16 in interview in April 2017 noted 'On every indicator we're in a better place but we're nowhere near where we should be.....'

Overall the financial position in BCUHB was found to be unacceptable and untenable. The Board had led a pan BCUHB benchmarking exercise to identify examples of inefficiency. Whilst the understanding of the issues were becoming clearer, how this would be translated into the IMTP still lacked clarity. However the 2017 joint HIW/WAO review found the Board was beginning to address some key longstanding clinical issues. Staff number 16 agreed with the findings of the joint HIW/WAO review and stated at interview 'We're overspending and underperforming, so that's not good....And the frustration, what keeps me awake is the fact that we've got enough money, we just don't spend it terribly well, we're inefficient, we've got variations in outcomes clinically still.'

*“The same people were around the table when I came into my role as had been there, certainly in the previous year and it creates an amount of difficulty. I think it's and it's just not around governance, there's an issue of capacity and capability in other key roles around the Board table, even today...”*

*“The organisation's come from a place where it never had a clear strategic direction. It had 'Healthcare in North Wales is Changing' but that was almost like a picking bits of services rather than taking that overview.”*

<sup>175</sup> <http://wames.org.uk/cms-english/2017/12/north-wales-living-healthier-staying-well-consultation/>

<sup>176</sup> See example in link <https://www.bcugetinvolved.wales/lhsw>

### 17.33 HIW and WAO (2017) on BCUHBs Management and Organisational Structures

There had been significant work undertaken regarding the new BCUHB organisational structure which had been reviewed positively. The structure provided clear lines of accountability and allowed for increased capacity. The previous Clinical Programme Group (CPG) structure had been replaced with a new 'Divisional structure'.

HIW noted that three 'Area Directors', each for the areas known as 'east', 'west' and 'central' were in post and reporting to the Chief Operating Officer. These Area Directors had responsibility for community and primary care services as well as some services across North Wales (HIW 2017, page 21.) There were some notes of caution from HIW in describing the role of Area Directors in that:

The 'area roles' had taken a long time to establish, particularly around levels of autonomy and decision making authority;

Whilst the roles were regarded as largely positive, there were some concerns regarding the level of over commitment of the Area Director roles;

Where Area Directors held 'pan North Wales roles and responsibilities it was not yet clear if they had sufficient clarity of authority to drive the necessary service change.' (All HIW 2017, page 21.)

*“We’re overspending and underperforming, so that’s not good....And the frustration, what keeps me awake is the fact that we’ve got enough money, we just don’t spend it terribly well, we’re inefficient, we’ve got variations in outcomes clinically still..”*

### 17.34 HIW and WAO 2017 on Mental Health services at BCUHB

HIW noted that there were concerns regarding failure to escalate concerns about Community Mental Health teams. When progress was not achieved escalation did not happen (HIW 2017, page 23) but strengthened arrangements between BCUHB and the Local Authority had since been put in place. HIW noted that 'issues relating to quality and safety are now identified and reacted to more quickly than might have been the case previously.' HIW stated that 'The mental health service is at the start of a long journey and a sustained effort will be required to ensure that a culture exists which encourages issues to be acted upon quickly and effectively.'

HIW (2017) notes that 'There has been a concerted effort by the Health Board over the past 12 months to strengthen quality assurance arrangements in regards to mental health services. It is clear that some of the key appointments within this Division have had a positive impact.' (HIW 2017, page 23.)

*“The mental health service is at the start of a long journey and a sustained effort will be required to ensure that a culture exists which encourages issues to be acted upon quickly and effectively..”*

### 17.35 Quality and Safety Arrangements as discussed in the third joint HIW/WAO 'Overview of Governance Arrangements' at BCUHB (June 2017)

HIW/WAO noted that since 2014 significant revisions of quality and safety arrangements had taken place across BCUHB. In 2017 the Executive Director of Nursing and Midwifery became the chair of the Quality and Safety Group (QSG) with the Executive Medical Director the vice chair. The purpose of the QSG was to oversee the quality improvement strategy and to monitor clinical risks and seek assurance from its sub groups.

The HIW/WAO 2017 review observed that whilst the QSG was in its infancy it had a well-structured agenda with appropriate attendance and was focused on the correct issues. Areas for ongoing improvement included a stronger integration of risk management which would allow greater focus on clinical governance across BCUHB. Each Division now had its own QSE group. However the 2017 HIW/WAO review found that the introduction of the Quality Assurance Groups across the Divisions had been slow and there was variability in the effectiveness of the groups. The effectiveness of the QSG would be highly dependent upon the quality of information it received. Therefore there was limited assurance that correct issues were always being discussed and escalated appropriately. The review noted the BCUHB Board could still do more to engage with the medical workforce. This was commented upon by a number of consultant colleagues interviewed by the Ockenden team in between March and August 2017 including staff numbers 24, 31, 79, 39. These consultant colleagues fed back on a range of issues around the Board saying:

- They did not know the name of key post holders, (for example the BCUHB Medical Director);
- They did not know the names of any of the Independent Members (IMs);
- They did not see any members of the Board coming into their workplace, all of the consultants acknowledged there were emails, but most emails went unread because of pressure of work;
- Communication between clinical staff and the Board was often poor with the BBC and the local newspapers acknowledged as the place most clinical staff found out about what was happening at BCUHB;
- Some of the consultants were unsure about the names of the members of the MHL Divisional senior team, with the exception of the Divisional Medical Director. One consultant described seeing the Director for Mental Health once from June 2016 to January 2017.

*“Whilst the QSG was in its infancy it had a well-structured agenda with appropriate attendance and was focused on the correct issues. Areas for ongoing improvement included a stronger integration of risk management which would allow greater focus on clinical governance across BCUHB.”*

*“They did not know the names of any of the Independent Members (IMs)”*

*“Communication between clinical staff and the Board was often poor with the BBC and the local newspapers acknowledged as the place most clinical staff found out about what was happening at BCUHB.”*

### 17.36 2017 joint HIW/WAO review findings on Mental Health

The 2017 joint HIW/WAO review found that there had been a concentrated effort to improve quality assurance within mental health at BCUHB. (HIW/WAO 2017, page 23.) HIW/WAO stated that there had been some issues of concern with community mental health teams that had been raised by local authorities rather than within the MHL Division. (HIW/WAO 2017, page 23.) HIW/WAO were advised that arrangements for monthly joint oversight meetings between BCUHB and local authorities had now been strengthened. Staff number 54 described the governance structure within the MHL Division in the spring of 2017 'It's still very nascent and it's still quite new, some of the meetings are quite new, so some things will need to shake down...some things are being a bit overlapped.....'

It is stated by the 2017 joint HIW/WAO review that mental health services at BCUHB were beginning to emerge from a period of concern but the need for wider cultural change would not be rectified in the short term. There needed to be a continued emphasis on the early escalation of issues to ensure they were acted upon quickly and effectively. There would also be the need for BCUHB to respond effectively to the HASCAS and Ockenden reviews into mental health services once published.

### 17.37 The 2017 joint HIW/WAO review findings on complaints

Both the 2013 and 2014 HIW/WAO joint reviews identified concerns regarding the reporting, escalation, resolution and BCUHB organisational learning from complaints, concerns and incidents. This 2017 review noted an improvement in response time however there remained inconsistencies across the Divisions in complaint, concern and incident responses. There was still varied clinical input and a lack of co-ordination regarding organisational learning. This was said to have been exacerbated by staff shortages across the Divisions. Overall the 2017 joint HIW/WAO review found that there remained concerns that the BCUHB did not have consistent processes to ensure an effective response to complainant claims and incidents and found the lack of a process to ensure robust organisational learning across BCUHB.

Staff number 16 reflecting on the management of complaints in BCUHB in early 2017 said at interview 'I'm still unhappy about many of the things I see and read in concerns raised by people, what people want is a solution not a ..... long drawn out twenty page response.....'

*"I'm still unhappy about many of the things I see and read in concerns raised by people, what people want is a solution not a ..... long drawn out twenty page response....."*

In order to address the fragmented management of complaints, concerns and incidents, highlighted in the 2017 joint HIW/WAO review the Board responsibility for 'concerns' would be managed by the Executive Director of Nursing and Midwifery. This would be the fourth change in Executive leadership since the creation of BCUHB in 2009. Asked about the frequency with which the complaints and concerns portfolio at BCUHB had changed Executive leadership since 2009 Staff number 19 stated at interview 'That is a risk but it's a greater risk to have

left them where they were at those individual times.... Different Chief Execs have different views on how organisations should be run.....it's clear that the preferred portfolio holder is the Executive Director of Nursing and Midwifery, at an All Wales level.'

The concerns in the 2013 joint HIW/WAO review regarding quality, safety and governance arrangements at BCUHB were central to the report. The 2014 joint review had identified that more work was required. The 2017 joint HIW/WAO report indicated that the processes at BCUHB were evolving and still maturing. The main challenge remaining for BCUHB was to sustain the improvement to further strengthen accountability and authority. It was key that vacant posts were recruited to swiftly and that Area Directors were supported with appropriate management capacity. The quality and safety governance arrangements demonstrated effectiveness and evolving improvements. There needed to be a sustained focus to ensure consistency across BCUHB.

Staff number 16, a current Board member at interview stated 'Governance is about behaviours, it's not just about systems and structures.....I feel this organisation and the health service and people in North Wales deserve this to work properly..' (Staff number 16)

*“Governance is about behaviours, it's not just about systems and structures.....I feel this organisation and the health service and people in North Wales deserve this to work properly..”*  
(Staff number 16)



## 18 Chapter 10

### 18.1 The 'standing down' of the Mental Health and Learning Disabilities CPG

This occurred as part of a new structure for BCUHB involving the development of new 'Area' and 'Secondary Care' structures across BCUHB in late 2014/early 2015. The MHL D CPG was the first CPG to be 'stood down' in November/December 2014. The first part of that process was that the CPG was made accountable to an interim Director of Mental Health Services. A second interim Director of Mental Health followed the first when there was difficulty in recruiting to the substantive role of Director of Mental Health and Learning Disabilities for BCUHB despite the use of a recruitment 'Head Hunter' and UK wide advertisement.

Recruitment of a substantive Director of Mental Health and Learning Disabilities subsequently occurred with the new post holder in place from early May 2016. The post was subsequently made an Associate Director of the Board following the necessary approval by Welsh Government. Executive responsibility for Mental Health and Learning Disabilities transferred from the Chief Operating Officer to the Chief Executive at the beginning of April 2015 with the new Director of Mental Health and Learning Disabilities being directly accountable to the CEO.

The structures had improved clarity of accountability and local authorities had identified better engagement than previously highlighted. A number of challenges remained at the time of the 2017 joint HIW/WAO review. These included the volume of work required by the Area Director role and the large number of interim posts across BCUHB still reliant on agency and locum staff.

### 18.2 Describing lack of change in MHL D with the interim leadership team in place from 2014 to 2016

Many staff interviewed described the slow pace of change within Mental Health from the autumn of 2014. Whilst awaiting appointment of a substantive Director of Mental Health two interim Directors of Mental Health followed took up post, one following the other. Staff feedback on the eighteen month period with interim Directorship of the MHL D Division is mixed with many staff being extremely positive – particularly being positive about the visibility of the post holders. However, a number of staff describe the temporary nature of the structure over the next eighteen months as frustrating as it held up the change that was required. Staff number 54 told the Ockenden review team 'They either didn't know it needed to happen or they just didn't have the authority, maybe to make things happen because they were sort of temporary, interim people.'

*"They either didn't know it needed to happen or they just didn't have the authority, maybe to make things happen because they were sort of temporary, interim people.."*

Staff number 52, described asking the Senior Management Team within the CPG in late 2014 around the need to develop a Mental Health Strategy 'I remember having a conversation with the senior Management Team that said....we need to develop a strategy ...because you would expect to have one, their view was that

we had 'Together for Mental Health' from the Welsh Government and.....that should be adequate and I pushed back and said we need to at least contextualise that to our environment in North Wales.....'

In agreement with a range of other colleagues and a number of interim post holders taking up role following the removal of the CPG structure Staff number 1 described the governance systems in place in the Mental Health and Learning Disabilities, (MHLD) Division as 'embryonic' as of late 2016. Staff number 1 stated the term 'embryonic' 'would be fair in terms of describing the consistent approach to governance in late 2016. There have been interim Governance leads, there have been interim Director leads which have not helped because they have all had different approaches and views, so embryonic...yes because they have tried one thing, then it has waned and then they have tried something else..'

*“The governance systems in place in the Mental Health and Learning Disabilities, (MHLD) Division as 'embryonic' as of late 2016.”*

Staff number 27 told the Ockenden review team that governance where it existed in the CPG at the end of 2014 was 'very much around the Mental Health Measure<sup>177</sup> and very much around the Mental Health Act and what HIW might be looking at.....so outside of that there was very little governance.....the reporting mechanisms weren't properly in place.....not just for serious and untoward incidents but for incidents generally..' Staff number 26, a current Board member noted at interview with the Ockenden governance review team that in Wales 'the main metrics for Mental Health are the Mental Health Measure which is.....All Wales.....it's a very low level indicator.'

*“There have been interim Governance leads, there have been interim Director leads which have not helped because they have all had different approaches and views, so embryonic...yes because they have tried one thing, then it has waned and then they have tried something else..”*

By mid-2016 Staff number 26, at BCUHB described at interview with the Ockenden governance team that governance arrangements in place in the MHLD were still 'embryonic' and limited from a 'functionality perspective' in their ability to report in information both to the Division and into the 'corporate infrastructure' at BCUHB. Staff number 26 described a risk register at that time within the Division that was 'developed but it wasn't....being shared, it wasn't functional....they'd done it as a sort of desktop exercise..' Staff number 26 described that 'it did feel very much like firefighting..' Clinical Directors were described as 'just a title, they were just ploughing a lonely furrow. They had nothing around them, it was just a badge, whereas nowadays they have got the ... tripartite relationship of having a senior manager and a lead nurse working with them....'

*“It did feel very much like firefighting..”*

Staff numbers 13 and 26 described a number of positive developments within governance that were already in place by mid-2016. These included the assurance in place around the weekly MHLD Division 'Putting Things Right' or 'PTR' meeting. This was described by staff numbers 13 and 26 as a meeting:

- Attended by Clinical Directors from East, West, Central;
- Having representation from Quality and Safety leads and Heads of Nursing across the Division;
- To review all the Datix having been submitted in the previous week;

<sup>177</sup> See glossary

- At which multi professional discussions can be held to decide the correct level of investigation for each Datix;
- Where the timeliness of each investigation can be tracked;
- Where complaints, serious incidents, (SI's) claims, inquests can be reviewed;
- With 'real, live information we can work on instantly.' (staff number 13)

Staff number 13 described 'Numbers of Datix that were so high[in early 2016], it terrified me.' Staff numbers 13 and 26 also described a number of other developments in place by the end of 2016 including a Quality, Safety and Experience group, (with service user representation from Hafal<sup>178</sup>), a Patient Experience group, a Strategy and Partnership group and a Divisional Finance and Performance group.

Staff number 26 described at interview that if compared to the English NHS system the MHL Division 'would be a small to medium sized Trust.' However the management structure in place at the time did not reflect that. Staff number 26 described that below Director Level, there was a general manager, locality managers and matrons and 'no middle management, so there was no capacity at that level.' As a result of lack of management capacity staff number 26 describes 'no matter what the senior team were trying to do in terms of trying to ask people, to do things in a consistent way it was just getting lost.' The Senior Management Team was described as 'some sort of secret meeting that didn't communicate to people what was going on....'

Staff number 27 agreed and stated at interview: 'There was a huge big... I called it a chasm....' Staff number 27 also noted 'If this had been England [it] would have been a Mental Health Trust....' Staff number 26 said of governance in the Division as of mid-2016 that there was 'a total disconnect between.....two camps....the clinical side and then there was the corporate Divisional side....' Staff number 26 also noted the following in the MHL Division:

- No discipline around a meeting structure;
- No work programme;
- No cycle of business;
- A lack of awareness from members of the Divisional management team around work streams and work programmes that external consultants were working on.;
- Communication around governance was not 'joined up'.

Staff number 26 describes that whilst reporting through the Chief Operating Officer, which it had done until recently 'the Division didn't have the status...that it required to enact significant change....' At the time there was a lack of Board understanding regarding mental health with the Board being described by staff number 26 as 'very sighted on the specifics around Tawel Fan.....around special measures, very sighted around the special measures action plan...but generally...

*"No matter what the senior team were trying to do in terms of trying to ask people, to do things in a consistent way it was just getting lost.' The Senior Management Team was described as 'some sort of secret meeting that didn't communicate to people what was going on...."*

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<sup>178</sup> See glossary

quality, the whole spot light was on Tawel Fan.....' By mid-2016 staff number 26 described that from a corporate governance perspective BCUHB 'had really started to get their act together.' Staff number 26 described at interview with the Ockenden review team 'It felt a lot more joined up and a lot clearer around the governance structures, around how each of the sub committees of the Board fed into the Board..' Staff number 26 concluded 'the Board are well sighted now on issues of risk, quality, patient experience because of the papers that go through from the sub committees, particularly the QSE.'

A number of staff reflected at interview at the long term lack of an 'Older Adult' medical lead in Mental Health at BCUHB. The Ockenden governance review has not been able to ascertain why this leadership is not in place and when or why it was lost. The Ockenden review has been advised that medical leadership for older adults mental health was one of the aspects of medical leadership lost when structures were changed immediately post the closure of Tawel Fan ward. A number of staff have described to the review that at a time when that clinical leadership was most needed for Older Persons Mental Health it was lost and that the lack of replacement of this clinical leadership role continues to have implications for the service today. One member of staff told the Ockenden review 'When Tawel Fan was really very current and there were all the other issues about staffing, resourcing and everything we didn't have that.....it has felt a little bit rudderless... we could really do with a Clinical Lead for Older Adults .....we're trying to sort of change how things feel in older adults but.. It's very difficult when you haven't got that...person that advocates at high level...' Staff number 54 described the 'bit of a glaring lack that we don't have that key person....' The Ockenden review team understands that the role has yet to be replaced as of December 2017.

*"When Tawel Fan was really very current and there were all the other issues about staffing, resourcing and everything we didn't have that.....it has felt a little bit rudderless...we could really do with a Clinical Lead for Older Adults"*

A number of staff including 57, 38, 31 and 54 reflected at interview with the Ockenden team that within mental health, older person's mental health had felt like the lowest priority over a long period of time at BCUHB. Staff number 31 also reflected at interview on the loss of the Clinical Lead role for Older Persons Mental Health. Staff number 31 also advised the review that there is 'no leadership for older people, there is no medical leadership for older people....' Staff number 54 noted that front line staff were doing their best in the absence of a long term lead for older people but noted 'So the meetings have been a little bit less structured ...because we haven't really had that Chair.....'It [OPMH] does feel as if it's a bit rudderless..'

*"No leadership for older people, there is no medical leadership for older people...."*

Staff number 49 reflected on what was found within the Mental Health and Learning Disabilities, (MHLD) service at the time. Staff number 49 felt that the Mental Health Division was dispirited, with a lack of coherence and a lack of energetic leadership and ambition. BCUHB needed a team which was pushing for progress, offering BCUHB as an organisation solutions and having the ambition to support the delivery of those ambitions. This was not the situation within BCUHB at the time. Staff number 54 at interview in April 2017 reflected on a lack of staff support previously within Mental Health at BCUHB over many years and said 'If you've had years and years of not being supported by your management and of banging your head against walls with no effect at all, you learn not to do it, and so you learn not to put your head over the parapet and ....you just keep your head down...'

Staff number 54 considered progress some two years later and was positive about the way forward but honest about the limited progress to date. Staff number 54 told the Ockenden review team 'It's a process of evolution because it's still fairly new .....these things have only been in place about six months, eight months, maybe at the most.....the way forward is so different now than it was.....'

### 18.3 A recurring theme of lack of staff support in BCUHB for those staff working within and outside mental health services at BCUHB 2009 to the present day

Whilst this was not a specific part of the Ockenden governance review Terms of Reference a number of interviewees from outside and inside mental health have explained to the Ockenden team that at critical times BCUHB was not felt a supportive employer and situations were often handled very badly by senior managers and Executives and with a 'knee jerk' reaction at a time when staff most needed support. The numbers of staff relaying these concerns to the Ockenden governance review team were quite significant and therefore it is important that these findings are informed to BCUHB.

(This feedback was separate to and different to the actions taken around the closure of Tawel Fan ward, which have not been considered in this review of governance.) The following interviewees providing feedback around lack of support provided to BCUHB staff included staff numbers 11, 14, 25, 27, 30, 57, 58, 62, 65, 43, 35, 36, 69, 76 77 and 82. This perceived lack of support from BCUHB as an organisation, (not specifically referring to the former Mental Health and Learning Disabilities CPG or current MHLD Division) was not associated with any particular legacy area, e.g. East, West or Central but was felt across the organisation and at all levels of the organisation and was described by staff as being present over a very long period of time – since the formation of BCUHB.

Staff number 27 described to the Ockenden review team at interview their last day in employment in the NHS which was in BCUHB and told the Ockenden review team 'The most hurtful thing of all was I spent 30 years in the NHS..... and my last ever day was in Wrexham in North Wales, my last day ever and not a single Director or senior manager came and said goodbye to me..'

Many staff in their interviews discussed that the use of the grievance process was utilised widely across BCUHB with the example of a staff member making a complaint or taking out a grievance against another staff member. Both the person complained about and the complainant (both examples are found in the list of staff above) described that frequently investigations did not occur at all and that in some situations an investigation would be started, then halted or passed to several different 'investigation managers.' This meant that a 'complainant' and the person complained about would need to recount events to a number of different people, sometime over a prolonged period of time.

Some staff told the Ockenden review team that such processes were frequently left open and unresolved, sometimes for many years. In addition some staff including

*“If you’ve had years and years of not being supported by your management and of banging your head against walls with no effect at all, you learn not to do it, and so you learn not to put your head over the parapet and ....you just keep your head down...”*

*“The most hurtful thing of all was I spent 30 years in the NHS..... and my last ever day was in Wrexham in North Wales, my last day ever and not a single Director or senior manager came and said goodbye to me..”*



69 and 82 described to the Ockenden review that following the raising of concerns by individual staff members they themselves had a long period of suspension from duties imposed. These scenarios were said to have occurred inside and outside the MHLD Division but were not the focus of this governance review. The report author took advice from the Independent Oversight Panel where matters outside the MHLD division occurred. The staff members were advised to raise their concerns again within BCUHB but it was agreed that it would be noted within the report that staff from a number of specialities inside and outside the MHLD Division did contact the Ockenden review team to raise concerns about the systems, structures and processes of governance and staff morale at BCUHB outside the MHLD Division. Staff numbers 76 and 77 also contacted the Ockenden review team from outside the MHLD Division. They described high staff sickness levels, lack of management support when off sick, a lack of a line manager and a general belief that many staff across BCUHB are not supported. Others cited concerns around the 'Safe Haven' whistleblowing process within BCUHB with extended periods of over a year before resolution and again, multiple investigators appointed over a prolonged period of time. Overall staff stated that BCUHB did not welcome the raising of concerns via any route including the 'Safe Haven' route and some staff described feeling 'punished' by senior management for raising such concerns. This feedback was current as of May 2018 (just before the report went to print)

*“You should be making the organisation a positive place to work so people don't need to be resilient, it needs to be that way round..”*

Staff number 54 stated at interview in April 2017 that BCUHB still needed a whole new mind set around staff support and told the Ockenden team: 'You should be making the organisation a positive place to work so people don't need to be resilient, it needs to be that way round..' Staff 54 continued: 'So a little bit of finger pointing I think if people are off with stress, it's like oh really, still off with stress, ooh....we need to change that hugely so very much from the buildings people work in, they don't feel valued because the buildings are a bit tatty, to their work rota, to their line manager not having much emotional intelligence..... we're trying to get a whole range of things set up so that staff will actually feel that they are valued...'

*“So a little bit of finger pointing I think if people are off with stress, it's like oh really, still off with stress, ooh....”*

With specific reference to the Mental Health and Learning Disabilities Division the last eighteen months since the formation of the Division had started to be seen more positively by some staff 'I do feel that there is some movement and there's some action and some things have changed that needed changing..' Acknowledging the significant length of the journey ahead as of April 2017 staff number 54 said 'I'd say we're probably about a third of the way there, we're not even halfway yet. ...'

*“I do feel that there is some movement and there's some action and some things have changed that needed changing..”*

**The BCUHB Annual Governance Statement for the year 2015/16 considered with reference to a number of key themes relevant to a review of current governance arrangements in mental health and specifically older peoples mental health.**

The Annual Governance statement describes that during 2015/16 the Health Board had three different CEO/Accountable Officers in post. Post holder 1 was Accountable Officer until 8.6.15. Post holder 2 was appointed Accountable

Officer by Welsh Government from June 2015 until 28.2.16 following which Post holder 3 was then appointed as Accountable Officer with effect from 29.2.16. (BCUHB 2016, page 2.) This was a period of turmoil and change at the BCUHB Board not seen since 2013. The events are well known but are worthy of noting including in just one year:

The suspension of a CEO who had been in post for just under a year, (June 2015;)

The imposition of 'Special Measures' in June 2015;

An interim accountable officer/CEO in post for 9 months, from June 2015 to February 2016;

A third CEO taking up role at the end of February 2016;

The substantive Medical Director leaving for a new post elsewhere and an interim Medical Director once again, (from March 2016 onwards.)

Similarly the long term Executive Director of Nursing and Midwifery left BCUHB and an acting post holder was in place from April 2016 for three months.

There were also other changes at/around Board level including an interim Executive Director of Primary Care and Mental Health from March of 2015 to April 2016 and two interim Directors of Mental Health from August 2014 to May 2016.

The Annual Governance Statement described the start of the 'revised arrangements for operational services' that had commenced in May 2015. The purpose of these was to strengthen governance and accountability. These changes were a long awaited replacement for the former Clinical Programme Group structure. (BCUHB 2016, page 2.) The Annual Governance Statement **notes** further delay in implementation of the new structure and says:

'Following the imposition of special measures..... a number of concerns were raised with regard to the cost benefits of the new structure and some lines of accountability within it. As a consequence a 'pause' was introduced whilst further work took place to provide answers and assurances to the concerns raised.....' The position described in the Annual Governance Statement was that 'recruitment under way to posts in the new structure' (BCUHB (2016, page 2.) Once again, BCUHB was described as being 'part way through a change programme.' (BCUHB 2016, page 2.)

As a response to Special Measures BCUHB was described as developing 'a series of 100 Day Plans .... collectively aimed to ignite passion and drive to develop the Health Board and its staff in moving forward.' (BCUHB 2016, page 4.)

The Annual Governance statement for 2015/16 describes that HIW/WAO undertook a high level review of progress after four months of Special Measures. The advice provided by HIW/WAO was that BCUHB should remain in special

*“Following the imposition of special measures..... a number of concerns were raised with regard to the cost benefits of the new structure and some lines of accountability within it. As a consequence a 'pause' was introduced whilst further work took place to provide answers and assurances to the concerns raised.....”*

measures for the next two years. Progress and milestones would be reviewed every six months.' (BCUHB 2016, page 4.)

Staff number 28, provided a written statement for the Ockenden governance review and said that the decision for BCUHB to remain in special measures for a further two years was based on the need to 'tackle the long standing and systemic issues and develop longer term plans to ensure the Health Board is able to deliver high quality and sustainable services in the future.'

The Annual Governance statement for 2015/16 reports that The Deputy Minister for Health issued a Special Measures Improvement Framework to BCUHB on the 29.1.16 setting out expected improvement milestones over the next two years. These included, (amongst other areas) an expectation of improvement in four issues of long term concern which have been considered over the time span of this governance review.

- Leadership;
- Governance;
- Engagement;
- Mental Health. (BCUHB 2016, page 5.)

The Annual Governance Statement 2015/16 noted that BCUHBs approach to risk management was still subject to ongoing work and was now being supported by Ann Lloyd CBE as part of Special Measures.

(BCUHB 2016, page 21.)

**Principal risks to achieving the BCUHB corporate goals were said to include:**

- Failure to maintain the quality of patient services;
  - Failure to sustain an engaged and effective workforce;
  - Failure to engage with patients and reconnect with patients and reconnect with the wider public;
  - Failure to embed effective leadership and governance arrangements;
  - A new risk had been identified, that of the 'organisational culture' at BCUHB
- (BCUHB 2016, page 22.)

Mental Health services were described as a 'key special measures risk.' (BCUHB 2016, page 23.) The Annual Governance Statement described the focus on and progress in Mental Health services throughout 2015/16 'and the associated risks in relation to leadership, governance and the quality and safety of services.' (BCUHB 2016, page 23.) 2015/16 had seen the 'formation of a Mental Health and Learning Disabilities Division with the appointment of a substantive director with effect from 5.5.16. This post reports directly to the Chief Executive.

*“Mental Health services were described as a 'key special measures risk.'”*  
(BCUHB 2016, page 23.)

The Annual Governance Statement described that 'progress has been made in establishing user and carer engagement in the development of a Mental Health

Strategy. This was under development with engagement from a pan North Wales and cross sector Chief Executives' Leader and Chairs Group which would ensure the development of an integrated strategy for Mental Health and Wellbeing. (BCUHB 2016, page 23.) Staff number 54, explained to the the Ockenden governance review team at interview the progress made on the development and delivery of a Mental Health strategy as of April 2017 'We will have a Mental Health strategy ...we need some sort of implementation or delivery plan....it doesn't really feel that it's going anywhere very useful...I think we need to be more focused so it really needs to be taken in hand I think.'

It had taken almost seven years for BCUHB to have aligned mental health services with appropriate oversight from and line of sight/reporting directly to the CEO at BCUHB. Staff number 48, discussed at interview with the Ockenden team the mistakes made with the positioning mental health at BCUHB from 2009. Staff number 48 said 'Mental Health should not have been shoe horned under primary and community services....it shouldn't have been led by someone that had no particular interest and no particular expertise in actually what Mental Health for the future should look like. So I am critical of the previous regime.....I am critical of some of the Board members that allowed that to occur....'

In explaining the long length of time it had taken to appoint a substantive Director for Mental Health reporting to the CEO Staff number 48 stated at interview 'One of the issues that's interesting about Wales is the myopic view around actually who can be a Director, who can't be and what the reporting lines need to look like.....it was quite a challenge to have a Director that wasn't part of the establishment order appointed..'

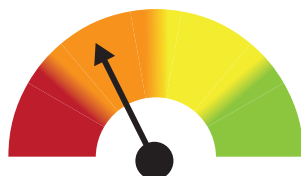
In Mental Health and Learning Disabilities the following were described as priorities for BCUHB:

- Responding to concerns;
- Listening and engagement were amongst those areas identified for focused service improvement in 2016/17 (BCUHB 2016, page 25.) The Annual Governance Statement described 'a very active programme of public engagement commenced during 2015.' (BCUHB 2016, page 30)
- The Annual Governance Statement described how BCUHB had 'taken the opportunity to strengthen its quality and governance arrangements in respect of 'Older People's Mental Health Services, governance and leadership and the quality of services for older people more generally.' (BCUHB 2016, page 29.)

*“Mental Health should not have been shoe horned under primary and community services....it shouldn't have been led by someone that had no particular interest and no particular expertise in actually what Mental Health for the future should look like. So I am critical of the previous regime.....I am critical of some of the Board members that allowed that to occur.....”*

## 18.4 Internal Audit 2016/17

As with the previous year Internal Audit advised that the BCUHB Board could take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review were suitably designed and applied effectively.



A number of internal audits were described as receiving limited assurance, including:

- Partnership governance arrangements;
- Putting Things Right – management of concerns. (BCUHB 2016, page 41.) This was three years after the completion of a number of external reviews into the 'concerns' function at BCUHB.
- In addition the Structured Assessment 2015 noted in its summary conclusions that a lot of work was underway to improve governance, but some fundamental challenges remained and required urgent resolution.
- Other performance work highlighted that variations in practice across BCUHB remained a challenge, although there were some signs of progress. (BCUHB 2016, page 42.)

*“A lot of work was underway to improve governance, but some fundamental challenges remained and required urgent resolution.”*

### 18.5 Was BCUHB an organisation that connected with its staff in 2016/17?

**No**

The Ockenden team has carefully considered feedback from within many staff and service user interviews and a wide range of internal and external documentary sources. All of these indicate that engagement with staff across BCUHB was generally poor in 2016/17 and had been poor (with limited evidence of improvement) for many years prior to this. Staff number 49 noted a sense of disconnect between BCUHB staff and the wider organisation that was BCUHB which then impacted on progress. Staff number 49 noted that it was not evident that BCUHB overall was a learning organisation, although there were some excellent examples in some parts of the organisation. Organisational learning had not, at that point in time become central to the organisational culture at BCUHB. The Ockenden governance review team found this evidenced by repeated external reviews many giving the same messages and providing the same feedback and recommendations that required attention by the BCUHB Board. The Ockenden governance review team found very little evidence of such action by the Board.

Staff number 20 reflected on this lack of engagement with staff and lack of utilising the skills and knowledge available to BCUHB as an organisation with reference to mental health. Staff number 20 described to the Ockenden team at interview looking for colleagues within the Mental Health services at BCUHB that were known to be of high calibre 'I found myself hunting for the good people..... and I was hunting and hunting for these people and you would eventually find them somewhere low down in the organisation totally demoralised, tucked away somewhere and completely forgotten about.'

*“I found myself hunting for the good people..... and I was hunting and hunting for these people and you would eventually find them somewhere low down in the organisation totally demoralised, tucked away somewhere and completely forgotten about.”*



## 18.6 The challenge remaining with Infection prevention and control at BCUHB by 2016

The Ockenden review team has been supplied by BCUHB with an internal action plan dated February 2016 reviewing progress in the three years since the original 2013 Duerden report. Staff number 1, a former interim Board member noted at interview that the BCUHB Board had clear awareness of where progress against the original 2013 Duerden recommendations had been slow. 'The improvements and the pace of that improvement and where he still saw that we needed to make those improvements have been clear.' Staff number 1 noted at interview that the BCUHB Board had been in receipt of three formal reports from Professor Duerden in total and associated with those reports an individual and then combined action plan with each of those reports.

Staff number 4, reviewing progress in infection prevention at BCUHB as of 2016 stated in interview that Duerden would 'observe there is still more to do in terms of some of the consistent application of practice and the following of guidelines....' In addition staff number 4 noted continuing 'issues around anti-microbial prescribing', the recruitment of a single medical leadership role for Infection Prevention across BCUHB. Other areas of the Duerden (2013) recommendations had been positively progressed including improvement in root cause analysis and the ward metrics programme.

Evidence of the slow progress made by BCUHB in meeting the Duerden recommendations from 2013 to 2016 is seen in the internal document provided by BCUHB titled 'BCUHB Infection Prevention Improvement Plan – v5 10th March 2014, Update for Professor B Duerden re: Outstanding issues February 2016' as provided to the Ockenden governance review team by BCUHB. This internal BCUHB document reports on the progress made by BCUHB in infection prevention and control since the original Duerden report of 2013, almost three years earlier. The document states that for BCUHB to implement an 'integrated infection prevention improvement plan' (BCUHB 2016, page 1) will require 'culture change, will require leadership and focus at all levels of the Health Board. This includes effective managerial, clinical and medical leadership focused on infection prevention improvement.....' (BCUHB 2016 page.1.) The action plan has within it:

14 aspects graded 'blue' described as 'completed, including ongoing arrangements where robust assurance is said to have been received to confirm it has become embedded practice.'

20 aspects graded 'green' described as 'on target for completion by deadline date.'

31 aspects graded 'amber' described as 'Delay or risk of delay but some progress is being made. Escalation may be required to CPG, Site and/or Executive lead....'

3 aspects graded 'red': Progress not being made, or very significant delay in progress. Escalation to Executive lead made.

(See BCUHB 2016, pages 1 and 2)

*“For BCUHB to implement an ‘integrated infection prevention improvement plan’ (BCUHB 2016, page 1) will require ‘culture change, will require leadership and focus at all levels of the Health Board. This includes effective managerial, clinical and medical leadership focused on infection prevention improvement.....”*

Within the aspects of the 2013 Duerden recommendations graded 'blue' described by BCUHB as 'completed, including ongoing arrangements where 'robust' assurance has been received to confirm it has become embedded practice' (BCUHB 2016, page 1) there still remains limited evidence around use of an appropriate 'lessons learned format'. Section 12.6 (BCUHB 2016, page 16) says 'lessons learnt format in use, but still not being used for every RCA (root cause analysis.)

In aspects described as green or 'on target for completion by deadline date' (BCUHB 2016, page 1) there remains limited evidence of review of ward dashboards which were intended to integrate data on infections and data on infection prevention standards of practice. (BCUHB 2016, page 10). The action plan states that 'Consistency of process, and review down to individual clinical level requires further development....' (BCUHB 2016, page 10).

The thirty one (31) aspects of the Duerden (2013) recommendations graded amber which BCUHB describe as: Delay or risk of delay but some progress is being made. Escalation may be required to CPG, Site and/or Executive lead....' (BCUHB 2016, page 1) are wide ranging and included low compliance with training (section 4.5, page 7 citing a training rate of 34% across BCUHB as of February 2014) and a lack of key leads in CPGs and Divisions for infection prevention and control. The summary states 'This has become less clear with the changed organisational structure, but there are some key leads in place and others are emerging....' (BCUHB 2016, page 8, section 4.6).

The three aspects graded 'red' described by BCUHB as: 'progress not being made, or very significant delay in progress. Escalation to Executive lead made' centre on workforce and included as of February 2016 the lack of a lead Infection Control Doctor, (BCUHB pages 4 and 9.)

The **HIW Annual Report for the year 2016/17 for BCUHB** considered a number of key themes of relevance to a review of current governance arrangements in older people's mental health.

During the year HIW conducted 24 inspections to BCUHB. This included 3 hospital inspections, 3 Mental Health Act visits and 2 Mental Health unit inspections. (HIW 2017, page 5.)

HIW stated that their inspections 'generally indicate that care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff.' (HIW 2017, page 5.) This had been the long term feedback from HIW stretching back to 2009.

- Improvements were required in relation to the timely referral and processing of DoLS assessments with this emerging as a consistent theme across several inspections in 2016/17.
- Staff training around aspects such as DoLS and Mental Capacity Act requires strengthening.

*“Consistency of process, and review down to individual clinical level requires further development....”*  
(BCUHB 2016, page 10)

*“HIW stated that their inspections 'generally indicate that care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff.' ”*  
(HIW 2017, page 5.)

- Work is required to ensure that documentation reflects the person centred approach to the provision of care. (All HIW 2017, page 5.)
- In Holywell Hospital in November 2016 HIW issued an Immediate Assurance letter in relation to delays in undertaking DoLS assessments.
- Improvements were also identified in relation to staff knowledge, understanding and lack of training with regards to DoLS in a number of care settings.

### **Mental Health – key findings:**

Another long term concern was raised again by HIW in 2016/17. This was around the completion and organisation of Mental Health Act documentation and care treatment plans needed improvements. HIW concluded from a number of inspections across a range of care settings that 'BCUHB needed to address its governance systems to ensure timely identification and escalation of any quality and safety issues.' (HIW 2017, page 7.)

In February 2017, HIW inspected Ysbyty Cefni. This was described as largely a positive inspection. HIW saw staff treating patients with respect and compassion. HIW said that care was 'provided in a patient centred and individualised way and care records supported this approach.' (HIW 2017, page 7.)

**The BCUHB Annual Governance Statement 2016/17 published in June 2017 considered a number of key themes relevant to a review of the current systems, structures and processes of governance in older person's mental health.**

Challenges remained at BCUHB, the Public Accounts Committee had published a report in February 2016, stating that BCUHB had more work to do to make its governance and management arrangements fully fit for purpose. This is considered within the Ockenden report. BCUHB entered a period of relative stability at the end of 2016, with all Board positions filled. Staff number 67 had stated at interview with the Ockenden team the challenge facing the Health Board in early 2016 was the structure at BCUHB 'hadn't really been fully implemented.' The challenge remained as of Spring 2017 for BCUHB 'to get some, senior people appointed to those posts and get some stability and appoint people of as high a calibre as they could possibly get and people with the experience that we needed for what is a very big organisation...'

Leadership capacity and capability had been a long term challenge for BCUHB from its inception in 2009. Staff number 1, discussed this at interview with the Ockenden review team stating 'I think there has been a lot of work to establish operational and accountability arrangement but there is still variance..... There is a mixed bag in terms of the profile of the strength of leadership across areas...'

Staff number 1 also noted a lack of Board understanding of the basic systems, structures and processes of governance that should have been in place from the creation of BCUHB. This lack of understanding still persisted until the time of interview in late 2016 according to staff number 1. At interview Staff number 1 reflected on fundamental issues and concerns still present in late 2016, seven

*“BCUHB needed to address its governance systems to ensure timely identification and escalation of any quality and safety issues.”*  
(HIW 2017, page 7.)

years after the formation of BCUHB and said 'I think the correlation and the understanding between a Board Assurance Framework and a Corporate Risk Register and then the CPG Risk registers and the link between what automatically passes from a CPG risk register (at a certain score) onto the Corporate Risk Register was not understood. I still think it is not completely understood....'

## 18.7 What do we know about 2016/17 at BCUHB?

The **HIW Annual Report for the year 2016/17 for BCUHB** considered a number of key themes of relevance to a review of current governance arrangements in older people's mental health

During the year HIW conducted 24 inspections to BCUHB. This included 3 hospital inspections, 3 Mental Health Act visits and 2 Mental Health unit inspections. (HIW 2017, page 5.)

HIW stated that their inspections 'generally indicate that 'care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff.' (HIW 2017, page 5.) This had been the long term feedback from HIW stretching back to 2009.

- Improvements were required in relation to the timely referral and processing of DoLS assessments with this emerging as a consistent theme across several inspections in 2016/17;
- Staff training around aspects such as DoLS and Mental Capacity Act requires strengthening;
- Work is required to ensure that documentation reflects the person centred approach to the provision of care. (All HIW 2017, page 5.)
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### Mental Health – key findings:

Another long term concern was raised again by HIW in 2016/17. This was around the completion and organisation of Mental Health Act documentation. It was also found that care and treatment plans needed significant improvement. HIW concluded from a number of inspections across a range of care settings that 'BCUHB needed to address its governance systems to ensure timely identification and escalation of any quality and safety issues.' (HIW 2017, page 7.)

In February 2017, HIW inspected Ysbyty Cefni. This was described as largely a positive inspection. HIW saw staff treating patients with respect and compassion. HIW said that 'Care was provided in a patient centred and individualised way and care records supported this approach.' (HIW 2017, page 7 on Ysbyty Cefni)

*"I think the correlation and the understanding between a Board Assurance Framework and a Corporate Risk Register and then the CPG Risk registers and the link between what automatically passes from a CPG risk register (at a certain score) onto the Corporate Risk Register was not understood. I still think it is not completely understood...."*

(Staff interview December 2016.)

*"Care provided to patients is kind, compassionate and effective, being delivered by committed and enthusiastic staff."*

(HIW 2017, page 5.)

*"BCUHB needed to address its governance systems to ensure timely identification and escalation of any quality and safety issues."*

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Staff number 1 also noted a lack of Board understanding of the basic systems, structures and processes of governance that should have been in place from the creation of BCUHB. This lack of understanding still persisted until the time of interview in late 2016 according to staff number 1. At interview Staff number 1 reflected on fundamental issues and concerns still present in late 2016, seven years after the formation of BCUHB and said 'I think the correlation and the understanding between a Board Assurance Framework and a Corporate Risk Register and then the CPG Risk registers and the link between what automatically passes from a CPG risk register (at a certain score) onto the Corporate Risk Register was not understood. I still think it is not completely understood....'

*“There has been a lot of work to establish operational and accountability arrangement but there is still variance.....  
‘There is a mixed bag in terms of the profile of the strength of leadership across areas...’”*

## **18.8 Safeguarding Adults at BCUHB after the closure of Tawel Fan ward.to the current day**

Progress in appointing to the role of Named Doctor for Safeguarding Adults was minimal from 2011 onwards. Every BCUHB Annual Safeguarding Report from 2011 onwards notes the lack of a pan BCUHB named doctor for safeguarding with no resolution. (See BCUHB Annual Report 2014-2015<sup>179</sup> p 14) and the lack of a named Doctor for safeguarding adults was noted as a 'weakness' in the BCUHB Annual Safeguarding Report covering the period 31.03.15 – April 2016 at BCUHB.

The Corporate Risk Register (CRR 4) noted in November 2013 'If the Health Board fails to provide the resources provided to respond to increasing demand for safeguarding services then as a consequence there could be an increase in

<sup>179</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/V%205%20%20FINAL%20SAFEGURDING%20ANNUAL%20REPORT%202014-2015%20PDF.PDF>



potential risk or harm to vulnerable people.' The risk score was recorded as '20' (red) in November 2013 and remained as '20' (red) in May 2015. In August 2015 an internal BCUHB email dated 14th August 2015, timed at 1105hrs provided to the Ockenden review states a decision was taken for the safeguarding risk to be:

1. 'Reworded/updated following comments from QSE and IGC and controls, further actions in place.
2. Risk ratings to be reviewed and recalculated based on further controls in place.
3. Risk to be de-escalated and managed at a strategic corporate nursing level'.

## 18.9 Continuing risks in safeguarding as of 2016

The subsequent and continuing risks in safeguarding 'were identified during a thorough diagnostic of safeguarding activities' undertaken between October and December 2016 following the appointment of the new and current Executive Director of Nursing at BCUHB.

This 'diagnostic' found that a number of risks associated with safeguarding including a risk to BCUHB 'of sanctions caused by significant failures to comply with safeguarding legislation (Mental Capacity Act and Deprivation of Liberty Safeguards' scored 25, (red). Other risks including that '40% of BCUHB staff are not trained in safeguarding leading to a risk that patient safety could be compromised due to staff not recognising a critical safeguarding indicator' and 'A risk that not all safeguarding events are recorded on Datix probably caused by poor uptake of training..' change to scored 20, (red.) In light of the continuation of very significant risks around the BCUHB safeguarding adults function in BCUHB remaining as late as 2017 the de-escalation of safeguarding that took place in August 2015 apparently removing it from the BCUHB corporate risk register therefore cannot be explained by the Ockenden governance review team.

By way of explanation, a senior member of the BCUHB team has suggested to the Ockenden governance review team that that the management of de-escalation of safeguarding to be managed at a 'strategic' level in August 2015 'had been noted previously as evidence of good practice in dynamic risk management.' Taking into account the failure of BCUHB to reduce the risk associated with adult safeguarding, (it was scored as 20 'red' in November 2013 and remained 'red' with a score of 20 in May 2015 and August 2015. It was then de-escalated from the corporate risk register at its long term score of 20, the risk was not reduced and safeguarding was re escalated to the corporate risk register in May 2016 at the same score. There is little in this scenario that the Ockenden team finds to be either good practice or 'dynamic' as regards risk management.

The BCUHB Annual Safeguarding report 2017-18<sup>180</sup> still reports significant risk with attendance at training 'that continues to be problematic.' (BCUHB 2018)

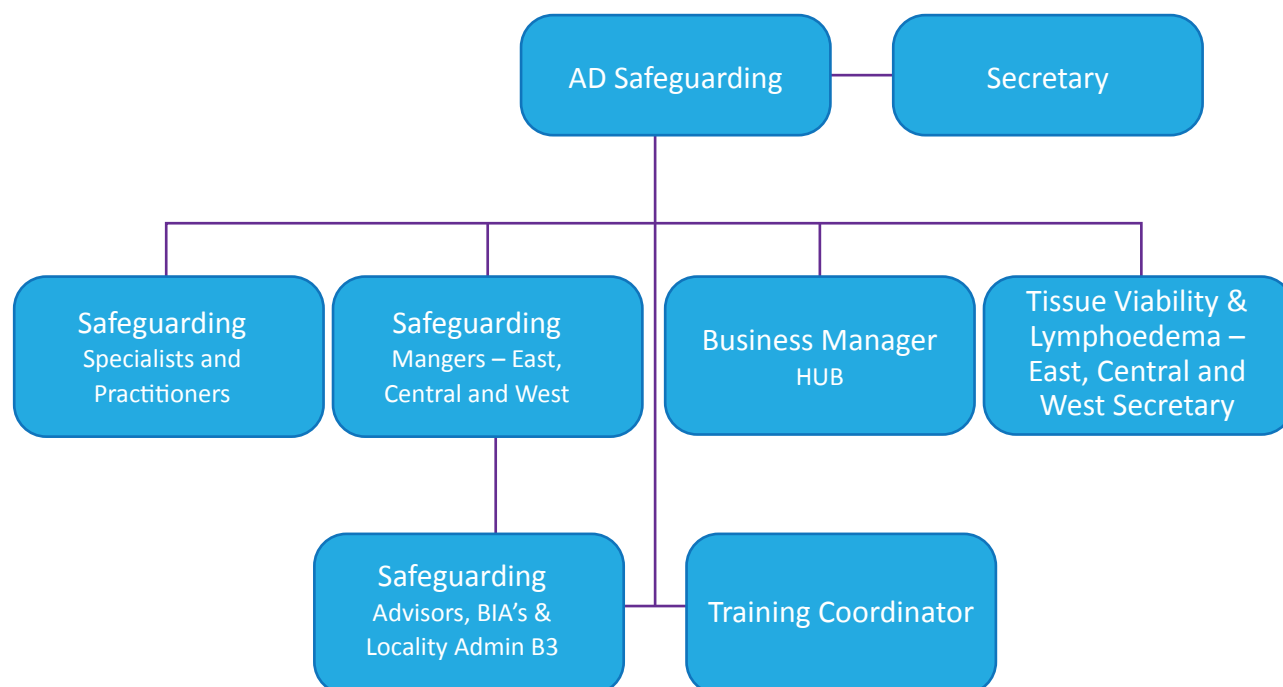
*"40% of BCUHB staff are not trained in safeguarding leading to a risk that patient safety could be compromised due to staff not recognising a critical safeguarding indicator"*

*"A risk that not all safeguarding events are recorded on Datix probably caused by poor uptake of training.."*

(Annual safeguard report 2017)

<sup>180</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/Safeguarding%20Annual%20Report%202017-2018%20Final\\_Post%20QSE.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/Safeguarding%20Annual%20Report%202017-2018%20Final_Post%20QSE.pdf)

and difficulty in achieving the required training at Level 1 (BCUHB 2018, page 8.) There has been long term absence within safeguarding team from the beginning of 2016 until the end of 2017. There remains a need for BCUHB to update its policies and procedures in line with the Social Services and Wellbeing Act 2014<sup>181</sup>. These BCUHB policy updates should have been in place prior to the implementation of the legislation in April 2016. On a very positive note, there has been significant investment in a new safeguarding structure under the leadership of the Executive Director of Nursing and Midwifery. An internal chart showing the recent safeguarding service redesign at BCUHB is reproduced below.



The above structure was undated but was provided to the Ockenden governance review team in March 2018 by the Executive Director of Nursing and Midwifery

Welsh Government confirmed to BCUHB in April 2017 in written correspondence to the CEO that progress had been made in a number of areas including governance arrangements, Board effectiveness, staff and public engagement, maternity services and GP out of hours services. Further work was said to be required on:

- Mental Health;
- Concerns handling and lessons learnt;
- Service planning and developing stronger working relationships with key partners.

<sup>181</sup> [http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw\\_20140004\\_en.pdf](http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf)

## 18.10 Continuing difficulties with information management in mental health services at BCUHB

This issue of difficulties with 'information management' within mental health services at BCUHB persisted at the time of completing the report, (December 2017) Staff number 4, had had advised the Ockenden review team at interview in 2016 'There is a new information system on the horizon. The Community Care Information System which will integrate health and social care ...is on the horizon and one of the priorities we have.....is to get Mental Health onto that system sooner rather than later, so it will be the Inpatient record and the Community record for mental health and it will connect with Social Services. There will be a single connected record.....that...is strategically a huge risk management and quality issue as well as an information management issue.'

Staff number 4 updated the Ockenden review team with progress in developing an information system across Mental Health in late November 2017. Staff number 4 said: 'The system...referred to is the 'Welsh Community Care Information System' which is a joint health and social care record system. Our intention to roll out first in mental health reflected the current deficit in access to integrated electronic records for community teams. The system will also support inpatient settings and therefore will provide continuity of access to information in different care settings. This is a national programme and we have pushed to be early adopters. Unfortunately there have been technical problems with the system which has introduced delays to its introduction. I.....do not have revised dates.'

## 18.11 Current progress with strategic planning in BCUHB as in the Annual Governance Statement 2016-17

This outlined that an annual 'Operating Plan' continued but that BCUHB believed it had 'a clear timeline for the development of the Health Board's overall strategy which will provide the strategic context for the IMTP' (BCUHB 2017, page 6.) The Annual Governance Statement 2016-17 described that 'three Strategic Framework documents' had been developed to meet the requirements of phase 2 of Special Measures. These included Mental Health services. (BCUHB 2017, page 6.)

Staff number 28, used a 'travel' analogy in interview to describe the journey BCUHB was on as of January 2017 and said 'If you use the analogy of saying right there is a strategy of going to Birmingham and you actually ask the question well are we going to go by car or by rail ..... what's the detail. If we start breaking it down to the detail of .....How that change will manifest itself in different communities, that .... tangible detail ... doesn't exist at the moment .....the Health Board has/doesn't have a problem in communicating those higher level descriptions of the direction of travel, but turning it into something tangible.

*"If you use the analogy of saying right there is a strategy of going to Birmingham and you actually ask the question well are we going to go by car or by rail ..... what's the detail. If we start breaking it down to the detail of .....How that change will manifest itself in different communities, that .... tangible detail ... doesn't exist at the moment .....the Health Board has/ doesn't have a problem in communicating those higher level descriptions of the direction of travel, but turning it into something tangible."*

By way of clarification and in a post-interview note staff number 28 added 'The Health Board is seeking to engage with communities to hear their views without having a preferred plan. This is a difficult balance as communities often don't want the Health Board to have a preferred option before engaging, but will also be concerned that they are being asked for views in the absence of a Health Board view where they might reasonably argue that the Health Board has the staff, resources and expertise to bring forward proposals.'

### Board Effectiveness and Standards in 2016-17

The Annual Governance Statement noted that Board Development sessions had continued throughout 2016-17 with Mrs Ann Lloyd. The WAO Structured Assessment 2016 stated that Board effectiveness had improved during the past year, with the Board beginning to behave like a team, with self-reflection, learning and improvement actions taking place.' (BCUHB 2017, page 10). WAO also found that committee effectiveness had improved during 2016, with evidence of better scrutiny and challenge by those committees. (BCUHB 2017, page 11.)

The work of the Mental Health Act Committee was described in considerable detail in the Annual Governance statement and had significant relevance to a review of the current systems, structures and processes of governance in older people's mental health at BCUHB. The Annual Governance Statement described a 'fundamental review of the data and format of presentation of reports.' (BCUHB 2017, page 16.) Other issues covered that are of relevance to this governance review were said to be:

- Deprivation of Liberty Safeguards reports including Authorisation Applications and risks in meeting the legislative timeframe;
- Review of the Independent Mental Health Advocacy (IMHA) Monitoring Report;
- Updates on HIW visits and reports.

The BCUHB Mental Health Act Committee were said to have acted upon a number of significant issues including:

- DoLS – the Committee had reviewed DoLS data for the last two financial years, the Independent Mental Health Advocate (IMHA) role and supporting data.
- Best Interest Assessor appointments and training, risk review and next steps in terms of the Service realignment.
- The safeguarding risk register has been reviewed within the Safeguarding Group chaired by the Executive Director of Nursing and Midwifery and the risk relating to DoLS has been discussed at length. The risk level remained unchanged at that moment in time pending completion of the training and full recruitment of the Best Interest Assessors.
- The HIW Annual Report for 2015/16 was published in August 2016. Within it there were references to reviews undertaken which specifically relate to the Mental Health Act. It was recognised that the specific elements relating

*“The Health Board is seeking to engage with communities to hear their views without having a preferred plan. This is a difficult balance as communities often don't want the Health Board to have a preferred option before engaging, but will also be concerned that they are being asked for views in the absence of a Health Board view where they might reasonably argue that the Health Board has the staff, resources and expertise to bring forward proposals.”*

*The safeguarding risk register has been reviewed within the Safeguarding Group chaired by the Executive Director of Nursing and Midwifery and the risk relating to DoLS has been discussed at length.*

to the Mental Health Act should have been presented to the Committee and therefore a change to future reporting arrangements was agreed.

- Performance monitoring – It was stated that the Mental Health and Learning Disabilities Division continued to improve the Mental Health Act/Mental Capacity Act and Mental Health Measures performance report 'and the Committee commended the work undertaken to date.'

**Consideration of work relevant to a review of current governance arrangements in Older People's Mental that was undertaken by the BCUHB Quality, Safety and Experience Committee:**

- Endorsement of the BCUHB Service User Experience Strategy from 2016 to 2019;
- Listening and Learning reports including a specific patient story;
- 'Progress report into standards for accessible communication';
- 'Putting Things Right' Annual Report;
- Welsh Risk Pool report into concerns and claims management;
- Endorsement of new and/or updated policies or procedures e.g. the BCUHB Being Open Policy, (which had originally been developed outside BCUHB in 2008/9).
- Safeguarding reports (including specific report on adult safeguarding);
- Mental health assurance and service development reports including the Tawel Fan mortality review; (in private committee.) (BCUHB 2017, page 18.)

The Committee was also said to have acted upon the following significant issues relevant to a review of current governance arrangements in Older Peoples Mental Health including:

- Concerns regarding the instability of the nursing home market place in North Wales and the reduction in nursing care beds which had impacted negatively on delayed transfers of care<sup>182</sup> performance.
- The Committee was concerned by risks highlighted by a safeguarding report, resulting in the revision of the corporate risk register and the establishment of new interim arrangements for the safeguarding team (BCUHB 2017, page 19.) The safeguarding 'Risk Description' as discussed at the January 2017 Board is appended below with an explanation as to how the 'risk score' is calculated. The Risk Description says 'There is a risk that the Health Board will fail to provide adequate resources to respond to increasing demand (including HASCAS) for safeguarding services. This is due to significant changes in the safeguarding team which could lead to an increase in potential risk or harm to vulnerable people.'

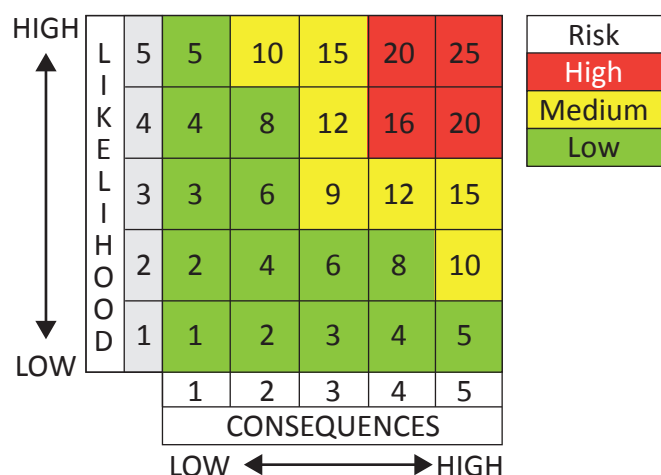
*“There is a risk that the Health Board will fail to provide adequate resources to respond to increasing demand (including HASCAS) for safeguarding services. This is due to significant changes in the safeguarding team which could lead to an increase in potential risk or harm to vulnerable people.”*

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<sup>182</sup> See glossary



**Risk rating (current)** Likelihood 4 x Consequence 5 = 20



**Risk rating (target)** 12 (target date) 31.12.2016

**Further action to achieve the target risk score was identified to take place over the next three months as the following:**

1. Further the resilience and capacity within the team through interim management arrangements and additional capacity procured from external sources; (Dec 2016).
2. Safeguarding Committee minutes to be reported to QAE/QSE – Assurance Reports to the QAE the gaps in the safeguarding structure were resolved; (March 2017).
3. Review of the resources needed to effectively manage the wider safeguarding agenda including DOLS, the MCA and dementia. Through this review ensure that any potential gaps are identified, managed and any risks are mitigated; (December 2016.)
4. Maintain ongoing discussion with Area and Secondary Care teams to ensure safeguarding support to operational safeguarding processes and put in place interim structures to ensure safe and effective systems and processes for safeguarding; (December 2016.)
5. Review previous briefing papers regarding administration and clinical safeguarding posts and consider the requirements of any additional requirement identified in light of the new legislation; (December 2016.)
6. Review the governance and reporting framework and accountability of the Deprivation of Liberties (DoLS) and Mental Capacity Act requirements for BCUHB. Confirm the funding required to support these requirements aligned with the legacy document handing over the responsibility for DoLS and other issues from the Executive Medical Director to the Executive Nurse Director. (December 2016.)
7. Engagement with Information Management & Technology (IM&T) to implement an agreed process to improve information sharing with

external agencies and implement safeguarding 'alerts' and similar using a consistent process; (December 2016.)

8. Identification of corporate safeguarding advice and support to enable a consistent approach to the support and monitoring of safeguarding performance indicators across BCUHB; (December 2016.) for Areas/Secondary Care/Divisions (December 2016.)
9. Formally review the joint agency management of paediatric and adult safeguarding processes with the operational teams to ensure compatible systems and clarity about any system wide improvements required; (December 2016.)

Principal risks to achievement of BCUHBs strategic goals were discussed. These included:

- Mental Health services, which was still described as one of BCUHB's 'top clinical risks.'
- Failure to engage with patients and reconnect with the wider public (BCUHB 2017, page 25.)
- Failure to embed effective leadership and governance arrangements. Staff number 1, noted at interview the continued inability of BCUHB to look at trends in analysing serious incidents and any subsequent learning from those incidents. 'Can we actually press a button to produce the trends and themes from all our serious incidents? No we can't....' Staff number 1 continued 'We cannot lay our finger at the moment on how many action plans have been completed, i.e. got all the evidence to show they have been completed and of those action plans, where are the issues that are BCU wide. Therefore trends for BCU or where the particular trends and themes (that are site specific or ward specific) and that data.....you cannot lay your hands on it...' (December 2016.)

The Annual Governance Statement 2016-2017 recognised that Mental Health services remained a key 'special measures' risk. BCUHB recognised that there was a significant challenge in sustainably improving mental health services across North Wales. Particular emphasis was being placed on addressing the key risks through the development of effective leadership and governance structures, supported by systems, structures and processes to underpin operational delivery, service development and the delivery of high quality, safe care.

*“We cannot lay our finger at the moment on how many action plans have been completed, i.e. got all the evidence to show they have been completed and of those action plans, where are the issues that are BCU wide. Therefore trends for BCU or where the particular trends and themes (that are site specific or ward specific) and that data..... you cannot lay your hands on it...”*  
(December 2016.)

## 18.12 Compliance with the Mental Health Measure in 2016-17

Compliance with the Mental Health Act and Mental Health (Wales) Measure had improved. Exception reports into the Mental Health Measure were received at the BCUHB Board when performance did not meet the expected target. As an example in March 2017, the BCUHB Board received an exception report into BCUHBs performance on the Mental Health Measure – Adult when the BCUHB performance was below target for both the percentage of assessments undertaken within 28 days of referral, and the percentage of therapeutic interventions within 28 days of assessment.

When this occurred the BCUHB Board reports described a detailed recovery plan including additional support, training and advice in the Mental Health Measure, extraordinary performance meetings and a greater sophistication in reporting arrangements.

Exception reports to the Board were also presented when the performance by the MH & LD Division as regards valid Care and Treatment Plans (CTPs) fell below the required level. The Mental Health Measure requires all relevant patients in receipt of secondary care services to have a valid CTP. The Ockenden review of governance was advised by senior staff members at BCUHB that prior to 2017 DoLS remained under the Executive portfolio of the Executive Medical Director but with a 'safety net' of reporting to the Corporate Safeguarding Sub Committee to support triangulation of data, information, risk and activity. From 2017, the Ockenden team was advised that arrangements were secured to move the management of DoLS (as had been planned in 2016) into the Corporate safeguarding team under the accountability of the Executive Director of Nursing and away from the portfolio of the Executive Medical Director.

### 18.13 Improvements in governance in the Mental Health and Learning Disabilities Division in 2017 as described in the BCUHB Annual Governance Statement 2016-17

Improvements were said to have been made to internal governance arrangements within the Division. A new strategy for mental health services was under development, with expert external input. A formal patient engagement strategy for Older Adults' Mental Health had also been developed. A mental health experience sub-group was said to have been established, to utilise service user and carer experience of services to shape and inform future service development and improvement. Staff number 54 told the Ockenden review team 'I think we've done all the preparatory work through the development of the strategy and ....the proof of the pudding will be in the delivery but I personally feel that we are nearing that...jumping off place.'

Asked to score Mental Health service provision between 0 and 10 staff number 52, responded at interview 'Probably edging towards a 6....Not because we might always be performing at a 6 but we know what our issues are now and we know how we're going to get to where we need to get to.....I don't think people had a clue and I don't think the wider organisation was sighted on where it needs to get to, that is now not the case.....I just think everybody is very aware now of Mental Health Services and that absolutely wasn't the case three years ago.'

In May, at the BCUHB Board meeting (18th May 2017) the BCUHB Board received a presentation on 'Special Measures – Mental Health Improvement Update'

The representatives of the Division delivered a presentation which provided information on:

- A three phase plan which had been established as a result of the recommendations of special measures;

*“I think we've done all the preparatory work through the development of the strategy and ....the proof of the pudding will be in the delivery but I personally feel that we are nearing that... jumping off place.”*

*“Probably edging towards a 6....Not because we might always be performing at a 6 but we know what our issues are now and we know how we're going to get to where we need to get to.....I don't think people had a clue and I don't think the wider organisation was sighted on where it needs to get to, that is now not the case.....I just think everybody is very aware now of Mental Health Services and that absolutely wasn't the case three years ago..”*

- Achievements (e.g. Patient Experience Group, the role of CANIAD, listening and learning and use of real time feedback system and the Divisional quality & safety group);
- The role of the 'Putting Things Right' group to review incidents, concerns and identify themes;
- Falls prevention work with a focus on older person's mental health;
- Progress with managing and monitoring incidents with a stated 50% reduction in numbers awaiting review;
- Embedding risk management;
- Key risk areas; which were stated to be the out of hours services, capital funding and the Divisional workforce;
- Detail of the learning disability care bundles;
- Information on a 'Learning Event' held in January 2017 including focus on a carer's story;
- A focus on best practice;
- Next steps for the Division.

The Board noted the paper, recognising the substantial progress that had been made but acknowledging the amount of work still to be done within mental health services in North Wales.

#### 18.14 Risk Description around the potential risk of poor care provision in the MHLD 2017 (March 2017)

'There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which can result in poor quality outcomes for patients.

**Risk rating (current)** 15 (described as a medium risk)

The score is made up possibly of 3 as a likelihood multiplied by 5 as a consequence giving an overall score of 15

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Risk
High
Medium
Low

*“There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which can result in poor quality outcomes for patients..”*  
(March 2017)

**Risk rating** (target) 9, remaining a medium risk on the matrix below.

**Assurance:** More than twenty five actions were listed, as taking place to reduce the risk that patients receive inappropriate care within Mental Health services at BCUHB due to failings due to failings in leadership and governance at all levels within the Division which can result in poor quality outcomes for patients. (see below), thus underlining the very significant efforts made to improve the provision of mental health care and specifically older person's mental health care in BCUHB.

### 18.15 Meeting the recommendations from HIW visits in the MHL Division – the progress as of 2017:

The BCUHB Annual Governance statement 2016/17 said that: 'All recommendations identified by HIW following inspections of mental health and learning disability sites have either been progressed or fully completed.' (BCUHB 2017, page 27.) This proved to be incorrect later in the year following an HIW visit to the Ablett Unit in November 2017. HIW said that the visit to the Ablett unit 'was in response to an increased number of reported incidents at the unit over previous months.' (HIW 2017, page 2.) HIW had last visited the Ablett Unit in June 2014. They concluded that 'cumulatively, we believe that a number of the issues we identified ....represent a risk to patient safety. It is also concerning to note that some of the issues that we found during this inspection were also apparent during our last visit in June 2014, despite the health board developing a clear action plan in response to that visit stating that these issues would be resolved..' (HIW 2018, page 3.)

The wards visited at the Ablett unit on these occasions were Cynydd and Dinas; Dinas being a mixed male and female adult ward, rather than one designated officially for elderly people.

In a meeting in 2017, attended by Donna Ockenden, service user 7 described how elderly patients with dementia were transferred to Dinas ward and cared for on Dinas ward rather than Tegid ward, because of lack of space on Tegid ward, (Tegid ward is the designated ward for older people within the Ablett unit.) In follow up communication between service user 7 and Donna Ockenden in October 2017 and May 2018 service user 7 emphasised the vulnerability of older people who were still being cared for alongside 'working aged adults' as of the end of 2017. Service user 7 described frail elderly people mixing with fit young men, at mealtimes in the canteen style arrangement that occurred in the Ablett unit. Service user 7 described that there remained no help at mealtimes for older frail persons and that 'trays were put back untouched if food was not eaten.'

The concerns of service user 7 at the time were relayed directly to the Chair, CEO and Director of Mental Health at BCUHB by service user 7, in the presence of Assembly Member Darren Millar with Donna Ockenden present at that meeting in April 2017. Service user 7 described that even following this escalation of concerns they had still had to re escalate ongoing concerns to the most senior level within the MHL Division at BCUHB for resolution.

*"Cumulatively, we believe that a number of the issues we identified ....represent a risk to patient safety. It is also concerning to note that some of the issues that we found during this inspection were also apparent during our last visit in June 2014, despite the health board developing a clear action plan in response to that visit stating that these issues would be resolved.."*  
(HIW 2018, page 3.)

*"Service user 7 described no help at mealtimes for older frail persons and that trays were put back untouched if food was not eaten."*  
(Eye witness account October 2017.)



HIW stated:

There were continuing issues with lack of effective observation of patients on Dinas ward; (see HIW 2018, pages 5, 10, 14.)

There was no nurse call system and vision panels in patient bedrooms in Dinas ward; (see HIW 2018 pages 5, 6, 12, 13, 14.)

The bathrooms were in need of refurbishment, including a need to reposition the nurse call alarm; (HIW 2018, page 6.)

*“There was no nurse call system and vision panels in patient bedrooms in Dinas ward.”*

*(see HIW 2018 pages 5, 6, 12, 13, 14.)*

In undertaking the extensive listening and engagement exercises across BCUHB and the six counties of North Wales from April 2017 to October 2017 there remained significant concern amongst service users and service user representatives around poor provision of mental health care both on an inpatient and outpatient basis. There was further discussion at the BCUHB Board in December 2017, regarding the possibility of undertaking a 'deep dive' into BCUHB's Mental Health services. This was decided against at this point in time.

The actions being undertaken throughout 2017 by the Mental Health and Learning Disabilities Division were described as:

1. An 'improvement plan' already in place and subject to ongoing review;
2. An experienced interim Director was in place to review systems;
3. A substantive Director of Mental Health & Learning Disabilities had commenced in June 2016;
4. Enhanced monitoring in progress at Board level;
5. Renewed focus and escalation arrangements were in place for dealing with operational issues;
6. An experienced NHS Director had been appointed to further develop governance within mental health and ensure integration and alignment with Board objectives;
7. Staff organisational development and engagement programme were described as 'being developed';
8. Development of the Mental Health strategy was stated to be 'progressing well';
9. The Medical Director for Mental Health & Learning Disabilities had been appointed in post;
10. Support from Welsh Government was said to be in place for ongoing improvement projects, these were said to have commenced and were being managed by interim Programme Managers;
11. Three interim deputy Area Clinical Directors had been appointed;
12. A programme of organisational development for the senior leadership team and middle managers had commenced;

13. The recruitment process was to commence for three each of area manager and assistant nurse director roles;
14. A nursing structure was being developed – to dovetail the overarching Divisional management structure;
15. A mental health nurse consultant was to be recruited on a part time basis to support the development of nursing and governance structures;
16. Bed management and the patient flow project were described as 'ongoing';
17. Older Person's Mental Health action plans were described as 'in place and being reviewed and monitored.';
18. A full review of the Divisional risk register was described as 'ongoing' to include training, systems and process;
19. The external investigation by the Health and Social Care Advisory Service (HASCAS) had commenced;
20. External review of wider governance arrangements was underway led by Donna Ockenden;
21. The Divisional governance structure had been approved both at corporate level and by the Divisional Leadership Team. This was agreed and in place from June 2016;

22. The Division had a risk register – the development of which was described as 'well underway' in the localities. A dedicated 'risk consultant' had been appointed to lead this work with Divisional staff;

One member of front line staff discussed the issue of the risk register at interview with the Ockenden team in August 2017. In response to a question whether there was a risk register in the locality where staff number 79 worked the response of staff number 79 was 'I don't know.' Staff number 79 continued 'It might be on the email but there are so many emails so I don't know...' There was similar feedback from a number of consultant colleagues including staff number 24 who was 'not sure' if there was a risk register in January 2017 and staff number 39 who said 'I think there is a Risk management group' but responded 'No' when asked if she/he had any knowledge what was on the risk register;

23. A weekly 'PTR' meeting was in place chaired by the Divisional Nurse Director to consider any death, incidents or complaints arising in the previous week and putting initial corrective action in place and agreeing the most appropriate review process including identification of Independent Members (IMs) as chair of panels. Staff number 13 told the Ockenden team at interview 'the PTR [meeting] is the most important.....it's about monitoring really if you're having falls or if you're having assaults or if you're having patients restrained, its understanding where those things are happening and getting actions in there quickly and making sense of what's happening....that to me is what clinical governance is really all about.' Other initiatives included:

*“Older Person's Mental Health action plans were described as 'in place and being reviewed and monitored.’”*

*“In response to a question whether there was a risk register in the locality where staff number 79 worked the response of staff number 79 was 'I don't know.’”*

*(Staff interview August 2017)*

*“The PTR [meeting] is the most important.....it's about monitoring really if you're having falls or if you're having assaults or if you're having patients restrained, its understanding where those things are happening and getting actions in there quickly and making sense of what's happening....that to me is what clinical governance is really all about.”*

24. The development of a Divisional Performance Dashboard and the development of specific nursing metrics were said to be underway;

25. A performance analyst post had been funded;

26. The Divisional management 'holding' structure had been agreed; the first cohort of roles were to be in post by September 2016.

### 18.16 The 'management holding structure' as discussed with the Ockenden review team in 2017

Staff number 26 explained the rationale underpinning the 'holding structure' in interview with the Ockenden review team in January 2017. This was said to be necessary because:

- The Division was in the midst of developing a 3-5 year strategy for Mental health;
- The previous work completed on the structure prior to the appointment of staff number 26 had not been led within the division and was therefore not connected or joined up.

Staff number 26 acknowledged some of the staff ambivalence around the 'holding structure' with some staff saying 'it will never happen, we have seen it all before and it never happens because I think they have been promised jam tomorrow before.'

Staff spoke to the Ockenden governance review about the uncertainty caused by the continuation of the 'holding structure'. One staff member at first spoke positively about the new holding structure and said 'I am XXXX (role identifier removed) until the end of June, I received a letter, it was given as six months, so we've just started, it feels like we've just started really.....but it feels so much more structured now, I don't wake up in the middle of the night sort of, you know, that anxiety really...' However the long term nature of the holding structure did cause significant concern with staff number 55 concluding: 'You don't know who you can trust....I think it's while we're still...you know, because people are vying for position.' Staff number 54 stated 'There are a lot of interim people, we've got the holding structure currently which is going to be reviewed again in the next few months .....yes some of them are very interim.'

Board reports indicate that the 'holding' or interim structure for the Mental Health and Learning Disabilities Division was subsequently approved in December 2017. The effect of having an interim or holding structure for the Mental Health and Learning Disabilities Division over such a long period of time was summarised by staff number 54 at interview: 'Some of my colleagues on the coalface, you know, they look up and say we've got yet another new manager at a really high level but we're desperate for Band 5 nurses or whatever and can't quite see how that works, but there was such a lot of work to do, you know.'

*"Some of my colleagues on the coalface, you know, they look up and say we've got yet another new manager at a really high level but we're desperate for Band 5 nurses or whatever and can't quite see how that works, but there was such a lot of work to do, you know."*

Staff number 54 commented positively at interview 'It's felt very different and looked very different since that time' (referring to January 2017). Staff number 25 notes of continual restructure within BCUHB 'Every time the organisation was restructured, delays in progress were evident. Management and senior positions were identified as interim until permanent positions were filled, posts were vacant and staff became more involved in achieving positions via the OCP. (Organisational Change Process.) This was a prolonged and somewhat challenging and delayed process. During this period organisational development, action and progress was either delayed, duplicated or cancelled....'

### 18.17 Quality and governance arrangements as described in The 2016/17 BCUHB Annual Governance Statement that are relevant to a review of governance arrangements in older people's mental health

BCUHB had been working to improve lessons learnt from concerns with the development of a Learning Framework. The 'concerns' function was also to transfer under the leadership of the Executive Director of Nursing and Midwifery Director in order to strengthen the triangulation of themes and the ability of the Health Board to learn from concerns, complaints and incidents. This was the fourth change of responsible Director since 2009. Throughout the 2017 Board minutes reviewed by the Ockenden team it is clear there is close attention paid to improvement in the concerns process by the Executive team. Issues raised throughout 2017 as a reason for inconsistent performance include:

- Experiencing some timing pressures, for complaint acknowledgement over the holiday periods;
- Receipt of letters elsewhere in BCUHB rather than the 'concerns' team.

Progress made, as stated within the Board minutes of February 2017 was stated to be:

- 405 formal concerns were open, (across BCUHB) at the start of January 2017. This showed a continuing and decreasing trend;
- There were said to be consistently more cases closed than are opened, with 132 complaints closed and 89 opened in November 2016;
- The delivery of the 30 day target was continuing to increase as well as a reduction in the number of complaints open over 6 months;
- The 'concerns' process was being reviewed and revised during January 2017;
- The Divisions were said to be revising their governance structures to improve the timeliness of reviews into concerns. This was said to be the stage of the process where the majority of cases face delays;
- BCUHB were developing a PALs-type<sup>183</sup> service during 2017, aiming to increase opportunities to:
- Resolve issues for complainants quickly without the need to make a formal complaint.

*“Every time the organisation was restructured, delays in progress were evident. Management and senior positions were identified as interim until permanent positions were filled, posts were vacant and staff became more involved in achieving positions via the OCP. (Organisational Change Process.) This was a prolonged and somewhat challenging and delayed process. During this period organisational development, action and progress was either delayed, duplicated or cancelled....”*

<sup>183</sup> See glossary

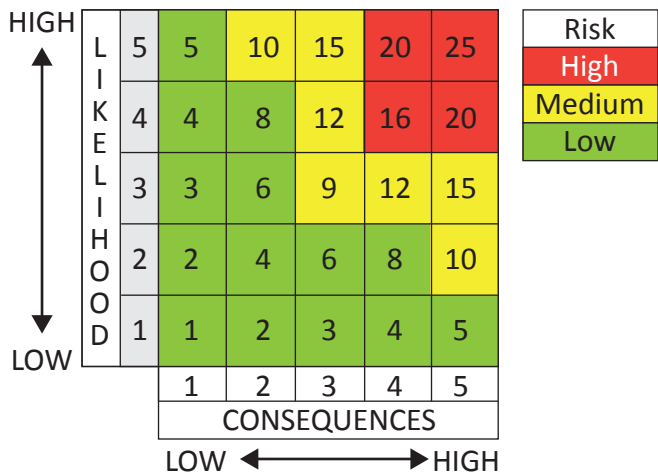
18.18 Risk Description: The ‘concerns’ process

‘There is a risk that the Health Board does not listen and learn from patient experience due to the untimely management and review of concerns leading to repeated failures in quality and safety of care’.

This had been a long term risk probably since the creation of BCUHB but had been clearly articulated in the two external reviews of the ‘Concerns’ process undertaken in 2013. Progress had been very limited since then. Service user feedback in the first Ockenden report in Tawel Fan ward highlighted this as a significant issue. It remained a significant concern throughout the service user feedback obtained throughout 2017.

**Risk rating (current)** was described as 16 in February 2017;

The score of 16 was calculated as 4 as a likelihood of occurring multiplied by 4 as a consequence , therefore calculated as a high risk of 16 on the matrix below



*“There is a risk that the Health Board does not listen and learn from patient experience due to the untimely management and review of concerns leading to repeated failures in quality and safety of care.”*

The risk rating target was scored as 12 with a target date as the 31st March 2017. This was calculated as a reduced likelihood of 3 multiplied by 4 as the consequence resulting in a target score of 12, a medium risk on the matrix above.

**BCUHB described their six point action plan to achieve the target risk score as:**

- 1. The ‘concerns’ management and review processes were being reviewed during December/January.
  - 2. A training needs analysis for concerns procedure was being developed with an associated training programme.
  - 3. Finalisation of the governance and leadership roles in operational management structures and development of teams and processes in line with the Listening Organisation and emerging national model (additional funding will form part of this).
  - 4. Establishment of the operational model and implement PALS type service.
  - 5. Manage performance in line with revised trajectories.
  - 6. Mechanisms for learning were being developed and embedded.
- The illustration below shows a programme for ‘Concerns’ training that will be occurring throughout the Spring of 2018, as supplied to the Ockenden review by the current Executive Director of Nursing and Midwifery in March 2018.

*“Mechanisms for learning were being developed and embedded.”*  
(February 2017)



April 2018	May 2018	June 2018
<p>Wednesday, 4th April</p> <p><b>Concerns Training</b> From 9.00am (Full day)</p> <p>Alyn Waters Conference Centre, Gwersyllt</p>	<p>Wednesday, 2nd May</p> <p><b>Root Cause Analysis</b> (1.00 – 4.30pm)</p> <p>Training Room A, Former HQ/ IMT Building</p>	<p>Monday, 4th June</p> <p><b>Root Cause Analysis</b> (1.00 – 4.30pm)</p> <p>Training Room B, Former HQ/ IMT Building</p>
<p>Thursday, 12th April</p> <p><b>Root Cause Analysis</b> (9.00am – 12.30pm)</p> <p>Alyn Waters Conference Centre, Gwersyllt</p>	<p>Friday, 4th May</p> <p><b>Concerns Training</b> – From 9.00am (full day)</p> <p>Training Room A, Former HQ/ IMT Building</p>	<p>Tuesday, 5th June</p> <p><b>Concerns Training</b> – From 9.00am (full day)</p> <p>Training Room A, Former HQ/ IMT Building</p>
<p>Thursday, 12th April</p> <p><b>Statement Writing</b> (3 x 1 hour sessions)</p> <p>1.00 – 2.00pm 2.00 – 3.00pm 3.00 – 4.00pm</p> <p>Alyn Waters Conference Centre, Gwersyllt</p>	<p>Thursday, 10th May</p> <p><b>Statement Writing</b> (3 x 1 hour sessions)</p> <p>1.30 – 2.30pm 2.30 – 3.30pm 3.30 – 4.30pm</p> <p>Bridge Seminar Room, WMH</p>	<p>Thursday, 7th June</p> <p><b>Statement Writing</b> (3 x 1 hour sessions)</p> <p>1.30 – 2.30pm 2.30 – 3.30pm 3.30 – 4.30pm</p> <p>Bridge Seminar Room, WMH</p>

Source of information: received from the BCUHB Executive Director of Nursing and Midwifery, March 2018

**\*\* As this is a rolling Training Programme for the East area, further sessions for each of the training elements will be added in the coming months \*\***

**Concerns training, full day:** provides an overview of complaints (OTS, formal, customer service), incident management, claims (personal injury & clinical negligence) and inquests.

**Root cause analysis, ½ day:** provides an understanding of investigation tools and techniques including 5 why's<sup>184</sup> and fishbone analysis<sup>185</sup>.

**Statement writing, 1hr rolling sessions:** why statements are required, what are they used for, how to write a good statement, templates to be used.

The overview of progress made at the Board was very much around 'numbers' and the 'process' rather than the poor experience of those elderly people and service user representatives which was described in all of the listening and engagement events hosted by the Ockenden team throughout April to July 2017.

*“Very active programme of public engagement” that took place during 2016. (BCUHB 2017, page 32.)*

<sup>184</sup> See glossary

<sup>185</sup> See glossary

Improving visibility and engagement with key stakeholders had been a key priority for BCUHB throughout 2016 and the **Annual Governance Statement 2016/17** described a 'very active programme of public engagement' that took place during 2016. (BCUHB 2017, page 32.) Staff number 67, reflected in interview with the Ockenden team 'There are some amazing people doing amazing things, there are some real challenges that the rest of the NHS is facing that might be a little bit higher here .....there are certain challenges that are .....unique to this place either because of its history or its size or whatever, so you layer those up.... there's amazing good practice and then there is a level of challenge that is very very high and I think it will take us some time.....it will take some time to get this place to where you'd want it to be...'

Staff number 28, described the position with staff engagement in BCUHB in December 2016 via a written statement submitted to the review. Staff number 28 said 'The Board has approved a new staff engagement strategy and is currently working through an implementation plan to put in place a range of initiatives to improve the ways in which staff voices are heard and how staff are engaged in securing improvements to their working environment.

Staff number 67 advised the Ockenden review team at interview in June 2017 'we are seeing some significant improvements in terms of morale and engagement, evidenced by last year's staff survey.' Staff number 67 also advised the Ockenden review team 'the reason why there's a lot of the firefighting there is [around staff engagement] is because of the vacancies that we've got...' Staff number 67 stated at interview in June 2017 that going forward BCUHB would be taking a proactive approach to staff engagement with 'temperature checks.....on a kind of monthly basis.'

### The Health and Care Standards: Revised Framework

'A Ward to Board HARM Dashboard was to be launched across all wards from spring 2017. It was advised by BCUHB to have been launched at the BCUHB Board in August 2017. The intention of BCUHB was to develop a culture where the aim of zero harm is considered the norm. (BCUHB 2017, page 34.) Below is an example of the HARM Dashboard under development as supplied to the Ockenden team in March 2018 by the current Executive Director of Nursing and Midwifery. This looks at quality and safety at a ward level and is able to measure progress on key indicators. (BCUHB 2018)

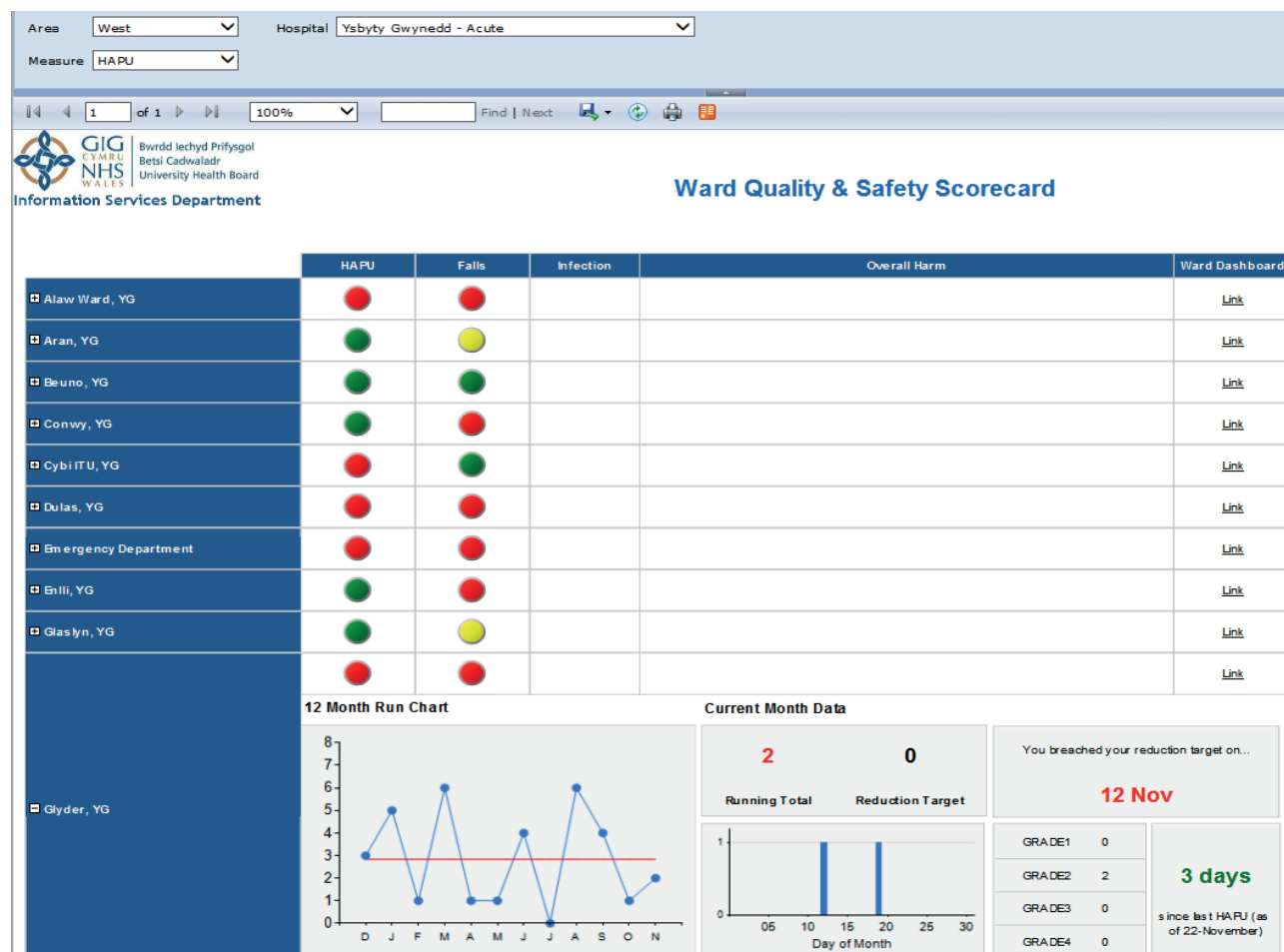
The example provided below shows that information is now being collected across a range of measures that would be regarded as causing 'harm' in an inpatient setting. The examples cited in the dashboard are hospital acquired pressure ulcers<sup>186</sup> (or HAPU) and falls. The example provided is for Ysbyty Gwynedd, and the wards within Ysbyty Gwynedd are listed down the left hand side. The traffic light system of red, amber, and green is utilised. Red areas are those generally that would be considered to be a concern, amber would indicate caution and green would be seen as positive. At the time of writing this report

*"There are some amazing people doing amazing things, there are some real challenges that the rest of the NHS is facing that might be a little bit higher here .....there are certain challenges that are .....unique to this place either because of its history or its size or whatever, so you layer those up.... there's amazing good practice and then there is a level of challenge that is very very high and I think it will take us some time.....it will take some time to get this place to where you'd want it to be..."*

*"The intention of BCUHB was to develop a culture where the aim of zero harm is considered the norm."*  
(BCUHB 2017, page 34.)

<sup>186</sup> See glossary

there would be insufficient data collected to be able to draw meaningful conclusions from the 'HARM Dashboard' but the Ockenden review team recognises the value of this methodology going forward.



Source of information, Executive Director of Nursing and Midwifery, BCUHB March 2018

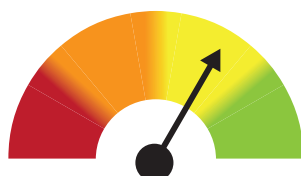
## Internal Audit

Staff number 67 discussed at interview with the Ockenden team the progress made as of June 2017. Staff number 67 advised the Ockenden team that in early 2016 'the majority of the building blocks were there that I would expect from an organisational structure, whether its Board, sub committees, whether it's risk registers....walkabouts...training...development, a whole range of things that you would think are there as a governance structure ...'

Staff number 67 describing to the Ockenden review team the situation as of June 2017 that the Committee structure within BCUHB 'works better' but 'I wouldn't say it is fully sorted, I think the understanding of risk in the organisation and our risk registers has improved.....we've got the ward dashboards, that we're bringing in but I think all of it is a work in progress...' Staff number 67 concluded 'If you look at any system in terms of what it's meant to give you, which is assurance and outcomes.....the outcomes that we're getting from it you wouldn't say are where you'd want to be....'

*"The Board has approved a new staff engagement strategy and is currently working through an implementation plan to put in place a range of initiatives to improve the ways in which staff voices are heard and how staff are engaged in securing improvements to their working environment."*

In 2017 internal audit at BCUHB informed the CEO that 'The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitable designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have **low to moderate impact on residual risk** exposure until resolved.'



**The WAO Structured Assessment report for 2016 stated that BCUHB was 'laying some sound foundations to secure its future and the pace of change was increasing, although there was considerable further work to do in important areas.'**

Formal recommendations from the WAO Structured Assessment in 2016 still included a number of themes from previous years including feedback from the original 2013 joint HIW/WAO report reviewing governance arrangements in BCUHB and reviews of the concerns processes from the summer and later 2013. With reference to 'learning lessons' – BCUHB were described as still needing to put in place further work to improve clinical leadership and ownership of Putting Things Right processes, to support the improvement needed in response times and learning lessons from complaints, incidents and claims. This had been a consistent theme and concern at BCUHB for more than five years.

- Learning lessons – BCUHB needed to strengthen its processes for systematically reporting, cascading and implementing lessons learnt across BCUHB.
- Culture – work was still required to support a positive and open culture from 'Ward to Board.' This work needed to expand across BCUHB to help the wider organisation understand and apply positive values and behaviours.

Staff number 4 said at interview with the Ockenden team in late 2016 'I think it is still work in progress and it's something the Board need to be very mindful of over the next couple of years in terms of moving things forward, but I think there are some positive things there.' A ward based nurse in Older Persons Mental Health explained to the Ockenden review team frustration that because of poor staffing levels there was still a real lack of time to engage effectively with the new governance meetings that in 2017 were acknowledged to be happening (Staff number 38, nursing, describing the position in February 2017.) Staff number 4, discussing information flows in Mental Health told the Ockenden review team in April 2017 'I think we still have not got to the point where we're clear about .... how that critical information gets garnered and presented to give a rounded picture, I think that is still a challenge..'

*"In early 2016 'the majority of the building blocks were there that I would expect from an organisational structure'"*

(Staff interview June 2017)

*"The Committee structure within BCUHB 'works better' but 'I wouldn't say it is fully sorted, I think the understanding of risk in the organisation and our risk registers has improved..... we've got the ward dashboards, that we're bringing in but I think all of it is a work in progress..."*

(Staff interview June 2017)

*"Laying some sound foundations to secure its future and the pace of change was increasing, although there was considerable further work to do in important areas."*

(WAO 2016)

Staff number 44 a former Board member said of the information presented to the Board at the time 'I have concerns about their performance data, actually the data is probably correct as far as I can tell, well as far as any of us can tell I suppose, but it never or hardly ever changes. We have pages and pages and pages of.....It's just pages of red.....I don't think I've seen a green yet, there's the odd amber in there, but it's just pages of red.....I'm talking forty pages probably, of red, at the last Board....' Staff number 26 at interview with the Ockenden team also described the extensive length of the monthly BCUHB Board performance report and noted that what was required was a more succinct 'heat map' structure but that 'when a Board is in special measures ...there is a tendency to overload on the detail..'

Staff number 4, discussed at interview with the Ockenden team the range of information now available to the Board in gaining understanding of mental health services at BCUHB. Staff number 4 told the Ockenden team at interview 'There's still a way to go, in terms of the datasets and the information that would readily flow and be accessible, to allow that to be as live and responsive as one might want it to be, so there's still some information system gaps but, in terms of the information we hold..... the processes and systems that the Division now operates to look at their concerns...incidents.....external reports, to engage with their staff are far better than they were previously... those .....are all elements of a healthy organisation that has a better understanding of the way its services are operating.'

### 18.19 A review of BCUHB Board minutes for 2017 to highlight discussions of issues of relevance to a review of current systems, structures and processes of governance within older person's mental health

Alongside the Annual Governance Statement for 2016/17 The Ockenden review team considered all the publicly available Board minutes throughout 2017. In reviewing these minutes the team were looking for issues that had relevance to a review and understanding of the systems, structures and processes of governance 'on the ground' both across BCUHB in the Mental Health and Learning Disabilities Division and more specifically in Older Peoples Mental Health as required by the Terms of Reference underpinning this governance review.

Following on from several readings of each set of Board meetings from December to January 2017 the Ockenden team then undertook a further analysis of Board minutes and compared the position as explained in Board minutes with feedback from current BCUHB staff and current and recent carers, service users and service user representatives. The purpose of this second layer of analysis was to understand whether the experience of current BCUHB staff and current and recent carers and service user representatives was adequately understood and articulated at the BCUHB Board. One key question the Ockenden governance review team needed to answer in was 'in 2017 had the BCUHB Board achieved that which had eluded them collectively for so long – a clear and effective line of sight from 'Ward to Board?'

*“Work was still required to support a positive and open culture from 'Ward to Board.' This work needed to expand across BCUHB to help the wider organisation understand and apply positive values and behaviours.”*

(WAO Structured Assessment report 2016)

*“I have concerns about their performance data, actually the data is probably correct as far as I can tell, well as far as any of us can tell I suppose, but it never or hardly ever changes. We have pages and pages and pages of..... It's just pages of red..... I don't think I've seen a green yet, there's the odd amber in there, but it's just pages of red.....I'm talking forty pages probably, of red, at the last Board....”*



## 18.20 Review of key risks at BCUHB in 2017

### Risk: Use of 'Out of Area' beds in mental health:

The Board minutes of the 19th January 2017 described that:

The Director of Finance presented the Finance report and drew the Board's attention to key headlines including the overspend at month 7 of £26.6m, £17.5m of which related to the planned budget deficit of £30m. The most significant variance (of just under £3m) was due to **out of area placements in Mental Health**. The Director of Finance explained steps to be taken to address service and financial sustainability in Mental Health services.

The Finance Report for Month 8, (November 2016) was discussed at the Board. This had particular relevance to an understanding of current governance arrangements in Older Peoples Mental Health at BCUHB and reflected on the discussions that had been held in earlier Board meetings.

'Members were informed that key financial pressures and risks remained within the areas of mental health and agency staffing costs. BCUHB had received confirmation from Welsh Government that there would be no further allocation for special measures. This would add further pressure – specifically around mental health.'

It was reported that the BCUHB forecast planned deficit remained at £30m but that in order to deliver this the Board would need to take a range of actions including implementing control totals across divisions, drawing up a financial recovery plan to be monitored weekly by the Executive Team, and developing a range of communications from the Chief Executive describing the financial challenge. Delivery of the forecast would require a continued focused attention on cost containment for the remainder of the financial year, and the ability of the Board to absorb further risk was said to be 'limited by continued operational pressures.'

## 18.21 What do service user representatives say about 'the human cost' of using out of area beds?

The continued usage of out of area placements and pay overspends due to the high usage of nurse and medical agency continued throughout 2017. These were of concern to both service user representatives and current staff within the MHLD Division. HIW also raised concerns around temporary staff use and staffing shortages within their BCUHB Annual Report of 2016/2017 and within the reports arising from many of the HIW inspection visits undertaken across BCUHB that year. Whilst these were of significant concern from a financial perspective the impact upon service users around out of area care remained significant as did the consequences of the shortage of staff and unfamiliar staff as care provider due to continued vacancies and a high use of temporary staff up until the end of 2017.

*"I think we still have not got to the point where we're clear about .... how that critical information gets garnered and presented to give a rounded picture, I think that is still a challenge.. "*

(Staff interview April 2017)

*"in 2017 had the BCUHB Board achieved that which had eluded them collectively for so long – a clear and effective line of sight from 'Ward to Board?'"*

*"The impact upon service users around out of area care remained significant as did the consequences of the shortage of staff and unfamiliar staff as care provider due to continued vacancies and a high use of temporary staff up until the end of 2017."*

A number of service user representatives engaging with the Ockenden team throughout 2017 highlighted poor experience as a result of out of area placements with families and carers representatives describing isolation of patients from families and friends and familiar social settings long and often distressing journeys to access care. Service user representatives and staff described the use of beds in Shrewsbury, (Family 86) and South Wales (Family 65).

Family 86 spoke to the Ockenden review in December 2017 about an incident in Autumn 2017 and described their relative having to leave North Wales in the middle of night for an out of area bed in Shrewsbury. Family 86 said 'I got X to bed, [and] sound asleep [and] at quarter to two in the morning the transport came so I had to get this severely demented X up and out of bed and off with three complete strangers on a long journey to Shrewsbury, it was like what, I wouldn't do this to my dog.'

Family 86 said 'quarter to two in the morning and X was admitted to X in Shrewsbury at four forty am....I don't understand why it took that long because it takes me about an hour and a half to drive there so I don't know what process he went through before admission.'

Family 65 told the Ockenden team in August 2017 'You know if you're going to section someone and put them 172 miles away from home, yes you've got a duty of care, you must have to bring that person back.....But I had to spend basically, Oh I'd say a year there. They forgot to take Y's clothes up there, so I had to go there next day....'

Service user representatives, and staff including service user representatives number 60 and 73 and staff numbers 43 and 79 gave examples of care provided in Southampton, Bradford, Bristol, Coventry, London and Manchester – where beds within the Ablett unit were full as late as August 2017. Staff number 79 described at interview in August 2017 an elderly patient from BCUHB needing to travel to Southampton for care and said 'One gentleman, [an] old man even died and his daughter was up here and it was very sad...'

Whilst the finance underpinning the purchase of out of area placements was understandably of grave concern to the position at BCUHB and thus is recorded on the BCUHB Risk and Assurance Framework as below – the Ockenden team did not find any consideration in the Board discussions of the 'human factors' underpinning the regular use of 'beds' for older peoples mental health care so far from home. Neither did the Ockenden team find examples of 'patient and carer stories' highlighting the distress experienced by families and carers in these situations. Where patient stories were told about Mental Health at the Board, particularly around older persons mental health they tended to be positive and did not reflect the feedback from service users recorded at the Ockenden 'Listening and Engagement events' from 2017 or from front line clinical staff who continue to advise the Ockenden review of poor levels of staffing, lack of availability of beds and as a consequence poor quality of care to patients (April 2018).

*"I got X to bed, [and] sound asleep [and] at quarter to two in the morning the transport came so I had to get this severely demented X up and out of bed and off with three complete strangers on a long journey to Shrewsbury, it was like what, I wouldn't do this to my dog.."*

*"You know if you're going to section someone and put them 172 miles away from home, yes you've got a duty of care, you must have to bring that person back..... But I had to spend basically, Oh I'd say a year there. They forgot to take Y's clothes up there, so I had to go there next day...."*

**EXAMPLE:**

**Typical mileage from the Ablett unit at Glan Clwyd Hospital, Bodelwyddan to some of the units described where 'out of area care' was provided in 2017:**

(This assumes a 'straightforward' car journey and that the carer/patient representative is a car driver/owner. If public transport were used a single visit would necessitate at least an overnight stay.)

From the Ablett Unit at Glan Clwyd Hospital, Bodelwyddan, LL18 5UT to:

**Cygnnet Hospital, Bierley, Bradford, BD4 6AD**

- Single Journey – 101.1 miles
- Return Journey – 202.2 miles

**Cygnnet Hospital, Wyke, Bradford, BN12 8LR**

- Single Journey – 100.63 miles
- Return Journey – 201.26 miles

**Cygnnet Hospital, Coventry, CV2 4FN**

- Single Journey – 143 miles
- Return Journey – 286 miles

**South West London & St George's Mental Health Trust, London, SW17 7DJ**

- Single Journey – 247.16 miles
- Return Journey – 494.32 miles

**Phoenix House, Welshpool, SY21 7BY**

- Single Journey – 67.66 miles
- Return Journey – 135.32

This use of 'out of area' beds and care was considered in discussion of the BCUHB Risk and Assurance Framework in January 2017.

**Risk Description:** 'There is a risk that patient experience and outcomes may be adversely affected due to mismatches in demand and capacity across the whole system'.

*“Members were informed that key financial pressures and risks remained within the areas of mental health and agency staffing costs. BCUHB had received confirmation from Welsh Government that there would be no further allocation for special measures. This would add further pressure – specifically around mental health.”*

*“There is a risk that patient experience and outcomes may be adversely affected due to mismatches in demand and capacity across the whole system.”*

(BCUHB, January 2017)

**Risk rating** The 'current risk' was scored as 20, with 5 as a likelihood multiplied by 4 as a consequence. This shows as a high, (or red) risk on the matrix below.

<div style="display: flex; align-items: center;"> <div style="width: 10px; height: 10px; background-color: black; margin-right: 5px;"></div> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">LIKELIHOOD</div> </div>	HIGH	5	5	10	15	20	25
		4	4	8	12	16	20
		3	3	6	9	12	15
		2	2	4	6	8	10
	LOW	1	1	2	3	4	5
			1	2	3	4	5
			CONSEQUENCES				
			<div style="display: flex; justify-content: space-between; width: 100%;"> <span>LOW</span> <span>HIGH</span> </div>				

Risk
High
Medium
Low

*“It’s very difficult on the shop floor, it feels like you are constantly firefighting... it’s worse now ... because we’ve got no staff and we’re using a lot of agency staff....”*

(Staff number 38, Interview February 2017, page 9.)

The target risk rating was described as 16 with a target date to reduce the risk to 16 as the 31st March 2017. However, the Ockenden team heard from a number of service user representatives that this practice continued long after March 2017 and it was a subject of lengthy discussion and concern at an ‘engagement and listening event’ held by the Ockenden team in Prestatyn in July 2017.

**Further action to achieve the target by BCUHB and the MHL Division was said to** include 'work through the 'transformation group' to develop integrated pathways between Primary, Community, Mental Health, and Secondary Care the target date for this was stated to be March 2017.

Referring to continuing pressure around staff and lack of beds in inpatient wards Staff number 38 told the Ockenden review team in February 2017: ‘It’s very difficult on the shop floor, it feels like you are constantly firefighting...it’s worse now ...because we’ve got no staff and we’re using a lot of agency staff....’

## 18.22 Key issues in pressures on frontline clinical staff in 2017 – beds and staffing

Recognising the pressures on frontline clinical care and those delivering it as of the end of 2016, staff number 1 told the Ockenden review team that much more still needed to be done by senior and middle managers to support staff. ‘I think there is a need for senior and middle managers to be much more explicit about the expectations on them and the support they need to give to frontline teams. I think when you engage with the ward manager, (junior sister or a staff nurse) on the ward or within Community teams, mental health teams then there is going to be variability in terms of the response.’

Staff number 54 also recognised the current pressures on frontline clinical staff and balanced those with the efforts being made by the MHL Divisional management team in early 2017. These issues resonated with feedback provided directly to the Ockenden review team in 2017. Staff 54 said ‘I see the changes that have been made at the top and so .....I’m saying to my colleagues, you

*“Staff 54 said ‘I see the changes that have been made at the top and so .....I’m saying to my colleagues, you know changes are coming, honest, it’s really there, the management are onside, they understand what it’s like for staff, they’re putting things in place that will make a difference, but I don’t think that has quite trickled down .....they see themselves as being vastly overworked and highly pressured and high caseloads..”*

know changes are coming, honest, it's really there, the management are onside, they understand what it's like for staff, they're putting things in place that will make a difference, but I don't think that has quite trickled down .....they see themselves as being vastly overworked and highly pressured and high caseloads..'

Staff number 75, described further pressure on frontline staff as of the summer of 2017. Staff number 75 a Dementia Support Worker described an inability to work within the role of Dementia support worker in July 2017 because of shortage of staff and said at interview with the Ockenden team 'You're pulled to do Healthcares\* as well all the time.....you find sometimes you're more Healthcare, but our matron doesn't want that, but that's how it is...' (\*'Healthcares' being the phrase used locally within BCUHB for a Health Care Support worker)

Staff number 75 continued 'Our major issue is we're constantly short staffed ....I would come in a morning and they would be.... 'Oh thank God you're in this morning.....can you just help me get so and so out of bed or.....any chance you can just assist me to wash so and so this morning...'

Staff number 22, currently a front line senior clinical nurse described the following at interview 'I have repeatedly asked for a formal review of the staffing levels to reflect the current acuity, the increase in the number of beds.....I have repeatedly said we need to look at ...how we manage the shortage of nurses.'

Staff number 53, a senior clinical nurse discussed medical staff shortages in an older persons mental health inpatient ward setting as of April 2017 and told the Ockenden review team 'All this week...there's been nobody, [no medical cover] between five and nine and sometimes between nine at night and nine in the morning there hasn't been anybody either....we'd have to go to A and E.....we have managed to build up a relationship with the general ward so we can run some ideas by them....but that's based on goodwill rather than actually a structure.'

### 18.23 Description of low staffing levels in an inpatient mental health unit in BCUHB as of October 2017 as provided by a frontline nurse

A letter was sent to the Ockenden review team containing an article from the local newspaper called The Daily Post dated 10 October 2017 from a frontline clinical nurse who has contributed to the governance review. The nurse said 'I am sending you a copy of an article that was in last weeks Daily Post. I don't know who the member of staff is, but I do know that the staff I work with (and myself) would agree with every word. It just demonstrates that nothing has changed for the better'.

The headline reads 'We feel more like prison guards than nurses'... life on the front line at North Wales' stretched mental health units'.

*"Our major issue is we're constantly short staffed ....I would come in a morning and they would be.... 'Oh thank God you're in this morning.....can you just help me get so and so out of bed or.....any chance you can just assist me to wash so and so this morning..."*

*"All this week... there's been nobody, [no medical cover] between five and nine and sometimes between nine at night and nine in the morning there hasn't been anybody either....we'd have to go to A and E.....we have managed to build up a relationship with the general ward so we can run some ideas by them....but that's based on goodwill rather than actually a structure."*

(ward nurse, older persons inpatient mental health unit April 2017)



In summary, and in the article a North Wales mental health nurse professional spoke of how she and her colleagues spoke of feeling 'exhausted, depleted and unheard' in what she called a 'dangerous environment' because of the strain the service is under.

The nurse went on to say "how would I feel about being a nurse? Vulnerable, unsafe, unsupported by senior management, as they are ignorant to the fact it happens – despite all the incident reporting. Why? Because they don't go onto the wards anymore. They stay in their offices telling the heads of the trust we don't have any issues, when clearly if they talked to the staff on the floor we no longer feel safe'.

The nurse also describes patients as 'not safe as there are not enough staff and patients remaining unmedicated due to no doctors on wards' She added 'money comes before staff and patient safety. I feel I am no longer a nurse but a prison guard trying to keep the wards and patients safe'.

BCUHB were reported as saying that it couldn't comment on the claims but said patient and staff wellbeing was of 'paramount importance'.

Possibly as a consequence of pressure on front line staff a number of staff reported to the Ockenden review team that staff morale remained poor well into 2017. In describing staff morale in April 2017 one current front line member of staff told the Ockenden team staff morale in the MHL Division was 'Not good, Not good, I think it's been worse, I think it has been absolutely dreadful, currently I'd just say it's probably not very good..' The staff member added 'It's very hard when people are working on the coalface...for them to appreciate that actually the juggernaut has slowed, let alone turned, because for them the things haven't really changed, things are much the same. Yes, there might be some mindfulness classes on offer or a yoga class ... but is not sufficient in any sense...'

Staff number 35, working clinically on front line care in an inpatient mental health unit which cared for older people told the Ockenden team at interview 'Staff do feel quite disheartened... there is a constant pressure within acute care especially. There is constant pressure and demands on beds, discharge patients, discharge....' Staff number 43 said 'It sometimes feels like they're trying to run the service to the ground so that it can be ....closed.'

#### 18.24 Review of a 'Delayed Transfer of Care' patients report at the BCUHB Board in February 2017 and its relevance to an understanding of current governance arrangements in Older Peoples Mental health at BCUHB

A 'Delayed Transfer of Care patient' is one where there is a delayed transfer of care from acute or non-acute (including community and mental health) care and occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

- a) A clinical decision has been made that patient is ready for transfer **AND**

*"I have repeatedly asked for a formal review of the staffing levels to reflect the current acuity, the increase in the number of beds.....I have repeatedly said we need to look at ...how we manage the shortage of nurses.."*

*"Staff do feel quite disheartened... there is a constant pressure within acute care especially. There is constant pressure and demands on beds, discharge patients, discharge...."*

*"It sometimes feels like they're trying to run the service to the ground so that it can be ....closed."*

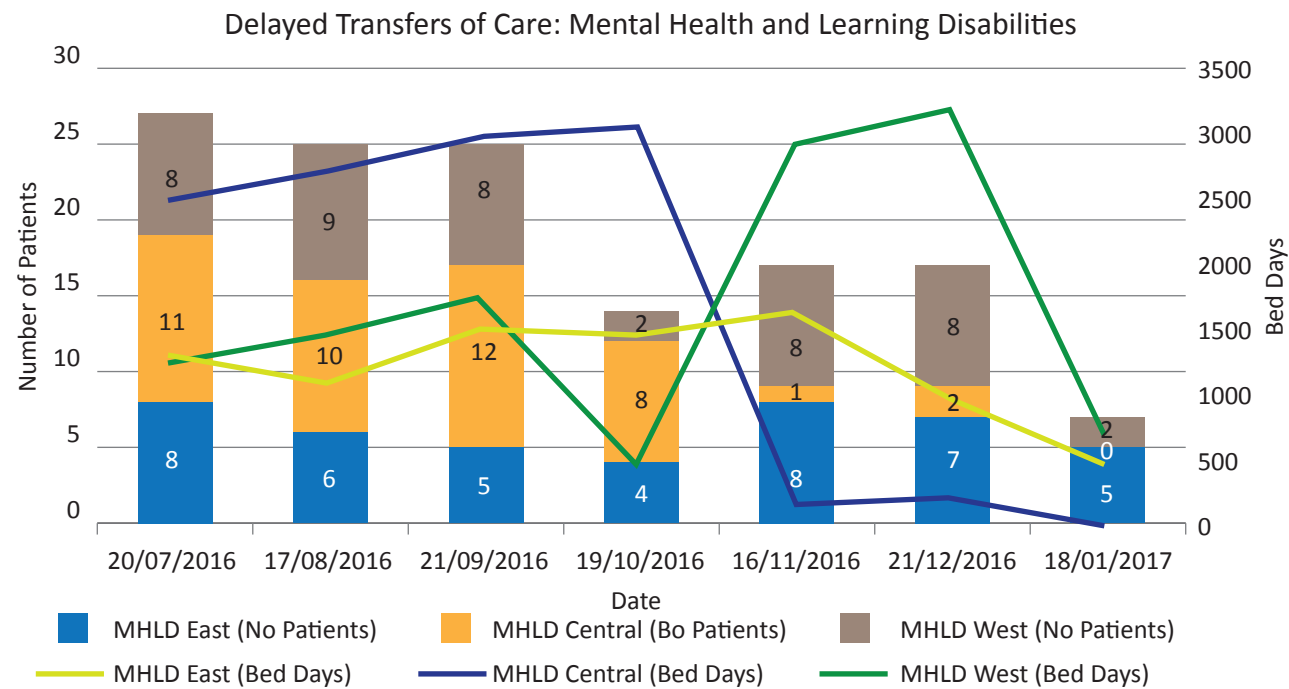
- b) A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
- c) The patient is safe to discharge/transfer.

Examples can include a patient awaiting a nursing home placement or on occasions for modifications to be made at home or equipment provided at home or an appropriate care package to be put in place to allow transfer home. On occasions ‘DTOC’ situations can arise when a patients previous arrangements for care change, for example someone who has previously been a carer becomes too frail or ill to continue to undertake those carer responsibilities.

Use of beds by DTOC patients in BCUHB was said to be the second highest in Wales and the highest of Health Boards with acute hospitals. The median length of delay for non-mental health is 15 days and for mental health patients, it is 71 days. The main reasons for delays were said to be related to choice, delays in assessment processes, and lack of homecare provision.

18.25 Graph showing DTOC in the Mental Health and Learning Disabilities Division as of January 2017

The figure below illustrates the Mental Health and Learning Disability position for BCUHB in terms of DTOC by area as of mid-January 2017. The graph depicts some fluctuation over this sixth month period, this is explored below. Overall, however, the data shows a general decreasing trend.



The sharp fall in figures for the Central area and increase in the West area between October and November can be attributed to the fact that Bryn-Y-Neuadd was reclassified into the West area from Central at this point. The sharp fall in figures for West between December and January can be attributed to the recognition

that five Learning Disability patients with extremely complex needs were not correctly classified as DTOC, thus they were removed from the figures (and will be reported at a local divisional level). In general terms there has been a substantial reduction in total number of MHL patients delayed across BCUHB from 27 in July to 7 by mid-January. This is also true of total number of bed days delayed with the July figure of 5065 reducing to 1130 by mid-January. Bed stock for the MHL Division across BCUHB stood at between 248 and 250 beds.

The report noted that in January 2017 Mental Health and Learning Disability services were said to have been running at 110% bed occupancy across older persons and adult services with the use of escalation beds. Within this report is reference regarding the 'sofa system' as described by a service user, number 7 and staff numbers 38 and 68. This involved inpatients sleeping in ward communal areas such as TV rooms and lounges when a bedroom was not available. HIW had also drawn attention to the issue of bed capacity in mental health services in a number of reports from 2010 onwards where patients on leave from a ward setting returned to find their bed in use by another patient and their personal possessions in storage.

A number of staff working currently within Older Persons Mental described the pressures upon ward staff, (across all of the inpatient units) to manage the difficulties of insufficient beds, (known as 'bed pressures'.) These included staff numbers 24, 31, 35, 39, 38, 40, 43, 59, 79, and 68. The staff explaining their concerns regarding 'bed pressures' are all front line clinical staff and cover a range of current BCUHB staff from 'support worker' to ward nurse, to ward manager to consultant medical staff.. The interviews with these staff were carried out from January to August 2017.

Staff number 35 described bed numbers in a specific ward that would fluctuate between 16 and 18, (meaning that a bay for four people would be extended to 5 people) and that 'frailty' bays, which was a system where older frail people should be nursed rather than mix them in a bay with fit younger people, (or adults of working age) with mental health issues would not be able to operate. Describing five people in a bay intended for four people staff number 35 said 'That is very close proximity, it's very very close as to where they were sleeping....'. HIW had recommended that the ward numbers should reduce to 16, staff number 35 confirmed at interview 'we did go down to 16 and I think we maintained it for quite a while and then the bed pressure came on and then our numbers started fluctuating to 18..'. Staff number 35 explained 'If we have to give personal care, if we can't move them to the side room, we will have to do that in a bay area...'

The DTOC report noted a number of issues relevant to the current governance arrangements in Older Persons Mental Health. These included the inability to secure 'elderly mentally impaired placements.' The report described the actions implemented by the Division in order to monitor the exceptional issues highlighted. In addition to ongoing weekly reviews, DTOC features in discussion within the daily bed management call and teams reported greater adherence to DTOC procedures. Additionally, teams were stated to be attending at the weekly

locality meeting and stated they had increased engagement with the Continuing Health Care (CHC) processes and the Local Authority to address delays. The separation of the reporting stream for complex learning disabilities patients has been mentioned above and this had contributed to improved accuracy of reporting. The daily bed management call is referred to in the interview of staff number 38, where the 'sofa system' was said to be known by members of the Divisional senior management team.

Staff number 38 described to the Ockenden review team other examples of lack of action around significant risk in older person's mental health inpatient units as of February 2017. These were occurring due to 'bed pressures' as difficult decisions were being made around admitting patients to unsuitable clinical areas. Staff number 38 said:

'I raised concerns 12 months ago because we were constantly getting adult patients on the ward (older persons ward) because of pressure of beds.... like a paranoid male....' This situation presented great potential risk to the frail elderly patients within this particular older persons mental health ward when a younger, physically fit male with significant acute mental health issues was admitted to the older persons ward. Staff number 38 was complimentary of the leadership seen within the Mental Health Division at the time and said the practice was stopped with immediate effect. However the situation continued to re occur 'more recently it is happening again.....and you do get a bit battle fatigued, you get a bit burnt out...'

Service user number 7 highlighted their own personal experience of bed pressures within mental health in April 2017 when they met Donna Ockenden. Service user 7 described delayed admission to an inpatient bed due to lack of availability of local beds. Service user 7 was offered an out of area bed in Brighton but declined due to the distance from their family who were an important part of their support. When admitted to an inpatient 'bed' there was no bed. Instead, they were told 'we offer a sofa system.' (Service user 7, interview April 2017.)

As a temporary measure service user 7 was so desperate, that service user 7 spent a number of nights sleeping on a sofa in the day room of an inpatient ward. Service user 7 told Donna Ockenden 'If you are that desperate for help, as I was you will sleep on a sofa'. This sofa was found in a communal area, used by all of the patients in the ward until midnight. This included patients of both genders wandering in and out of the lounge whilst service user 7 was trying to sleep. Service user 7 described feeling very unsafe whilst an inpatient. Service user 7 described using new medication that made service user 7 feel 'heavily sedated' and being very frightened of sleeping on a sofa in a communal area that other patients were able to access freely. Service user 7 asked if the door to the communal lounge could be watched and observed by staff and was told that was not possible.

*"I raised concerns 12 months ago because we were constantly getting adult patients on the ward (older persons ward) because of pressure of beds.... like a paranoid male...."*

*"You do get a bit battle fatigued, you get a bit burnt out..."*

*"As a temporary measure service user 7 was so desperate, that service user 7 spent a number of nights sleeping on a sofa in the day room of an inpatient ward."*

*"Service user 7 described using new medication that made service user 7 feel 'heavily sedated' and being very frightened of sleeping on a sofa in a communal area that other patients were able to access freely."*

The meeting with service user 7 was held in the presence of the BCUHB Director of Mental Health services, the CEO and Chairman of BCUHB, service user 7's Mental Health advocate and service user 7's Assembly Member. Staff number 68 stated at interview in June 2017 that the 'sofa system' was 'absolutely' known about by senior managers at BCUHB.

Staff number 38 advised the Ockenden review team that 'they admit patients to sofas, it's a regular occurrence.....because there's no beds.....they hope there's going to be a bed.....it happens all the time.' Staff 38 continued 'they have a bed management meeting on the phone twice a day..... And they will say .....10 patients in beds, 1 on a sofa, it's shocking....' Staff number 68 agreed with the information given by staff number 38 and the experience of service user 7. In interview in June 2017 staff number 68 told the Ockenden team of being 'absolutely' aware of the 'sofa system' Staff number 68 told the Ockenden team 'It gets into a much broader issue about beds, about patient flow, about CMHTs, I think it goes back to a historic issue in terms of there was a reduction of beds...' Staff number 68 concluded 'My own view is there's not enough beds...'

Similar issues around use of communal areas when there were insufficient beds was found in an HIW inspection of Heddfan unit in June 2017, two months after Donna Ockenden first met service user 7.

The DTOC report states that numbers of patients seeking admission to hospital has increased across the region. Feedback from staff suggests the limited number of admissions may be due to bed pressures – influenced by Delayed Transfers Of Care (DTOC) and placements within North Wales, where needed. This has led to the use of acute beds outside North Wales, which it is acknowledged is far from ideal for patients, their carers and families.

Common principles said to be shared by the local councils and the health board include service user and carer involvement and participation; community advocacy; carers support and the role of learning and work opportunities in recovery; joint working between agencies. As of February 2017 the DTOC report stated that there needed to be a clear pathway from acute services into community based services.

*“Staff number 68 stated at interview in June 2017 that the ‘sofa system’ was ‘absolutely’ known about by senior managers at BCUHB.”*

*“they have a bed management meeting on the phone twice a day..... And they will say .....10 patients in beds, 1 on a sofa, it’s shocking....”*

*“‘It gets into a much broader issue about beds, about patient flow, about CMHTs, I think it goes back to a historic issue in terms of there was a reduction of beds...’”*



## 19 Chapter 11

### Overview of Deprivation of Liberty Safeguards<sup>187</sup> (DoLS) with specific reference to BCUHB

#### 19.1 Training in DoLS

On the inception of the Health Board in 2009 the organization had to take on the roles of Supervisory Body and Managing Authority<sup>188</sup> for DoLS (see above). The input of the Medical Director with responsibilities for the Mental Health Act<sup>189</sup> (MHA) and also Mental Capacity Act<sup>190</sup> (MCA) was vital to this role. The issue of DoLS was raised in the inaugural meeting of the Mental Health Act (MHA) committee on the 18.3.10. At the next meeting in May 2010 it was agreed that BCUHB needed a planned approach towards training for DoLS described as a 'comprehensive training and awareness programme.' The minutes note that a 'training plan was being prepared....' It was agreed that this would be brought back to the MHA Committee meeting in July 2010.

At the July 2010 meeting of the Mental Health Act Committee, it was discussed again that training in DoLS would be arranged 'as soon as possible' for key individuals. In the section of the minutes titled 'Issues of Significance for Reporting to the Board' again training for key individuals is to be arranged 'as soon as possible....' In October 2010 at the same Committee it is acknowledged that 'training is paramount....' (10/36). In the same meeting 10/41 in the section 'Issues of Significance for Reporting to the Board' it is noted that 'the need for training and refresher training' (associated with DoLS) 'is paramount.' Throughout a review of minutes from the Committee over the next year there is little, (if any) evidence that whilst recognising that training is of 'paramount' importance that any significant progress was made by BCUHB on first establishing and subsequently embedding that training.

Problems continued in the Mental Health and Learning Disabilities (MHLD) CPG with adherence to training in other key areas linked to DoLS. In a memo dated November 2012 from the Associate Chief of Staff (Nursing) to managers across the CPG it is stated 'Please note that some areas require urgent attention as assurance is absent.' The overall attendance at training up to the end of October 2012 is recorded as 35% for 'awareness' of the Mental Capacity Act (MCA) and 'general awareness' of the Mental Health Act is recorded at 45%.

#### Organisational responsibility for DoLS at BCUHB:

Discussion at the MHA Committee (July 2010 Item 10/26.) showed that the creation of the Health Board produced difficulties in ensuring that lines of responsibility for DoLS were clear across the geographical area now served by

*“BCUHB needed a planned approach towards training for DoLS described as a ‘comprehensive training and awareness programme.’”*  
(BCUHB, May 2010)

*“training in DoLS would be arranged ‘as soon as possible’ for key individuals”*  
(BCUHB, July 2010)

*“training is paramount....”*  
(10/36)”  
(BCUHB, October 2010)

*“Please note that some areas require urgent attention as assurance is absent.”*

*“The overall attendance at training up to the end of October 2012 is recorded as 35% for ‘awareness’ of the Mental Capacity Act (MCA) and ‘general awareness’ of the Mental Health Act is recorded at 45%.”*

<sup>187</sup> See appendix for further background on the Mental Capacity Act and background to DoLS

<sup>188</sup> See appendix

<sup>189</sup> See glossary

<sup>190</sup> See glossary

BCUHB. In July 2010 it was stated that the issue of responsibility at operational level for DoLS had yet to be discussed at the Board of Directors. The report summarised the activity of requests for Authorisation from 1st April to 30th June 2010. The issue of operational responsibility for DoLS also did not appear to have been progressed at the following meeting in October 2010 (see section 10/34, matters arising.) It was reported that the responsible Director had taken the issue of responsibility at operational level for DoLS to the Board of Directors: 'further discussion' was said to be required.

Subsequently DoLS was monitored through the MHA Committee which received quarterly reports about the level of DoLS activity. For the most part prior to the Cheshire West<sup>191</sup> judgement these were perfunctory, the same text is used in each report with the numbers only changing. The data is summarized under East, Central, West and Out of County.

## 19.2 The Mental Health Act (MHA) Committee and Tawel Fan ward

Examples of discussion included those found in the MHA Committee (28.10.11) 'Deprivation of Liberty Safeguards Quarterly Report' in which five instances are cited (two in Tawel Fan ward.) In each case a 'standard' 28 days DoLS authorisation is requested and issued 'to facilitate discharge to a specialist care home.' (Pages 5 and 6) The MHA Committee 18.04.12 cites one case of DoLS from Tawel Fan ward – 'to facilitate discharge'. (Page 3.) The **MHA Committee (2.08. 12) cites one case of DoLS from Tawel Fan 'to identify a care home' There is no further discussion or information regarding these cases.**

*“MHA Committee (2.08. 12) cites one case of DoLS from Tawel Fan 'to identify a care home' There is no further discussion or information regarding these cases.”*

## 19.3 The Mental Health Act Committee and its role in scrutiny of DoLS

The DoLS Quarterly reports are noted in the MHA Committee minutes with the levels of discussion appearing to be minimal. There does not appear to be any input from CPGs other than the Mental Health and Learning Disabilities (MHLD) CPG to this committee perhaps indicating that the use of DoLS across CPGs other than MHLD is limited. In the Mental Health Act Committee minutes dated 19th January 2012 a paper is presented summarising the activity for authorisation of DoLS for November and December 2011. It was noted that two cases had resulted in applications for further review; one had been subject to further assessment; one was not authorised and one very complex case was not eligible. There was no discussion of any of the cases within the minutes, The Committee **noted** the report. (Page 4)

In the Mental Health Act Committee 18th April 2013 Minutes (MH13/017.02. page 6) it is noted that the number of DoLS 'applications being received under DoLS 'was still low and that further training, including a new e learning module would been (sic) to be undertaken..' (Page 6). Also reported (page 6) were

*“applications being received under DoLS 'was still low and that further training, including a new e learning module would been (sic) to be undertaken ”*

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<sup>191</sup> See appendix

discussions with the Assistant Medical Director and the lead Nurse for safeguarding and that 'due to the specialist nature of DoLS and the inherent risk, it was proposed that this would also be reported through the BCUHB safeguarding Structure as there was a need to embed this within the Health Board.

The MHA Committee recognized the changes brought about by the 2014 Cheshire West judgement and the increased number of applications (Mental Health Act Committee 15th July 2014 Item MH14.033.1) More broadly prior to the Cheshire West Judgement there is some awareness of DoLS across BCUHB but it appears relatively limited as evidenced by the low numbers of applications that are being reported to the Mental Health Act Committee. This is recognized in the minutes of the meetings with many attempts made to set up training.

#### 19.4 CSSIW review and BCUHB 2014

The Care and Social Services Inspectorate Wales (CSSIW) National review of DoLS held jointly with Healthcare Inspectorate Wales (HIW) took place in April and May 2014. Published in May 2014 it involved a survey of the Local Health Boards and Local Authorities in Wales. Fieldwork was also carried out in all Local Health Boards and one Local Authority on each Local Health Board footprint of the use of Deprivation of Liberty Safeguards (DoLS) in Wales 2014.

An overarching All Wales Report (A national review of the use of Deprivation of Liberty Safeguards (DoLS) in Wales) 2014 was published alongside more detailed 'local' reviews. Gwynedd Local Authority and Betsi Cadwaladr University Health Board were reviewed. They note that the outcomes for inpatients were 'generally satisfactory', (page 6).

Inspectors saw 'detailed schedules of the extensive training provided together with feedback from a range of staff who attended and valued the input. This has to be balanced with the difficulties of releasing staff for training.' (Page 10) Best Interest Assessors (BIA's) from the Health Board were stated to be concerned that 'other disciplines in healthcare may not see DoLS as a mainstream issue affecting a wide variety of patients'. (Page 9) The Medical Director 'indicated that there were fewer DoLS referrals than he would have anticipated and felt that further training was necessary. (Page 5)

*"other disciplines in healthcare may not see DoLS as a mainstream issue affecting a wide variety of patients'. (Page 9)"*

#### 19.5 Recommendations for BCUHB from the 2014 CSSIW report

Seven recommendations relevant to BCUHB were made at the end of the Report which included the need to:

1. Continue to develop understanding of MCA, DoLS and the Supreme Court Judgement at all levels;
2. Ensure performance is reported to senior managers and elected members regularly;

3. Develop more robust quality assurance measures ensuring that all applications, assessments and authorisations comply with legislation and guidance;
4. Review the Best interest Assessor<sup>192</sup> and section 12 Doctor<sup>193</sup> capacity to ensure they have sufficient workforce in these areas to meet the requirements under DoLS;
5. Review their engagement with the relevant person, their families and carers. This included the need to gain feedback on the clarity and effectiveness of available information;
6. Consider where closer partnership working, (between the council and BCUHB) could bring benefits and improve outcomes for patients and families;
7. Ensure that training in the Mental Capacity Act and DoLS becomes mandatory and is delivered regularly. The effectiveness of the training should be audited (page 13.)

Elsewhere within BCUHB DoLS is given only minimal mention. The 2011 BCUHB 'Restraint Policy' includes sections on the Mental Capacity Act (2005) and consent but says little about capacity with only a single line on cognitive impairment stating 'Patients with cognitive impairment will often not understand oral explanations, and additional consideration has to be taken' (page 13). The policy was due for updating in June 2014 but had not been updated as of September 2017. An email received in the Ockenden team office from staff member 85 on the 26.9.17 stated 'For information, this policy is currently awaiting re-ratification on a corporate level.' It is of significant concern to the Ockenden review team that a policy of such significance to Mental Health Care provision across North Wales has been permitted to become out of date and is out of date by such a significant time period. This concern holds true regardless as to whether there are significant changes to the policy or not.

*“Patients with cognitive impairment will often not understand oral explanations, and additional consideration has to be taken’ (page 13)”*  
(BCUHB 2011)

*“The policy was due for updating in June 2014 but had not been updated as of September 2017.”*

## 19.6 Wales's wide response to the 2014 Cheshire West Ruling

The advent of the 2014 Cheshire West<sup>194</sup> ruling clearly galvanized DoLS at a national level across Wales (see NHS Wales 'Implications of the Supreme Court judgement regarding the Deprivation of Liberty Safeguards' report to the Quality and Safety Committee 11th June 2014) BCUHB responded with a 'relaunch' of the procedures and arranged conferences and briefings that were attended by BCUHB employees.

## 19.7 BCUHB Response

Even prior to the 2014 Cheshire West judgement and the CSSIW report (2014) the low levels of DoLS applications across BCUHB are beginning to raise concerns (see the safeguarding report to the Board dated 28th November 2013 with

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<sup>192</sup> See glossary

<sup>193</sup> See glossary

<sup>194</sup> See glossary

reference paper 13/191. This says 'perhaps [this] indicates a low level of knowledge of DoLS on ward areas across BCUHB'. The report notes the responsibilities of the Health Board to ensure its employees have 'knowledge consistent with their roles, responsibilities and authority' is noted. The report suggests that DoLS is out of alignment with other governance structures so that is seen as an issue purely for the Mental Health CPG. In order to improve the situation this paper proposes that DoLS information is directed through the Quality and Safety Committee and that DoLS operational staff should join appropriate governance fora outwith the Mental Health CPG. It is also proposed that adult protection training should now include DoLS. It notes that six BCUHB staff had been trained to provide advice across the whole of BCUHB.

*“The problems of day to day management of the DoLS process across BCUHB were evidenced by the breaches in protocol seen over the previous month which had totalled 41 and were for various reasons, mostly around lack of key staff and poor documentation.”*  
(BCUHB July 2014)

## 19.8 Progress with DoLS at BCUHB by 2014

In July 2014 the Partnership Improvement and Development Manager presented a paper to the MHA committee that attempts to understand the DoLS activity involved (largely in the acute wards) and the likely workforce resources required to meet the need. This is in terms of the roles of Best Interest Assessors (BIAs), Section 12 Approved Doctors and IMCAs<sup>195</sup> (The problems of day to day management of the DoLS process across BCUHB were evidenced by the breaches in protocol seen over the previous month which had totalled 41 and were for various reasons, mostly around lack of key staff and poor documentation.)

### Proposals in the action plan include:

- Consideration of the place of reporting given the relationship of DoLS to safeguarding;
- Scoping the issue in supported accommodation;
- The development of a staff training and communication plan;
- The development of a larger network of Health Boards to ensure consistency of approach and the potential of sharing good practice.

Following this proposal in 2014 the DoLS data has been reported to both the Mental Health Act Committee and the Quality and Safety Committee. It has also been reported to the BCUHB Board as a part of the Annual BCUHB safeguarding report. This includes not only vulnerable adults but also includes the important issues of child safeguarding.

## 19.9 Key point: what was the progress with training in DoLS from 2014 onwards?

### Minimal progress was made.

Despite the apparently positive findings of the CSSIW report (May 2014) training issues around DoLS were and remained a major concern at BCUHB. A source of concern regarding the lack of compliance in DoLS training is the HIW – Inspection

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<sup>195</sup> See glossary



Management Letter dated June 2014 regarding the Ablett Unit in Ysbyty Glan Clwyd. This inspection came after the closure of Tawel Fan ward in December 2013 but focused on other wards remaining open in the Ablett Unit. The letter states 'on Tegid and Dinas wards there was 0% compliance in Mental Capacity Act 2005 training.' Also stated within the management letter is that the Mental Health Act 1983 and Deprivation of Liberty Safeguards (DoLS) training on Dinas ward had 0% compliance.'

There was clearly a continuing difficulty in delivering the training since an inspection a year later reports '...on Tegid and Dinas wards there was still 0% compliance in Mental Capacity Act 2005 training. (See HIW 'Glan Clwyd Hospital – Ablett Unit – Inspection – 6-8 July 2015 report.)

In units not specifically dedicated to mental health problems (but where elderly people presenting with dementia amongst other co morbidities) are cared for difficulties in DoLS compliance also persist. An example is Deeside community Hospital HIW visit taking place on 24-25 November 2016 where DoLS issues identified by HIW were stated to be of such significant severity that HIW required immediate reassurance that BCUHB would put in place remedial actions.

The HIW BCUHB Annual Report 2014-15 notes under 'Key Themes' that access to training was 'another regular theme arising from our inspections'. This included both training pertinent to role but also mandatory training. The report described inconsistency in recording and evidencing in 'key and important aspects' of care. This included the Mental Health Act, Mental Capacity Act and DoLS. The HIW BCUHB Annual Report 2015-2016 reports that there has been progress in the systems to monitor mandatory training in the mental health units but 'some areas had poor completion rates and at the time of our visit were 0%'. External monitoring suggested that training was not being adequately delivered up to this period. The MHA Committee in its June 2016 minutes reported that MCA and DoLS training had been incorporated into the Mandatory Training Policy with increasing numbers of face to face sessions across BCUHB.

The 2014 CSSIW report also required that BCUHB assessed the effectiveness of the training it provided. One measure would be the number of DoLS applications both in absolute terms and as a rate per 100,000 of population as this would allow meaningful comparison with other Health Boards across Wales.

A recent joint CSSIW HIW Deprivation of Liberty Safeguards Annual Monitoring Report (2015-16) notes that in absolute terms BCUHB received 788 applications, more than any other Health Board across Wales. (Page 12.) This is a significant rise since the 2014 Cheshire West judgement when the number was below 100. However this number is still fewer than might be expected as the rate per 100,000 of the population is only 98 per 100,000 population. It is stated that only the Aneurin Bevan Health Board has a lower rate (35 per 100,000 population.) whilst the highest rate is Abertawe Bro Morgannwg Health Board (340 per 100,000 population; see page 9). This report suggests that there is still considerable variation in practice across Wales and that BCUHB is still not recognising all those patients who should be managed under the DoLS process.

*“On Tegid and Dinas wards there was 0% compliance in Mental Capacity Act 2005 training.’ Also stated within the management letter is that The Mental Health Act 1983 and Deprivation of Liberty Safeguards (DoLS) training on Dinas ward had 0% compliance.”*

*“DoLS issues identified by HIW were stated to be of such significant severity that HIW required immediate reassurance that BCUHB would put in place remedial actions.”*

*“...On Tegid and Dinas wards there was still 0% compliance in Mental Capacity Act 2005 training.”*  
(See HIW 'Glan Clwyd Hospital – Ablett Unit – Inspection – 6-8 July 2015 Report.)

## 19.10 Key point: The DoLS position in BCUHB in 2017

In a recent report for BCUHB, (March 2017) the majority of DoLS applications are urgent – 701 out of a total of 788 and only 1% of urgent decisions were made in the allotted time span (the average for Health Boards across Wales was 28%). (see page 12.) This shows BCUHB as a significant negative outlier when compared to other Health Boards. It is acknowledged by BCUHB that 'compliance with DoLS legislation remains a concern'. (Quality, Safety and Experience Committee 29th March 2017 QS17/65.7)

The 2015-16 report states that overall 'the delays in decision making raise a serious concern about the effectiveness of the safeguards and the risk of unauthorised and unnecessary deprivations of liberty in hospitals..' (page 12)

*“compliance with DoLS legislation remains a concern”.  
(Quality, Safety and Experience Committee 29th March 2017 QS17/65.7) ”*

## 19.11 Conclusions on Deprivation of Liberty Safeguards or DoLS

### 19.12 Wales

Deprivation of Liberty Safeguards introduced in 2009 have provided significant challenges to organizations throughout England and Wales particularly following the 2014 Cheshire West Judgement. The reorganization of Health Services across Wales and specifically in North Wales in 2009 coincided with the introduction of DoLS legislation.

### 19.13 BCUHB

There appears to have been an initial period of ensuring the functions of the Supervisory and Managing Authority were clarified and put on a sound footing. Prior to the closure of Tawel Fan ward in December 2013 DoLS had a relatively low profile, particularly in the Mental Health and Learning Disabilities CPG. The numbers of applications and authorisations were low across the Health Board although numbers across Wales were small at this time. The compliance with DoLS training also appeared to be persistently low.

*“The compliance with DoLS training also appeared to be persistently low.”*

There is evidence of a limited corporate response by BCUHB to the 2014 Cheshire West judgement and the CSSIW report of 2014. The accounting and reporting lines for DoLS were changed and added to. From May 2014 DoLS reports came not only to the Mental Health Act Committee but also to the 'Safeguarding and Protection of People at Risk' Sub committee of the Quality and Safety Committee (later the Quality, Safety and Experience Committee).

### 19.14 The BCUHB Board and DoLS

The BCUHB Board was kept informed of the difficulties BCUHB had in adhering to DoLS requirements through the Annual Safeguarding Report. There was little evidence of any action taken as a result of this information reaching the Board. The DoLS coordinators at BCUHB have faced an uphill and ongoing struggle to manage the process of getting a DoLS authorized in a timely manner. Some

action have been taken to recruit to these posts but these do not appear to have been sufficient given that DoLS breaches continue to be reported by HIW.

It is noted in a report titled 'Deprivation of Liberty Safeguards—Legacy Statement' dated January 2016 that almost all the increase in DoLS applications came from a single site, ('Wrexham General') suggesting localized efforts in raising the profile of DoLS that is not found across all other areas of BCUHB. (See page 4). This is attributed to 'a level of knowledge of MCA within key Managing Authority (MA) staff and engagement with the DoLS process' (see page 5). This 'Legacy Statement' proposes a transfer of 'some functions of Supervisory Body from the Office of the Medical Director to the Executive Director of Nursing', thus ensuring that DoLS then becomes part of the Adult Safeguarding portfolio. This proposal is set out in a lengthy (50 page) document.

### 19.15 Overview of DoLS training and BCUHB

DoLS training was eventually made mandatory across BCUHB in 2016 and the levels of training in the Mental Health and LD CPG were wholly inadequate for a year and more following the 2014 Cheshire West judgement. BCUHB as an organization appeared to have been slow when DoLS was initially introduced to understand the implications of DoLS across the organization. However with the 2014 Cheshire West judgement there is evidence of some work to scale up the operation of DoLS to meet the increasing numbers of applications and to raise the importance of the issue across the governance structure of BCUHB.

Implementation of DoLS has proved to be a difficult issue for many organizations. More broadly, both within BCUHB and nationally the focus has been on numbers and the ways in which the complex processes involved with DoLS have been applied. There has not yet been a systematic attempt to understand the experience of those who are subject to the DoLS processes or further to understand the experience of their carers.

*“There has not yet been a systematic attempt to understand the experience of those who are subject to the DoLS processes or further to understand the experience of their carers.”*

### 19.16 DoLS, BCUHB and the BCUHB risk register

In both 2015 and 2016 continuing concerns regarding DoLS and Adult Safeguarding were raised across BCUHB. A Governance Framework and Risk Register provided to the review (v2 dated 15.11.15) gives a 'Red' 4x 5 score of 20 to the following BCUHB Risk/Issue 'Implementation of adult safeguarding requirements within national legislation(i.e. Social Services and Wellbeing Act- Wales, 2014; **DoLS**, MCA, neglect.'

The risk register states the position at that date to be 'limited resource within the corporate team to address [the] adult safeguarding agenda, leading to limited assurance to [the BCUHB] Board that appropriate safeguards are in place to meet statutory and legislative duties..' A later report in December 2016 titled 'Annual Safeguarding Report BCUHB' covering the period from 31.03.15 to 01.04.16 by Dr Louise Bell included the table 'Safeguarding Risk Register – top scoring risks (as of 16.12.16). This provides a 'red' risk of 5 x 5 (25) for the following: 'There is a risk

*“Limited resource within corporate team to address adult safeguarding agenda, leading to limited assurance to Board that appropriate safeguards are in place to meet statutory and legislative duties..”*

of sanctions caused by significant failures to comply with safeguarding legislation (Mental Capacity Act and Deprivation of Liberty Safeguards.) (page 3) Also noted as 4x4=16 is 'There is a risk associated with the four current safeguarding teams (Adults; DoLS, Children, Midwifery) currently working in isolation leading to a risk of significant harm created by 'silo' working and poor communication....'

*“There is a risk associated with the four current safeguarding teams (Adults; DoLS, Children, Midwifery) currently working in isolation leading to a risk of significant harm created by 'silo' working and poor communication...”*  
(BCUHB December 2016)

### 19.17 Case study 2 – Experience of DoLS

In the summer of 2017 the Ockenden review team received an example of feedback from a carer, (service user number 42) regarding her family experience of the Deprivation of Liberty, (DoLS) process in North Wales. Permission has been given by the carer to share this experience within the report in an anonymized form. The full case study is reproduced in the appendices.

The summary has been prepared using the 7 'C's' methodology that was utilized throughout all of the service user engagement and listening events from April to July 2017. Explanation of the 7 'C's' methodology is found in greater detail later in the report.

### 19.18 Why is it important to consider this story of DoLS in North Wales?

The story told by service user representative number 42 in June of 2017 largely concerned an experience of DoLS in a care home in North Wales following the decision made to close the home.

**It is important to note that this is not a case study that describes any inaction on the part of BCUHB but instead shows that BCUHB staff who knew this vulnerable elderly lady well were not consulted in her care provision/planning.**

In reviewing the current governance of the DoLS process as applied to this elderly lady, it was considered important by the Ockenden review team to relate this experience as told by her next of kin. The story showed a lack of communication with (and involvement of) BCUHB clinical staff 'on the ground', (the elderly patients own CPN and community nurse who had cared for the elderly person for over two years were not consulted by either the care home, the Best Interest Assessor, (BIA) or the Relevant person's Representative (RPR) as part of the DoLS process.)

There are also aspects of the distressing experience described by the carer that are relevant to, and resonate with wider aspects of both the situation in DoLS within BCUHB and other aspects of the systems, structures and processes around the management of complaints from the carers and representatives of elderly vulnerable people that the review has been told about within BCUHB. On balance, the Ockenden governance review team felt it should highlight. The experience of service user representative, number 42 representing her elderly number at a 'listening and engagement event' in the summer of 2017 showed a DoLS system in North Wales that in the last eighteen months was still not fit for purpose and did little if anything to protect the interest of vulnerable elderly people across North Wales.

## 20 Chapter 12

### 20.1 Service user and service user representative engagement in the Ockenden review:

**Introduction to the 'Listening and Engagement' events held across North Wales as part of the service user and service user representative engagement in the review of current governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB.)**

### 20.2 Feedback from individual engagement and listening events – where were they held?

- 3rd April Llanwrst
- 4th April Llandudno
- Bangor 8th May 2017
- Tywyn 9th May 2017
- Pwllhelli 10th May 2017
- Llangefni 5th June 2017
- Rhyl 6th June 2017
- Holywell 7th June 2017
- Wrexham 4th July 2017
- Prestatyn 5th July 2017

### 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



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).

*“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).”*

## 20.4 The NWCHC values are stated as:

### To be:

- Open, honest, trustworthy and accountable;
- Independent, impartial and acting with integrity;
- Challenging and critical in a constructive and realistic way;
- Efficient and effective;
- Respectful of patients views, experiences and concerns;
- Complying with legislation and regulations in relation to Data Protection, Welsh Language and Equality, Diversity and Human Rights; Health and Safety.

## 20.5 The Core Activities of the NWCHC are described by them as:

- Speaking up to protect and improve health services;
- Monitoring and scrutinising health services to ensure their quality and safety;
- Influencing NHS service changes so they reflect what matters most to patients and the public;
- Helping patients and the public to raise concerns or complaints about the NHS when things go wrong.

NWCHC had extensive and long term experience of undertaking public engagement and formal consultation exercises across the whole of North Wales. Its experience had enabled it to develop wide-ranging networks across the region and to build upon its resources and tools for undertaking public engagement.

## 20.6 Who are NWCHC?

NWCHC is made up of more than seventy members who are placed across the six counties of North Wales. They are one of its main 'links' to the many diverse communities in the region. The members are supported by a team of staff based in its Wrexham and Bangor offices. To date NWCHC members have gained experience of undertaking surveys, questionnaires, distributing fliers and networking with patients and the public about a range of healthcare issues. NWCHC members' experience of visiting health care settings across the region has provided them with the skills required to 'engage' with people from all walks of life. The NWCHC has a number of members and staff who are able to communicate effectively through the medium of Welsh.

## 20.7 How do NWCHC make contact with the public in North Wales?

As of spring 2017 NWCHC had a large following through its social media pages. It had gained circa 1200 followers who actively shared the information that is posted by NWCHC. Its social media pages enabled it to publicise information and for views to be shared with NWCHC from members of the public on a confidential basis.

NWCHC also had an extensive database of contacts across the region, these were said to include all Town and Community Councils; Assembly Members (AMs) & Members of Parliament (MPs), County Voluntary Councils; patient and support groups; Third Sector organisations; social and community based groups (such as the Women's Institute or WI, and the Rotary club.) They had contact with a wide range of media organisations (including local and national publications, radio, television, and community papers and newsletters) The NWCHC considered themselves to have developed good links with groups representing the less frequently heard, (for example carers of all ages). Its database allowed it to distribute information to a wide ranging audience at short notice.

*“NWCHC considered themselves to have developed good links with groups representing the less frequently heard, (for example carers of all ages).”*

NWCHC had commissioned a 'Survey-Me' app. This is a mobile survey 'app' for smartphones and tablets and is designed to capture people's opinion in 'real time'. Survey-Me compiles information received and produces results as they are collected. It can be used on-line or face to face. A number of NWCHC members had been provided with tablets which could be used to undertake surveys in this way. Training had also been provided to NWCHC members who wished to use this tool.

The NWCHC's Independent Advocacy Service had a good reputation across North Wales in helping people who wished to raise concerns or complaints about the NHS. This was through providing a free, independent, confidential, non-legal, client-led service. It helps patients or their representatives in making a complaint under the NHS 'concerns' process. Its advocacy staff are well-trained and committed to the central principles of independence, confidentiality, best interests and empowerment. All services provided are with an end aim being to resolve issues satisfactorily, but also encouraging lessons to be learnt from the experiences shared and improving services for future service users.

## 20.8 The Public Engagement and Listening Events held from April to July 2017

The aim of these events was more specifically designed to look at the second part of the Ockenden review – to review governance arrangements relating to Older People's Mental Health (OPMH) Services from the formation of the Betsi Cadwaladr University Health Board (BCUHB) in 2009 until the current time. The public engagement and listening events would also clearly undertake to bring any information relevant to either part of the review should this emerge during any session. The sessions were planned across the six counties of North Wales and were facilitated and supported by the NWCHC at each venue. Venues and

locations were visited as advised by the NWCHC to ensure that the Ockenden governance review reached out to and was representative of older people across the BCUHB OPMH catchment area. Each individual session was led by Donna Ockenden with the NWCHC in attendance at each session. Practical arrangements such as selection of and booking of venues and rooms was also completed by the NWCHC administration team.

*“Venues and locations were visited as advised by the NWCHC to ensure that the Ockenden governance review reached out to and was representative of older people across the BCUHB OPMH catchment area.”*

## 20.9 Planning the Engagement Events – an Overview

### Components and Structure

Taking these broad themes and the Ockenden review Terms of Reference into account, three key components for the events were identified.

1. **Introduction** from Donna Ockenden of the Ockenden review team clearly outlining the nature of the review and importantly setting out the parameters within which the Ockenden team would work to ensure that contributions appropriate to the agenda were generated;
  - a) The ways information would be utilised to support the work of the review in producing a report of value to the BCUHB and the communities it serves;
  - b) The importance of confidentiality within the meetings;
  - c) That information would need to be shared with BCUHB and other appropriate persons/organisations in the event that evidence of serious harm or potential criminal wrong doing came to light.
2. A series of smaller 'break out' and discussion sessions based around seven main 'C' themes which were known throughout the Ockenden review as the '7' C's:
  - a) **Compliments**;
  - b) **Comments**;
  - c) **Concerns**;
  - d) **Complaints**;
  - e) **Care planning**;
  - f) **Care delivery**;
  - g) **Communication and engagement**;
  - h) Any other information that did not fit into the '7'C's' above but was relevant to the Ockenden governance review would be considered and recorded.
3. **Individual sessions.** It was envisaged that some people might not want to be part of the group work and may wish to talk to members of the governance review team on a one to one basis. This would always be facilitated where the need arose.

It was recognised that the events must be able to offer to help those who might experience distress during the discussions. A NWCHC officer and NWCHC members plus Donna Ockenden of the Ockenden team would be available to signpost attendees to the most appropriate course of actions should it be clear that individuals had needs that extended beyond those of the review process.

## 20.10 Identifying venues and a timetable

The catchment area covered by the BCUHB was known by the Ockenden review team to be geographically extensive. Working with the NWCHC every effort was made to provide coverage across the Health Board catchment area, recognizing that there are potentially different experiences in different geographical areas.

Appropriate venues and timings were identified by the NWCHC who also undertook the facilitation, communication and registration process for the meetings. NWCHC officers planned to attend the venues supporting the running of the events and to discuss issues that arose with individuals that were felt to be within the NWCHC's sphere of activity, but outwith that of the Ockenden governance review. Should it be felt that an individual required signposting to BCUHB services, then that would occur by the most appropriate route, and supported by the NWCHC.

It was originally agreed that the events would take place during the months of April, May and June 2017 and that there was a need to raise an awareness of the events at the earliest stage possible – despite the fact that venues and dates had not been decided upon. A press release was agreed and widely distributed by the NWCHC on 17th February 2017. This was produced in Welsh (Appendix 1a) and in English (Appendix 1b) and was shared with the NWCHC's contacts and networks. The press release was also publicised on the NWCHC's social media pages.

Dates and venues for the events taking place in April and May were agreed on the 24th March 2017. These were as follows:

- 3rd April 2017 at Glasdir, Plas yn Dre, Llanrwst, Conwy;
- 4th April 2017 at the Conwy Business Centre, Llandudno Junction, Conwy;
- 8th May 2017 at the Management Centre, Bangor Business School, Bangor, Gwynedd;
- 9th May 2017 at Neuadd Pendre Social Centre, Tywyn, Gwynedd;
- 10th May 2017 at Plas Heli, Hafan, Pwllheli, Gwynedd.

Due to the nature of the geography of the North Wales region it was recognised that listening to the voices of people living and receiving care across the BCUHB catchment area would mean offering more than one engagement event for each of the six local authority areas.

On the 24th March 2017, a second press release was issued confirming the dates and venues for the events planned to take place during April and May. The press release was published in Welsh (Appendix 1c) and English (Appendix 1d). Again,

*“The catchment area covered by the BCUHB was known by the Ockenden review team to be geographically extensive. Working with the NWCHC every effort was made to provide coverage across the Health Board catchment area, recognizing that there are potentially different experiences in different geographical areas.”*

the press releases were shared with the NWCHC's contacts and networks. They were also publicised on the NWCHC's social media pages.

As had been indicated in the first press release (Appendix 1a and Appendix 1c) it was recognised that further events were needed. Additional dates and venues were agreed to take place in July 2017. A third press release was issued on the 12th April 2017. The press release was published in Welsh (Appendix 1e) and English (Appendix 1f). The press releases were again shared with the NWCHC's contacts and networks. They were also publicised on the NWCHC's social media pages.

The NWCHC's contacts and networks distribution lists contained in the region of 800 individual contacts. These include but are not limited to – all Town and Community Councils in the BCUHB area; Assembly Members and Members of Parliament; Press and Media contacts; Newsletters and Community Newspapers; County Voluntary Services Councils for the 6 Local Authority Councils; Voluntary Organisations and support groups; Local Authority (Social Services); Patient support groups; Bangor University and Glyndwr University; Colleges of further education; Citizens Advice Bureaux and BCUHB itself.

Following each press release, the NWCHC received enquiries from members of the public and from people representing a range of organisations. Some wished to book themselves on to their chosen event, others required further information. The NWCHC also followed up the press releases by contacting a range of organisations.

The appendices provide a list showing the range of organisations who had either made contact with the NWCHC or had been contacted by the NWCHC about the Ockenden review planned engagement and listening events. The NWCHC also used its social media platforms, (Facebook and Twitter) to publicise the events. Before and during the engagement and listening events the number of Tweet 'impressions' on the NWCHC's Twitter account relating to the events was 36,095. Tweet 'impressions' are the number of times a single 'Tweet' or message has been viewed.

Finally, the NWCHC enabled people to make contact about the events either through its website, social media pages; e-mail, telephone and by post. The NWCHC also offered a mobile survey 'app' for smartphones and tablets called 'Survey-Me' so that people could also provide views on services as well as book on to the engagement events.

*“Before and during the engagement and listening events the number of Tweet ‘impressions’ on the NWCHC’s Twitter account relating to the events was 36,095. Tweet ‘impressions’ are the number of times a single ‘Tweet’ or message has been viewed.”*

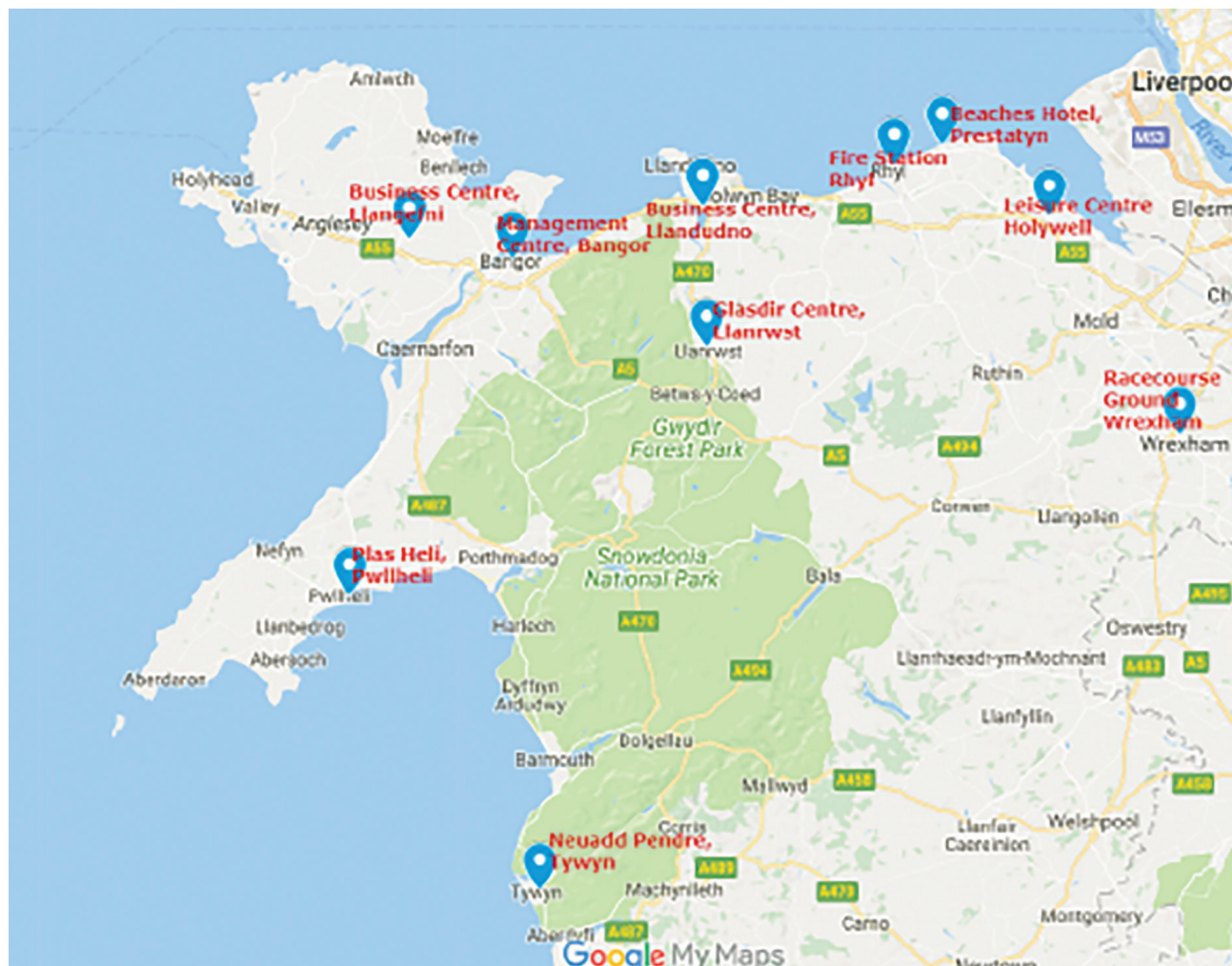
## 20.11 A breakdown of the number of people and/or organisations who made contact with the NWCHC about the engagement and listening events is as follows:

- 15 – via Survey-Me app
- 26 – Via NWCHC e-mail address
- 25 – via NWCHC telephone
- 11 – Other (letter/word of mouth)
- (Total 77)**



## 20.12 Delivering the Ockenden review listening and engagement events across North Wales – an overview

The following map of North Wales shows the location of the venues for all of the engagement and listening events. The event planned to have taken place at Ruthin on the 3rd of July was cancelled due to unavoidable travel problems encountered by the team whilst enroute! Those who had planned on attending the event were notified and either attended the event on the 4th July or arrangements were made for Donna Ockenden to contact them in person.



### Venues visited by Donna Ockenden for the 'Listening and Engagement' events April to July 2018

**April:** Glasdir Centre, Llanrwst  
LL26 0DF

Conwy Business Centre, Llandudno  
LL31 9XX

**May:** Management Centre, Bangor  
LL57 2DG

Neuadd Pendre, Tywyn LL36 9D

Plas Heli, Pwllheli LL53 5YT

**June:** Anglesey Business Centre,  
Llangefni LL77 7XA

Community Fire Station, Rhyl  
LL18 3DG

Leisure Centre, Holywell CH8 7UZ

**July:** Racecourse Ground,  
Wrexham LL11 2AH

Beaches Hotel, Prestatyn LL19 7LG

## 20.13 Background to development of the 7C's methodology used in the Listening and Engagement events

A number of documents informed the development of the '7C's' framework underpinning the Ockenden review engagement and listening exercises across North Wales.

1. **'Dignity and Essentials of Care Inspections 2014-15' from Healthcare Inspectorate Wales (HIW).** This document reported on the inspections that HIW undertook over the period 2014 – 2015. Overall forty six inspections took place with seventeen immediate action letters issued. BCUHB received seven inspections and six immediate action letters were issued.
2. **'Older Persons Framework for Action 2013-17'** in which the Older Persons Commissioner for Wales argues for 'safe, efficient, dignified care', 'choice and control' and effective engagement of older people in decision making about the future of services and facilities.
3. **'Cracks in the Pathway'** from the Care Quality Commission (CQC 2014) puts stress on patient and carer engagement particularly in the planning and delivery of care to ensure individualized programmes of care. Listening, feedback and learning are central to this process.
4. **'Better Care in my Hands'**, also from the CQC in 2016 important issues in the development of meaningful, responsive, effective care: – with consideration of information, advocacy, involvement, capacity, education and family involvement.
5. **'Building Bridges, Breaking Barriers'** from the CQC in 2017 looks at identification of need, prevention, individual care, planning and assessment, recognition and management of change but particularly the co-ordination of care across providers.
6. **The Terms of Reference** for both the Ockenden review and the HASCAS review (both BCUHB 2015).

## 20.14 Format and Content of the 'Listening and Engagement' Events

Attendees were asked to register their attendance prior to the events with the NWCHC in order that the team could prepare the most appropriate structure to the particular session. For the April 2017 events, Donna Ockenden was accompanied to the events in Llanrwst and Llandudno Junction by two members of her team and NWCHC officers. For these events it was agreed that attendees could conduct individual discussions with either Donna Ockenden or members of her team, in private sessions. Prior to the individual discussions, Donna Ockenden provided an overview of the review and the format of the engagement events by presenting a brief 'PowerPoint' presentation. The presentations slides were provided in both Welsh (Appendix 3a) and in English (Appendix 3b) and copies of the presentations were available in Welsh and in English as paper copy handouts.

The remaining events all followed a similar format. These events were facilitated by Donna Ockenden and a NWCHC officer. An introduction was provided by Donna Ockenden with the use of PowerPoint (see Appendix 3a and 3b). The main session was based on discussion focusing on the '7 C's' –

- a) **C**ompliments, **C**omments, **C**oncerns and **C**omplaints;
- b) **C**are planning and **C**are delivery;
- c) **C**ommunication and engagement.

Attendees took part in a 'round-table' discussion focusing on their own experiences of the 7 C's in Older Peoples Mental Health Care in turn. Detailed and contemporaneous notes of all discussions were taken based on the feedback given. Where attendees felt that they were not comfortable in talking openly about their experiences, one-to-one 'break-out' sessions were offered, where attendees could talk to Donna Ockenden on an individual basis. Where time was limited, Donna Ockenden arranged to either meet with individual attendees at an agreed later date or to conduct a discussion over the telephone.

Following all of these events, contact details were provided by all attendees. Donna Ockenden wrote to each attendee to thank them for their attendance and input and advised them of the next steps following the engagement events. Each attendee at the engagement events was subsequently sent the notes of the event they attended with their own contribution highlighted via an individual number. The unique 'number' attributed to each attendee was only known to the Ockenden team and the attendee themselves. Each attendee was given the opportunity to check both the general discussion recorded as occurring in the session they attended and check and verify any contributions attributed to the individual. In some cases service user representatives did not wish to have a number and these responses are recorded without a number as requested.

## 20.15 Structure of the Engagement Events:

Taking the broad themes from these documents and the Ockenden review Terms of Reference, (BCUHB 2015) into account there followed discussion with both the North Wales Community Health Council and BCUHB. Three key components for the events were subsequently identified.

- a) **Introduction** from the Ockenden review team clearly outlining the nature of the review and importantly setting out the parameters within which we were working to ensure that contributions appropriate to the agenda are generated. Essentially this covered what was of relevance to the review and what was within its remit, (and what was not) Guidance was given as to how any information gained would be employed to support the work of the Ockenden governance review in producing a report of value to BCUHB and the communities served by BCUHB.
- b) The importance of confidentiality within the meetings.

*“what was of relevance to the review and what was within its remit, (and what was not)”*

- c) That information would need to be shared in the event that evidence of serious harm or potential criminal wrong doing came to light.
- 1. A series of smaller 'break out' sessions were proposed based around themes broken down into the '7' C's:
  - a) **C**ompliments, **C**omments, **C**oncerns and **C**omplaints.
  - b) **C**are planning and **C**are delivery
  - c) **C**ommunication and engagement
- 2. Individual sessions: – It was envisaged that some people would not want to be part of the group and might wish to talk on a one to one basis. Arrangements for this were put in place. One to one sessions could also offer help to those who might experience distress during these sessions. The availability of one to one sessions was discussed in the introduction to each session. NWCHC members and members of the Ockenden team were available to signpost attendees to the most appropriate course of action should it be clear that an individual had needs that extended beyond those of the Ockenden review process.

## 20.16 Attendees

Attendees were asked to register their attendance prior to the meetings with the NWCHC in order to prepare the most appropriate structure for a particular session. Attendees were initially asked to express a preference for one of the 'break out' sessions. Following on from the first sessions in April 2017 the feedback gained was that attendees wished to comment on all aspects of the 7'C's and this was facilitated from the May 2017 sessions onwards. The NWCHC engaged throughout the spring and summer of 2017 with local third sector providers in order to ensure the most representative opinion and thus ensuring the Ockenden governance review worked beyond gathering a series of individual responses.

## 20.17 Meeting administration

The catchment area covered by BCUHB is known to be geographically extensive. Working with the NWCHC there was every effort made to provide coverage across the Health Board catchment area. This was important as both the NWCHC and the Ockenden team recognized that there were potentially different experiences of healthcare provision for older people in different areas of North Wales. Listening to the voices of people living in and receiving care or acting as carers across the BCUHB catchment area inevitably involved both the NWCHC and the Ockenden review team in a significant amount of time to cover the area. This was achieved by extending the listening and engagement phase from April 2017 to July 2017, (inclusive) and offering further one to one telephone calls and face to face meetings with Donna Ockenden if required. Attendees were also able to submit documentation for consideration by the Ockenden review team of they felt that this contributed to the Ockenden review team's consideration of

*“Listening to the voices of people living in and receiving care or acting as carers across the BCUHB catchment area inevitably involved both the NWCHC and the Ockenden review team in a significant amount of time to cover the area.”*

the systems, structures and processes of governance underpinning Older People's Mental Health.

Appropriate venues and timings were identified by the NWCHC who also undertook the facilitation, communication and registration process for the meetings. Organization and leadership of the 'open meeting', 'break out' sessions and individual sessions at the venues were undertaken by Donna Ockenden as was any individual follow up requested or required by individual attendees relevant to the governance review.

NWCHC members were present at the venues and supported the running of the meeting venues. They were available to discuss issues that arose with individuals that were felt to be within their sphere of activity, but outside that of the Ockenden review. Where it was felt that an individual required signposting to BCUHB services that would occur by the most appropriate route. With permission of the individual concerned contact details could be taken at the event and passed on promptly to appropriate staff within BCUHB where this was felt necessary. Although these 'signposting' arrangements were available to be put in place if necessary they were not actually ever used throughout the listening and engagement events. Attendees at the events were all very clear as to the purpose of the events and did not require further signposting to or support from BCUHB via the Ockenden team or NWCHC throughout the spring/summer of 2017.

## 20.18 Utilising the 7C's framework

Each session followed the same format utilising the framework of the '7 C's' so that, as far as was possible the areas of information gathered was consistent. In Part A of each event Donna Ockenden gave a brief presentation about the background and purpose of the governance review. Attendees were asked to give feedback about their experiences of utilising current governance arrangements within Older Persons Mental Health at BCUHB focusing on each of the 7 'C's' in turn. Quotations from those taking part are provided in Part B below.

## 20.19 Feedback from the event on 8th May 2017 – Management Centre Bangor

### Summary of feedback on the 7C's

#### Compliments:

The session opened with those in attendance at Bangor asked to focus on complimenting BCUHB for the things they did well. As someone who had worked in and around the NHS for more than thirty years Donna Ockenden reminded the attendees that frontline NHS staff very much appreciated positive feedback and that she would ensure that any such feedback was passed promptly to BCUHB for sharing with staff.

Attendees found it very difficult to think of any compliments. There was some recognition from attendees that individual members of staff within the BCUHB

*“Attendees at the events were all very clear as to the purpose of the events and did not require further signposting to or support from BCUHB via the Ockenden team or NWCHC throughout the spring/summer of 2017.”*

*“Donna Ockenden reminded the attendees that frontline NHS staff very much appreciated positive feedback and that she would ensure that any such feedback was passed promptly to BCUHB for sharing with staff.”*

*“There was some recognition from attendees that individual members of staff within the BCUHB 'system' were trying their best, often in very difficult circumstances and that in these situations, people were not quick enough to compliment.”*



'system' were trying their best, often in very difficult circumstances and that in these situations, people were not quick enough to compliment.

### **Concerns and Complaints:**

There was a strong feeling of apathy and unhappiness amongst those attending about the complaints system both overall and specific to older person's mental health care. Delays on the part of the Health Board in responding to complaints was discussed as a concern as was the poor quality of responses once received. Others felt that the complaint process was not clear and transparent that the Health Board had an air of 'arrogance' when dealing with any complaints. Some talked about the reluctance to complain – particularly amongst the elderly – others said that they didn't know how to go making a complaint using the BCUHB complaints process.

### **Care Planning:**

Discussion took place with service users and their representatives at Bangor about the delays in diagnosing dementia across North Wales. Further discussion ensued around the lack of imagination in discussing and developing care plans. Care plans were described as standardised with no room for individuality and with little or nothing perceived as being done to ensure that the individual was at the heart of any care planned or delivered. Delayed Transfers of Care and the lack of 'dementia' beds and EMI residential homes were also discussed.

### **Care Provision/Care Delivery:**

Concern was expressed about the lack of support for carers. Discussion also took place about staff shortages across both nursing and medical staff in the care of older people with mental health problems across the BCUHB catchment area. Carers described long waiting lists and how these then caused delays in the care process. Lack of any therapies and activities for older persons for dementia was noted. In particular, attendees questioned when such activities were provided, whether they are tailored around the patients' needs. Others queried how patients with learning difficulties or younger people with dementia were catered for. The experience attendees had was that these were both groups of people 'forgotten' by the BCUHB system. The issue of travelling times across North Wales in order to access care led to questions about whether there were enough staff employed by BCUHB to deliver the care required. An increase in independent mental health advocacy support was said to be urgently needed. The language barrier for elderly Welsh speaking patients was also seen as being problematic in accessing care provided by BCUHB.

### **Communication:**

Attendees expressed concern at a lack of public knowledge surrounding today's event, although it was noted that many agencies had been contacted and a lot of information about the event shared amongst existing networks. Some questioned why BCUHB was not in attendance and not appearing to be visibly involved in speaking with and listening to service users and their representatives. Discussion

*“Delays on the part of the Health Board in responding to complaints was discussed as a concern as was the poor quality of responses once received.”*

*“Care plans were described as standardised with no room for individuality and with little or nothing perceived as being done to ensure that the individual was at the heart of any care planned or delivered.”*

*“Lack of any therapies and activities for older persons for dementia was noted.”*

*“The language barrier for elderly Welsh speaking patients was also seen as being problematic in accessing care provided by BCUHB.”*

took place about the BCUHB system for engagement and its current and long term lack of visibility across many parts of Gwynedd and Anglesey. The role of Independent Members of the Health Board in engagement was queried. Attendees felt that there were too many organisations in North Wales dealing with the same issues – and as such there were too many structures and job titles. Some described difficulties in communicating with the Health Board and others talked about a lack of understanding about the services that are delivered in the many hospitals across the region. Poor communication between the BCUHB and the third sector overall was described, as well as a lack of knowledge on the part of some nursing staff about individual patients when in discussions with social workers.

#### Comments:

Attendees expressed concern that no-one had been seen to have been held accountable for what had happened in the Tawel Fan ward and at the lack of accountability on the part of BCUHB. There was concern that this report following the Ockenden team governance review would be either 'shelved' or not published in its entirety, or that following receipt by BCUHB, there would be a lengthy delay in publishing it or making it available to the public. Attendees queried the impact that Donna Ockenden's report would have and whether any lessons would be learnt by BCUHB as a result.

Discussion then took place about the many changes to health services in North Wales in recent years with reference to BCUHB's lack of implementation of plans following the BCUHB's pan North Wales consultation 'Healthcare in North Wales is Changing' which took place in 2012. The role of Healthcare Inspectorate Wales was discussed and there was concern that there was no 'inspectorate of standards' where both health and social care was in question. Attendees stressed that the Ockenden report should recommend that there be an increase in Independent Advocacy for Older People with Mental Health problems in the region. The values, governance and accountability of BCUHB were also questioned.

*“The role of Independent Members of the Health Board in engagement was queried.”*

*“The lack of accountability on the part of BCUHB.”*

*“Attendees queried the impact that Donna Ockenden's report would have and whether any lessons would be learnt by BCUHB as a result.”*

## 20.20 Bangor feedback – detailed discussion and individual comments recorded 'on the day'

For information on detailed discussion and individual comments recorded 'on the day' please see the appendices at the end of the report. It is recommended that any reader of this report does read in full the feedback from service users and their representatives. This will help the reader to understand the context in which the systems, structures and processes of governance underpinning Older Persons Mental Health care provided by BCUHB operates from the perspective of the service users and service user representatives met in 2017.

## 20.21 Feedback from event 9th May 2017 – Tywyn

### Summary of the feedback on the 7C's

#### Compliments:

Attendees gave examples of excellent care by individuals outside the BCUHB provision of Older Persons Mental Health care including local GPs and support workers. Praise was also given about the service at the Minor Injuries Unit at Dolgellau Hospital.

#### Concerns and Complaints:

Attendees gave very little mention as to their experiences of raising a concern or a complaint with the Health Board. It was felt overall that families were reluctant to complain to BCUHB in fear of the reprisals as a result of making a complaint.

#### Care Planning:

Discussion took place surrounding the mixed approach in planning care with a limited understanding on what services were available to older people with mental health problems. A frequent use of locum GPs in the local area meant that when carers went to GPs for advice they had little knowledge of local services and systems and a lack of understanding about individual patients. One attendee described the process of seeking help around healthcare for older people as 'intimidating and scary'. (Service user 58, Tywyn, May 2017).

#### Care Provision/Care Delivery:

Much discussion took place surrounding the theme of social isolation and isolation from the healthcare needed for elderly people with mental health issues. Attendees told of the difficulty that distances between hospitals and other BCUHB sites have for family members when visiting loved ones. They described poor public transport systems and of the isolation of elderly people when they are inpatients – sometimes more than 50 miles away from home. Attendees described services and support that were not centred on the patient, such as the current (May 2017) 'Americanised' tools for speech therapy in dementia patients and of inappropriate and meaningless activities that were arranged with no consideration of the elderly person's interests and routines. Those attendees who had caring responsibilities, told of the complete lack of respite and support, with some saying that they had had very little contact with social workers. Due to the geography of the area, attendees described a difficulty in understanding what care and support services were available locally. There was also concern raised about the lack of facilities and support for younger people who were suffering from dementia. Staff shortages and a problem in recruiting new staff to the area due to its location were also reported.

#### Communication:

Attendees told of their experiences of poor communication and a lack of sharing information between health services provided by BCUHB and social services – and between organisations in general. Communication was also described as

*“Attendees gave examples of excellent care by individuals outside the BCUHB provision of Older Persons Mental Health care including local GPs and support workers. Praise was also given about the service at the Minor Injuries Unit at Dolgellau Hospital.”*

*“It was felt overall that families were reluctant to complain to BCUHB in fear of the reprisals as a result of making a complaint.”*

*“A frequent use of locum GPs in the local area meant that when carers went to GPs for advice they had little knowledge of local services and systems and a lack of understanding about individual patients.”*

poor when families had loved ones staying in hospitals some distances away. Discussion also took place about a heavy reliance on locum GPs, meaning that there was often little understanding on the part of a locum GP about issues such as the patient's history and family support. Attendees described their experiences of receiving a poor standard in written communication from the Betsi Cadwaladr Health Board and of their ongoing difficulties in finding information about hospital and community services from the BCUHB website.

#### **Comments:**

Discussion took place about the need for Donna Ockenden's report to demonstrate the strength of feeling around poor care provision for elderly people and their families and carers amongst local people in Tywyn and surrounding areas.

#### **Detailed discussion**

For information on detailed discussion and individual comments recorded 'on the day' in Tywyn please see the appendices at the end of the report. It is recommended that any reader of this report does consider in full the feedback from service users and their representatives. This will help the reader to understand the context in which the systems, structures and processes of governance underpinning Older Persons Mental Health care provided by BCUHB operates from the perspective of the service users, carers and service user representatives met across North Wales in 2017.

### **20.22 10th May 2017 – Pwllheli**

#### **Summary feedback on the 7 C's**

##### **Compliments:**

An attendee complimented the Occupational Therapy staff at the Hergest Unit in Ysbyty Gwynedd – however they said that the Nursing Staff at the Hergest were not visible and it was the Occupational Therapy staff who were interested in communicating with them as a family.

##### **Concerns and Complaints:**

The complaints system was described as protracted with a high turnaround of staff within the 'reviews team' with the volume of work being used as an excuse to explain the delays within the system. An attendee described complaints as being viewed by the Health Board as a 'nuisance'.

##### **Care Planning:**

Discussion took place regarding a lack of information sharing between agencies, often where risk assessments were an issue and in relation to a risk of violence or aggression from patients. Some attendees spoke of the lack of involving staff in plans to close or reduce community services and with no discussion from

*“Those attendees who had caring responsibilities, told of the complete lack of respite and support, with some saying that they had had very little contact with social workers.”*  
*“Attendees described their experiences of receiving a poor standard in written communication from the Betsi Cadwaladr Health Board and of their ongoing difficulties in finding information about hospital and community services from the BCUHB website.”*

*“Discussion took place about the need for Donna Ockenden's report to demonstrate the strength of feeling around poor care provision for elderly people and their families and carers amongst local people in Tywyn and surrounding areas.”*

managers with front line staff about the future plans for older person's mental health services. (Pwllhelli May 2017)

Attendees spoke of no involvement with families and a lack of choice when planning care for elderly relatives. Discussion was also had about the little understanding of county wide services in Gwynedd for elderly people/patients following discharge from units such as the Hergest Unit.

#### **Care Provision/Care Delivery:**

Attendees spoke of staff having difficulties in being supported with their training and development – some reported that staff in the area were remote and felt isolated. One attendee said that the Health Boards management structure was unclear and that they were not clear about the decision making process within the Health Board. They were unsure who the current Director of Nursing was either for Mental Health or BCUHB as a whole. Attendees told of a high turnover of staff in the area and difficulties in recruiting and retaining staff such as nurses, consultants and GPs. Discussion took place from families about difficulties in accessing information from health care and social care agencies. Individualised care was described as being non-existent. An attendee relayed an experience of being 'lied-to' at a multi-disciplinary team meeting and of a patients' case being closed without any consultation with the patients' family. Attendees spoke of a continuing lack of collaboration between agencies and of a lack of understanding of what services were provided locally.

#### **Communication:**

Attendees described a lack of understanding of the Health Boards role and remit and of its future plans for care delivery. Donna Ockenden was welcomed to Pwllheli and it was questioned why there was no representation by the Health Board or Local Authority representatives at the event. Attendees described a lack of communication between Health Board managers and staff relating to changes in service provision, with senior leaders within the Health Board being described as 'not visible'. Discussion took place from families and carers regarding problems experienced in making contact with BCUHB with no contact information being provided on literature, telephone numbers being changed and no-one being available to deal effectively with telephone calls.

#### **Comments:**

Attendees suggested that Donna Ockenden speak to EMI residential care home providers to hear from their perspective the difficulties faced in caring for older persons with mental health problems.

#### **Detailed discussion**

For information on detailed discussion and individual comments recorded 'on the day' in Pwllheli please see the appendices. It is recommended that any reader of this report does consider fully the feedback from users and service user representatives. This will help the reader to understand the context in which the systems, structures and processes of governance underpinning Older Persons

*“Complaints as being viewed by the Health Board as a ‘nuisance’”*

*“The complaints system was described as protracted with a high turnaround of staff within the ‘reviews team’”*

*“Attendees spoke of no involvement with families and a lack of choice when planning care for elderly relatives.”*

*“Attendees spoke of staff having difficulties in being supported with their training and development – some reported that staff in the area were remote and felt isolated.”*

*“Problems experienced in making contact with BCUHB with no contact information being provided on literature, telephone numbers being changed and no-one being available to deal effectively with telephone calls.”*



Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health

Mental Health care provided by BCUHB operates from the perspective of the service users and service user representatives met in Pwllheli in 2017.

## 20.23 5th June 2017 – Llangefni

### Summary feedback of the 7 C's

#### Compliments:

Attendees praised the support from the third sector in Anglesey. Comment was made about the valued memory clinics facilitated by the Alzheimer's Society and of the excellent home care provided by 'Cymorth Llaw' a privately run organisation. Attendees talked about a good local support network being in place on Anglesey. The care given by individual members of nursing staff on the Fali Ward at Ysbyty Penrhos Stanley was also praised.

*“Attendees praised the support from the third sector in Anglesey.”*

#### Concerns and Complaints:

Discussion took place surrounding a review following complaints about Bryn Hesketh hospital and the perceived impact of this on the level of staffing at that hospital. Frustrations were described about the effectiveness of making a complaint and the fear that families had about raising a complaint in the first place. People also described a fear of the possible repercussions of making a complaint in that it might have detrimental impact on the care delivered to their loved ones. (Llangefni June 2017)

*“Attendees talked about a good local support network being in place on Anglesey.”*

#### Care Planning:

Attendees expressed a need for more dialogue and planning to take place between all organisations/individuals involved in patient care planning. Some spoke of the heavy workload of local GPs which meant that some GPs were not able to effectively take part in discussions surrounding the plans for individual care.

*“Frustrations were described about the effectiveness of making a complaint and the fear that families had about raising a complaint in the first place. People also described a fear of the possible repercussions of making a complaint in that it might have detrimental impact on the care delivered to their loved ones.”*

#### Care Provision/Care Delivery:

Discussion took place about a lack of investment into early intervention and prevention where dementia is in question. Attendees described a lack of support and delays for patients and their families following an initial diagnosis of dementia, some spoke of their concern that no effective communication was taking place between agencies following a diagnosis of dementia. (Llangefni June 2017).

Great support was given for the role of the memory clinics and the need for a greater recognition of their important role in the early stages following a dementia diagnosis. Attendees described the pressures placed on the third sector by health and social services. A lack of a joined up approach and a lack of seamless services was described as being evident in care pathways. (Llangefni June 2017) Discussion took place regarding the pressures upon health care staff which resulted in a lack of creative thinking by health care staff when it came to delivering patient and exploring new methods of patient care. (Llangefni June 2017)

(Llangefni June 2017)

Attendees described health care staff as working in unsafe and unsuitable situations and that staff were becoming complacent of these instances. (Llangefni June 2017) The closure of hospital wards and the lack of EMI nursing provision on Anglesey was of concern and attendees described their concern at the lack of patient facilities (such as a suitable garden area for patients) at Ysbyty Cefni. (Llangefni June 2017) Attendees were also concerned at the lack of staff at Ysbyty Cefni. Attendees described examples of patient 'neglect' where patient toileting and feeding needs arose. (Llangefni June 2017) An instance was relayed when Community Support Officers assisted with the cleaning of a soiled patient in her own home because they knew that the carer would take several hours to arrive and did not feel they could or should leave the distressed elderly person in a soiled state at home. Discussion took place about healthcare staff not having the appropriate tools to do their jobs and of an evident lack of care and support staff within the community. (Llangefni June 2017) Attendees spoke of community care staff not having the time to deliver a quality patient centred care service. (Llangefni June 2017)

*“Discussion took place regarding the pressures upon health care staff which resulted in a lack of creative thinking by health care staff when it came to delivering patient and exploring new methods of patient care.”*  
(Llangefni June 2017)

### **Communication:**

Attendees spoke of a lack of communication between organisations and the lack of a joined up approach where strategic planning is concerned. (Llangefni June 2017) Some mentioned that there was no real external communication about the Health Board being in special measures. Discussion took place about a lack of understanding of the services provided at Ysbyty Cefni. (Llangefni June 2017) Attendees also spoke of management not engaging and listening to staff and a need for a 'single point of contact' between organisations where health and social care is concerned. (Llangefni June 2017)

*“Attendees were also concerned at the lack of staff at Ysbyty Cefni.”*

The communication between GPs and Social Services on Anglesey was described as being very good. It was suggested that BCUHB needed to provide more 'good news' stories to the public.

### **Comments:**

Attendees queried the impact of Donna Ockenden's report and expressed concern that lessons would not be learnt following its publication. (Llangefni June 2017)

A lack of 'quality' in care was described. Criticisms were made about BCUHB's new Mental Health Strategy. (Llangefni June 2017)

*“The communication between GPs and Social Services on Anglesey was described as being very good.”*

### **Detailed discussion at Llangefni**

For information on detailed discussion and individual comments recorded 'on the day' in Llangefni please see the appendices at the end of the report.. It is recommended that any reader of this report does consider in full the feedback from service users. This will help the reader to understand the context in which the systems, structures and processes of governance underpinning Older Persons Mental Health care provided by BCUHB operates from the perspective of the service users and service user representatives met in 2017.

## 20.24 6th June 2017 – Rhyl

### Part A

#### Summary of issues discussed:

Discussions at this event were once again centred around the '7 'C's'. Following a brief presentation about the background and purpose of the governance review attendees were asked to give feedback about their experiences focusing on each of the 7 'C's' in turn. Quotations from those taking part are found within the appendices.

*“Some spoke of the care delivered by individuals as being good, however this was lost in a system which did not seem to be working seamlessly.”*

## 20.25 Summary feedback of the 7 C's

#### Compliments:

Attendees mentioned that there were some positive experiences had but these tended to be outweighed by the negative. (Rhyl June 2017) Some spoke of the care delivered by individuals as being good, however this was lost in a system which did not seem to be working seamlessly. Glantraeth was described as an exemplar site with a warm and welcoming atmosphere and caring staff. The Care of the Elderly and dementia ward at Ysbyty Wrexham Maelor was described as having caring staff and very good carers. Staff at the Ablett Unit were described as empathetic. Many told of the good support provided by the voluntary organisations such as Hafal, but described services as not seamless due to the large number of organisations in existence.

*“Glantraeth was described as an exemplar site with a warm and welcoming atmosphere and caring staff.”*

#### Concerns and Complaints:

Recognition was given to 'good work' undertaken by the new Public Services Ombudsman for Wales but it was queried whether this would be acted upon by the Health Board. (Rhyl June 2017)

*“Problems in accessing health care, due to a lack of hospital beds for mental health patients was described.”*

#### Care Planning:

Discussion took place about the lack of bespoke services for patients and of professional interests overriding the patients' best interests. Problems in accessing health care, due to a lack of hospital beds for mental health patients was described. Attendees spoke of a high turnaround in social workers and of patient reviews being rarely held. Some spoke of delays in care planning and concerns were raised about DOLS checks not being undertaken for self-funding patients. (Rhyl June 2017) Concern was expressed about those patients who had moved to North Wales being left out of the system.

*“Concerns were expressed as to a 'wilful blindness' when it came to understanding DOLS, the Mental Health Act and human rights in general.”*

#### Care Provision/Care Delivery:

Much discussion took place surrounding an apparent lack of professional leadership in North Wales. Concerns were expressed as to a 'wilful blindness' when it came to understanding DOLS, the Mental Health Act and human rights in general. The DOLS system was described as a scandal in North Wales with professionals from across the organisations having a lack of understanding

regarding its legal context. (Rhyl June 2017) Concern was expressed that Healthcare Inspectorate Wales doesn't appear to 'escalate issues'. Systems were being described as being too big to manage and with a lack of leaders who were prepared to challenge systems and processes. Training and recruitment within the BCUHB was described as ineffective. (Rhyl June 2017) Some members of staff were described as having a lack of compassion and being too heavily involved in audits and paperwork. (Rhyl June 2017) Others talked of a lack of care amongst staff and that the right people were not delivering care where needed.

*“Training and recruitment within the BCUHB was described as ineffective.”*  
(Rhyl June 2017)

### **Communication:**

Discussion took place about a failure by the Health Board to communicate effectively with the seldom heard, such as travelling communities. (Rhyl June 2017) A frequent turnaround in Health Board staff dealing with engagement was discussed and with no changes in the system taking place. (Rhyl June 2017) Mention was given to a retired Chief Executive of a previous smaller Trust in North Wales and how he had personal knowledge of the names of staff – the current Health Board was described as too big for personal staff interaction by its leaders. Communication between leaders and staff was described as only taking place when problems arose and some talked about a collusion between matrons and middle managers. (Rhyl June 2017) Discussion also took place about the need for the health board to remain under 'special measures'.

*“A frequent turnaround in Health Board staff dealing with engagement was discussed and with no changes in the system taking place.”*  
(Rhyl June 2017)

### **Comments:**

Attendees queried whether all patients on the Tawel Fan ward were allocated social workers. It was asked whether those social workers had been interviewed as part of the reviews relating to Tawel Fan.

### **Detailed discussion at Rhyl**

For information on detailed discussion and individual comments recorded 'on the day' in Rhyl please see the appendices. It is recommended that any reader of this report does consider fully the feedback from service users and their representatives. This will help the reader to understand the context in which the systems, structures and processes of governance underpinning Older Persons Mental Health care provided by BCUHB operates from the perspective of the service users and service user representatives met in 2017.

## **20.26 7th June 2017 – Holywell**

### **Part A**

#### **Summary of issues discussed:**

Discussions at this event were once again centred on the '7 'C's'. Following a brief presentation about the background and purpose of the review which is contained within the appendices, attendees were asked to give feedback about their experiences focusing on each of the 7 'C's' in turn. Direct quotations from those taking part are listed within the appendices.

## Summary feedback of the 7 C's

### Compliments:

Attendees spoke of their experiences of excellent end of life care provided by multi-agency working. (Holywell June 2017) Discussion took place about a variance in practice when it came to the delivery of dementia care with care being described as good once staff had received training in dementia. Nursing staff were described as being 'good' – because of the fact that they are nurses and not because of the systems put in place by the Health Board. Attendees spoke of the excellent care received from the third sector with mention being given to Crossroads. Examples of good care from individuals was discussed, but concern was raised that systems and organisations that had worked well had disappeared or had had their funding removed.

### Concerns and Complaints:

Discussion took place about the problems in being able to contact personnel within the Health Board that were prepared to listen to complaints. (Holywell June 2017) Some feared of the repercussions of raising a complaint or a concern. (Holywell June 2017) Attendees also spoke of a 'constant re-organisation' and lack of accountability. (Holywell June 2017)

### Care Planning:

Some attendees spoke of a lack of care plans in the Wrexham area. Others spoke of the problems with diagnosing dementia and making inroads in to the 'care-planning' system. (Holywell June 2017) Delays in referrals were also relayed. Attendees spoke of a 'prescribed disengagement' in the diagnosis and care planning of older patients with mental health problems and of no pathway of care being present. (Holywell June 2017) Discussion took place surrounding a lack of support services and signposting between health care, social care and the third sector. (Holywell June 2017)

### Care Provision/Care Delivery:

Many attendees spoke at length of their experiences of care delivery. Some spoke of the lack of support for carers, others gave examples of a reliance on families in providing hospital based care. (Holywell June 2017) Attendees gave examples of good initiatives in care delivery being 'piloted' but not followed through (Holywell June 2017) and others spoke of a reluctance on the part of elderly patients in access mental health services because of stigmatisation. Discussion was held about a lack of understanding amongst health service workers about the rights of a Lasting Power of Attorney, which often resulted in a breakdown in communication between families and health staff at times of crisis. Some attendees spoke of elderly patients with mental health problems experiencing long waits at A&E departments, others spoke of a hostile attitude from staff when relatives had raised queries about their loved ones circumstances. (Holywell June 2017) Reference was made to Ward 1 at Ysbyty Glan Clwyd as having no 'care for the elderly' and of staff not being able to monitor patients effectively due to heavy workloads. One delegate spoke of an instance

*“Discussion took place about the problems in being able to contact personnel within the Health Board that were prepared to listen to complaints.”*

(Holywell June 2017)

*“Attendees also spoke of a 'constant re-organisation' and lack of accountability.”*

(Holywell June 2017)

*“Some spoke of the lack of support for carers, others gave examples of a reliance on families in providing hospital based care.”*

(Holywell June 2017)

*“Attendees gave examples of good initiatives in care delivery being 'piloted' but not followed through.”*

(Holywell June 2017)



demonstrating a lack of dignity and respect at Holywell Hospital, where it appeared that an elderly patient was being treated like a naughty child. (Holywell June 2017) Attendees spoke of the pressures on carers and of patients who are cared for within in their own homes not being monitored. One attendee gave an example of a patient whom they found had not had being given breakfast and had no food in the house. Discussion was held about the lack of involvement by families in the assessment of patients when being discharged from mental health beds and when being transferred to nursing homes. (Holywell June 2017)

*“Attendees spoke of the pressures on carers and of patients who are cared for within in their own homes not being monitored.”*

#### **Communication:**

Discussion took place about the lack of engagement by the Health Board and the difficulties in accessing information. (Holywell June 2017) Positive experiences of receiving information from the third sector were recalled. Attendees spoke of a lack of sharing of information and of social workers closing cases without consultation with families and carers. Attendees also spoke of lack of joined up communication between health care, social care and the third sector.

*“Attendees also spoke of lack of joined up communication between health care, social care and the third sector.”*

#### **Comments:**

Frustrations were aired at the inability to change systems and at a lack of leadership. Concern was expressed for those patients who had no families. Reference to the Health Board's new dementia strategy was made as being a 'wish-list'. (Holywell June 2017) Attendees spoke of numerous reorganisations within the Health Board and that this had resulted in teams and care being disrupted. (Holywell June 2017) Recognition was given to some good practices being in place but that systems did not allow for the good practice to spread across organisations. (Holywell June 2017)

*“Reference to the Health Board's new dementia strategy was made as being a 'wish-list'.”*  
(Holywell June 2017)

#### **Detailed discussion at Holywell**

For information on detailed discussion and individual comments recorded 'on the day' in Holywell please see the appendices at the end of the report.. It is recommended that any reader of this report does consider in full feedback from service users and their representatives. This will help the reader to understand the context in which the systems, structures and processes of governance underpinning Older Persons Mental Health care provided by BCUHB operates from the perspective of the service users and service user representatives met in 2017.

## **20.27 4th July 2017 – Wrexham**

### **Part A**

#### **Summary of issues discussed:**

Discussions at this event were once again centred around the 7 'C's. Following a brief presentation about the background and purpose of the review, attendees were asked to give feedback about their experiences focusing on each of the 7 'C's in turn. Quotations from those taking part are found within the appendices.

## 20.28 Summary feedback of the 7 C's

### Compliments:

Attendees gave examples of good care received by relatives from staff who appeared to be working under pressure. Staff on wards at Ysbyty Wrexham Maelor and Ysbyty Gwynedd were praised and the GP Out of Hours service was described as 'excellent'.

### Concerns and Complaints:

Discussion took place about elderly patients turning for help at the point of crisis. Some described the Health Board as having a culture of bullying where complaints were concerned. (Wrexham July 2017)

### Care Planning:

Attendees told of a lack of information about care packages and choices. Some told of there being no evidence of support from health care and social care services in relation to the home 'enhanced care' service. Concern was also expressed about the lack of mental health advocacy services in Flintshire.

### Care Provision/Care Delivery:

Discussion took place about the lack of support for staff from management and of the problems in the recruitment and retention of health care staff. (Wrexham July 2017)

Attendees spoke of a lack of facilities in some rural areas of North Wales and problems with the provision of care packages in areas such as Ruthin, Pwllheli, Towyn, Bala and Corwen. (Wrexham July 2017)

Concern was also expressed about the lack of facilities in the South of Gwynedd and that there had been delays in implementing service changes across the whole of the North Wales region following the Health Boards formal consultation 'Healthcare in North Wales is Changing 2012', which saw the removal of services from some areas but with nothing being put in their place. (Wrexham July 2017)

Attendees discussed their concerns about the pressures faced by carers and that the services provided by carers were poorly resourced and not appreciated. (Wrexham July 2017)

Discussion took place about the reliance on the third sector to provide services, with the Third Sector not having the capacity or resources to deal with the demand. (Wrexham July 2017)

'Hoarding' amongst older people with mental health problems, (and increased risk of fire etc as a result of this) was outlined as being an issue that was poorly understood and with little resource to address. (Wrexham July 2017)

Attendees spoke of complex systems in accessing care and support and of an uncertainty in relation to Continuing Healthcare, (CHC) packages.

*“Staff on wards at Ysbyty Wrexham Maelor and Ysbyty Gwynedd were praised and the GP Out of Hours service was described as ‘excellent’.”*

*“Discussion took place about elderly patients turning for help at the point of crisis. Some described the Health Board as having a culture of bullying where complaints were concerned.”*  
(Wrexham July 2017)

*“Attendees spoke of a lack of facilities in some rural areas of North Wales and problems with the provision of care packages in areas such as Ruthin, Pwllheli, Towyn, Bala and Corwen.”*  
(Wrexham July 2017)

### Communication:

Attendees spoke of receiving correspondence with incorrect information about patients (Wrexham July 2017) and of the complexity in understanding what services were available in North Wales – and how to contact the appropriate service. Some attendees spoke of the Health Board using jargon in its communication. (Wrexham July 2017) Other attendees spoke of the lack of information given by the Health Board to the general public and that often people looked at BCUHB's website to try and find out information when needed. (Wrexham July 2017) Some spoke of work that they had undertaken in relation to patient engagement but with no feedback being received from BCUHB. (Wrexham July 2017)

*“Concerns about the pressures faced by carers and that the services provided by carers were poorly resourced and not appreciated.”*  
(Wrexham July 2017)

### Comments:

Some attendees described the Heddfan Unit as being poorly designed. Concerns were raised about the emphasis on health care being on cutting costs. Attendees spoke of the Health Board being reorganised however other organisations had not been similarly restructured on a pan North Wales basis. Concern was raised that health board staff were being lost to the Berwyn Prison – the new North Wales prison in Wrexham.

*“Attendees spoke of the Health Board using jargon in its communication.”*  
(Wrexham July 2017)

## Part B

### Detailed discussion at Wrexham

For information on detailed discussion and individual comments recorded 'on the day' in Wrexham please see the appendices at the end of the report. It is recommended that any reader of this report does consider fully the feedback from service users and their representatives. This will help the reader to understand the context in which the systems, structures and processes of governance underpinning Older Persons Mental Health care provided by BCUHB operates from the perspective of the service users and service user representatives met in 2017.

## Ends

## 20.29 5th July 2017 – Prestatyn

### Part A

#### Summary of issues discussed:

Discussions at this event were once again centred around the 7 'C's. Following a brief presentation about the background and purpose of the review, attendees were asked to give feedback about their experiences focusing on each of the 7 'C's in turn. Quotations from those taking part are found within the appendices.

*“The team at the Ablett Unit was noted as being a committed staff who were working very well under extreme pressures.”*

## 20.30 Summary feedback of the 7 C's

### Compliments:

The good care at Llandudno General Hospital was discussed with reference to a pilot of an initiative to reduce inappropriate admissions. Concern was expressed however, that this initiative had not been rolled out to other hospitals in the BCUHB area. Attendees spoke of some instances of good care being delivered at the Tawel Fan ward by domestic staff. The Carers Trust support for families dealing with dementia was commended. Some attendees commented that most examples of good services seemed to fall outside of the Mental Health service. The team at the Ablett Unit was noted as being a committed staff who were working very well under extreme pressures.

### Concerns and Complaints:

Some of the attendees described the difficulties that they had experienced with engaging with the BCUHB's complaints system. (Prestatyn July 2017) Others spoke of discussions with senior health board members who had given assurances that actions would be taken, but with no follow up. The health boards complaints system was described as shambolic (Prestatyn July 2017) and some attendees described their difficulties of navigating through a very shambolic, corporate and defensive system. (Prestatyn July 2017)

### Care Planning:

Much discussion took place around the problems encountered with discharge from hospitals. Some described this as 'chaotic' with no interaction with mental health advocacy services and no co-ordination in general. (Prestatyn July 2017) Others described discharge planning as being 'last-minute' and not centred around the best needs of the patient. (Prestatyn July 2017) Attendees spoke of the waiting times for diagnosis on the Glantraeth and Heddffan units as being 'appalling' with families being left with no access to services for up to a year because of the lack of a proper diagnosis of dementia. (Prestatyn July 2017)

### Care Provision/Care Delivery:

Discussion took place about the lack of information concerning the availability of care options for patients, meaning that some of the younger patients with dementia were being placed in older peoples residential homes, when they could instead, be cared for within their homes. (Prestatyn July 2017) Attendees also stated that there was very little for younger people with onset dementia. Some attendees spoke of care records being generic and others spoke of a 'sofa system' in North Wales due to the lack of hospital beds. (Prestatyn July 2017) Many spoke of patients from North Wales being sent to 'out of area' placements – such as Southampton, Essex, Bradford and Newcastle. (Prestatyn July 2017) Others spoke of the experiences of patients with mental health problems being kept at A&E for days at a time or returning to A&E over consecutive days. (Prestatyn July 2017)

*“Some of the attendees described the difficulties that they had experienced with engaging with the BCUHB's complaints system. Others spoke of discussions with senior health board members who had given assurances that actions would be taken, but with no follow up.”*  
(Prestatyn July 2017)

*“Attendees spoke of the waiting times for diagnosis on the Glantraeth and Heddffan units as being 'appalling' with families being left with no access to services for up to a year because of the lack of a proper diagnosis of dementia.”*  
(Prestatyn July 2017)

*“Many spoke of patients from North Wales being sent to 'out of area' placements – such as Southampton, Essex, Bradford and Newcastle.”*  
(Prestatyn July 2017)

A number of attendees relayed their experiences of loved ones on hospital wards and of deterioration in their health and a lack of understanding of their dementia needs. (Prestatyn July 2017) Discussion took place about the lack of activities on wards for older people with mental health problems. (Prestatyn July 2017) Attendees spoke of the health boards 'Butterfly Scheme' – some described this as being not effective in practice and of it attaching a stigma to patients. John's Campaign was discussed, however it was felt that this had not been rolled out across the health board and some spoke of the problems they had encountered when experiencing protected mealtimes. (Prestatyn July 2017) Dignity and respect of patients was described as being 'low on the horizon' and that patients and families had little choice in the provision and delivery of their care. (Prestatyn July 2017)

*“A number of attendees relayed their experiences of loved ones on hospital wards and of deterioration in their health and a lack of understanding of their dementia needs.”*

(Prestatyn July 2017)

Attendees spoke of BCUHB staff having a low morale and of working under considerable pressures. (Prestatyn July 2017) A lack of support from management and a lack of candour, transparency and trust was also described. (Prestatyn July 2017)

*“Attendees spoke of BCUHB staff having a low morale and of working under considerable pressures.”*

(Prestatyn July 2017)

#### **Communication:**

Discussion described communication as being poor and often difficult. (Prestatyn July 2017) Some described the health board as being 'faceless' and with a sense of 'secrecy'. (Prestatyn July 2017) Some attendees spoke of always receiving correspondence at the weekend – when there was no-one available to discuss issues of concern or to answer questions raised. (Prestatyn July 2017) Others described a reluctance by BCUHB staff to assist with queries. (Prestatyn July 2017)

*“A lack of support from management and a lack of candour, transparency and trust was also described.”*

(Prestatyn July 2017)

Comment was made about the health board being portrayed as a 'rosy picture' in its press releases however behind the scene the reality was chaotic. (Prestatyn July 2017) Attendees spoke of the health board giving the impression that 'it knows best' – some spoke of the Health Board communication as being 'all spin'. (Prestatyn July 2017) An example of patients records being changed and lost was given – this was described as the Health Board having some 'dark and sinister methods of communication'. Some attendees discussed their reluctance to communicate with the Health Board as there was a fear that they would be removed as a carer for their relative. (Prestatyn July 2017)

#### **Comments:**

Discussion took place about BCUHB 's recent Dementia strategy. Attendees described this as being a 'wish-list'(Prestatyn July 2017) and referred to a 'mish-mash' of strategies being produced by the Health Board. (Prestatyn July 2017) Attendees described a defensive approach by the Health Board which restricted staff in developing new initiatives. Some spoke of no improvements in care being evident following the closure of the Tawel Fan ward. Others expressed concern that the negativity surrounding BCUHB has resulted in a decreased ability to recruit new staff into North Wales.

*“Attendees referred to a 'mish-mash' of strategies being produced by the Health Board.”*

(Prestatyn July 2017)



## Detailed discussion at Prestatyn

For information on detailed discussion and individual comments recorded 'on the day' in Prestatyn please see the appendices at the end of the report.. It is recommended that any reader of this report does consider in full the feedback from users and their representatives. This will help the reader to understand the context in which the systems, structures and processes of governance underpinning Older Persons Mental Health care provided by BCUHB operates from the perspective of the service users and service user representatives met in 2017.

Shortly after the feedback from service users and their representatives in Prestatyn in July 2017 the BCUHB Board discussed 'risk' in mental health services. The Ockenden governance review team wished to consider to what extent if any, the discussions at the BCUHB Board resonated with the concerns that had been raised by service user representatives that month in Prestatyn and in previous months across the six counties of North Wales.

### 20.31 What were the BCUHB Board discussing as regards Mental Health services in July 2017 at/around the time of the Prestatyn event?

**At the BCUHB Board Meeting on the 20th July 2017 risk in mental health services was discussed.**

### 20.32 Risk: Mental Health Services

This stated that 'There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which could result in poor quality outcomes for patients.'

**Director lead:** Director of Mental Health and Learning Disabilities

**Assuring Committee:** Quality, Safety and Experience Committee

**Date Opened:** 1 October 2013

**Date last reviewed:** 29/06/2017

**Target risk date:** 14 July 2017

**(RAG\*rating):** Red

*“Some attendees discussed their reluctance to communicate with the Health Board as there was a fear that they would be removed as a carer for their relative.”*

(Prestatyn July 2017)

*“Comment was made about the health board being portrayed as a ‘rosy picture’ in its press releases however behind the scene the reality was chaotic.”*

(Prestatyn July 2017)

*“There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which could result in poor quality outcomes for patients.”*

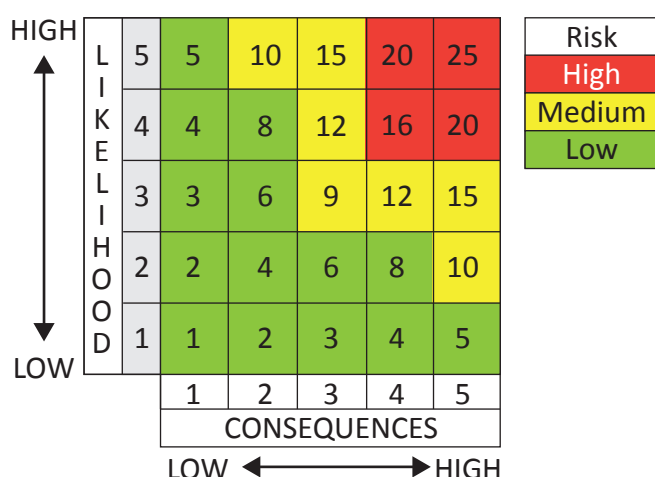
(BCUHB July 2017)

### Impact Likelihood Score Movement since last presented to Board in January 2017

The initial risk rating was calculated a 4 (likelihood) multiplied by a 5 (consequences) giving a score of 20 a red or 'high' risk.

The current risk rating was calculated as a 4 (likelihood) multiplied a 3 (consequences) giving an overall current risk score of a 12. On the grid this can be seen as a yellow / amber (or medium risk.)

The target risk score was calculated as a 3 (likelihood) multiplied by a 3 (consequences.) This gave a target risk score of 9. On the grid this can be seen as a yellow or amber medium risk.



### Detail of the controls described as being put in place to reach the target score:

An 'improvement plan' was described as being in place and subject to ongoing review with the following actions:

1. Enhanced monitoring of mental health services in progress at Board level;
2. Renewed focus and escalation arrangements for dealing with operational issues;
3. A governance framework had been developed and implemented within mental health;
4. A staff organisational development and engagement programme was described as underway;
5. A revised BCUHB mental health strategy had been approved by the BCUHB Board;
6. A revised senior management and clinical leadership structure had been implemented;
7. Older Person's Mental Health action plans were said to be in place;
8. A full review of the Divisional risk register had been completed;
9. A weekly PTR<sup>196</sup> meeting was in place.

<sup>196</sup> See glossary

**Further actions were described to achieve the target risk score – with the aim of further reducing the risk within mental health services. These were described as**

1. Ongoing implementation of performance and accountability reviews across the Division;
2. Continuing to improve the internal divisional communication systems;
3. Contributing to the HASCAS<sup>197</sup> review and wider governance review;
4. Undertake review of demand, capacity and skill mix, (what was required of the Division in terms of care provision and ensuring there was the ability to provide this, by the correctly configured workforce.);
5. A need to review the roles and accountability of middle management within the MHL Division.

### 20.33 What were the BCUHB Board discussing as regards Mental Health services in September 2017?

At the BCUHB Board Meeting on the 21st of September 2017 there was an item described as the 'Special Measures Improvement Framework Task & Finish group;' (or 'SMIF.'). A number of key continuing risks and concerns were discussed around the Mental Health and Learning Disabilities (MHL) Division. These included the concern that sustainability of progress within MHL remained a key issue. The SMIF noted that the stability of the Mental Health & Learning Disabilities Division's management team was an area that had required additional high-level input to ensure that advances described as being made were able to be maintained going forward. This was due to long term sickness absences within the Division's senior management team.

*“The stability of the Mental Health & Learning Disabilities Division's management team was an area that had required additional high-level input to ensure that advances described as being made were able to be maintained going forward. This was due to long term sickness absences within the Division's senior management team.”*

### 20.34 What were the BCUHB Board discussing as regards Mental Health services at BCUHB from October to December 2017?

The BCUHB Board minutes of October 2017 note that the Executive Director of Finance had explained the main cost drivers in the Mental Health Division (which had been reported as having a £4.7 million overspend.) were said to be largely due to out of area placements; (where mental health beds had to be sourced outside North Wales) continuing healthcare costs<sup>198</sup>, nurse agency<sup>199</sup> costs and undelivered savings.

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<sup>197</sup>

<sup>198</sup> All 192 to 194, see glossary

<sup>199</sup>

### Item: Quality, Safety & Experience Committee

The Committee received an in-committee (or private/not discussed in public) paper on progress towards meeting the HIW recommendations about the operation of the Deprivation of Liberty Safeguards (DOLS) within the Health Board.

The Committee received an in-committee update on safeguarding arrangements both within BCUHB and within the regional structures. Some progress had been achieved in the Health Board's internal arrangements. The Committee noted it would receive the regular safeguarding annual report early in 2018 ahead of this going to the full BCUHB Board. The Committee were assured that the recommendations of a recent internal audit review into governance arrangements within the Mental Health & Learning Disabilities (MHLDS) Division were now in place, with only one action outstanding. The Committee noted that governance arrangements were assessed as providing 'moderate assurance'.

Members were assured that the spike in the number of medication errors reported within the MHLDS Division data for July 2017 had been reviewed. In the succeeding month's data the number of such errors returned to a normal level. The majority of the errors reported had been deemed to be negligible, with no attributable longer term trends identified.

The Committee took assurance that places had been secured on the Manchester University training course for Best Interest Assessors (BIA<sup>200</sup>). This would help to improve the Board's response to the Deprivation of Liberty Safeguards (DOLS<sup>201</sup>) legislation.'

The Mental Health strategy was discussed and the interim 'programme consultant' for the Mental Health Strategy outlined the implementation plan for the 'Together for Mental Health in North Wales' strategy. A number of key points were raised in discussion:

- Concern was expressed regarding stability within the MHLDS system bearing in mind the current leadership challenges;
- There was a welcome for the work being carried out, and the need was noted for holistic partnership working to be effective if the strategy is to succeed;
- Also recognised was that there is a socio-economic challenge with regard to mental health and it is important to focus upon the needs of children and young people to ensure their (positive) mental health if a long term benefit is to be secured.

The key advice and feedback for the BCUHB Board was that there needed to be recognition that the leadership challenges are significant within mental health at that time. Successful implementation of the strategy will require these to be

*“Concern was expressed regarding stability within the MHLDS system bearing in mind the current leadership challenges.”*

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<sup>200</sup> See glossary

<sup>201</sup> See glossary

overcome. It was recognised that the focus on partnership working to implement the mental health strategy would need to be maintained. It was acknowledged that the whole of BCUHB needed to play a part in delivering mental health and wellbeing, not just the Mental Health division.

### 20.35 BCUHB Board Meeting – 16 November 2017 – what was discussed regarding Mental Health?

In the 'Special Measures Improvement Framework Task & Finish' (SMIF T&F) Group a number of key concerns were once again elaborated.

Some concerns were expressed regarding the need for further work on clinical and staff engagement. There were also concerns regarding sickness absences and the need to maintain leadership, operational and financial stability in the Mental Health and Learning Disabilities Division. It was noted that action was being taken to address this. These findings and discussions resonated with the findings of the Ockenden review team up to and including the end of December 2017.

There was further discussion around the financial position of the MHLD with concerns expressed around 'out of area' placements and individual care packages including continuing health care. Other areas of concern was the spend on nurse agency costs and undelivered savings.

### 20.36 Praise for support service helping people live with dementia and their carers presented at the Board

According to a Board discussion people living with dementia and their carers were receiving better support following diagnosis, thanks to a partnership between BCUHB and a North Wales charity (The Carers Trust North Wales Crossroads.)

Since being established in October 2016, the Dementia Support Service partnership was stated to have helped over 600 people who had received a diagnosis of dementia. The collaboration was said to ensure that every person diagnosed with dementia and their carer had a named 'Dementia Coordinator' who can provide advice, support and signposting to other support services. A named service user was among those to have praised the service, having benefitted from it ever since their spouse was diagnosed with dementia in February 2017. The carer said: 'It can be quite bewildering when a loved one is diagnosed with dementia and there is lots of information to take in and different organisations who offer different support. Having a named person who you can contact is really reassuring. I've been kept informed about lots of different events that are happening.' This feedback to the Board did not resonate with the lived experience of carers and service user representatives met with during the listening and engagement exercises and the follow up discussions that took place until December 2017.

*“The whole of BCUHB needed to play a part in delivering mental health and wellbeing, not just the Mental Health division.”*

*“Concerns regarding sickness absences and the need to maintain leadership, operational and financial stability in the Mental Health and Learning Disabilities Division.”*

(BCUHB November 2017)

*“It can be quite bewildering when a loved one is diagnosed with dementia and there is lots of information to take in and different organisations who offer different support. Having a named person who you can contact is really reassuring. I've been kept informed about lots of different events that are happening.”*



## 20.37 The BCUHB Board Meeting – 14 December 2017 – what was discussed regarding mental health at BCUHB?

The Special Measures Improvement Framework Task & Finish (SMIF T&F) group considered whether there was a need at this point to conduct a 'deep dive' into the Mental Health & Learning Disabilities (MHL) Division. This was in the light of some concerns expressed about the current leadership capacity in the Division and the deteriorating financial position.

However, it was felt that more time should be allowed for both new interim arrangements to settle before conducting a deep dive. Additionally, the group was reminded of the recent internal audit review of the division's internal governance arrangements and the moderate assurance judgement awarded to the latter. It was decided to allow more time for the improvement work around internal governance, which was reported as underway, to have an impact. It was agreed that a supportive approach will be taken to enable the Division to make the necessary progress.

It was also stated that the development of the Mental Health strategy had been successful and that this was now being rolled out, with the operational detail and in year priorities being drawn up in each of the county level local implementation teams. In addition, the draft consultation on the new divisional structure has been completed and the outputs of this exercise were now being considered by the Divisional senior management team. The opinion was expressed that BCUHB's Mental Health services would remain as part of any future 'special measures' programme and that there would be time for a deep dive as part of the early work in the new 'phase four'.

The SMIF T & F group considered that the risks and timescales associated with the special measures improvement framework were being managed appropriately. Overall, satisfactory progress was said to be being made in most areas – noting the concerns regarding MHL services. However, the group acknowledged that there was more to be done to increase the pace of improvement in some areas and sustain improvements already made in some key areas as outlined above.

## 20.38 Report: BCUHB progress in staff training in Dementia care

This report outlined the introduction of a new measure which is the 'percentage of NHS employed staff who come into contact with the public who are trained in an appropriate level of dementia care.'

### Current BCUHB position:

BCUHB was described as having circa 16,500 staff in total, 12,289 of which were said to meet the criteria for dementia training. This was based on the BCUHB headcount data and is always open to a degree of error as people move in and

*“The Special Measures Improvement Framework Task & Finish (SMIF T&F) group considered whether there was a need at this point to conduct a ‘deep dive’ into the Mental Health & Learning Disabilities (MHL) Division.”*

(BCUHB December 2017)

*“It was agreed that a supportive approach will be taken to enable the Division to make the necessary progress.”*

(December 2017)

*“BCUHB’s Mental Health services would remain as part of any future ‘special measures’ programme and that there would be time for a deep dive as part of the early work in the new ‘phase four’.”*

(BCUHB December 2017)

out of the organisation. Of the 12,289 cohort, 84.6% (10,407) have received some form of training with regards dementia.

#### **What BCUHB said it was doing about this?**

9,684 have received training at the 'informed' level and 723 have received enhanced training (although this enhanced training didn't entirely meet the criteria for 'skilled' as specified in the 'Good Work' framework. Therefore this was work that needed completion.

**When BCUHB expected to be making the required progress:** BCUHB described that it had been alerted in the BCUHB dementia action plan the need to align training appropriately to the framework. It was anticipated that BCUHB would be reporting successfully under all three categories from 2018-19. No further detail regarding a target date was provided.

### **20.39 Conclusion of key points from consideration of BCUHB Board papers until December 2017:**

In summary, many of the issues raised and discussed by the BCUHB Board in the six months to the end of December 2017 were familiar to the staff, carers and service user representatives who contributed to and participated in the Ockenden review of governance. These included consideration of carers support, support at diagnosis of dementia, out of area care, the use of agency/temporary staff, (contributing to a deterioration of the BCUHB financial position), the improvements needed in training about dementia and the complaints and concerns process. The difference was that all of the BCUHB Board discussions demonstrated limited understanding of the **impact** of key issues under discussion.

For example the need to improve upon the management of the concerns process as discussed at the BCUHB Board failed to show understanding of the significant effect this was having on a number of families who felt as though they battled with BCUHB to gain an accurate and appropriate response to their complaints. There was also no recognition that as of late 2017 the North Wales Community Health Council (NWCHC) was extensively involved in a number of cases, supporting families towards resolution of complaints, as were local Assembly Members. This evidence has been seen by the Ockenden team. Families supported by the NWCHC included 61, 1, 65, 66, 74, 77, 78, 82, 15, 71, 72, 21 and 78. Families supported by local AMs included 89, 90, 21, 78, 103, 104, 105, 99, 86, 84, 82, 77, 74, 61, 7 and 100. Secondly, the high use of agency, (temporary) staff was contributing to a financial position that continued to be of concern; However what was not discussed was the very significant pressure on staff from working either with reduced numbers of staff or with unfamiliar colleagues and for service users and their representatives the lack of continuity of carer where carers described having to repeatedly repeat case and medical histories. In some cases where locum medical colleagues left at short notice plans that were agreed during outpatient clinics were demonstrated to the Ockenden review team to have not happened, sometimes with a delay of a number of months before 'care needs' were picked back up again.

*“The need to improve upon the management of the concerns process as discussed at the BCUHB Board failed to show understanding of the significant effect this was having on a number of families who felt as though they battled with BCUHB to gain an accurate and appropriate response to their complaints.”*

(BCUHB December 2017)

*“The very significant pressure on staff from working either with reduced numbers of staff or with unfamiliar colleagues and for service users and their representatives the lack of continuity of carer where carers described having to repeatedly repeat case and medical histories.”*

(BCUHB December 2017)

## 21 Chapter 13

### 21.1 Recommendations and findings

#### Introduction to recommendations and findings:

The findings and recommendations of the Ockenden review pertaining to failings in the systems, structures and processes of governance at BCUHB have been widely acknowledged in multiple internal and external reviews from 2012 to the current time (the end of December 2017). Much of this information is already in the public domain and has been extensively reviewed in the main report. Many of the recommendations made by the Ockenden review team have been made, at least in part by many external reviews preceding this review. In summary if an organisation such as BCUHB is underpinned by poor systems, structures and processes of governance (as BCUHB was from its creation) then there is very likely to be an inability of the organisation to identify and 'put right' failings. There will also be an inability to respond effectively to concerns from staff, service users and service user representatives and there will be an inability for an organisation such as BCUHB to ensure organisational learning from failings and concerns. This has been (and remains) the situation within BCUHB from 2009 to the end of 2017.

The Ockenden review of governance engaged with 135 current and former members of BCUHB staff and 105 current service users and service user representatives. 200 interviews were carried out, most face to face, a small number on the telephone. Extensive amounts of supplementary documentation were sent to the Ockenden team by the BCUHB staff, carers and service user representatives who engaged with the Ockenden review.

Current and former members of BCUHB staff, especially those engaged or associated with provision of (or direct line management of) front line patient care were more likely to have views that resonated and agreed with the views expressed by service users and their representatives. The Ockenden review team found that staff currently working at senior management and Board level were more likely to believe that significant progress had been made than either front line clinical staff or current service users.

The Ockenden team heard from very significant numbers of current and former BCUHB staff and current and recent service user representatives who all described from 2009 to the current day insufficient resources, (finance, staffing, training and equipment) to provide appropriate care to a very vulnerable patient group. Unfortunately despite an extensive review of evidence of over 4000 individual documents alongside over 200 interviews the Ockenden review has no assurance that these issues were resolved at anything more than a very embryonic stage.

Current service user representatives and current BCUHB staff highlighted to the Ockenden review their very significant concerns regarding the systems, structures and processes underpinning the patient pathway and delivery of patient care,

*“The findings and recommendations of the Ockenden review pertaining to failings in the systems, structures and processes of governance at BCUHB have been widely acknowledged in multiple internal and external reviews from 2012 to the current time (the end of December 2017).”*

*“Current and former members of BCUHB staff, especially those engaged or associated with provision of (or direct line management of) front line patient care were more likely to have views that resonated and agreed with the views expressed by service users and their representatives.”*

*“If an organisation such as BCUHB is underpinned by poor systems, structures and processes of governance (as BCUHB was from its creation) then there is very likely to be an inability of the organisation to identify and 'put right' failings.”*

response to concerns when they were presented to BCUHB and a current inability of BCUHB to evidence organisational learning from concerns, complaints and patient safety incidents.

As of the current time service user representatives and a wide range of BCUHB staff also held similar views on their ability to engage with BCUHB as an organisation. One staff member, number 56 summed up in interview in the summer of 2017 a situation described by service users and staff alike as 'It doesn't feel to me, as a member of staff, that there is a measureable and smart plan to even getting your act together .....so even when they are getting their act together it just feels like it's ever changing and the ground is almost slipping beneath your feet, you think you're getting to grips with things and then something else changes.....everybody has their own vested interests and priorities but there's no.... cohesion and different pockets of different works and departments will go off and do one thing, which could have a detrimental impact on another..'

The findings and recommendations of the Ockenden review can be understood at a pan Wales level, at an across BCUHB and North Wales level and finally at an individual level affecting individual service users, service user representatives, carers and staff.

### **Overview of the findings and recommendations of the Ockenden governance review:**

The findings arising from the Ockenden review cover the period from the 'birth' of BCUHB in late 2009 to the end of December 2017. This is a lengthy period of just over eight years. In some areas staff and service user representations have provided updates to the author on the progress of specific issues as late as May 2018 and where these progress reports have been provided they have been considered and included within the main report.

As discussed in the main report BCUHB has been subject to multiple external reviews from at least 2012 and on an ongoing basis to the current time. Scrutiny within mental health and specifically older persons mental health by Healthcare Inspectorate Wales (HIW) has occurred on a continual basis from autumn 2009 to the current day. Therefore at any one time BCUHB has been found to be working with the recommendations of multiple external action plans. In addition BCUHB was placed into Special Measures<sup>202</sup> three years ago in June 2015 and remains under Special Measures at the current time. (April 2018.)

Consideration of **all**<sup>203</sup> of the correspondence, reports and action plans (concerning the care of older people and specifically older people requiring mental health support) to and from HIW and BCUHB from 2009 to the current

*“The Ockenden review of governance engaged with 135 current and former members of BCUHB staff and 105 current service users and service user representatives. 200 interviews were carried out”*

*“It doesn't feel to me, as a member of staff, that there is a measureable and smart plan to even getting your act together .....so even when they are getting their act together it just feels like it's ever changing and the ground is almost slipping beneath your feet, you think you're getting to grips with things and then something else changes..... everybody has their own vested interests and priorities but there's no.... cohesion.”*

<sup>202</sup> See glossary main report

<sup>203</sup> These have been provided to the Ockenden review by the CEO of HIW

day and mapping and triangulation of those findings against many of the external reviews from 2012 onwards show a high degree of connectivity between the

- HIW findings and recommendations;
- Issues and concerns found on Tawel Fan ward;
- *and* multiple external reviews concerning BCUHB as a whole.

Disappointingly, the same findings and recommendations were repeated over and over again by HIW to BCUHB from 2009 onwards and to the current time. Unfortunately there has often been limited progress made by BCUHB from one HIW visit or external review to another, even when an action plan was developed and a number of years elapsed between one HIW inspection/external review and another. In addition the Ockenden team found little or no organisational learning from the action plans developed from one HIW visit, inspection or external review to another. Generally HIW inspections across (for example) a range of inpatient mental health units found the same issues to be of concern on a repeated basis over very many years.

The Ockenden review team has reviewed multiple action plans and note that many actions are simply carried forward from one external review/HIW inspection to the next. Most of the action plans seen are not SMART<sup>204</sup>, Going forward all action plans from the 'ward' to the BCUHB 'Board' will need to be:

**Specific** as to the responsible persons, resources required and the oversight and scrutiny to be put in place;

**Measureable**, with performance monitoring arrangements clearly identified and followed and details where escalation should occur in the event of the required progress not being made;

**Achievable** with clarity around aims and objectives and how these integrate with other existing priorities;

**Relevant** – with actions that refer specifically to the matter requiring resolution;

**Timely** with clarity around required timeframes and dates for completion and details of escalation where timelines are not met.

*“Unfortunately there has often been limited progress made by BCUHB from one HIW visit or external review to another, even when an action plan was developed and a number of years elapsed between one HIW inspection/ external review and another.”*

*“The patient pathway for service users of older people's mental health (OPMH) was fragmented from the 'birth' of BCUHB in 2009 and remains fragmented today from the perspective of many service users, service user representatives and carers (as of the end of 2017.)”*

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<sup>204</sup> See glossary main report



## Finding 1

**The patient pathway for service users of older people's mental health (OPMH) was fragmented from the 'birth' of BCUHB in 2009 and remains fragmented today from the perspective of many service users, service user representatives and carers (as of the end of 2017.)**

The setting up of BCUHB with eleven (11) Clinical Programme Groups (or CPGs) who worked in an independent, disparate and often fragmented way had a negative effect on the delivery of care to older people from 2009 onwards. In the setting up of the CPGs there was a complete lack of strategic direction by the then BCUHB Board and a lack of effective Board oversight and scrutiny. Some Independent Members of the BCUHB Board produced evidence to the Ockenden review team showing that they raised concerns over many years with the then CEO and to Welsh Government but as described in the main report little action was taken in response to these concerns at the time.

The Ockenden review has reviewed extensive evidence that shows that this combination of a lack of Board effectiveness in oversight coupled with stringent financial restrictions meant that mental health and specifically older people's mental health within mental health became a 'Cinderella' service. The MHLDP CPG was described by one Board member as being 'left to do its own thing'.

The 11 CPGs were allowed to operate as autonomous individual bodies within the wider BCUHB and were able to develop service provision as they saw fit rather than consider the 'connectivity' that should have happened across all CPGs and across BCUHB and North Wales. This was described in interview as 'eleven different versions of the world..' existing in BCUHB. This affected provision of services to vulnerable older people such as occupational therapy, physiotherapy, medical care and urgent care.

As a result service user representatives and carers described to the Ockenden review throughout 2017:

- Delays, distress and loss of dignity when seeking medical and urgent care,
- Over use of Accident and Emergency (A and E) departments (for 'simple' conditions such as urinary tract infections) that could and should be treated at/close to home.
- Poor experience of care in A and E and Medical Assessment Units<sup>205</sup> that was often delayed and where staff lacked the time, resources and skills to care for vulnerable older people.
- Out of area treatment – both within BCUHB but at a great distance from home, and outside North Wales in areas as far away as Southampton, London, Shrewsbury, South Wales and Coventry. Both of these scenarios have led to isolation from family, friends, familiar routines and support

*“Some Independent Members of the BCUHB Board produced evidence to the Ockenden review team showing that they raised concerns over many years with the then CEO and to Welsh Government but as described in the main report little action was taken in response to these concerns at the time.”*

*“Delays, distress and loss of dignity when seeking medical and urgent care”*

*“Could and should be treated at/close to home”*

*“Poor experience of care in A and E and Medical Assessment Units that was often delayed and where staff lacked the time, resources and skills to care for vulnerable older people.”*

<sup>205</sup> See <http://www.storiesofdementia.com/2018/04/research-report.html> for further detail and examples

systems and in almost all cases has been described as hugely detrimental to the well being of vulnerable older people.

### **Recommendation 1:**

As of the end of 2017 there has been insufficient evidence seen by the Ockenden review team that the patient pathway and the systems, structures and processes of governance underpinning service provision for vulnerable older people at BCUHB is improving. The current service model remains fragmented with multiple service providers across health, social care, the third sector and other independent providers. This view has been reached following extensive documentary review and interviews and discussion with current BCUHB staff and recent and current carers, service user representatives and independent providers of care across North Wales.

Many current BCUHB staff told the Ockenden review that they did not understand fully the complexities of current service provision and availability in older people's health care themselves and therefore felt unable to explain it to service users and carers. The review, redesign and development of a new service model for older people and those with dementia across the six counties of North Wales requires urgent prioritisation and action by the BCUHB Board and the Mental Health and Learning Disabilities Division as of May 2018. There will be the need for extensive multi-agency working between BCUHB and a range of partners with continuing robust and outcome focused oversight by the BCUHB Board and Welsh Government as this work progresses.

Progress on this work should be reported to the BCUHB Board on a quarterly basis, starting from the progress made by the end of quarter 2 of 2018/19, (the end of September 2018.)

### **Finding 2**

The Ockenden team has very serious concerns regarding the management of the clinical workforce in mental health and older person's mental health, (OPMH) at BCUHB from 2009 to the current day. Conclusive evidence has been seen by the Ockenden review team that from the early days of BCUHB even when posts were deemed as clinically essential by the Mental Health and Learning Disabilities (MHLDD) CPG they were subject to a prolonged process of Executive led 'vacancy control.' This is described in detail in the main report. This left OPMH services chronically understaffed, at a time when patient numbers and acuity was increasing.

The Ockenden team has also heard and seen evidence of the random and indiscriminate application and prolonged use of a scheme known as 'VER' or Voluntary Early Release at BCUHB. This led to the significant loss of skilled and experienced staff from the clinical and managerial staff from within the MHLDD CPG and within older people's mental health over a number of years. It was explained by multiple former BCUHB employees that the BCUHB Executive team had full knowledge of the VER process over several years. It is likely that other wards, departments and CPGs were similarly affected but the Ockenden team

*“The review, redesign and development of a new service model for older people and those with dementia across the six counties of North Wales requires urgent prioritisation and action by the BCUHB Board and the Mental Health and Learning Disabilities Division as of May 2018.”*

*“The Ockenden team has also heard and seen evidence of the random and indiscriminate application and prolonged use of a scheme known as 'VER' or Voluntary Early Release. This led to the significant loss of skilled and experience staff from the clinical and managerial staff from within the MHLDD CPG and within older people's mental health over a number of years.”*

has not considered that detail as its focus is on the governance of older people's mental health. There was no evidence seen of strategic and appropriate Board oversight of this significant loss of skilled workforce via 'VER'. A senior member of staff in post at the time said 'If somebody asked for it, it was difficult to make a case for them not going....'

Unfortunately clinical staff in post at the current time within mental health and OPMH describe staffing as 'worse now' and referred in interview to 'constantly firefighting.' Clinical services were frequently described as existing on the 'good will' of staff with high levels of agency and temporary staff. There remained a high usage of locum medical staff as of the end of December 2017, with a high turnover within the locum medical workforce. This was described to the Ockenden review as impacting significantly on timeliness, quality and continuity of care to service users within OPMH. As of the summer of 2017 Dementia support workers described being frequently unable to do their own roles as they were 'pulled' on a regular basis to help with the physical care of patients in support of the 'health cares.' (Health care support workers.)

BCUHB have advised the Ockenden governance review team that as of May 2018 there are 23 WTE<sup>206</sup> Dementia 'support workers' across the three main hospital sites, community hospitals and in memory services with an additional 7 workers in post under contract with the 'Carer's Trust.'<sup>207</sup> In the MHL Division there are 10 dedicated activity workers in OPMH inpatient wards and in addition to the Consultant Nurse there are three Dementia specialist nurses, one in YGC, one in OPMH and one in the safeguarding team.

## Recommendation 2:

- a) The financial position of BCUHB is well known to be of significant concern. The Ockenden governance review was informed that 'Quality Impact Assessments' (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB Board) were 'still in the process of refinement' (as of spring 2017.) This therefore is likely to remain an issue that will require evidence of focused Board attention going forward.
- b) There will need to be further urgent and sustained Board attention to full integration of the systems, structures and processes underpinning financial, corporate and clinical governance and the Board will need to assure itself that it has effective integration and timely oversight and scrutiny of workforce planning, financial planning, performance and quality going forward.
- c) BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MHL Division and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MHL Division will need to utilise

*“There remained a high usage of locum medical staff as of the end of December 2017, with a high turnover within the locum medical workforce.”*

*“BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MHL Division and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward.”*

<sup>206</sup> Whole Time Equivalent or 'full time roles'

<sup>207</sup> <https://carers.org/>

this support to creatively explore different ways of working and new and effective ways of recruiting and retaining staff. There will need to be efficient, (timely) and effective recruitment processes in place at all times to support the MHL Division going forward.

- d) There is currently only one Consultant Nurse in Dementia for the whole of BCUHB. With the extensive work plan now and going forward to the future this single post-holder is already likely to be stretched very thinly. It is unlikely that BCUHB has sufficient Consultant Nurse resource to even begin to get to grips with the recommendations arising from this review and the HASCAS investigation. BCUHB should take active steps to appoint a second Consultant Nurse in Dementia.

Recommendations 4a to 4d should start with immediate effect and there should be evidence of significant progress by the end of quarter 2 2018/19, (the end of September 2018.) Taking into account recruitment times it would be anticipated all required post holders would be in place by the beginning of quarter 4 2018/2019 (January 2019).

### Finding 3

From 2009 onwards to the current day the Ockenden team have seen many examples of both out of date policies within mental health care and former and current BCUHB staff have described to the Ockenden team lack of evidenced based policies and procedures. Also described to the Ockenden team has been the long term lack of sufficient access to IT equipment which will hinder the ability of staff to access electronic copies of policies and make it more likely that 'workarounds' will be created with wards creating their own 'paper' files of policies that have the potential to become out of date.

The Ockenden review team has not been provided with any evidence suggesting a consistent and systematic approach to the development of new policies. Many staff described the continuing use of 'paper copy' policies and the continuing use of 'legacy' policies. On some occasions clinical practice is said to be still decided by individual clinicians rather than by utilisation of BCUHB wide policies and guidance.

The Ockenden team notes with concern that evidenced based care of the older adult still appears to be at an 'embryonic' stage with care of the older adult at policy level (where it exists) still seen to be an 'add on' to existing policies.

An example is the 2011 BCUHB 'Restraint Policy' which includes sections on the Mental Capacity Act (2005) and consent but says little about capacity with only a single line on cognitive impairment stating 'Patients with cognitive impairment will often not understand oral explanations, and additional consideration has to be taken' (page 13). What this 'additional consideration' should be is not specified. This policy was due for updating in June 2014 but had not been updated as of September 2017. An email received in the Ockenden team office from staff member 85 on the 26.9.17 stated 'For information, this policy is

*"It is unlikely that BCUHB has sufficient Consultant Nurse resource to even begin to get to grips with the recommendations arising from this review and the HASCAS investigation. BCUHB should take active steps to appoint a second Consultant Nurse in Dementia."*

HASCAS investigation

*"From 2009 onwards to the current day the Ockenden team have seen many examples of both out of date policies within mental health care and former and current BCUHB staff have described to the Ockenden team lack of evidenced based policies and procedures."*

*"Many staff described the continuing use of 'paper copy' policies and the continuing use of 'legacy' policies."*



currently awaiting re-ratification on a corporate level.' It is of significant concern to the Ockenden review team that a policy of such significance to provision of mental health care across North Wales has been permitted to become out of date and is out of date by such a significant time period. This concern holds true regardless as to whether there are significant changes to the policy or not.

In addition the Ockenden team heard during numerous interviews with current BCUHB staff that there was a lack of comprehensive systems, structures and processes to underpin effective audit of clinical practice.

### **Recommendation 3:**

If the situation above is found within mental health across BCUHB then it is reasonably likely to be existing in other specialities across BCUHB. Previous external reviews from 2012 onwards found the similar/same issues and concerns across multiple services, departments and CPGs. The Board should assure itself of the current situation by:

Ensuring a review of all clinical policies within all BCUHB Divisions. This review should include quality checks on how the policies and guidelines were ratified, their due date of review and a full understanding of those policies that are overdue for review.

This review will need to be undertaken of all BCUHB policies held on the intranet and a BCUHB Board 'amnesty' announced for submission of all paper copies of policies and guidance held within individual clinical areas in hospitals and across the community. Once an appropriate archive of these policies are created they should be destroyed so that they cannot be returned to clinical practice as a 'work around solution' to lack of access to policies and guidance electronically.

BCUHB should then undertake a comprehensive review of all existing BCUHB policies to ensure the needs of older adults are specifically considered within all relevant policies. (Clearly, some clinical areas would be exempt.) Policies should be rewritten, (or if required new policies created) to ensure that all policies utilise evidenced based practice in the care of older adults and older adults with dementia. These policies must be readily available to support clinical staff in the effective delivery of care to older adults. It is likely that BCUHB will require expertise from multi professional colleagues, carers and service user representatives to ensure these new BCUHB policies are fit for purpose. There will also need to be reviews of the IT systems available to all clinical areas in hospital, community and primary care since BCUHB must now move away from 'paper copy' guidelines. However to do so, means that all staff must have easy access to the BCUHB intranet. This is not currently said to be the case by all BCUHB staff.

### **Finding 4**

The gap between the 'ward' and the 'Board' is still described by many frontline clinical staff as a 'chasm' and many service user representatives and carers described themselves as being aware of this. Current BCUHB staff were mostly

*“A BCUHB Board ‘amnesty’ announced for submission of all paper copies of policies and guidance held within individual clinical areas in hospitals and across the community. Once an appropriate archive of these policies are created they should be destroyed so that they cannot be returned to clinical practice”*

*“All staff must have easy access to the BCUHB intranet.”*

*“The gap between the ‘ward’ and the ‘Board’ is still described by many frontline clinical staff as a ‘chasm’ and many service user representatives and carers described themselves as being aware of this.”*



unaware of the names of the Executive Directors, including the Executive Medical Director and the Executive Director of Nursing. Most staff knew of the CEO only via his weekly email 'My Week' (although readership of 'My Week' was varied. Some staff enjoyed reading it, others said they did not read it either due to pressure of time or volume of emails received. Some staff told the Ockenden governance review they made a point of deleting it without reading it, dismissing it as 'spin'.) The only Board member name universally known to staff was the current Chairman, with the Vice Chair known to some staff. Staff could not name any other Independent Members of the BCUHB Board. Overall the Ockenden review found that from 2009 to the end of December 2017 staff knowledge of and engagement with the BCUHB Board amongst clinical staff was (and remains) poor.

A similar situation was found within the MHL Division. From 2009 onwards most clinically facing staff within the then CPG described limited visibility of the CPG senior leadership team. This can be partially explained by the fact that the role of the Chief of Staff was very part time and the role of the ACOS Nursing was combined with a clinical caseload for a number of years. There was also a very limited supporting management infrastructure between those roles and clinical services.

In the current time the Medical Director of the MHL Division is well known by the consultants interviewed as part of the Ockenden review. Other members of the senior management team are not as well-known and are considered to be less visible. Initial feedback from staff in the autumn of 2016 was that senior staff were seen in the ward areas 'on a Saturday' but this level of visibility, (seeing senior managers within the clinical areas, regardless of the day of the week) does not seem to have been maintained beyond the end of 2016. Local managers in wards, clinics and departments were often perceived positively. As an example, one staff member described at interview positively their local (departmental) management as 'fantastic line managers, but the people at the top, I don't think they really understand.'

Former and current staff working within frontline clinical services were (and are) of the opinion that the Board and senior managers within BCUHB do not understand the pressures faced by front line clinical staff delivering direct patient care. Front line clinical staff described a lack of engagement both with the Board and the former CPG, (current Division) senior management team. Many service users in the North Wales wide 'Listening and Engagement' events occurring in 2017 demonstrated considerable sympathy for front line staff working within older people's mental health services at BCUHB describing them as having a 'lack of opportunity for promotion',<sup>208</sup> 'working every hour God sends to cover the service',<sup>209</sup> 'working in a system under siege',<sup>210</sup> 'remote from managers',<sup>211</sup> and 'staff need 2 things, to be valued and to have the tools to do their job, BCU don't do any of these things...'<sup>212</sup>. There is considerable additional feedback from service user representatives found within the appendices of the main report and

*"Staff could not name any other Independent Members of the BCUHB Board. Overall the Ockenden review found that from 2009 to the end of December 2017 staff knowledge of and engagement with the BCUHB Board amongst clinical staff was (and remains) poor."*

*"Fantastic line managers, but the people at the top, I don't think they really understand."*

*"Former and current staff working within frontline clinical services were (and are) of the opinion that the Board and senior managers within BCUHB do not understand the pressures faced by front line clinical staff delivering direct patient care."*

<sup>208</sup> Service user representative 27, June 2017

<sup>209</sup> Service user representative 34, June 2017

<sup>210</sup> Service user representative 9, June 2017

<sup>211</sup> Service user representative 22, June 2017

<sup>212</sup> Service user representative 27, June 2017

the reader is advised to consider these to fully understand the views of service user representatives and carers on this and other issues.

#### **Recommendation 4:**

Staff engagement with an NHS organisation is known<sup>213</sup> to reduce staff absence and turnover, reduce patient mortality and morbidity and overall increase patient satisfaction. (Kings Fund 2012) There is an urgent need for both the BCUHB Board and the MHL Divisional senior management team to begin to effectively engage with staff. The Kings Fund (2012, page 7) describe an early NHS wide definition of engagement thus 'A measure of how people connect in their work and feel committed to their organisation and its goals. People who are highly engaged in an activity feel excited and enthusiastic about their role, say time passes quickly at work, devote extra effort to the activity, identify with the task and describe themselves to others in the context of their task (doctor, nurse, NHS manager), think about the questions or challenges posed by the activity during their spare moments (for example when travelling to and from work), resist distractions, find it easy to stay focused and invite others into the activity or organisation (their enthusiasm is contagious.)'

At the current time with the multiple challenges ahead BCUHB is in very significant need of a committed, excited and enthusiastic workforce. Many of those staff met with as part of the Ockenden review described 'going the extra mile' for their patients on a daily basis and some service user representatives did recognise that. However there was a marked difference between the attitude of 'going the extra mile' for patients in their care heard from many staff and the feelings of apathy and disengagement many staff had towards BCUHB as their employing organisation.

#### **Recommendation 4a:**

The BCUHB Board and the MHL Divisional Senior Management team is recommended first to ask of front line staff 'what does the term 'staff engagement' mean to you, what would effective staff engagement look like for you?' and then to develop a system of bespoke, meaningful and sustained staff engagement first across mental health and specifically older persons mental health. The Board may then wish to consider how effective their engagement is with staff across BCUHB and decide whether a new Board approach is required to staff engagement across the whole of BCUHB.

#### **Recommendation 4b:**

The Ockenden review team was informed that the NHS Staff survey across Wales is completed every three years and is next due in 2019. Welsh Government may wish to consider an annual staff survey in line with that carried out in England. A three year gap in formally ascertaining the views of NHS staff in Wales is considered by the Ockenden review team to be too long.

*“Staff need 2 things, to be valued and to have the tools to do their job, BCU don't do any of these things...”*

*“There was a marked difference between the 'going the extra mile' for patients in their care attitude heard from many staff and the feelings of apathy and disengagement many staff had towards BCUHB as their employing organisation.”*

*“‘what does the term 'staff engagement' mean to you, what would effective staff engagement look like for you?’”*

<sup>213</sup> <https://www.kingsfund.org.uk/sites/default/files/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf>

#### **Recommendation 4c:**

Aside from any potential decision by Welsh Government, the BCUHB Board should commence a formal annual BCUHB staff survey starting with the all Wales annual staff survey in 2019 and using the same methodology utilised for the all Wales NHS staff survey at BCUHB on an annual basis from 2020. The actions and progress arising from the new annual BCUHB staff survey should be reported to the public BCUHB Board on a quarterly basis.

#### **Recommendation 4d:**

Following on from the failure of BCUHB's attempt to create a clinically led organisation in 2009, which is well referenced in a number of external reports the BCUHB Board must now take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB. The recommendations a to c above refer to the need to improve staff engagement. BCUHB also needs to engage with a comprehensive BCUHB wide clinical leadership and management development scheme encouraging the widest range of clinical colleagues across medicine, nursing and professions allied to medicine to want to take responsibility for leadership and management of their individual services.

Any such scheme must learn the lessons from the failure of the BCUHB CPG system from 2009 onwards and ensure they are not repeated. The failure of the BCUHB CPG system must not be levelled simply at the door of the individual clinicians leading those CPGs. The failure of the CPG system is widely discussed in the main report and in multiple external reviews prior to the Ockenden review.

The BCUHB Board must take full and collective responsibility for the failure of the former CPG system from 2009 onwards. In particular it must acknowledge that many Independent Members of the Board raised very significant concerns regarding the CPG structure from very early in the history of BCUHB. These significant concerns, which were also escalated to Welsh Government were not acted upon collectively by the Board and Welsh Government. History may well have been different if the many Independent members raising concerns had been listened to and appropriate and timely action had been taken.

#### **Finding 5**

The Ockenden team has seen and heard significant evidence that patient numbers and acuity on Tawel Fan ward and all other inpatient mental health wards across BCUHB increased significantly from 2009 onwards. This increase in patient numbers and acuity was exacerbated by the following features:

- Home treatment teams were new and therefore embryonic in nature and could not care effectively at home for patients at crisis point. A number of service user representatives told the Ockenden review team of the distressing use of the Police to support admission of elderly relatives to hospital when situations at home had reached crisis point and could not be de-escalated.

*“The BCUHB Board should commence a formal annual BCUHB staff survey starting with the all Wales annual staff survey in 2019 and using the same methodology utilised for the all Wales NHS staff survey at BCUHB on an annual basis from 2020.”*

*“The failure of the BCUHB CPG system must not be levelled simply at the door of the individual clinicians leading those CPGs.”*

*“Inpatient beds were lost before the service developments to replace the ‘lost’ beds were introduced. Staff describe that some inpatient beds were closed at short notice with little time to plan; ‘they just came in and closed us [over] a couple of days.’”*

- A reduction in older people's mental health inpatient beds in order to facilitate the development of the home treatment teams and community services, i.e. inpatient beds were lost before the service developments to replace the 'lost' beds were introduced. Staff describe that some inpatient beds were closed at short notice with little time to plan; 'they just came in and closed us [over] a couple of days.'
- A loss of nursing home beds across North Wales from 2012 onwards despite (untested) assurances to the Board around 'Healthcare in North Wales is Changing'<sup>214</sup> (2012) that there were opportunities to 'commission' beds in EMI<sup>215</sup> homes. The reduction in EMI beds was happening at the time of the assurances to the Board around 'opportunities' to grow the numbers of EMI beds available to BCUHB but all of the recommendations made to the BCUHB Board were fully accepted with very minimal challenge.
- Long term issues around access to out of hours GP provision which are well documented elsewhere.

Feedback to the Ockenden review team from current BCUHB staff and current carers and service user representatives at all of the 'Listening and Engagement' in 2017 events shows that in 2017 there still remains a mismatch between patient acuity, patient numbers and service provision across OPMH in BCUHB.

- EMI nursing home capacity remained a concern.
- Community based services for older people's mental health was still very underdeveloped.
- There was immense pressure on the third sector to provide care and support to older people with mental health problems across North Wales.
- BCUHB staff, the third sector and carers and service user representatives all found the approach from BCUHB towards the third sector in 2017 to be fragmented, disorganised and chaotic with a lack of strategic approach. This was summarised by a current member of staff, who said of the approach by BCUHB in summer 2017: 'It creates pockets of gaps and then duplication and it doesn't allow people to access the support that is there....' The staff member continued: 'There's no cohesive approach and it's not that the work undertaken isn't good work, but it's just dotted around and people don't know that it's there....'
- One service user representative said 'There is a need to go back to basics to evaluate what services are required at the earliest times'
- There were believed to be insufficient inpatient bed numbers for older people with mental health issues in 2017
- Older people were frequently required to travel long distances for care and treatment either across North Wales (or in many examples provided by staff, service user representatives and carers) outside North Wales.

*"The reduction in EMI beds was happening at the time of the assurances to the Board around 'opportunities' to grow the numbers of EMI beds available to BCUHB"*

*"BCUHB staff, the third sector and carers and service user representatives all found the approach from BCUHB towards the third sector in 2017 to be fragmented, disorganised and chaotic with a lack of strategic approach."*

*"It creates pockets of gaps and then duplication and it doesn't allow people to access the support that is there...."*

*"Conversations between all should continue along the pathway – but everyone is stretched to the limit – GPs are drowning"*

(service user representative 34)

<sup>214</sup> See glossary, main report

<sup>215</sup> See glossary, main report

- 'Conversations between all should continue along the pathway – but everyone is stretched to the limit – GPs are drowning'; (service user representative 34)
- 'People are being ignored by the system. People should be asked what systems they would like. (service user representative number 9.)

### Recommendation 5:

BCUHB needs to work effectively at a strategic level with the third sector, carers, service user representatives and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales. Again the Ockenden team uses the word 'embryonic' to describe progress to date.

### Finding 6

With reference to the safeguarding adults function at BCUHB the Ockenden review team considered significant evidence that showed the systems, structures and processes of governance underpinning safeguarding and the resources provided to it to be sub optimal from the formation of BCUHB in 2009 until at least late 2016. A number of current and former BCUHB senior staff described that the setting up of individual governance structures within the eleven CPGs, described as a 'broad architecture of governance' by one member of staff had considerable implications for the development of adult safeguarding in BCUHB from 2009 onwards.

In addition former senior BCUHB staff described clearly that the formation of BCUHB across the six counties of North Wales caused significant disruption to relationships between internal safeguarding arrangements in the three main 'legacy' sites and external multi-agency working arrangements that were described as previously working effectively.

Senior staff within BCUHB describe the sporadic implementation of Datix<sup>216</sup> across BCUHB, without training in some areas and the difficulties across the CPGs of sharing information across SI's<sup>217</sup>, complaints, Datix, POVAs<sup>218</sup> and safeguarding alerts. Staff also described the lack of an 'automatic flag' or alert system on Datix against ward, name or department. Much record keeping associated with safeguarding and risk was 'paper copy' rather than electronic and this simply ceased to work following the birth of such a large organisation. All of this made it difficult for staff working within safeguarding to identify and therefore act upon and subsequently learn from any potential trends from specific clinical areas or services.

Clinical staff across OPMH described to the Ockenden review that they rarely received feedback from submission of safeguarding alerts, Datix, clinical incidents

*“A number of current and former BCUHB senior staff described that the setting up of individual governance structures within the eleven CPGs, described as a 'broad architecture of governance' by one member of staff had considerable implications for the development of adult safeguarding in BCUHB from 2009 onwards.”*

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<sup>216</sup> See glossary, main report

<sup>217</sup> See glossary, main report

<sup>218</sup> See glossary, main report



or complaints meaning that it was both difficult to provide effective care to some vulnerable adults alongside an absence of organisational learning.

Review of all the BCUHB Annual Safeguarding reports from 2010 to the current day and the Corporate Risk Register<sup>219</sup> (or CRR) from November 2013 to August 2015 and then from August 2015 to the current time (end of 2017) show that the 'risk' of potential harm to vulnerable people was recorded as a RAG rating<sup>220</sup> of '20' (red/high) in November 2013 and remained '20' (red/high) in May 2015. Despite this safeguarding was 'de-escalated' from the Corporate Risk Register in August 2015 to be managed 'at a strategic corporate nursing level.' The reason for this de-escalation remains unclear to the Ockenden team since a diagnostic review undertaken at the instruction of the then new Executive Director of Nursing found a number of very significant risks around safeguarding 'RAG' rated at 20 or 25.

Overall the Ockenden review found that Board scrutiny and oversight of safeguarding was weak and the BCUHB Board, (both Executive Directors and Independent Members) received poor quality information about the difficulties in safeguarding across BCUHB over a prolonged period of time from 2010 to the end of 2016.

#### **Current position in adult safeguarding at BCUHB as of December 2017 and recommendation 6:**

The BCUHB annual 'safeguarding report' for 2017-18<sup>221</sup> still reports significant risk in the adult safeguarding function at BCUHB. The following challenges remain which are of a very urgent nature:

- Attendance at safeguarding training remains problematic and there is continued difficulty in achieving the required training at level 1 across BCUHB. Therefore BCUHB will need to review and update its safeguarding training and ensure it is up to date and incorporates relevant legislation. Where recent training was out of date, those who have had training since April 2016 will need appropriately updated training to be delivered.
- Adherence to the standards required in the number of BCUHB staff accessing safeguarding training has been a chronic and long term problem. BCUHB now need to develop a SMART<sup>222</sup> action plan with progress reported quarterly to the BCUHB Board. If there is not a significant and sustained improvement by the end of quarter 3 of 2018/19 the BCUHB Board should consider further external assistance including the potential of external assistance from Welsh Government.
- The current safeguarding database still lacks the ability to triangulate data from various databases across BCUHB. This is a continuing risk to the safety of vulnerable adults receiving care at BCUHB.

*“The ‘risk’ of potential harm to vulnerable people was recorded as a RAG rating of ‘20’ (red/high) in November 2013 and remained ‘20’ (red/high) in May 2015. Despite this safeguarding was ‘de-escalated’ from the Corporate Risk Register in August 2015 to be managed ‘at a strategic corporate nursing level.’”*

*“The BCUHB annual ‘safeguarding report’ for 2017-18 still reports significant risk in the adult safeguarding function at BCUHB.”*

<sup>219</sup> See glossary, main report

<sup>220</sup> See glossary, main report

<sup>221</sup> See main report footnote 141 for further detail

<sup>222</sup> Specific, Measureable, Achievable, Relevant and Timely

- There has been long term absence of key safeguarding personnel from the beginning of 2016 to the end of 2017. However the current Executive Director of Nursing has provided significant resource for a new safeguarding structure bringing together safeguarding adults and children, tissue viability and lymphoedema,<sup>223</sup> Deprivation of Liberty standards or DoLS<sup>224</sup> plus a safeguarding lead for dementia. The revised structure is described in more detail in the main report.
- BCUHB should undertake a formal and externally led evaluation of the effectiveness of the new safeguarding structure by the end of the last quarter of 2018/19, i.e. to be completed by 31st March 2019.) The resulting report should be presented to the BCUHB Board in public by the beginning of quarter 2 2019/20 - July 2019.
- BCUHB still needs to update its policies and procedures in line with the Social Services and Wellbeing Act 2014.<sup>225</sup> These BCUHB policy updates should have been in place prior to the implementation of the legislation in April 2016 and there has been very significant delay. This must proceed without further delay and must be complete by the end of the third quarter 2018/19 – the end of December 2018.

*“The current Executive Director of Nursing has committed significant resource and provided energy and determination into developing sound foundations for the safeguarding structure going forward.”*

#### **Overview of progress to date made by BCUHB with reference to recommendation 6:**

The current Executive Director of Nursing has committed significant resource and provided energy and determination into developing sound foundations for the safeguarding structure going forward. However for an organisation such as BCUHB approaching its ninth birthday a very significant amount of work still needs to be done. This will need continued Board scrutiny and oversight, may still yet require external support and **must** be reported to Welsh Government if (for any reason) progress in the future falters or slows down. Clear timescales and expectations are set out above.

*“The Ockenden governance review team is very clear that the ‘concerns’ (or PTR) process at BCUHB has been in a state of almost continual failure since the creation of BCUHB in October 2009.”*

#### **Finding 7**

The Ockenden governance review team is very clear that the ‘concerns’ (or PTR)<sup>226</sup> process at BCUHB has been in a state of almost continual failure since the creation of BCUHB in October 2009. The failures have been well documented in a number of external reviews from 2013 to the current day. This is discussed in greater detail in the main report. BCUHB have described a ‘root and branch’ review of the whole BCUHB complaints process that commenced in September 2017 under the leadership of the Executive Director of Nursing and Midwifery. As part of this BCUHB have reported to the Ockenden governance review a very significant reduction in the number of open complaints between August 2017 when there were said to be 450 complaints open to April 2018 when there were said to be 250 complaints open. It is acknowledged that significant effort is being

*“There is always a delay in receiving a response to any concern/ complaint – and when you get the response its quality is poor”*  
(Bangor, May 2017)

<sup>223</sup> See main report glossary

<sup>224</sup> See main report glossary

<sup>225</sup> [http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw\\_20140004\\_en.pdf](http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf)

<sup>226</sup> See glossary, main report for definition

put into improving the management of concerns in 2017. However these efforts have yet to 'bear fruit' in terms of the actual experience of carers, service users and service user representatives who participated in the Ockenden review throughout 2016 and 2017.

Findings from service users included the following, (with further detail of service user viewpoints available in the main report.)

- There is always a delay in receiving a response to any concern/complaint – and when you get the response its quality is poor' (Bangor, May 2017)
- 'The health board is arrogant when it responds to complaints – there is an impression that they just don't care'; (Bangor, May 2017)
- 'The mantra 'say what you mean, mean what you say; doesn't apply'; (Bangor, May 2017)
- 'They (BCUHB) treat you like dirt. An advocate was asked 'who are you to be speaking on behalf of this patient?' (Bangor, May 2017)
- 'People just give up complaining'; (Bangor, May 2017)
- 'Elderly people in particular have just not been brought up to 'complain' – it is just not in their upbringing. They are often fearful to speak up and are therefore vulnerable'; (Bangor, May 2017)
- 'Leaders need to embrace change and lead from the front – they need to respond to change/criticism'; (Bangor, May 2017)
- 'Many people just don't know how to complain – and are fearful of doing so'; (Bangor, May 2017)
- 'Life is too busy in particular if you are caring for an elderly person – you are constantly overwhelmed with what you have to do – going through making a complaint is something that you just wouldn't have time to do'; (Bangor, May 2017)
- 'Families are in fear of reprisal for asking questions, or raising a concern or a complaint'; (Tywyn, May 2017, service user representative 20)
- We have to keep rattling cages – it's so frustrating, however [we have] power to change things if we continually rattle cages together. However people run out of puff and give up and all that is left is a nice paper trail and nothing else. (Llangefni June 2017, service user representative 34)
- 'Families are just too terrified to complain in case their relatives might get shipped off to England. They are just frightened to speak out'; (Llangefni June 2017, service user representative 30)
- 'People think – 'if I'm really nice to them then they will look after dad – best if I not complain'; (Llangefni June 2017 service user representative)
- 'People just don't make complaints in the first place – I think the number of complaints/levels of dissatisfaction are grossly under reported'; (Llangefni June 2017, service user representative 30)

*“Elderly people in particular have just not been brought up to 'complain' – it is just not in their upbringing. They are often fearful to speak up and are therefore vulnerable”*

(Bangor, May 2017)

*“Life is too busy in particular if you are caring for an elderly person – you are constantly overwhelmed with what you have to do – going through making a complaint is something that you just wouldn't have time to do”*

(Bangor, May 2017)

*“Families are in fear of reprisal for asking questions, or raising a concern or a complaint”*

(Tywyn, May 2017, service user representative 20)

- 'Protracted timescales – people are hiding behind the 'volume of work' excuse. Often staff have moved on so it is difficult to investigate. Complaints are treated as a nuisance' (Pwllheli June 2017, service user representative 21)

Most service user representatives and carers met with as part of the Ockenden review of governance had very little faith or confidence in the ability of BCUHB to 'put things right' with the concerns process as of the end of 2017 and into the spring of 2018.

The Ockenden review team met with and received communication from a number of North Wales Assembly Members<sup>227</sup> or AMs. Having gained consent from their constituents they shared with the Ockenden team communication from constituents showing poor systems, structures and processes of governance around complaints and concerns at BCUHB from 2009 onwards to the current day. Of great concern to the Ockenden review team is that North Wales AMs are still, as of late 2017 needing to become involved on a regular basis supporting their constituents through the complaints process at BCUHB.

In addition it is clear to the Ockenden review team that the North Wales Community Health Council (NWCHC) also plays a very significant role, (on a regular basis) in supporting the resolution of complaints both inside and outside OPMH at BCUHB as of spring 2018. An experienced advocate told the Ockenden review in December 2017 that BCUHB in its management of concerns 'plod on for a couple of years as they are, and they get decidedly worse and then the Health Board gets someone in [who] stamps all over everybody, and then they become very proactive in..... well they try and get rid of all the backlog, .....then the new ones that are coming in, they become the backlog and then they toddle on a bit longer and then they get somebody else in. There seems to be this circle where they never seem to get it right, they never seem to be able to get to a position where they are actually smashing that thirty day, or even the six month timeline, really.'

An experienced advocate raised the following case study with the Ockenden review as of the end of 2017. This case had been previously raised with BCUHB and occurred in 2017. It was raised to illustrate the importance of the role of the advocate for vulnerable older people within the Ockenden governance review. Minor details have been changed from those supplied by the advocate to ensure anonymity. The case occurred at a BCUHB main hospital site, outside the MHL Division.

Miss S attended hospital following a fall and fracturing her patella. She was admitted initially in August, 2017. It was decided by the medical team that the injury would be treated conservatively and no surgery would be conducted due to the surgical risk she posed. On this admission a cast was placed on her leg. In early September Miss S was re-admitted to the DGH due to multiple pressure sores caused by the cast. She was moved to X Community Hospital a few days later.

No Advocate, (IMCA), was consulted on the decision to not treat her injury. Due to Miss S being deemed to lack capacity, because of her advanced dementia, and

*“People think – ‘if I’m really nice to them then they will look after dad – best if I not complain”*

(Llangefni June 2017 service user representative)

*“Of great concern to the Ockenden review team is that North Wales AMs are still, as of late 2017 needing to become involved in supporting their constituents through the complaints process at BCUHB.”*

*“It is clear to the Ockenden review team that the North Wales Community Health Council (NWCHC) also plays a very significant role, (on a regular basis) in supporting the resolution of complaints both inside and outside OPMH at BCUHB as of spring 2018.”*

<sup>227</sup> See glossary, main report



not having family or friends to act on her behalf, she should have been provided with an IMCA as per the Mental Capacity Act 2005.

As a result of the surgeons making their own decision and not liaising, as they should have done, with an IMCA, the decision to not treat Miss S was based on the presenting picture of her knee only and did not look at the overall effects to her. Miss S was in hospital for a number of weeks where she declined physically and mentally and was ultimately moved to another care home due to her increasing needs. The care home she was at previously knew her very well and she had been with them for a number of years. It is yet to be seen what effect moving homes will have on her further.

The sores caused by the cast were grade 3-4 on the vaginal area and grade 4 on the back of the thigh. She also had a graze on her inner ankle and a necrotic heel. There was an infection in her groin, which was treated with antibiotics too. It is not clear what thought was put in to Miss S's lifestyle when the cast was applied and the effects it would have on her. It could be argued that were an IMCA involved this would have been raised as a potential issue.' (Service user representative number 103.)

Service user 1 submitted a detailed timeline to the Ockenden review showing their efforts to resolve a complaint around poor care provided to their spouse with end of life care at YGC in 2017. Service user 1 said 'Seeing all the dates in front of me it makes me realise, how dare they keep a grieving widow, who had been through so much trauma, waiting for so long for the answers to why her husband was put through so much, leaving him without dignity when he was dying and so vulnerable. I think I was being given the run around, hoping I would just give up and go away.' (Service user 1, on reviewing their concerns 'timeline' in April 2018.)

This situation around management of complaints and concerns at BCUHB was reflected in the 2017 joint HIW/WAO report. Whilst HIW/WAO noted that BCUHB had 'started to improve the timeliness of responding to complaints.' HIW stated they had seen 'little evidence to suggest that the Health Board is learning effectively.' HIW also noted that which had been stated by a number of interviewees to the Ockenden review team, that there was limited evidence of 'lessons learnt' on a consistent and systematic basis across sites and divisions. (HIW 2017, page 10.)

### **Recommendation from finding 7:**

Whilst it is acknowledged that on many occasions since 2009 BCUHB has made an effort to improve the timeliness of responses to concerns in line with the requirement of Putting Things Right (2011) this has not yet been sustained on an ongoing and long term basis. BCUHB needs to resolve this situation finally by the end of quarter 2 of 2018/19, (i.e. the end of September 2018)

In addition the Ockenden governance review team heard from multiple service user representatives and individual families and carers of very poor and protracted experiences in trying to resolve complaints. Donna Ockenden personally escalated

*“Service user 1 said ‘Seeing all the dates in front of me it makes me realise, how dare they keep a grieving widow, who had been through so much trauma, waiting for so long for the answers to why her husband was put through so much, leaving him without dignity when he was dying and so vulnerable. I think I was being given the run around, hoping I would just give up and go away.’”*

(Service user 1, on reviewing their concerns 'timeline' in April 2018.)

*“It is clear that the BCUHB Board have very little knowledge of the actual everyday experience of families, service users and service user representatives who try to make complaints to BCUHB as an organisation.”*



to Executive level three complaints characterised by poor responses over a very protracted timescale. Following that escalation there was a further extended period of time before any progress was made. In one case an external investigator has just been appointed (May 2018) following escalation of very serious concerns to the the BCUHB Executive team by Donna Ockenden in August 2017.

It is clear that the BCUHB Board have very little knowledge of the **actual** everyday experience of families, service users and service user representatives who try to make complaints to BCUHB as an organisation. Service user representatives also raised with Donna Ockenden the reluctance of families and service users to complain and the fear they have of complaining. This means that the number of complaints from older people and their families is highly unlikely to be an accurate illustration of the real views of service users and their families.

Service user representatives and carers in mental health and older peoples mental health (and staff involved in service user and carer engagement) have described to the Ockenden review team how carers feel 'saturated' by the multiple ways in which BCUHB attempt to ascertain their views but then perceive that BCUHB do very little with those views and feedback. Therefore the Ockenden review is reluctant to recommend that the BCUHB Board and the MHLD senior management team undertake specific and targeted further user engagement looking at complaints and concerns. However the BCUHB Board needs to be aware of the considerable and deep seated unhappiness expressed by a range of carers and service user representatives across a range of issues – one of which is the current inability of BCUHB to effectively respond to concerns in a timely manner.

## Finding 8

**The Ockenden review found communication with carers and service users to require significant improvement throughout the lifetime of this review and up to and including December 2017.**

**The Ockenden team heard about difficulties in accessing information from BCUHB about dementia from a range of carers and accessed the BCUHB website to assess what information was available.**

There was considerable concern expressed by service users and their representatives about the delays in diagnosing dementia across North Wales. Once dementia was diagnosed service users and their representatives described an absence of advice and information for carers and families. There was particular concern around lack of support for those with younger onset dementia. Further concerns were expressed around care plans with care plans described as standardised with limited/no individuality. Carers stated that they saw little being done by BCUHB to ensure that the individual was at the heart of any care planned or delivered.

The BCUHB website has an area described as a 'Dementia Toolkit'<sup>228</sup> where very basic information can be accessed and printed on for example Alzheimer's

*“Carers feel ‘saturated’ by the multiple ways in which BCUHB attempt to ascertain their views but then perceive that BCUHB do very little with those views and feedback.”*

*“However the BCUHB Board needs to be aware of the considerable and deep seated unhappiness expressed by a range of carers and service user representatives across a range of issues – one of which is the current inability of BCUHB to effectively respond to concerns in a timely manner.”*

<sup>228</sup> <http://www.wales.nhs.uk/sitesplus/861/page/65255>

disease<sup>229</sup>, Lewy Body dementia<sup>230</sup>, management of vascular dementia<sup>231</sup> and mild memory problems<sup>232</sup>. These are provided in English with the option for Welsh translation<sup>233</sup> from the BCUHB website and the links are found below. The Ockenden review team noted that this information is in a very small font of circa a font sized 6, (it can be increased to circa font sized 12,) It requires IT skills to 'click through' multiple links, all in small font. The information as presented on the BCUHB website on dementia is unlikely to be helpful to elderly carers or service users. BCUHB has advised Donna Ockenden that 'a dementia handbook and memory training<sup>234</sup> guide produced by the Alzheimer's society' are given to patients and families on diagnosis. This is not available electronically but information is available in the link below.

*“The information as presented on the BCUHB website on dementia is unlikely to be helpful to elderly carers or service users.”*

A range of dates are found on the BCUHB for events associated with dementia from 'Monday 15th May' onwards<sup>235</sup>. The year is not specified. In 2018 15th May is a Tuesday so it appears the events are from 2017 not 2018. The page has not been updated. Other information on the page<sup>236</sup> includes information on the '**Dementia RED – Information Service.**' This is described as:

'Dementia RED (Respect, Empathy, Dignity) is a series of information centre points within GP surgeries throughout North Wales. The aim is to help people with concerns about dementia to access appropriate information and support. Available to registered patients at the practice hosting the Information Point.' The Ockenden review team could not find any further information on those GP surgeries hosting the information point, so this was unlikely to be of much help to carers, service user representatives or people with dementia themselves. A 2015 evaluation report was found on line<sup>237</sup> which indicates that this was potentially a short term project that has now concluded. This would not explain why there is still a reference to the scheme on the BCUHB website as of April 2018.

The BCUHB 'Dementia strategy' could not be found on the BCUHB website<sup>238</sup> as of April 2018 when the words 'dementia strategy'<sup>239</sup> were repeatedly used to facilitate a search. A 2014-2016 update was found as part of Quality, Safety and Experience papers instead. An updated 2018 'Dementia Strategy' was not available as part of the 'Dementia toolkit' area of the BCUHB website. The Dementia strategy has been reviewed by the Ockenden governance review team. It remains very 'high level' and aspirational and there does not appear (as of spring 2018) to be a SMART<sup>240</sup> action plan accompanying it which describes how the aspirations within it will be achieved and when.

*“Significant further work still needs to be done by BCUHB in improving the information available to service users with dementia, their carers and service user representatives.”*

<sup>229</sup> <http://www.wales.nhs.uk/sitesplus/861/page/64863>

<sup>230</sup> <http://www.wales.nhs.uk/sitesplus/861/page/64866>

<sup>231</sup> <http://www.wales.nhs.uk/sitesplus/861/page/64868>

<sup>232</sup> <http://www.wales.nhs.uk/sitesplus/861/page/64872>

<sup>233</sup> <http://www.wales.nhs.uk/sitesplus/861/tudalen/64899>

<sup>234</sup> <https://www.alzheimers.org.uk/research/care-and-cure-research-magazine/training-your-brain>

<sup>235</sup> <http://www.wales.nhs.uk/sitesplus/861/page/65253>

<sup>236</sup> <http://www.wales.nhs.uk/sitesplus/861/page/65331>

<sup>237</sup> [http://dsdc.bangor.ac.uk/documents/DementiaREDMidtermevaluationreport\\_FINAL.pdf](http://dsdc.bangor.ac.uk/documents/DementiaREDMidtermevaluationreport_FINAL.pdf)

<sup>238</sup> <http://www.wales.nhs.uk/sitesplus/861/Home>

<sup>239</sup> [http://www.wales.nhs.uk/sitesplus/documents/861/qs14\\_61.3%20bcuhb%20dementia%20strategy%202014\\_16.pdf](http://www.wales.nhs.uk/sitesplus/documents/861/qs14_61.3%20bcuhb%20dementia%20strategy%202014_16.pdf)

<sup>240</sup> See glossary, main report

BCUHB advises that dementia training for families has been 'road tested' with carers in 2017 and will be launched during 'Dementia Action Week' in 2018.

#### **Recommendation 8:**

Significant further work still needs to be done by BCUHB in improving the information available to service users with dementia, their carers and service user representatives. It is clear that an attempt has been made to provide information on the BCUHB website but the BCUHB Board now needs to ensure appropriate resources, skills and time are provided on a substantive basis to ensure a range of high quality and appropriate resources and information are easily available to service users, service user representatives and carers. Communications need to be easily accessible to patients and carers. There is a great deal of difference between the accessibility of the information available on the Alzheimer's Society<sup>241</sup> website and the information available on the BCUHB website. It is acknowledged that there will be a much greater range of information on the Alzheimer's Society website.

In order to ensure recruitment to this service the BCUHB Board should provide an update on progress by the end of quarter 2, (end of September 2018) with the launch of a new suite of bilingual (English and Welsh) resources available no later than the end of quarter 3, (the end of December 2018.) Front line clinical staff, carers and service user representatives need to be involved in the development of these resources from the earliest stage to ensure they are relevant and appropriate.

The BCUHB Board need to commit the appropriate resources to ensure that the currently high level 'Dementia strategy' becomes an achievable and relevant part of everyday care and clinical practice of people with dementia. It appears that as of April 2018 BCUHB still need to ascertain the workforce needed to deliver upon the 'Dementia Strategy' since the Ockenden team has not seen any evidence to suggest that this work is either underway or has already been completed. The 'Dementia Strategy' should also incorporate current and forward looking workforce and service plans for the provision of appropriate levels of therapy and non-medical care for people with dementia since again, the Ockenden team has not seen evidence to suggest that this aspect of the 'Dementia Strategy' has been completed.

This work needs to commence within quarter 2 of 2018/19 with significant progress reported to the BCUHB Board at the beginning and end of quarter 3, (October and December 2018) and quarter 4; ending March 31st 2019. Progress throughout 2019 will need to be monitored by the BCUHB Board to ensure it does not slip, falter or become delayed.

The 'Dementia Strategy' should be developed to work across all relevant clinical services across BCUHB, not just within the MHL Division. The 'Dementia Strategy' should incorporate care across home, primary care and secondary care.

*“The BCUHB Board now needs to ensure appropriate resources, skills and time are provided on a substantive basis to ensure a range of high quality and appropriate resources and information are easily available to service user, service user representatives and carers. Communications need to be easily accessible to patients and carers.”*

*“The BCUHB Board need to commit the appropriate resources to ensure that the currently high level 'Dementia Strategy' becomes an achievable and relevant part of everyday care and clinical practice of people with dementia.”*

<sup>241</sup> [https://www.alzheimers.org.uk/?gclid=EAlalQobChMIw4fVu4392gIVyLvtCh0YhgAuEAAAYASAAEgJZCPD\\_BwE](https://www.alzheimers.org.uk/?gclid=EAlalQobChMIw4fVu4392gIVyLvtCh0YhgAuEAAAYASAAEgJZCPD_BwE)

## Finding 9

### Deprivation of Liberty Safeguards or DoLS

The Ockenden review team has reviewed a significant amount of information indicating that BCUHB has struggled to provide an effective response to DoLS over the years from 2009. In the documentation seen by the Ockenden team there are multiple references to failures to ensure adequate and appropriate training and long term confusion over lines of responsibility for DoLS. In a recent report for BCUHB, (March 2017) it was stated that the majority of DoLS applications are urgent but only 1% of urgent decisions were made in the allotted time span (the average for Health Boards across Wales was 28%). This shows BCUHB as a significant negative outlier when compared to other Health Boards across Wales. It is acknowledged by BCUHB that 'compliance with DoLS legislation remains a concern' (Quality, Safety and Experience Committee 29th March 2017 QS17/65.7)

The BCUHB 2015-16 Annual safeguarding report states that overall 'the delays in decision making raise a serious concern about the effectiveness of the safeguards and the risk of unauthorised and unnecessary deprivations of liberty in hospitals....' (Page 12)

The 2017-2018 BCUHB 'Safeguarding and Protection of People at Risk of Harm, Annual Report' sets out an overview of progress to date and notes that progress to date has been 'gradual.' A work plan around DoLS for 2017-2018 is set out at 14.4 (BCUHB 2018, page 10.)

### Recommendation 9:

BCUHB will complete and report to the BCUHB Board in quarter 1 2018-2019, (by the end of June 2019) a review of the 2017-2018 DoLS work plan as set out in the 2017-2018 Annual Report.

Any remaining actions are required to be SMART and fully implemented within the third quarter 2018-19, (by December 2018) with progress reported to the BCUHB Board throughout quarter 3.

## Finding 10

**The Ockenden review found that BCUHB demonstrated a lack of an effective and sustained response to numerous external reviews and inspections of services at BCUHB from October 2009 to the current day. This included failure by BCUHB to act upon repeated concerns raised by HIW raised from 2009 to 2017.**

The Ockenden review team has considered a vast volume of evidence that has shown that BCUHB was subject to extensive external review and scrutiny from 2009 to the end of December 2017. This is described fully in the main report. HIW reviews and inspections happen in a large number of BCUHB services associated with the care of vulnerable elderly people over a period of time in excess of seven years. Some issues around estates, staffing, poor documentation, lack of meaningful activities for patients and concerns around medicines

*"The 'Dementia strategy' should be developed to work across all relevant clinical services across BCUHB, not just within the MHLD Division. The 'Dementia Strategy' should incorporate care across home, primary care and secondary care."*

*"It is acknowledged by BCUHB that 'compliance with DoLS legislation remains a concern'"*

(Quality, Safety and Experience Committee 29th March 2017 QS17/65.7)

management are repeated over multiple HIW visits to many sites over many years.

There are some examples of good practice found by HIW over the period of these reviews. Staff are frequently commented on in a positive way. Throughout these reports and over this prolonged period of time there are a long catalogue of issues at BCUHB that are similar across many of the HIW inspection reports. These are repeated across multiple inpatient units with very little assurance that the situation is improving.

One example is the lack of action BCUHB took following the Healthcare Inspectorate Wales (HIW) Mental Health Act visit to Tawel Fan ward in July 2013. Those receiving the feedback from the visit on the day failed to realise the seriousness of the issues raised. A member of the Board was not present for feedback, there has been no evidence seen by the Ockenden governance review team that the feedback was shared with either the CPG Chief of Staff or the Executive team. Finally, there was a significant failing in the systems, structures and processes within HIW at the time in that communication from HIW to the then interim CEO at BCUHB was also significantly delayed from July 2013 to October 2013. This is acknowledged by the CEO of HIW Dr Katherine Chamberlain in the following interview<sup>242</sup>.

The Ockenden review team has seen evidence that HIW did improve their scrutiny of inpatient units providing care to vulnerable older people at BCUHB in the years after Tawel Fan ward closed. The Ockenden review has seen evidence of improved timescales in the issuing of communication to BCUHB following HIW visits and inspections, a more 'robust' tone to the communication and the repeated follow up of action plans where they were deemed by HIW not to provide sufficient assurance. These issues are all discussed in greater detail in the main report.

In March 2014 following concerns expressed by the Health and Social Care Committee of the National Assembly of Wales<sup>243</sup> an extensive review<sup>244</sup> of the work of HIW was undertaken by Ruth Marks. The 'executive summary' of the Marks (2014) report is available via the link below. It is not the role of this governance review to comment on the recommendations of the Marks report other than to say that they are extensive, (there are 42 recommendations) and comprehensive in nature with recommendations for HIW itself, Welsh Government and joint recommendations across health and social care and Community Health Councils.

With direct reference to BCUHB and in relation to mental health inpatient settings it is of concern that to the current time BCUHB continues to make slow progress in many of the recommendations made by HIW over many years. The most recent example of this was seen in the HIW<sup>245</sup> November 2017 visit to the Ablett unit

*“Some issues around estates, staffing, poor documentation, lack of meaningful activities, medicines management are repeated over multiple HIW visits to many sites over many years.”*

*“With direct reference to BCUHB and in relation to mental health inpatient settings it is of concern that to the current time BCUHB continues to make slow progress in many of the recommendations made by HIW over many years.”*

<sup>242</sup> <http://www.bbc.co.uk/news/av/uk-wales-32939961/glan-clwyd-hospital-care-inspectorate-sorry-for-failings>

<sup>243</sup> <http://www.senedd.assembly.wales/documents/s25533/Key%20conclusion%20and%20recommendation%20-%20March%202014.pdf>

<sup>244</sup> [http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board\\_Item\\_5.1a\\_Independent%20Review%20of%20HIW\\_Appendix%201\\_EXECUTIVE%20SUMMARY.pdf](http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board_Item_5.1a_Independent%20Review%20of%20HIW_Appendix%201_EXECUTIVE%20SUMMARY.pdf)

<sup>245</sup> <http://hiw.org.uk/docs/hiw/inspectionreports/180222abletten.pdf>



where HIW said of two wards Cynnydd and Dinas 'we found that the environment of the two wards we visited were not fit for purpose. Cumulatively, we believe that a number of the issues we identified during our inspection represent a risk to patient safety....' (HIW 2018, page 3.) Although Dinas was not a designated ward for care of the older person with mental health needs service users and advocates told the Ockenden team throughout this review that it was often used to provide care and treatment for elderly people when Tegid ward in the Ablett unit was full.

HIW (2018) expressed its concern that 'some of the issues that we found during this inspection were also present during our last visit in June 2014, despite the Health Board developing a clear action plan<sup>246</sup> in response to that visit stating that these issues would be resolved.' (HIW 2018, page 3.) The external BCUHB response to the report is found within the link below as covered on BBC news<sup>247</sup> Whilst the headline that the Tawel Fan ward was to be possibly 'demolished' was extensively covered on the BBC Wales news there was little acknowledgement from BCUHB regarding the key issue that they had, (following a 2014 HIW inspection) developed an action plan that stated concerns raised in 2014 would be resolved. Three and a half years later HIW found this not to be the case.

The June 2017 joint HIW/WAO 'An Overview of Governance Arrangements' report concerning BCUHB stated that 'much effort and importance has been placed on ensuring that the inspectorate's reports are responded to in a timely and substantial way, with regular papers to the QSE Committee tracking progress against recommendations.' (HIW 2017, page 24.) This was clearly not the case as regards the 2014 visit to the Ablett unit.

#### Recommendation 10:

- a) BCUHB needs to undertake a review of all external reviews (including those by HIW, the NHS Delivery Unit and others) where any findings, recommendations and requirement may have concerned older people and specifically the care of older people with mental health concerns. As a result of the November 2017 HIW inspection of the Ablett unit where assurances were given of actions to be taken more than three years earlier and this did not occur the BCUHB Board need to assure itself that there are no other 'legacy issues' remaining that could be causing a continued risk to patients as is set out in the above report.
- b) The exercise needs to be completed across all Divisions and all sites by the end of the second quarter 2018/2019, (the end of September 2018) and reported to the BCUHB Board by November 2018.
- c) As a result of the evidence presented within the Ockenden governance review that BCUHB repeatedly failed to deliver in a timely way upon multiple HIW recommendations concerning care of older people and care of older people with mental health needs Welsh Government should undertake and publish a review of progress against the Marks

*"We found that the environment of the two wards we visited were not fit for purpose. Cumulatively, we believe that a number of the issues we identified during our inspection represent a risk to patient safety...."*

(HIW 2018, page 3.)

*"Some of the issues that we found during this inspection were also present during our last visit in June 2014, despite the Health Board developing a clear action plan in response to that visit stating that these issues would be resolved."*

(HIW 2018, page 3.)

*"The BCUHB Board need to assure itself that there are no other 'legacy issues' remaining that could be causing a continued risk to patients as is set out in the above report."*

<sup>246</sup> <https://gov.wales/docs/hiw/inspectionreports/Ablett%20Unit%20-%20Inspection%20-%20June%202014%20-%20Letter%20-%20Management%20Letter.pdf>

<sup>247</sup> <http://www.bbc.co.uk/news/uk-wales-north-east-wales-43789383>

report (2014). Marks noted in 2014 that her report 'proposed a package of reforms and if implemented [Marks believed] they would place HIW at the cutting edge of healthcare regulation and inspection.' (Executive summary of Marks 2014, page 4.) Three and a half years of the three to five years Marks suggested would be required to meet the recommendations has passed since the publication of the Marks (2014) report. (Marks 2014, page 5.) The Ockenden governance review team believes it would be in the public interest (and the public would be interested) to understand the progress HIW has made to date against recommendations made with a three to five year timespan.

- d) The Ockenden governance review wishes to emphasise that there is no suggestion within the above recommendation to Welsh Government that HIW are not meeting the standards currently required of them.
- e) Marks (2014) considers that HIW can continue to develop along the lines of its counterpart in Scotland<sup>248</sup>. (Marks 2014, page 17.) The Ockenden review also considers that the model of regulation of healthcare in England by the Care Quality Commission<sup>249</sup> should be further considered for introduction in Wales and delivered by HIW. This would strengthen the ability of HIW to take action when an organisation such as BCUHB simply failed to act upon, (either in whole or in part) recommendations made to them which were clearly impacting upon service provision and / or safety. The greater clarity obtained from the CQC around whether a service is considered 'Outstanding', 'Good', 'Requires Improvement' or 'Inadequate' can be supportive and useful to service users, staff, individual services within an NHS Trust as well as overarching NHS Trusts. Individual staff or teams working within a service that is rated 'Good' or 'Outstanding' in an otherwise poorly performing NHS Trust can feel proud of their individual efforts to provide good care. These ratings are awarded following the asking of five standard questions – are services safe, effective, caring, responsive to people's needs and well led?

## Finding 11

**The Ockenden review found a long term failure by the BCUHB Board to ensure fit for purpose estates and equipment that would facilitate the provision of a high standard of mental health and older persons mental healthcare from 2009 to the current day. This remained a concern at the end of December 2017.**

Evidence for this finding is discussed in great depth throughout the main report and this recommendation links in with recommendation 10, although recommendation 10 has a much wider remit.

Poor quality estates including delayed repairs which include chronic estates and equipment problems since 2009 up to and including the current day have been informed to the Ockenden review. These occur within a number of inpatient

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<sup>248</sup> [http://www.healthcareimprovementscotland.org/our\\_work/inspecting\\_and\\_regulating\\_care.aspx](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care.aspx)

<sup>249</sup> <http://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards>

mental health units and units providing care to vulnerable older people and have been described by a wide range of external reports, current BCUHB staff and carers and service user representatives.

The provision of care within poor quality buildings and estates has been stated by the Kings Fund (2004) to affect the experience of care<sup>250</sup>, and will affect the ability of staff to deliver high quality care and is known to affect staff attendance and morale<sup>251</sup>. The information found within the main report will not be repeated here. One senior staff member said in interview with the Ockenden team in October 2016<sup>252</sup>. 'It is so important around estates because if you don't look after the estates it makes people feel they don't matter and that makes the patients feel they don't matter so it's really important..' The staff member continued: 'When you see gardens overgrown, it's just not right. It's not right the staff are feeling that they have to come in and I've seen staff come in on the weekends doing the gardening so it is hard and there's a lot of demands on estates and I think that mental health would be [regarded as] quiet but I don't think we're quiet anymore. I think we're probably the noisiest now.'

#### **Recommendation 11:**

BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly, this should include clarity and specificity of all outstanding estates issues including outstanding repairs and estates issues raised as concerns within internal audits and external reviews and inspections.

This estates inventory should be prepared for each ward, clinic, department, inpatient unit and hospital department where care is provided to older people and older people with mental health issues. This includes those areas where care is provided to people with dementia.

Secondly, the estates inventory must include for each area set out above an audit based on the work of Enhancing the Healing Environment<sup>253</sup>. It is recognised that this is a substantial piece of work across BCUHB but the systems, structures and processes underpinning this work can be set up relatively quickly as it is based on work already proven to be successful elsewhere. Further information on the EHE programme and the NHS Trusts where it has been successful associated with dementia is found in the footnote<sup>254,255</sup>.

*"It is so important around estates because if you don't look after the estates it makes people feel they don't matter and that makes the patients feel they don't matter so it's really important.."*

*"BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly, this should include clarity and specificity of all outstanding estates issues including outstanding repairs and estates issues raised as concerns within internal audits and external reviews and inspections."*

<sup>250</sup> <https://www.kingsfund.org.uk/publications/enhancing-healing-environment>

<sup>251</sup> [https://www.bpf.org.uk/sites/default/files/resources/BPF-Quality-Buildings-Quality-Care-Nov-15-web\\_0.pdf](https://www.bpf.org.uk/sites/default/files/resources/BPF-Quality-Buildings-Quality-Care-Nov-15-web_0.pdf)

<sup>252</sup> Excerpt from interview

<sup>253</sup> <https://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-in-dementia-care>

<sup>254</sup> The EHE programme to improve the environment of care for people with dementia was funded by the Department of Health. It involved 23 teams from acute, community and mental health NHS trusts who worked on a range of projects across the dementia care pathway and sought to make hospital environments less alienating for people with cognitive problems. Projects have demonstrated that relatively inexpensive interventions, such as changes to lighting, floor coverings and improved way-finding, can have a significant impact. Evaluation has shown that environmental improvements can have a positive effect on reducing falls, violent and aggressive behaviours, and improving staff recruitment and retention. The EHE schemes have shown that it is possible to improve the quality and outcomes of care for people with dementia as well as improve staff morale and reduce overall costs by making inexpensive changes to the environment of care.

<sup>255</sup> <https://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia>

Thirdly, there should be an update to the BCUHB Board at the end of quarter 2 of 2018/19, (the end of September 2018, for all elements of this work stream including progress on outstanding maintenance and estates issues,) and quarterly progress thereafter until the end of quarter 2 2019/20. To reduce the amount of time spent on getting projects off the ground BCUHB staff should be encouraged, supported and funded, (time and their travel costs paid) to undertake visits to NHS Trusts who have already been successful in this initiative.

## Finding 12

**The Ockenden governance review has found a continuing lack of sustainable service development and a lack of clinical strategy development across older peoples care and care of older people with mental health (OPMH) six years after the 2012 consultation 'Healthcare in North Wales is Changing'**

The 2012 consultation 'Healthcare in North Wales is Changing' is discussed in depth in the main report. The Ockenden governance review notes that multiple external reviews from 2012 onwards have highlighted to BCUHB the combined and long term challenges it still faces around the lack of a long term clinical strategy across BCUHB, not just older people, mental health provision. This means that at the current time BCUHB has a lack of a clear plan for how clinical services in North Wales should be shaped so that they are clinically and financially viable. This is set against a backdrop of:

- Increasing acuity of BCUHB's patients and therefore increasing clinical demand;
- Long term issues with recruitment, particularly medical recruitment and a long term high reliance on agency and locum staffing;
- 'Higher-than-desired service costs'. (HIW 2017, page 10.)

The combination of all of the above, means that concerns with the financial sustainability of the current services continue. In the documents reviewed by the Ockenden team there was little evidence seen of any integration between workforce design and workforce planning<sup>256</sup> and the development of a long term clinical strategy. HIW (2017) agree and say that they saw 'little evidence to indicate that workforce modelling is sufficiently informing the design of services [at BCUHB] (HIW 2017, page 17.)

## Recommendation 12:

This has been and remains an urgent priority for the BCUHB Board to drive forward and one they are acutely aware of. BCUHB must continue to ensure it remains focused on building and sustaining positive relationships with a wide range of partners going forward as this will be fundamental to success going forward.

*“To reduce the amount of time spent on getting projects off the ground BCUHB staff should be encouraged, supported and funded, (given the time) to undertake visits to NHS Trusts who have already been successful in this initiative.”*

*“It was described by staff and carers that there are 'specific pockets' of good practice but that almost all positive feedback from carers was obtained from individual staff making extra efforts to be 'carer inclusive.' Often these BCUHB staff were carers themselves.”*

<sup>256</sup> Workforce planning is getting the right number of people with the right skills employed in the right place at the right time to deliver an organisation's short- and long-term objectives. It covers a diverse range of activities, such as succession planning, flexible working, job design, and many more. Whatever its precise form, workforce planning should be linked to strategic business goals and viewed as an important part of the strategic business planning process. (CIPD 2016)

### Finding 13

The Ockenden review has found little evidence of an effective system, structure or process in place to provide consistent assessment, support and advice to carers of people with dementia across the BCUHB catchment area.

The experience of service user representatives and carers is discussed in detail in the main report. Current BCUHB staff and carers and a wide range of service user representatives all told the Ockenden governance review the same thing as regards carer support and interaction. As of the summer and autumn of 2017 carers and service user representatives were described as 'very very dissatisfied.'<sup>257</sup> It was described by staff and carers that there are 'specific pockets' of good practice but that almost all positive feedback from carers was obtained from individual staff making extra efforts to be 'carer inclusive.' Often these BCUHB staff were carers themselves.

Carers told the Ockenden review of governance that they were experiencing an 'over-saturation' of feedback to and from BCUHB with rarely seeing a 'tangible outcome.' Staff, carers and service user representatives described the lack of a 'cohesive approach' to carers. Information provided to the Ockenden review from within the MHLD Division described the culture within mental health towards carers as 'it's very closed doors and they're not very receptive to help or support or discussion even....' [about involvement of carers in service design and feedback]. HIW (2017) noted the following of the 'culture' within mental health at BCUHB saying 'a sustained effort will be required to ensure that a culture exists which encourages issues to be acted upon quickly and effectively.' (HIW 2017 page 23.)

The Ockenden review was provided with extensive evidence that the systems, structures and process of governance including the systems described as being in place for supporting carers were frequently not in place in reality. Multiple examples of this were provided. One example, (service user representative 86) submitted communication to and from themselves and BCUHB dated November 2017. This described a lengthy apology from BCUHB that includes the following:

- Acknowledgement that there were discrepancies in documentation, where it was documented that advice was given to the family at the point of diagnosis of dementia and it was not. BCUHB acknowledged in this letter of November 2017 that this was in line with feedback from other families/carers.
- Referrals for support that were acknowledged by BCUHB as needing to be made were not made
- BCUHB acknowledged the lack of availability of support or activities for people with young onset dementia
- There was an acknowledgement from BCUHB of the lack of carer's assessment and lack of carers support

*“They were experiencing an ‘over-saturation’ of feedback to and from BCUHB with rarely seeing a ‘tangible outcome.’”*

*“There is currently (and has been across almost the whole time period of the Ockenden governance review) a ‘perfect storm’ of significant vacancies, long term high use of temporary and agency staff, (across medical and nursing positions), very recent long term absence amongst the senior leadership team, significant pressure associated with patient acuity, patient numbers and insufficient beds.”*

<sup>257</sup> Excerpt from a single staff interview but reflective of feedback from almost all service user representatives and many other staff.



- BCUHB acknowledged a lack of clarity around the family's named point of contact at BCUHB
- BCUHB apologised for the lack of joined up working with social services
- BCUHB apologised for the lack of prior information and support for the family prior to attending two Mental Health Act assessment meetings. The family had no prior discussions to the purpose of the meetings

**Recommendation 13:**

There will need to be sustained, visible (in the clinical areas), stable leadership within MHL Division over a long period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way. There is currently (and has been across almost the whole time period of the Ockenden governance review) a 'perfect storm' of significant vacancies, long term high use of temporary and agency staff, (across medical and nursing positions), very recent long term absence amongst the senior leadership team, significant pressure associated with patient acuity, patient numbers and insufficient beds. All this is combined with very well known and significant financial pressure in the MHL Division specifically and in BCUHB as a whole organisation. Some clinically based staff described that they believed that the senior management team within the MHL Division did not understand the pressures felt by staff in providing clinical care over a prolonged period of time in such very difficult circumstances.

The cultural change and change in attitude that is necessary towards dementia needs to happen across BCUHB, and to happen from 'Board to ward'. This cultural change needs to happen not just within MHL Division but everywhere within BCUHB where care and treatment may be provided to persons with dementia, their families and friends.

**Recommendation 14:**

The Ockenden review team has found little evidence of sustained Board leadership in creating an appropriate culture around dementia and dementia care at BCUHB. This should be the responsibility of every Board member, not just those Executives labelled as 'clinical.'

The work of Kate Swaffer and the work of the World Health Organization, (WHO) around a 'human rights' based approach to people living with dementia is recommended to BCUHB. It is recommended that understanding of this work should be introduced from 'ward to Board' and across all BCUHB healthcare facilities in hospital and community and into all staff orientation, training and development at BCUHB.

This approach must start at the Board. As leaders of BCUHB the Board must be able to demonstrate a significant knowledge base around dementia and this knowledge base at Board level should be framed according to the standards set by WHO, (already adopted by the Scottish Government.)

*“The Ockenden review team has found little evidence of sustained Board leadership in dementia care. This should be the responsibility of every Board member, not just those Executives labelled as ‘clinical.’”*

*“As leaders of BCUHB the Board must be able to demonstrate a significant knowledge base around dementia and this knowledge base at Board level should be framed according to the standards set by WHO, (already adopted by the Scottish Government.)”*

Swaffer (2014) has developed a term called 'Prescribed Dis-engagement'<sup>258</sup> and describes her own experience, having been newly diagnosed with dementia being told to 'give up' a pre diagnosis life 'and put all the planning in place for the demise of herself as a person newly diagnosed with dementia. Swaffer describes being told 'to give up work, give up study, and to go home and live for the time I had left....' She says 'Dementia is the only disease or condition and the only terminal illness that I know of where patients are told to go home, and give up their pre diagnosis lives, rather than to 'fight for their lives..' (Swaffer 2014, page 1.) Swaffer states that the attitude and culture amongst healthcare staff of 'Prescribed Dis-engagement' sets up for the person with dementia 'a chain reaction of defeat and fear, which negatively impacts a person's ability to be positive, resilient and proactive....' This resilience, positivity and a proactive approach to living with dementia is crucial following a diagnosis of dementia.

The WHO describe the need for a human rights based approach to people living with dementia. The WHO approach known as PANEL (Participation, Accountability, Non-discrimination, Empowerment and Legality) has been endorsed by the United Nations and adopted by the Scottish Government. The approach states that 'The voices of older people living with dementia and those who look after them need to be heard in a meaningful way...' (United Nations 2014.)

The work of Swaffer and the WHO/United Nations should be introduced to the Board in a Board seminar/Development day in the second quarter of 2018-19 and a programme of introduction to the whole of BCUHB should commence in the third quarter of 2018-19 with reports to the Board on the introduction.

In conclusion, the Ockenden review of governance has found that the systems, structures and processes of governance, management and leadership introduced by the BCUHB Board from 2009 were wholly inappropriate and significantly flawed from their inception.

The significant flaws were alerted to the BCUHB Board both internally – by a number of Independent Members and externally by multiple external reviews before action began to be taken. Where progress has been made it has been far too slow. Since the birth of BCUHB the Board has failed to assure itself of a clear, consistent and effective line of sight from 'ward' to 'Board' with significant and deeply concerning consequences for its patients, their carers and many of its frontline staff.

*“Dementia is the only disease or condition and the only terminal illness that I know of where patients are told to go home, and give up their pre diagnosis lives, rather than to 'fight for their lives..”*

(Kate Swaffer 2014)

*“The voices of older people living with dementia and those who look after them need to be heard in a meaningful way...”*

(United Nations 2014.)

*“There needs to be a visible and accessible Board lead for dementia at BCUHB. Previous 'Champion' roles at BCUHB have not been completely successful because they are often not known to service users and front line staff. The BCUHB Board now has an opportunity to make a real difference and should seize this opportunity to do so.”*

<sup>258</sup> TM <http://journals.sagepub.com/doi/pdf/10.1177/1471301214548136>

## 22 Appendix 1 – Background to DoLS

### 22.1 What is the Mental Capacity Act (2005)?

The Mental Capacity Act 2005 (MCA) aimed to protect people who lacked capacity whilst ensuring that they are able to participate in making decisions that affect their lives to the maximum extent possible. The Act incorporates five key principles:

1. A person must be assumed to have capacity – unless it is established they lack capacity;
2. A person must not be treated as being unable to make decisions unless all practicable steps have been taken without success;
3. A person is not to be treated as lacking the capacity to make a decision simply because they make – or are perceived to make – an unwise decision;
4. An action taken or decision made on behalf of a person assessed as lacking capacity must be taken/made in their best interests;
5. Any action or decision must be carried out in such a way that is least restrictive of the person's rights and freedom of action.

The implementation of the Act in clinical practice led to an increased awareness of capacity and consent in all areas of practice. Many healthcare providers developed more rigorous processes to ensure that capacity and consent were assessed in a systematic way and recorded in a consistent manner across an organisation.

### 22.2 What are Deprivation of Liberty Safeguards or DoLS

Legislation was incorporated into the Mental Capacity Act in 2007 and came into effect across the UK in April 2009. The DoLS process was designed to provide further protection to some of the most vulnerable individuals who lacked capacity and in whose best interests it was necessary to restrict or curtail their freedom of movement or choice. The DoLS process ensured that where it has been agreed as necessary to restrict movement or choice that this decision has been made lawfully and properly, ensuring the preservation of human rights and that care is delivered in their best interests and in the least restrictive way. The DoLS legislation applies in both hospitals and registered care homes.

The DoLS safeguards must be contrasted with detention under the Mental Health Act (MHA) 1983. This provided for the admission and detention in hospital for the assessment and treatment of mental disorders.

*“The DoLS process was designed to provide further protection to some of the most vulnerable individuals who lacked capacity and in whose best interests it was necessary to restrict or curtail their freedom of movement or choice.”*

## 22.3 Background to the Cheshire West Judgement (2014):

In March 2014 the Supreme Court Judgement (known as the Cheshire West Judgement) reminded authorities that they needed to be proactive in the identification of those who were potentially being deprived of their liberty. It ruled that those who were under constant supervision and control and not free to leave without the permission of (or assistance of carers) were also potentially subject to DoLS legislation. Thus it significantly increased the number of DoLS assessments required.

This judgement led to significant changes in clinical practice with consideration and applications for DoLS authorisations for those incapacitated patients who had previously complied with the interventions of their carers and did not clearly object to those interventions.

*“Those who were under constant supervision and control and not free to leave without the permission of (or assistance of carers) were also potentially subject to DoLS legislation.”*

## 22.4 Important terms in understanding Deprivation of Liberty Safeguards:

The decision to restrict a person of their liberty under DoLS legislation is known as an **'Authorisation'**. Requests and oversight of Deprivations of Liberty are by the **Managing Authority (MA)** (the care home or hospital where care is received). The request is authorized by the **Supervising Authority (SA)** usually the Local Authority or Health Board on review of the assessment of the person concerned.

There are **six** elements to the assessment that have to be complete before the Supervising Authority can grant the applications. These are:

- **Age** – the person must be over the age of 18
- **Best Interests** – This must establish if a deprivation of liberty is occurring, that it is required to keep the person from harm and the deprivation of liberty is proportionate to the likelihood and seriousness of that harm
- **No refusals** – The authorisation must not conflict with any advance decision.
- **Capacity** – The person must lack capacity
- **Mental Health** – The person must have a mental health disorder as defined by the Mental Health Act 1983 (MHA)
- **Eligibility** – Authorisations cannot take place for those detained or meeting the criteria for detention under the MHA 1983, subject to a requirement as to where you live or subject to the powers of recall.

*“Significant changes in clinical practice with consideration and applications for DoLS authorisations for those incapacitated patients who had previously complied with the interventions of their carers and did not clearly object to those interventions.”*

The Mental Health and Eligibility assessments are carried out by a doctor approved under **Section 12 of the MHA 1983**. Practice varies but this person usually also completes the Capacity Assessment.

## 22.5 What are Best Interest Assessors or (BIA)?

BIA may come from a range of mental health backgrounds but must have the appropriate qualifications and training. There is a duty to consult widely with carers, and those with Lasting Power of Attorney or Court of Protection deputies. Where there is no-one involved to represent the person's best interests an **Independent Mental Capacity Advocate (IMCA)** must be appointed to represent the person's interests:

- Where the Best Interest Assessor (BIA) may be an employee of the Supervising Authority (SA) or Managing Authority (MA) but not involved with the person's care.
- Where the SA and MA are the same the BIA must be independent.

**Authorisations** may be:

- **'Standard'** i.e. completed within 21 days and lasting for up to a year **or**
- **'Urgent'** in which the MA grants DoLS for a maximum of 7 days during which time an assessment for the Standard DoLS Authorisation must take place.

*“Where there is no-one involved to represent the person's best interests an Independent Mental Capacity Advocate (IMCA) must be appointed to represent the person's interest.”*

## 22.6 Explanation of the DoLS Position across Wales, 2013-14

In Wales the Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate Wales (CSSIW) are responsible for collating information across the country and producing an annual DoLS Monitoring Report. The joint CSSIW and HIW monitoring report for 2013-14 covers the period leading up to the Tawel Fan ward closure. However the full impact of the 2014 Cheshire West Judgement (that placed an onus on Managing Authority (MA's) to identify potential DoLS and Supervising Authority (SA's) to provide the workforce to ensure timely assessment and infrastructure to manage and monitor the DoLS applications) was not yet felt.

**The main findings for the period 2013-14 across Wales were reported as:**

- Awareness of DoLS and the process has improved but more needs to be done. There had been an increase in applications to the SA of approximately 20% over the previous 12 month period. Prior to this the numbers had been static.
- Significant variation in the way that Local Authorities and Health Boards fulfil their roles as Supervisory Bodies
- The number of authorisations remains very low as does the level of review (less than 10%)
- There is a rise in the number of people who received support from Independent Mental Capacity Advocate (IMCAs) from 27 to 28% of applications but this remained low and SAs were encouraged to raise the awareness of this service.



## 22.7 Reported Developments across Wales in 2013-14:

CSSIW and HIW significantly improved their joint working and methodological techniques as DoLS became included in the Dignity and Essential Care Inspections in addition to the Mental Health Act inspections. Over the 2013-14 period BCUHB had a rate of applications for DoLS of 5 per 100,000 of the population which had remained fairly constant over the previous 4 years. Only Abertawe Bro Morgannwg (ABMU) Health Board had a lower rate of applications.

In Health Boards across Wales whilst the number of applications for DoLS increased the percentage that were actually authorized (i.e. became valid) decreased. There was a 20% increase in applications and a 4% decrease in authorisations. This was felt to represent an increase in awareness of DoLS within hospitals generally but associated with the decrease in authorisations by Managing Authorities was a misunderstanding in some cases of when to correctly make a DoLS application.

## 22.8 Practice prior to the 2014 Cheshire West judgement:

In hospital wards in general (and in older adults mental health wards in particular) DoLS played a relatively small part in day to day clinical practice. Patients who lacked capacity and were actively trying to leave wards in the mental health setting were largely subject to the Mental Health Act (MHA) (see above) Patients who lacked capacity but were not actively trying to leave or were accepting of their management were deemed to be having their liberty 'restricted' rather than being deprived. The Mental Capacity Act (MCA) 2005 had laid imperatives on all clinical teams to be aware of capacity, record the capacity of their patients and the frameworks under which they were being managed. This would vary from unit to unit, organization to organization.

## 22.9 APPENDICES

Service User Listening and engagement events

April to July 2017

## 22.10 Example Press releases, Welsh and English

### Appendix 1a



#### DATGANIAD NEWYDDION

16 Chwefror 2017

#### TÎM OCKENDEN Â'R CORFF GWARCHOD YN YMUNO I ADOLYGU GOFAL IECHYD MEDDWL POBL HÛN

Bydd tîm annibynnol fydd yn edrych ar ofal pobl hûn gyda phroblemau iechyd meddwl yn teithio ar hyd a lled y rhanbarth y gwanwyn yma – gan roi cyfle i bobl rannu eu barn a'u profiadau fel rhan o'r adolygiad sy'n mynd rhagddo.

Fe fydd Donna Ockenden, ei thîm a Chyngor Iechyd Cymuned Gogledd Cymru (CICGC) – y corff gwarchod iechyd annibynnol – yn cynnal cyfres o ddigwyddiadau ar draws chwe sir gogledd Cymru gan wahodd staff GIG, cleifion a'u gofalmwr a'u teuluoedd i siarad am ofal a'r gwasanaethau a ddarperir i bobl hûn gyda phroblemau iechyd meddwl.

Dywed Donna Ockenden, 'Rwyf wrth fy modd y bydd Cyngor Iechyd Cymuned Gogledd Cymru yn ymuno gyda fy nhîm wrth i ni gynnal y digwyddiadau hyn. Bydd gwybodaeth leol CICGC a'r ffaith eu bod yn ddiuedd yn caniatáu i bobl siarad yn rhydd gyda mi a'r tîm a hynny yn gyfrinachol'.

Aeth Donna Ockenden yn ei blaen i ddweud, 'Mae'r gwaith yma'n rhan o'r adolygiad sy'n mynd rhagddo ar drefniadau llywodraethu Bwrdd Iechyd Prifysgol Betsi Cadwaladr mewn perthynas â gwasanaethau iechyd meddwl pobl hûn yng ngogledd Cymru. Mae fy adolygiad hefyd yn edrych ar natur y gofal a'r driniaeth i gleifion yn ward iechyd meddwl Ysbyty Glan Clwyd sef Tawel Fan – a gaewyd yn 2013. Bydd yr adolygiad yn ystyried systemau'r Bwrdd Iechyd yn y gorffennol ac yn awr, patrymau a phrosesau gwasanaethau cleifion preswyl iechyd meddwl pobl hûn. Mae estyn allan at gleifion a staff gofal iechyd yn y ffordd yma'n hanfodol fel bod yr adolygiad yn dod i wybod y gwir. Trwy gydol y gwaith byddwn yn sicrhau ein bod yn defnyddio dull annibynnol a gwrthrychol. Bydd gwrando ar staff, cleifion, gofalmwr a theuluoedd cleifion yn helpu fy nhîm i sicrhau fod lleisiau cleifion yn rhan ganolog o'r adroddiad terfynol.'

Dywedodd Cadeirydd corff gwarchod iechyd gogledd Cymru, Mrs Jackie Allen, 'Rydym yn edrych ymlaen at gael cyfarfod cymaint o bobl â phosib ar draws y gogledd fel rhan o waith Donna Ockenden. Er ein bod angen cadarnhau'r manylion ar y funud, roeddem yn credu y byddai'n ddefnyddiol rhoi cymaint o rybudd â phosib ynglŷn â phryd y cynhelir y cyfarfodydd ar draws y rhanbarth. Bydd ein timau ar gael yn ystod cyfres o ddyddiadau – yn y bore, amser cinio a gyda'r nos – fel bod pobl yn gallu dod i siarad gyda ni yn gyfrinachol os dymunant, am eu profiadau boed yn dda neu ddrwg.'

Meddai Mr Geoff Ryall-Harvey, Prif Swyddog CICGC 'Credaf yn gryf y bydd gwybodaeth leol aelodau CICGC a sgiliau fy staff o werth mawr i adolygiad annibynnol Donna Ockenden. Mae'n hanfodol fod lleisiau pobl ar draws y rhanbarth yn cael eu clywed ar gyfer darn mor bwysig o waith.

### **Cynhelir y cyfarfodydd ar y dyddiadau isod:**

Ebrill 2017 – 3ydd, 4ydd, 5ed a'r 6ed (amseroedd a lleoliadau i'w hysbysu)

Mai 2017 – 8fed, 9fed a'r 10fed (amseroedd a lleoliadau i'w hysbysu)

Mehefin 2017 – 5ed, 6ed a'r 7fed (amseroedd a lleoliadau i'w hysbysu)

Rhagwelir y bydd dyddiadau ychwanegol yn cael eu cyhoeddi maes o law.

I gael rhagor o wybodaeth neu i gael cyfweliad, cysylltwch â Carol Williams ar rhif ffôn: 01248 679 284 neu ebost [carol.williams@waleschc.org.uk](mailto:carol.williams@waleschc.org.uk)

## **DIWEDD**

### **Nodiadau i'r golygyddion**

1 Mae Cyngor Iechyd Cymuned Gogledd Cymru (CIC) yn gorff statudol annibynnol sy'n cynrychioli buddiannau'r cleifion a'r cyhoedd yn y Gwasanaeth Iechyd Gwladol yng ngogledd Cymru. Daeth i fodolaeth ar y 1af Ebrill 2010 fel rhan o ad-drefnu gwasanaethau iechyd yng Nghymru ac mae'n cynnwys siroedd Conwy, Sir Ddinbych, Sir y Fflint, Gwynedd, Wrecsam ac Ynys Môn. Mae poblogaeth gyfun y chwe sir oddeutu 675,500.

2 Mae gan y Cyngor Iechyd Cymuned chwe pwyllgor lleol, un i bob un o'r chwe sir. Mae pob pwyllgor lleol yn cynnwys aelodau o dair ffynhonnell: cynghorwyr a enwebwyd gan yr awdurdod lleol perthnasol, pobl a enwebwyd gan fudiadau yn y sector gwirfoddol lleol a phobl leol a benodwyd gan Lywodraeth Cynulliad Cymru.

## Appendix 1b



### NEWS RELEASE

**16th February 2017**

### **OCKENDEN TEAM AND WATCHDOG JOIN FORCES TO REVIEW OLDER PEOPLE'S MENTAL HEALTH CARE**

An independent team, looking at the care of older people with mental health problems in North Wales, will be travelling across the whole region this Spring, giving people the opportunity to share their views and experiences as part of an on-going review.

Donna Ockenden, her team and the North Wales Community Health Council (NWCHC) – the independent health watchdog, will be hosting a series of events across the six counties of North Wales, inviting NHS staff, patients, their carers and their families to talk about the care and services provided to older people with mental health problems.

Donna Ockenden says, 'I am delighted that the North Wales Community Health Council will be joining my team in hosting these events. The NWCHC's local knowledge and impartiality will allow people to talk freely to me and my team and in confidence'.

Donna Ockenden went on to say, 'This work is part of our on-going review of the Betsi Cadwaladr University Health Board's governance arrangements relating to older people's mental health services in North Wales. My review also surrounds the nature of the care and treatment of patients at the Ysbyty Glan Clwyd mental health ward – Tawel Fan – which was closed in 2013. The review will consider the Health Board's past and current systems, structures and processes for inpatient mental health services for older people. Reaching out to patients and health care staff in this way is crucial to my review establishing the truth. Throughout the work we are ensuring an independent and objective approach. Listening to staff, patients, carers and patient families will help my team ensure that patients' voices are a central part of my final report.'

The Chair of the North Wales health watchdog, Mrs Jackie Allen says, 'We are looking forward to meeting as many people from across North Wales as part of Donna Ockenden's work. Although we are still working through the finer details as to where we will be going – we thought it would be useful to give people as much notice as possible that we will be coming to various locations across the region. Our teams will be available on a series of dates – morning, noon and evening – so that people can come and talk to us – in confidence if they want – about their experiences, whether they be good or bad.'

Mr Geoff Ryall-Harvey, NWCHC Chief Officer commented 'I strongly believe that the local knowledge of the NWCHC membership and the skills of my staff will prove to be of significant value to Donna Ockenden's independent review. It is vital that people from all across the region are given the opportunity to have their voices heard for such an important piece of work.'

**Events will be taking place on the following dates:**

April 2017 – 3rd, 4th, 5th and 6th (times and venues to be advised)

May 2017 – 8th, 9th and 10th (times and venues to be advised)

June 2017 – 5th, 6th and 7th (times and venues to be advised)

It is anticipated that further dates will be announced in due course.

For further information or an interview, please contact Carol Williams on tel: 01248 679 284 or e-mail: [carol.williams@waleschc.org.uk](mailto:carol.williams@waleschc.org.uk)

**Note for editors**

1 North Wales Community Health Council (CHC) is an independent statutory organisation which represents the interests of patients and the public in the National Health Service in North Wales. It came into being on 1 April 2010 as part of the reorganization of health services in Wales and covers the counties of Conwy, Denbighshire, Flintshire, Gwynedd, Wrexham and Ynys Môn. The six counties have a combined population of around 675,500.

2 The Community Health Council has six local committees, one covering each of the six counties. Each local committee comprises members drawn from three sources: councillors nominated by the relevant local authority, people nominated by the local third sector organizations and local people appointed by Welsh Assembly Government.



## Appendix 1c



### DATGANIAD NEWYDDION

**24 MAWRTH 2017**

#### **Tîm Ockenden a'r Corff Gwarchod yn Ymuno â'i Gilydd i Adolygu ac Ystyried Gofal Iechyd Meddwl Pobl Hŷn**

Mae'r tîm annibynnol, a arweinir gan Donna Ockenden, sy'n edrych ar ofal pobl hŷn gyda phroblemau iechyd meddwl yng ngogledd Cymru wedi cadarnhau rhai o'r dyddiadau a'r lleoliadau i'r cyfarfodydd gwranddo ac ymgysylltu ar draws y rhanbarth y gwanwyn yma. Bydd y cyfarfodydd hyn yn gyfle i bobl rannu eu barn a'u profiadau fel rhan o adolygiad sy'n mynd rhagddo gan Donna Ockenden a'i thîm.

Bydd Donna Ockenden, ei thîm a Chyngor Iechyd Cymuned Gogledd Cymru (CICGC) – y corff gwarchod annibynnol, yn cynnal cyfres o gyfarfodydd ar draws chwe sir gogledd Cymru gan wahodd staff GIG, cleifion, eu gofalwyr a'u teuluoedd i siarad am y gofal a'r gwasanaethau gaiff eu darparu i bobl hŷn gyda phroblemau iechyd meddwl.

#### **Cynhelir cyfarfodydd yn y lleoliadau isod ar y dyddiadau a ganlyn:**

**3ydd Ebrill 2017 o 2.30pm i 6.00pm** yn Glasdir, Plas yn Dre, Llanrwst

**4ydd Ebrill 2017 o 11.00am i 3.00pm a 6.00pm i 8.00pm** yng Nghsnoľan Fusnes Conwy, Cyffordd Llandudno

**8fed Mai 2017 o 2.30pm i 5.00pm** yn y Ganolfan Reoli, Ysgol Fusnes Bangor, Bangor

**9fed Mai 2017 o 10.30am i 1.30pm** yn Neuadd Pendre, Tywyn

**10fed Mai 2017 o 9:00am i 11.30am** ym Mhlas Heli, Hafan, Pwllheli

*(Dalier sylw: rydym yn eich annog i roi gwybod i CICGC os ydych yn dymuno dod i un o'r cyfarfodydd uchod – gweler isod)*

Er mwyn sicrhau bod y cyfarfodydd yn cael eu cynnal ym mhob un o chwe siroedd y gogledd bydd cyfarfodydd eraill yn cael eu trefnu mewn rhannau eraill yn ystod Mehefin a dechrau Gorffennaf – byddwn yn cadarnhau manylion y dyddiadau yn fuan.

Dyweddodd Donna Ockenden, 'Mae'r gwaith yma yn rhan o'r adolygiad sy'n mynd rhagddo am Fwrdd Iechyd Prifysgol Betsi Cadwaladr sy'n ymwneud â gwasanaethau iechyd meddwl pobl hŷn yng ngogledd Cymru. Mae'r adolygiad hefyd yn edrych ar y digwyddiadau a arweiniodd at gau ward Tawel Fan yn Ysbyty Glan Clwyd yn Rhagfyr 2013. Bydd yr adolygiad yn ystyried systemau, strwythurau a phrosesau llywodraethu y Bwrdd Iechyd yn y gorffennol a'r rhai cyfredol, ar gyfer gwasanaethau iechyd meddwl i bobl hŷn. Mae estyn allan a gwrando ar gleifion, eu gofalwyr a'u cynrychiolwyr a staff gofal iechyd yn y modd yma'n hanfodol i'r adolygiad i benderfynu beth yw y gwir. Trwy gydol y gwaith yma rydym yn sicrhau ein bod yn defnyddio dull annibynnol a gwrthrychol o ymdrin â'r mater. Bydd cyfarfod a gwrando ar staff, cleifion, eu teuluoedd a'u gofalwyr ar draws siroedd y gogledd yn helpu fy nhîm i sicrhau fod lleisiau'r cleifion yn rhan ganolog o'r adroddiad terfynol.'

Aeth Donna Ockenden yn ei blaen i ddweud,, 'Rwyf wrth fy modd y bydd Cyngor Iechyd Cymuned Gogledd Cymru yn ymuno gyda fy nhîm wrth i ni gynnal y digwyddiadau hyn. Bydd gwybodaeth leol CICGC a'r ffaith eu bod yn ddi-dduedd yn caniatáu i bobl siarad yn rhydd gyda mi a'r tîm a hynny yn gyfrinachol'.

'Bydd y cyfarfodydd wedi eu llunio fel bod modd i bobl siarad gyda ni am faterion penodol sy'n ymwneud â'u profiadau o'r ddarpariaeth gwasanaethau iechyd meddwl i bobl hŷn ar draws gogledd Cymru. Fe fyddwn yn cynnal sesiynau grŵp gyda phob un yn canolbwyntio ar nifer o agweddau sy'n ymwneud â phrofiadau pobl. Gellir disgrifio y rhain fel y '7 C' sy'n cynnwys Canmolïaeth, (ble roedd y gofal yn dda, da iawn neu ardderchog), Concerns (Pryderon) neu Cwynion; (os oedd rhai, sut gawsant eu trin?) rhan y claf a'r teulu yn y Cynllunio gofal a'r Care provision (Darpariaeth gofal) a'r Cyfathrebu rhwng y claf, teulu a'r GIG yn lleol.

I roi gwybod i CICGC eich bod yn dymuno mynychu un o'r cyfarfodydd hyn neu i gael rhagor o wybodaeth neu gyfweliad, cysylltwch â Carol Williams ar: 01248 679 284 neu e-bost: [yourvoice@waleschc.org.uk](mailto:yourvoice@waleschc.org.uk).

Mae modd i chi hefyd gofrestru y byddwch yn mynd i gyfarfod ar ein ap SurveyMe yn:

<http://svy.at/xtb> UK – DO – 2017



## **Nodiadau i'r golygyddion**

(As per Appendix 1a)

## Appendix 1d



### NEWS RELEASE

**24 MARCH 2017**

#### **OCKENDEN TEAM AND WATCHDOG JOIN FORCES TO REVIEW AND CONSIDER OLDER PEOPLE'S MENTAL HEALTH CARE**

The independent team, led by Donna Ockenden looking at the care of older people with mental health problems in North Wales, has now confirmed some of the dates and locations for listening and engagement events across the whole region this Spring. These events will give people the opportunity to share their views and experiences as part of the on-going review by Donna Ockenden and her team.

Donna Ockenden, her team and the North Wales Community Health Council (NWCHC) – the independent health watchdog, will be hosting a series of events across all six counties of North Wales, inviting NHS staff, patients, their carers and their families to talk about the care and services provided to older people with mental health problems.

#### **Events will be taking place on the following dates and locations:**

**3rd April 2017 from 2.30pm to 6.00pm** at Glasdir, Plas yn Dre, Llanrwst

**4th April 2017 from 11.00am to 3.00pm and 6.00pm to 8.00pm** at the Conwy Business Centre, Llandudno Junction

**8th May 2017 from 2.30pm to 5.00pm** at the Management Centre, Bangor Business School, Bangor

**9th May 2017 from 10.30am to 1.30pm** at Neuadd Pendre Social Centre, Tywyn

**10th May 2017 from 9.00am to 11.30am** at Plas Heli, Hafan, Pwllheli

*(Please note: you are encouraged to advise the NWCHC should you wish to attend any of the above events – please see below).*

In order to ensure events are held in each of the six counties of North Wales further events are being arranged in other parts of North Wales in June and the first few days of July – details surrounding the dates and venues will be confirmed shortly.

Donna Ockenden says, 'This work is part of our on-going review of the Betsi Cadwaladr University Health Board relating to older people's mental health services in North Wales. The review also surrounds the events leading to the closure of the Tawel Fan ward at Ysbyty Glan Clwyd in December 2013. The review will consider the Health Board's past and current systems, structures and processes of governance for mental health services for older people. Reaching out and listening to patients, their carers and representatives and health care staff in this way is crucial to my review establishing the truth. Throughout this work we are ensuring an independent and objective approach. Meeting and listening to staff, patients, their families and carers across the six counties of North Wales will help my team ensure that patients' voices form a central part of my final report.'

Donna Ockenden went on to say, 'I am delighted that the North Wales Community Health Council will be joining my team in hosting these events. The NWCHC's local knowledge and impartiality will allow people to talk freely and in confidence to me and my team.

'The events will be structured to allow people to talk to us about specific issues concerning their experiences of the provision of mental health services for older people across North Wales. We will be holding 'break-out' sessions at each event focusing on a number of aspects surrounding people's experiences. These can be described as the '7 C's' and include **C**ompliments, (where care was good, very good or excellent), **C**oncerns or **C**omplaints; (if they occurred, how were they dealt with?) patient and family involvement in **C**are planning and **C**are provision and **C**ommunication between patient, family and the local NHS.

To advise the NWCHC that you wish to attend any of the events or for further information or an interview, please contact Carol Williams on tel: 01248 679 284 or e-mail: [yourvoice@waleschc.org.uk](mailto:yourvoice@waleschc.org.uk).

You can also register attendance via our SurveyMe app by using the following link:

<http://svy.at/xtb> UK – DO – 2017



#### **Note for editors**

(As per Appendix 1b)

## Appendix 1e



### DATGANIAD NEWYDDION

12 EBRILL 2017

#### **TÎM OCKENDEN A'R CORFF GWARCHOD YN YMUNO Â'I GILYDD I ADOLYGU AC YSTYRIED GOFAL IECHYD MEDDWL POBL HÛN**

Mae'r tîm annibynnol, a arweinir gan Donna Ockenden, sy'n edrych ar ofal pobl hÛn gyda phroblemau iechyd meddwl yng ngogledd Cymru wedi cadarnhau rhagor o ddyddiadau a lleoliadau i'r cyfarfodydd gwranddo ac ymgysylltu ar draws y rhanbarth yn ystod y gwanwyn a't haf yma. Bydd y cyfarfodydd hyn yn gyfle i bobl rannu eu barn a'u profiadau fel rhan o adolygiad sy'n mynd rhagddo gan Donna Ockenden a'i thîm.

Bydd Donna Ockenden, ei thîm a Chyngor Iechyd Cymuned Gogledd Cymru (CICGC) – y corff gwarchod annibynnol, yn cynnal cyfres o gyfarfodydd ar draws chwe sir gogledd Cymru gan wahodd staff GIG, cleifion, eu gofalwyr a'u teuluoedd i siarad am y gofal a'r gwasanaethau gaiff eu darparu i bobl hÛn gyda phroblemau iechyd meddwl.

#### **Cynhelir cyfarfodydd yn y lleoliadau isod ar y dyddiadau a ganlyn:**

**8fed Mai 2017 o 2.30pm i 5.00pm** yn y Ganolfan Reoli, Ysgol Fusnes Bangor, Bangor

**9fed Mai 2017 o 10.30am i 1.30pm** yn Neuadd Pendre, Tywyn

**10fed Mai 2017 o 9:00am i 11.00am** ym Mhlas Heli, Hafan, Pwllheli

**5ed Mehefin 2017 o 2.00pm i 5.00pm** yn y Ganolfan Fusnes, Swyddfeydd Cyngor Ynys Môn, Parc Busnes Bryn Cefni, Llangefni

**6ed Mehefin 2017 o 10.00am i 1.00pm a 2.30pm i 5.00pm** yng Ngorsaf Dân Cymuned y Rhyl, Ffordd yr Arfordir, Y Rhyl

**7fed Mehefin 2017 o 9.00am i 12 hanner dydd** yng Nghanolfan Hamdden Treffynnon, Ffordd Parc y Fron, Treffynnon

**3ydd Gorffennaf 2017 o 2.30pm i 5.30pm** yn Swyddfeydd DVSC, Canolfan Naylor Leyland, Stryd y Ffynnon, Rhuthun

**4ydd Gorffennaf 2017 o 2.00pm i 6.00pm** yng Nghlwb Pêl-droed Wrecsam, Y Cae Ras, Ffordd yr Wyddgrug, Wrecsam

**5ed Gorffennaf 2017 o 9.00am i 12 hanner dydd** yng Ngwesty'r Beaches, Ffordd Traeth y Dwyrain, Prestatyn



*(Dalier sylw: rydym yn eich annog i roi gwybod i CICGC os ydych yn dymuno dod i un o'r cyfarfodydd uchod – gweler isod)*

Dywedodd Donna Ockenden, 'Mae'r gwaith yma yn rhan o'r adolygiad sy'n mynd rhagddo am Fwrdd Iechyd Prifysgol Betsi Cadwaladr sy'n ymwneud â gwasanaethau iechyd meddwl pobl hŷn yng ngogledd Cymru. Mae'r adolygiad hefyd yn edrych ar y digwyddiadau a arweiniodd at gau ward Tawel Fan yn Ysbyty Glan Clwyd yn Rhagfyr 2013. Bydd yr adolygiad yn ystyried systemau, strwythurau a phrosesau llywodraethu y Bwrdd Iechyd yn y gorffennol a'r rhai cyfredol, ar gyfer gwasanaethau iechyd meddwl i bobl hŷn. Mae estyn allan a gwranddo ar gleifion, eu gofalmwr a'u cynrychiolwyr a staff gofal iechyd yn y modd yma'n hanfodol i'r adolygiad i benderfynu beth yw y gwir. Trwy gydol y gwaith yma rydym yn sicrhau ein bod yn defnyddio dull annibynnol a gwrthrychol o ymdrin â'r mater. Bydd cyfarfod a gwranddo ar staff, cleifion, eu teuluoedd a'u gofalmwr ar draws siroedd y gogledd yn helpu fy nhîm i sicrhau fod lleisiau'r cleifion yn rhan ganolog o'r adroddiad terfynol.'

Aeth Donna Ockenden yn ei blaen i ddweud,, 'Rwyf wrth fy modd y bydd Cyngor Iechyd Cymuned Gogledd Cymru yn ymuno gyda fy nhîm wrth i ni gynnal y digwyddiadau hyn. Bydd gwybodaeth leol CICGC a'r ffaith eu bod yn ddi-dduedd yn caniatáu i bobl siarad yn rhydd gyda mi a'r tîm a hynny yn gyfrinachol'.

'Bydd y cyfarfodydd wedi eu llunio fel bod modd i bobl siarad gyda ni am faterion penodol sy'n ymwneud â'u profiadau o'r ddarpariaeth gwasanaethau iechyd meddwl i bobl hŷn ar draws gogledd Cymru. Fe fyddwn yn cynnal sesiynau grŵp gyda phob un yn canolbwyntio ar nifer o agweddau sy'n ymwneud â phrofiadau pobl. Gellir disgrifio y rhain fel y '7 C' sy'n cynnwys Canmoliaeth, (ble roedd y gofal yn dda, da iawn neu ardderchog), Concerns (Pryderon) neu Cwynion; (os oedd rhai, sut gawsant eu trin?) rhan y claf a'r teulu yn y Cynllunio gofal a'r Care provision (Darpariaeth gofal) a'r Cyfathrebu rhwng y claf, teulu a'r GIG yn lleol.

I roi gwybod i CICGC eich bod yn dymuno mynychu un o'r cyfarfodydd hyn neu i gael rhagor o wybodaeth neu gyfweiliad, cysylltwch â Carol Williams ar: 01248 679 284 neu e-bost: [yourvoice@waleschc.org.uk](mailto:yourvoice@waleschc.org.uk).

Mae modd i chi hefyd gofrestru y byddwch yn mynd i gyfarfod ar ein ap SurveyMe yn:

<http://svy.at/xtb> UK – DO – 2017



## **Nodiadau i'r golygyddion**

(As per Appendix 1a)

## Appendix 1f



### NEWS RELEASE

**12 APRIL 2017**

#### **OCKENDEN TEAM AND WATCHDOG JOIN FORCES TO REVIEW AND CONSIDER OLDER PEOPLE'S MENTAL HEALTH CARE**

The independent team, led by Donna Ockenden looking at the care of older people with mental health problems in North Wales, has now confirmed further dates and locations for listening and engagement events across the whole region this Spring and Summer. These events will give people the opportunity to share their views and experiences as part of the on-going review by Donna Ockenden and her team.

Donna Ockenden, her team and the North Wales Community Health Council (NWCHC) – the independent health watchdog, will be hosting a series of events across all six counties of North Wales, inviting NHS staff, patients, their carers and their families to talk about the care and services provided to older people with mental health problems.

#### **Events will be taking place on the following dates and locations:**

**8th May 2017 from 2.30pm to 5.00pm** at the Management Centre, Bangor Business School, Bangor

**9th May 2017 from 10.30am to 1.30pm** at Neuadd Pendre Social Centre, Tywyn

**10th May 2017 from 9.00am to 11.00am** at Plas Heli, Hafan, Pwllheli

**5th June 2017 from 2.00pm to 5.00pm** at Business Centre, Isle of Anglesey Council Offices, Bryn Cefni Business Park, Llangefni

**6th June 2017 from 10.00am to 1.00pm and 2.30pm to 5.00pm** at Rhyl Community Fire Station, Rhyl Coast Road, Rhyl

**7th June 2017 from 9.00am to 12 noon** at Holywell Leisure Centre, Fron Park Road, Holywell

**3rd July 2017 from 2.30pm to 5.30pm** at DVSC Offices, Naylor Leyland Centre, Well Street, Ruthin

**4th July 2017 from 2.00pm to 6.00pm** at Wrexham Football Club, Racecourse Ground, Mold Road, Wrexham

**5th July 2017 from 9.00am to 12noon** at Beaches Hotel, Beach Road East, Prestatyn

*(Please note: you are encouraged to advise the NWCHC should you wish to attend any of the above events – please see below).*

Donna Ockenden says, 'This work is part of our on-going review of the Betsi Cadwaladr University Health Board relating to older people's mental health services in North Wales. The review also surrounds the events leading to the closure of the Tawel Fan ward at Ysbyty Glan Clwyd in December 2013. The review will consider the Health Board's past and current systems, structures and processes of governance for mental health services for older people. Reaching out and listening to patients, their carers and representatives and health care staff in this way is crucial to my review establishing the truth. Throughout this work we are ensuring an independent and objective approach. Meeting and listening to staff, patients, their families and carers across the six counties of North Wales will help my team ensure that patients' voices form a central part of my final report.'

Donna Ockenden went on to say, 'I am delighted that the North Wales Community Health Council will be joining my team in hosting these events. The NWCHC's local knowledge and impartiality will allow people to talk freely and in confidence to me and my team.

'The events will be structured to allow people to talk to us about specific issues concerning their experiences of the provision of mental health services for older people across North Wales. We will be holding 'break-out' sessions at each event focusing on a number of aspects surrounding people's experiences. These can be described as the '7 C's' and include **C**ompliments, (where care was good, very good or excellent), **C**oncerns or **C**omplaints; (if they occurred, how were they dealt with?) patient and family involvement in **C**are planning and **C**are provision and **C**ommunication between patient, family and the local NHS.

To advise the NWCHC that you wish to attend any of the events or for further information or an interview, please contact Carol Williams on tel: 01248 679 284 or e-mail: [yourvoice@waleschc.org.uk](mailto:yourvoice@waleschc.org.uk).

You can also register attendance via our SurveyMe app by using the following link:

<http://svy.at/xtb> UK – DO – 2017



#### **Note for editors**

(As per Appendix 1b)

## 22.11 Range of Organisations who contacted the NWCHC about the Ockenden Engagement and Listening Events:

Abbeyfield – Assisted Living

Age Connects North East Wales

Age Connects North Wales (Conwy)

Age Cymru (Gwynedd and Ynys Mon)

Agewell Centres in:

Llangefni

Amwlch

Llanrug

Agoriad Cyf

Alzheimers Society

Anglesey Council, Social Services

Older People's Champion

ASNEW (Advocacy Services North East Wales)

AVOW over 50s Forum

Bangor Samaritans

Bangor University

Citizens Advice Bureaux in:

Aberystwyth

Ceredigion

Holyhead

Llangefni

Ruthin

CADMHAS (Conwy and Denbighshire Mental Health Advocacy Scheme)

CAIS

CAMAD

Caniad

Care and Repair

Carers Outreach

Cilan Mental Health Resource Centre

Communities First

Contact the Elderly

CVSC (Conwy Voluntary Service Council)

Cynmdeithas Tai Clwyd

Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health

Cymryd Rhan

Denbighshire Council, Social Services

Digartref

DVSC (Denbighshire Voluntary Service Council)

Flintshire Council, Social Services

FLVC (Flintshire Local Voluntary Council)

Gofal Gofalwyr

Gwynedd Council, Wellbeing Manager

Hafal

KIM Inspire (Knowledge Inspiration Motivation)

Community Councillors

Medrwn Mon

MHAS (Mental Health Advocacy Scheme)

Merched Y Wawr

Mind

NEWCIS (North East Wales Carers Information Service)

National Federation of Women's Institutes

North Wales Advice and Advocacy Association

NW Crossroads

Prestatyn Town Council

Ruthin Town Council

Royal Voluntary Service Ynys Mon and Gwynedd

Seren Cyf

South Denbighshire Community Partnership

Talking Points

Tywyn Charitable Appeals Fund

Tywyn Town Council

United Against Dementia

Unllais

Morlo

West Wales Action for Mental Health

Wrexham Community Council

Wrexham Council Social Services

Wrexham Hospital League of Friends

Wrexham Maelor Royal Voluntary Service

Ynys Mon Council, Community Support Services



## 22.12 The PowerPoint Presentation used as an introduction at each 'Listening and Engagement' event by Donna Ockenden. (Welsh and English versions)

### Appendix 3a

#### Welsh

#### Donna Ockenden

Adolygiad o'r **Trefniadau Llywodraethu** sy'n ymwneud â gofal cleifion ar **Ward Tawel Fan** cyn iddi gau ar 19eg Rhagfyr 2013 – a'r **Trefniadau Llywodraethu Presennol** i **Iechyd Meddwl Pobl Hŷn** ym Mwrdd Iechyd Prifysgol Betsi Cadwaladr

#### Digwyddiadau Ymgysylltu Cyhoeddus a Gwranddo Haf 2017

##### (Slide 1) Croeso, Cyflwyniadau a Diolch

- Diolch i chi gyd am ddod
- Donna Ockenden ydi fy enw
- Diolch i CICGC am wneud y trefniadau ar hyd a lled y gogledd
- Byddwn yn ymweld â Chwe Sir y gogledd
- Digwyddiad gwranddo ac ymgysylltu yw hwn i sicrhau fod llais y defnyddiwr yn ganolog i'r adroddiad terfynol

##### (Slide 2) Pam ydyn ni yma?

- Mae lleisiau'r defnyddwyr gwasanaeth a chynrychiolwyr y defnyddwyr gwasanaeth yn **ganolog** i gwblhau ein gwaith yn gywir
- 'Ddim amdanon ni – Hebddo ni!'
- Mae ein gwaith mewn **dau ran** sy'n rhedeg fel continiwm
- 'Digwyddiadau a arweiniodd at gau Ward Tawel Fan'
- **Adolygiad ehangach** o'r systemau, strwythurau a phrosesau 'Llywodraethu' ar draws IMPH hyd yn awr

##### (Slide 3) Beth yr ydym yma i'w wneud? A'r ..... Rheolau Sylfaenol!

- Trafod canmoliaeth, sylwadau, pryderon, cwynion **ynglŷn â gwasanaethau y tu allan i IMPH**
- Trafod **unrhyw fater arall sy'n gysylltiedig** gyda BIPBC y tu allan i IMPH
- **Parchu** barn eraill – efallai nad ydych yn cytuno – ond dyna eu barn!
- **Cyfrinachedd** – dim recordio, dim nodiadau mewn unrhyw ffurf am stori rhywun arall
- **Caniatáu i eraill siarad**, bydd pawb yn cael cyfle

#### (Slide 4) Y Fframwaith

- Sut y gallwn ddefnyddio'r wybodaeth yma – yn yr adroddiad – os ydych yn cytuno
- Bydd yr holl gyfraniadau **yn anhysbys**, bydd angen i ni gael manylion cyswllt gan y rhai sy'n cymryd rhan – ond **ni fyddant** yn cael eu rhannu.  
**Bydd angen rhannu gwybodaeth pe byddai niwed difrifol neu gamymddwyn troseddol posib yn cael ei ddadlennu**  
Bydd **CICGC** yn cefnogi unigolion os oes angen cymryd pryderon neu gwynion ymlaen i BIPBC

#### (Slide 5) Y Sesiynau Trafod! Y7 C!

- Canmoliaeth, Comments (Sylwadau), Concerns (Pryderon) a Chwynion
- Cynllunio Gofal a Chyflawni Gofal
- Cyfathrebu ac Ymgysylltu
- Cyfle i Sgyrsiau unigol

#### (Slide 6) Amserlen ar ôl heddiw

- Byddwn yn gorffen ein 'gwaith maes' yn **nechrau Gorffennaf**
- Byddwn yn **ysgrifennu ein hadroddiad** yn ystod Gorffennaf ac Awst
- Byddwn yn gwirio cywirdeb ffeithiol gyda'r rhai fu'n cymryd rhan, ym **Medi**
- Rydym yn gobeithio **gorffen yr adroddiad** ym mis Hydref

#### (Slide 7) Heddiw!

- Trafodaeth gyffredinol o hyd at 30 munud
- Gwaith Grŵp/Byrddau ar y 7 C
- Canmoliaeth, Comments (Sylwadau), Concerns (Pryderon) a Chwynion
- Cynllunio Gofal a Chyflawni Gofal
- Cyfathrebu ac ymgysylltu
- Cyfle i Sgyrsiau unigol
- Dewch i ni fwrw iddi!

## Appendix 3b

The Powerpoint Presentation used as an introduction at each Listening and Engagement event by Donna Ockenden (English).

### Donna Ockenden

**Review of the Governance Arrangements relating to the care of patients on Tawel Fan Ward prior to its closure on 19th December 2013 – and Current Governance Arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board**

#### Public Engagement and Listening Events Summer 2017

##### (Slide 1) Welcome, Introductions and Thank you

- **Thank you** all for attending. My name is Donna Ockenden
- **Thank you** to the NWCHC for putting in place the arrangements across North Wales
- We will visit the **Six Counties** of North Wales
- This is a **listening and engagement event** to ensure the **user voice** is central to our final report

##### (Slide 2) Why are we here?

- The voices of service users and service user representatives is **central** to accurate completion of our work
- **'Nothing about us – Without us!'**
- Our work is in **two parts** which run as a continuum
- 'Events leading to the closure of Tawel Fan ward'
- A **wider review** of the systems, structures and processes of 'Governance' across OPMH to the current day

##### (Slide 3) And.....Ground Rules!

- Discuss compliments, comments, concerns, complaints **regarding services outside of OPMH**
- Discuss **any other issue associated with BCUHB outside OPMH**
- **Respect** other participant's views – you might not agree – but it's their view!
- **Confidentiality**-no recording or notetaking in any form regarding anyone else's story
- **Allow others to speak**, everyone will get an opportunity

**(Slide 4) The Framework**

- How we may use this information – within the report-if you agree
- All contributions **will be anonymised**, we would need to take contact details from participants – but these will **not** be shared.
- Information **would need to be shared** in the event of **serious harm or potential criminal wrong doing** being disclosed
- The **NWCHC** will support individuals if concerns or complaints need to be taken forward to BCUHB

**(Slide 5) The Breakout sessions! The 7 C's !**

- Compliments, **C**omments, **C**oncerns and **C**omplaints
- Care Planning and **C**are delivery
- Communication and engagement
- Opportunity for individual **C**onversations

**(Slide 6) Timeline after today**

- We finish our 'fieldwork' in **very early July**
- We will be **writing our report** in July and August. We will be checking with participants for factual accuracy in **September**
- We hope to **finish our report** in October

**(Slide 7) Today!**

- Up to 30 minutes general discussion
- Group/Table work on the 7 C's
- Compliments, **C**omments, **C**oncerns and **C**omplaints
- Care Planning and **C**are delivery
- Communication and engagement
- Opportunity for individual **C**onversations
- Lets get started!

## 22.13 Bangor feedback – detailed discussion and individual comments recorded 'on the day'

### Compliments

- 'People are not quick enough to compliment';

### Complaints/Concerns

- **12** 'What is there to gain from making a complaint against BCUHB? We have seen what has happened at Tawel Fan and nothing has changed? It has now been in Special Measures – what is really going to change as a result of that?'
- **11** 'If you are waiting for BCUHB to a. say sorry, b. be accountable, c. be responsible – then forget it';!
- **9** 'BCUHB is constantly under review';
- **9** 'When concerns are raised by staff – managers shut down';
- **12** 'Patients are left frightened to raise concerns';
- **9** 'There is a failure to respond to concerns';

*“If you are waiting for BCUHB to a. say sorry, b. be accountable, c. be responsible – then forget it”*

*“Patients are left frightened to raise concerns”*

### Care Planning

- **12** 'The process of dementia diagnosis for those with learning difficulties is doubly complex';
- **12** 'There is an arrogance amongst staff in care planning meetings – a sort of 'we know and you don't know' attitude. I've experienced this first hand this type of 'care'';
- **11** 'It's just like a 'conveyer belt of caring'. A tick box exercise with no thinking outside of the box';
- **10** 'Glaslyn Ward at Ysbyty Gwynedd is a dementia friendly ward with a mix of patients – but it can take 72 hours to be discharged from there';
- **12** 'There have been many closures of hospital beds across the region and lack of residential EMI beds. In Conwy 7 EMI homes have closed over the last 12-18 months. This is causing delayed transfers of care';
- **9** 'Who is making the diagnosis of dementia? Where does timeliness come into play?'

*“It's just like a 'conveyer belt of caring'. A tick box exercise with no thinking outside of the box”*

*“There have been many closures of hospital beds across the region and lack of residential EMI beds. In Conwy 7 EMI homes have closed over the last 12-18 months. This is causing delayed transfers of care”*

### Care Provision/Care Delivery

- **14** 'The support to allow patients to stay at home is non-existent';
- **14** 'Some of the 'carers' (provided by the health and social care system) can be very informal in their approach with patients – there doesn't seem to be respect for the older generation and then a lack of understanding as to the behaviour of older people with mental health problems';



- **9** 'The journey to get healthcare can be very difficult – accessing the service has lots of problems such as long waiting lists, shortages of doctors';
- **11** 'Why can't they treat the whole of me?'
- **9** 'There are so many changes in society – the family unit is just disappearing. There is an increase in drug and alcohol dependency. The idea of caring in the family is just not there and would put people under great stress';
- **11** 'Some kind of 'therapies' might help or some more activities for dementia patients';
- **11** 'There is a need to take away the negativity that surrounds the 'dementia sufferer'';
- **11** 'When I was visiting the Hergest Unit at Ysbyty Gwynedd recently I was told that the 2 activities co-ordinators were off on sick leave for a month each. They had not been replaced and no activities had been arranged for the patients – except for a bit of gardening';
- **11** 'When I visited Ysbyty Cefni recently I found that there were no activities planned for patients. Activities were supposed to take place between 10.00am and 12 noon – but there was nothing on. The matron 'struggled' to answer when I asked when they would be taking place';
- **10** 'I think the 'activities' planned for patients are just 'tokenistic'. This was something that the North Wales Community Health Council noticed when it completed its 'Loneliness in Hospital report' a couple of months back. The activities do not always appear to be patient centred';
- **10** 'What about young people who suffer from dementia? There is no service out there that provides care in the community – there is just no support out there';
- **12** 'There are just not enough dementia care beds';
- **12** 'Since Tawel Fan was closed there has been no plan to replace the beds that were there – nobody has looked into the consequence of this. There have also been issues with Bryn Hesketh which was investigated';
- **14** 'Travel time is always an issue';
- **14** 'Ynys Mon (Anglesey) is making some inroads into developing and delivering community care';
- **9** 'The increase in locum doctors has an impact on the quality of care provided';
- **12** 'There is a need for more mental health advocates and an independent advocacy for the patient with mental health problems. At the moment the provision doesn't even touch the surface. There is a need for more support to give patients independence – the system is creating a dependency on services therefore loss of independence for the patient';
- **11** 'It's not right that carers are being paid the minimum wage –There is an element of compassion fatigue within the health board. Staff are not being given any support, no training';

*“Some of the ‘carers’ (provided by the health and social care system) can be very informal in their approach with patients – there doesn’t seem to be respect for the older generation and then a lack of understanding as to the behaviour of older people with mental health problems”*

*“I think the ‘activities’ planned for patients are just ‘tokenistic’.”*

*“The increase in locum doctors has an impact on the quality of care provided”*

- 10 'There is a language barrier in delivering health care – some patients cannot speak in Welsh to a doctor – Welsh speaking staff should always be available';
- 9 'The public has not heard about these events';
- 9 'BCUHB should have engaged with whatever engagement is taking place regarding its services';
- 9 'There is a feeling of total apathy – or perhaps it's just that people are not working together';
- 11 'The system is not right for engagement';
- 12 'People's perceptions are that there is a long time-line since the events at Tawel Fan. How are the issues to be 'kept alive'?';
- 10 'There is either community apathy or the system has not been set up to allow people to engage effectively with the Health Board';
- 9 'Why isn't the Health Board present at these events – there is nobody here to listen to the public';
- 10 'How do the Independent Members of the Health Board scrutinise the Board? How do they connect with patients and the public? It would seem that Independent Members are not asking the relevant questions at Health Board meetings. They are supposed to challenge the Executives of the Health Board, but they do not';
- 10 'It would be good if the Health Board had some visibility on Anglesey – we would be glad to see the Independent Members there – engaging with the local population. It would be good to see some type of 'active forums' with the Health Board';
- 12 'There appears to be a huge gap in communication between the Health Board and the Third Sector. There is no two-way communication and there seems to be less direct involvement between the Third Sector and the Health Board';
- 12 'It is proving more and more difficult to get effective and direct communication between our clients, the Third Sector and the Health Board';
- 11 'The establishment of all these various bodies/organisations out there is creating more and more layers which impairs communication';
- 10 'Job titles [at BCUHB] are really confusing – they don't really tell you what people do and what they are responsible for';
- 10 'Whenever you make contact with someone within the Health Board you seem to be passed from pillar to post all of the time';
- 11 'There isn't a lot of information out there about the services that the Health Board provides – it is not clear what goes on in all hospitals';
- 11 'It is not easy to know who is in charge of some hospitals, for example there seems to be two 'Heads' at Ysbyty Cefni';

*“There is a language barrier in delivering health care – some patients cannot speak in Welsh to a doctor – Welsh speaking staff should always be available”*

*“It would be good if the Health Board had some visibility on Anglesey – we would be glad to see the Independent Members there – engaging with the local population. It would be good to see some type of 'active forums' with the Health Board”*

*“Whenever you make contact with someone within the Health Board you seem to be passed from pillar to post all of the time”*

- **12** 'There is just a lack of communication – when (social workers) ask lead nurses about their patients – they just cannot describe what the issues are with their patients';
- **14** 'The health board is trying – but it has left it so long to get the problems sorted. If they were open, honest and transparent – the public will go with them';
- 'Communication at family level is very poor';
- **11** 'The 3 District General Hospitals in North Wales are not viable. The Health Board should be adopting more business like models. Who are we? What are we doing? How are we going to get there?';

### Comments

- **9** 'There has been an unacceptable delay in taking actions from the Tawel Fan report';
- **9** 'The 'buck' is still floating – where does it stop? No-one is being held to account and there is seems to be no consequences to actions';
- **10** 'Nothing will be done, nothing is ever done in North Wales – what is the point of making changes? In 2012 the Health Board undertook a consultation 'Healthcare in North Wales is Changing', which proposed changes to health services across the region – many of these have still to be implemented .... We are so used to nothing happening';
- **9** 'To whose advantage will it be to delay the publication of the Ockenden report?';
- **10** 'We want transparency – will the report be received in public at the same time as the BCU receive it?';
- **9** 'How will the Ockenden recommendations be progressed – what is the plan?';
- **11** 'What are the Betsi's Core Values?';
- **9** 'No evidence of any planning from Betsi';
- **9** 'Not accountable for £1.2 billion';
- **9** 'We need a real strong inspectorate of standards';
- **9** 'The buck doesn't stop anywhere – it has to stop. People are fed up of hearing 'Lessons have been learned'. And then nothing happens until the next time. There is one crisis after another and no accountability';
- **10** 'The Ockenden report should be published for the Health Board and the public at the same time. It should not be shelved by the Health Board. It needs to be made public. We would be very concerned if there is any delay on the health board's part in publishing the report';
- **11** 'What effect will Donna's report have? Reports come and go, (about BCUHB) and there is no learning as a result';

*“How will the Ockenden recommendations be progressed – what is the plan?”*

- 9 'Tawel Fan staff/nursing staff should not be 'held out to dry' by the Health Board – it should be the managers. Where were the doctors on Tawel Fan? – seems to be no mention. What about social services – what was their input?';
- 9 'There are so many restrictions/changes – with no sign of improvement';
- 9 'Have BCUHB really quantified the problem? Do they really understand?';
- 9 'Tawel Fan is mid-air and floating';
- 9 'Lack of training, lack of awareness and safeguarding has been flagged up by HIW for the last 5 years or so – and no action seems to have been taken';
- 11 'Mental health care in North Wales has got to change – the Health Board needs to admit it has problems. Mental health issues are magnified for people who have learning difficulties or are hard of hearing. The Health Board is always putting a sticking plaster on the problems – and then crosses its fingers in the hope that all will turn out well – there is no thought about sustainability of the services';
- 12 'We want Donna's report to make a strong recommendation that there should be an Independent Advocacy service for dementia patients';

*“The Health Board is always putting a sticking plaster on the problems – and then crosses its fingers in the hope that all will turn out well – there is no thought about sustainability of the services”*

*“Our GP is very thorough.”*

## Ends

### 22.14 Tywyn feedback – detailed discussion and individual comments recorded 'on the day'

#### Compliments

- 'Our GP is very thorough';
- 72 'The Minor Injuries Unit in Dolgellau is open until 9.30pm – this is much appreciated';
- 71 'Our dad's support worker made dad a bacon butty one day as dad wasn't eating properly. It was just what dad needed. The support worker understood what dad wanted – what a difference this made!'

*“Dad's support worker made dad a bacon butty one day as dad wasn't eating properly. It was just what dad needed. The support worker understood what dad wanted – what a difference this made!”*

#### Concerns and Complaints

- 20 'Families are in fear of reprisal for asking questions, or raising a concern or a complaint';

#### Care Planning

- 58 'The whole experience feels like a cartoon image of a mouse with a big cat looking down on it. It just all feels so scary and intimidating';
- 18 'There is mixed support from GPs regarding older people's mental health services. Often we have locum GPs who have a limited knowledge of the patients themselves and even more limited knowledge of the local systems out there';

*“The whole experience feels like a cartoon image of a mouse with a big cat looking down on it. It just all feels so scary and intimidating”*

- **18** 'I would say that GPs knowledge of Older People's Mental Health Services is patchy';

Service users and their representatives focused on their experience of poor quality care provision and care delivery at Tywyn.

### Care Provision/Care Delivery

- **71** 'Dad needed speech therapy. He is originally from the North West of England. The speech therapy 'flash cards' had Americanised words such as 'Zucchini' (courgette), 'Trunk' (car boot), 'Candy' (sweets), 'Popsicle' (ice lolly). How on earth was dad to be expected to understand these? The tools to help speech therapy are not available in English let alone in Welsh!';
- **71** 'Dad has vascular dementia. He lives in Dolgellau and was admitted to Ysbyty Wrexham Maelor with a suspected stroke. For some reason he was moved to a side ward/rehabilitation ward. He was there on his own/no-one spoke to him. It is a 50 mile journey from home. A bus journey of at least an hour and three quarters. Once we get there – we have to wait an hour for visiting. Then another half hour wait for a bus and then an hour and three quarters back home. We left at 11.00am and got home at 6pm at night. That's a 6 and a half hour trip to visit dad';
- **72** 'It feels like the attitudes to older people with mental health problems hasn't changed much from about 50 years ago – you feel very isolated. No matter how loud you shout – no one seems to hear';
- **71** 'The activities at the day centre are just not suitable for dad – there was nothing there to interest or engage him. They gave him a colouring book and jigsaws. He's never coloured in a book before. Dad needed a sense of purpose – to be doing something where he thinks he is helping someone – like mending or fixing something. He went home – he wouldn't go back to the day centre';
- **71** 'We've got Dolgellau Hospital and Tywyn Memorial Hospital. Sometimes a psychiatrist (dealing with old age) comes from Wrexham. What else is there in Dolgellau? Y Lawnt/Plas Brith – CPN for care based at home (this is a BCUHB facility). Tywyn is a 16 bedded ward – community based but we think that there are only 12 beds open as there are not enough nurses';
- **19** 'There is some community mental health support – but this is not based specifically in Tywyn – there is also a Memory Group in Tywyn';
- **18** 'There is a Local Authority Older People's Residential home Llys Cadfan which has EMI beds – it has a good reputation';
- **18** 'What is there for families? Age Well Centres – run by Age UK Cymru. Lunch club, once a month (Tai Chi, Bingo – Dolgellau based) – but fairly restricted. These are not available in Tywyn';
- **19** 'A South Meirionnydd Older People's Forum meets once a month in Tywyn';
- **18** 'Uned Meirion – offers assessment and respite';

*"Dad needed speech therapy. He is originally from the North West of England. The speech therapy 'flash cards' had Americanised words such as 'Zucchini' (courgette), 'Trunk' (car boot), 'Candy' (sweets), 'Popsicle' (ice lolly). How on earth was dad to be expected to understand these? The tools to help speech therapy are not available in English let alone in Welsh!"*

*"It is a 50 mile journey from home. A bus journey of at least an hour and three quarters. Once we get there – we have to wait an hour for visiting. Then another half hour wait for a bus and then an hour and three quarters back home. We left at 11.00am and got home at 6pm at night. That's a 6 and a half hour trip to visit dad"*



- **17** 'There seems to be a lack of facilities for the 30-50 age group';
- **20** 'Usually families have to drive long distances and sometimes up to places such as Llangefni (3 and a half hour round trip) with elderly patients in order to access services';
- **19** 'We have outpatients here (Tywyn), we are very lucky with the new building and resources. However there is a lack of staff. I think the geographical location makes it particularly hard to attract new staff';
- **20** 'Local staff have no opportunity for promotion – there appears to be a poor recruitment process';
- **18** 'Location – multiple providers/long journeys/poor public transport. Older people who are not in receipt of benefits have to pay for transport.
- **18** 'Links in the community with BCUHB? None – its 37 miles to Bronglais hospital which is part of another Health Board (Hywel Dda). Cancer patients travel as far as the Singleton hospital with cardiac patients travelling to Swansea (Morriston)';
- **19** 'There are so many different providers of services with long journeys to get to them';
- **20** 'I have had a friend in Ysbyty Gwynedd, Bangor – she was suffering from severe depression. She has been there for weeks. It is difficult for family and friends to visit her. She feels isolated there';
- **20** 'my friend's father is in his 80's – he had a severe psychotic episode so the family took him to the Bronglais Hospital (I think the police were involved). There were no beds available for him. His son had to drive him to Ysbyty Cefni in Llangefni (father was still experiencing a psychotic episode – it is about a 2 hour journey). What is the Cefni hospital? Is it an assessment unit? Why are patients from as far south as Tywyn having to travel there?'
- **16** 'There are very poor public transport systems in this area – you have no funding to cover your travel costs and sometimes you will need to have an overnight stay';
- **18** 'Crisis support – Plas Brith is supposed to provide this, there is only one person there from 9am-5pm Monday to Friday. There is no-one there at 2 o'clock in the morning, you can only have a crisis during office hours! Outside of this it is likely to be dealt with by the police and a section 136 (arrest)';
- **72** 'I am a carer and can only do this with family support. I have a daughter who works locally, she has a family and works full time. I have only recently seen my husband's social worker for the first time in 4 years. There is no respite provided for me';
- **71** 'Dad has not always been old – he used to race motorbikes – no-one seems to understand this. Healthcare seems to be concentrated on individual symptoms not on the whole person'; No one cares about what Dad did in his past or the person he was.

*“Usually families have to drive long distances and sometimes up to places such as Llangefni (3 and a half hour round trip) with elderly patients in order to access services”*

*“Crisis support – Plas Brith is supposed to provide this, there is only one person there from 9am-5pm Monday to Friday. There is no-one there at 2 o'clock in the morning, you can only have a crisis during office hours! Outside of this it is likely to be dealt with by the police and a section 136 (arrest)”*

*“Dad has not always been old – he used to race motorbikes – no-one seems to understand this. Healthcare seems to be concentrated on individual symptoms not on the whole person”; No one cares about what Dad did in his past or the person he was.”*

- **16** 'We need to keep things in local communities – we can understand why centralising is happening but we just can't access the services';
- **19** 'Tywyn hospital seems to be moving backwards not forwards as it just can't get the staff';
- Our GPs are closed on a Wednesday afternoon';
- **71** 'Trying to find the smallest bit of help for mum and dad has been so hard. Dad started to get some kind of routine going – every week the mental health support worker would come to collect him to take him out to the market in Barmouth. The local bus drivers used to look out for dad on his way back from the market and dad loved to catch up with them on his journey home. Dad was comfortable with this routine, He would stand and wait at the window with his coat and hat on and be ready to be collected for his day out. But no-one turned up for 3 weeks in a row – dad still stood there with his hat and coat on waiting at the window – no-one came to collect him. Nobody told us why. We as a family were given no information on why the arrangements were changed. They then told us that they changed the day that the mental health worker would come to see dad – from a Wednesday (when the market was held at Barmouth) to either a Monday or a Tuesday. This meant that dad could no longer go to the market. This upset dad's routine – nobody seems to understand that dad needs a routine. He doesn't go to day care anymore – this was mums only respite';
- **71** 'Dad would go to a local day centre, but they could not tailor activities for dad. This was the only respite that mum would have. There just seems to be a lack of creative thinking – they are not looking him as an individual and catering for his needs';
- **72** 'I have zero help caring for my elderly husband who has dementia. As a carer, you are on an island with no support – it's your problem – you've got to cope with it. My husbands' condition did not 'fit the mould' for a typical stroke patient – it's so hard';
- **20** 'The elderly dementia patients are often given appointments at 9am. It is difficult to get those patients up and ready for hospital first thing in the morning! There's no thought involved in designing care provision for the elderly...'
- **20** 'Health care seems to be focused on the symptoms rather than on prevention';

*“Tywyn hospital seems to be moving backwards not forwards as it just can't get the staff.”*

*“I have zero help caring for my elderly husband who has dementia. As a carer, you are on an island with no support – it's your problem – you've got to cope with it. My husbands' condition did not 'fit the mould' for a typical stroke patient – it's so hard.”*

## Communication

- **71** 'Why don't they tell us what is happening to dad so we can explain to him – it's not easy when you are 50 miles away';
- **58** 'I don't really liaise with my GP – lot of locums, mentally I don't have any back up. My husband is in Liverpool. I am fed up of having to explain again and again what the problem is';
- **71** 'Nobody told us why. We as a family were given no information on why the arrangements were changed';

- **18** 'There is no information regarding rights and responsibilities from the BCUHB';
- **58** 'You have to explain yourself again and again as you are meeting so many different staff across BCUHB, no-one communicates with others or passes information on. You are constantly repeating things that you have already told them';
- **16** 'Lack of information sharing between organisations and support workers';
- **18** 'Lack of trust between charities (third sector), BCU, statutory services';
- **18** 'People are still using faxes between local GPs and the Mental Health team – there appears to be no electronic communication links';
- **19** 'There was a 'Hear to Help' group in Tywyn – but I can't find any information about it on the BCU website';
- **20** 'It is so difficult to find any comprehensive information on the BCU facilities – whether they are opened or closed etc. – often the times and contact details on the website are wrong';
- **16** 'They get it so wrong, so completely wrong in communicating with patients';
- **58** 'The written correspondence received from the Health Board is very poor, sometimes complex – I just can't understand it';
- **72** 'I don't think BCU knows where Dolgellau is';
- **72** 'No information given to our GP from 'central services' and it appears our GP has no 'back up' support';

*“There is no information regarding rights and responsibilities from the BCUHB”*

*“There was a 'Hear to Help' group in Tywyn – but I can't find any information about it on the BCU website”*

*“The written correspondence received from the Health Board is very poor, sometimes complex – I just can't understand it”*

#### Comments

- **20** 'Local people's voices should be threaded throughout Donna's final report'

#### Ends

### 22.15 Pwllheli feedback – detailed discussion and individual comments recorded 'on the day'

#### Compliments

- **21** The OT staff at Hergest were brilliant – but they were the public face of the BCUHB – they were the only people interacting with patients. Can't find any nursing staff in Hergest – they were all 'hiding' in their offices;

*“Local people's voices should be threaded throughout Donna's final report”*

#### Concerns and Complaints

- **21** 'Protracted timescales – people are hiding behind the 'volume of work' excuse. Often staff have moved on so it is difficult to investigate. Complaints are treated as a nuisance';

## Care Planning

- **21** 'Different agencies do not speak to each other and do not share information – they say it is because of 'confidentiality' reasons. This includes cases where there is a high risk of violence or aggression from the patient';
- **22** 'Dryll y Car was closed at very short notice – there was some community consultation; Staff are not involved in strategic directives and are not involved in discussions about future plans for the organisation – they are not aware about what is being planned';
- **22** 'Risk-assessments – information is not being shared locally';
- **78** 'What involvement and choices does the patient and family have when it comes to care planning?'
- **21** 'What EMI services are there in Gwynedd that can accept patients – as a 'catch-all' for discharges from Hergest (deeply troubled patients)?';

*“What involvement and choices does the patient and family have when it comes to care planning?”*

## Care Provision/Care Delivery

- **22** 'Staff within the BCUHB training department just do not accept phone calls or e-mails – and this is a BCUHB wide problem';
- **21** 'Communication lacking – families are sometimes waiting up to a week for call back from social services. I can't get any information from the heads of department – they won't tell me anything. It is a dysfunctional organisation'; (BCUHB)
- **78** 'I don't know who makes the decisions in the BCUHB';
- **22** 'Members of staff don't know who the Director of Nursing is';
- **22** 'Individual care no longer exists – it is not person centred; day services have been relocated from Ala Road to the Hafan Ward in Bryn Beryl – it is not ideal as there are 32 people in one location';
- **21** 'There needs to be a 'joint' approach to ageing. The left hand doesn't know what the right hand is doing';
- **78** 'Ysbyty Alltwen is 10-12 miles from Blaenau Ffestiniog – but the local population just will not go to Ysbyty Alltwen';
- **22** 'Bryn Beryl hospital has been turned into an assessment unit – Monday – Friday, 9am – 5pm. There is a minor injuries unit and about 9 hours of an x-ray service, but nobody is entirely clear as to what is on offer at Bryn Beryl hospital. If people don't know what is there then they won't use the service. It used to provide respite care but doesn't do this anymore';
- **22** 'Staff in this part of the world are remote – they are told by managers that the A55 runs throughout the whole of the BCUHB region therefore what is the problem with travelling and accessibility? It is obvious that they don't know this area';
- **22** 'There is a constant turnover of staff – it's hard to get consultants down here – we went through 3 consultants in 6 weeks. Some were leaving because of the great distances they had to travel. One consultant didn't

*“There needs to be a 'joint' approach to ageing. The left hand doesn't know what the right hand is doing”*

*“Staff in this part of the world are remote – they are told by managers that the A55 runs throughout the whole of the BCUHB region therefore what is the problem with travelling and accessibility? It is obvious that they don't know this area”*

even stay for a whole day – and quit in the afternoon. This was very recently (May 2017). There is also a real shortage of GPs in the area’;

- **21** My experiences over the last 4 years are relating to my mother and father. Mum developed acute mental health illness and was admitted to Hergest. She had attempted suicide. At a multi-disciplinary team meeting – I was lied to. I was told that BCUHB don't look at retrospective claims for mental health patients. I was told that my mother couldn't hurt anyone as her needs had decreased. I couldn't understand how people were saying what they were saying when I knew they were not true. A CPN closed my mother's case without actually meeting her’;
- **78** ‘Person centred care is not there’;

### Communication

- **23** ‘I know that there is something out there called the Betsi but I don't know exactly what it is’;
- **23** ‘A lot of people around here think of the Betsi as being Ysbyty Gwynedd’;
- **23** ‘Public are being told that the Betsi is being ‘split up’ to Centre, East and West, whatever that means’;
- **21** ‘It's great that Donna has come to Pwllheli – nobody ever comes here’;
- **21** ‘Where are the BCUHB and Local Authority Councillors? Why are they not here today? The absence of ‘Heads of Department’ is noted’;
- **22** ‘There is a lack of communication between the Board and staff. At Bryn Beryl hospital, staff were told overnight about the closure of 7 beds – there was no communication before then. Patients were sent elsewhere – we don't know where to’;
- **22** ‘Staff have many frustrations regarding communication – one of them being that they just don't know who the senior leaders are – they are just not visible’;
- **21** ‘In some of the written information that is produced by the Health Board there is no way of knowing how to make contact with the Health Board’;
- **21** ‘I'm always being given wrong telephone numbers by BCUHB, they are always changing the information on their website. The service is so bad it can't be real. I'm always getting answers to call saying ‘they no longer work here/I don't know/I think you've got the wrong number’;

### Comments

- **21** ‘Have you thought of contacting owners of EMI homes? They are private providers of BCUHB held services’;

*“Person centred care is not there”*

*“I know that there is something out there called the Betsi but I don't know exactly what it is”*

*“There is a lack of communication between the Board and staff. At Bryn Beryl hospital, staff were told overnight about the closure of 7 beds – there was no communication before then. Patients were sent elsewhere – we don't know where to”*

*“I'm always being given wrong telephone numbers by BCUHB, they are always changing the information on their website. The service is so bad it can't be real. I'm always getting answers to call saying ‘they no longer work here/I don't know/I think you've got the wrong number”*



## 22.16 Llangefni feedback – detailed discussion and individual comments recorded 'on the day'

### Compliments

- **32** 'Alzheimer's Society – help to promote a dementia friendly community in Llangefni, there is a steering group co-ordinated by Alzheimer's. Seiriol Ward (in Holyhead) has a very active dementia friendly support network';
- **26** 'Whenever I have phoned the Alzheimer's Society they have been able to help me'; (Llangefni June 2017)
- **34** 'There are some individual members of staff who really provide great care, but they are working against the odds'; (Llangefni June 2017)
- **31** 'The staff who are dealing with newly diagnosed dementia patients are very kind and understanding';
- **26** 'I've heard positive things about 'Cymorth Llaw' (private home care based in Anglesey and in Gwynedd)';
- **33** 'There is a day centre in Holyhead which is open every day of the year for the homeless and for people with very very poor living conditions. 'Lighthouse' – signposts to the Hergest Unit';

*“Whenever I have phoned the Alzheimer's Society they have been able to help me”*  
(Llangefni June 2017)

*“The staff who are dealing with newly diagnosed dementia patients are very kind and understanding”*

### Concerns and Complaints

- **79** 'There has been a crisis in Bryn Hesketh – people have been raising and escalating concerns with nothing being done about it. Staff are then off with sickness/stress'; (Llangefni June 2017)
- **34** 'We have to keep rattling cages – it's so frustrating, however power to change things if we continually rattle cages together. However people run out of puff and give up and all that is left is a nice paper trail and nothing else. Whatever happened to the Flynn and Eley recommendations – they seem to have disappeared?'; (Llangefni June 2017)
- **30** 'Families are just too terrified to complain in case their relatives might get shipped off to England. They are just frightened to speak out'; (Llangefni June 2017)
- 'People think – 'if I'm really nice to them then they will look after dad – best if I not complain'; (Llangefni June 2017)
- **30** 'People just don't make complaints in the first place – I think the number of complaints/levels of dissatisfaction are grossly under reported'; (Llangefni June 2017)
- **30** 'When you leave the ward at the end of visiting time and you have to leave Mam or Dad with those staff – then you are too frightened to say anything and complain'; (Llangefni June 2017)

*“There has been a crisis in Bryn Hesketh – people have been raising and escalating concerns with nothing being done about it. Staff are then off with sickness/stress”*  
(Llangefni June 2017)

*“People just don't make complaints in the first place – I think the number of complaints/levels of dissatisfaction are grossly under reported”*  
(Llangefni June 2017)

## Care Planning

- **34** 'There is a need to go back to basics to evaluate what services are required at the earliest times'
- **34** 'Conversations between all should continue along the pathway – but everyone is stretched to the limit – GPs are drowning'; (Llangefni June 2017)
- **9** 'People are being ignored by the system. People should be asked what systems they would like. If you look after your staff – they will look after you'; (Llangefni June 2017)

## Care Provision/Care Delivery

- **32** 'Following diagnosis – there is not much support – I think it is at crisis point in Gwynedd and Anglesey. (Llangefni June 2017)
- **32** 'Memory clinic does a lot of pre-diagnostic work – demonstrates diagnosis rather than focus on breaking bad news. At any time along the pathway there is an opportunity to say 'go no further'. Re-engagement is always possible';
- **34** 'Approach to giving a diagnosis of dementia should change – should be more about 'sharing a diagnosis' – rather than 'breaking bad news. Patients and their families need to be kept informed along the way'; (Llangefni June 2017)
- **32** 'On initial diagnosis the staff are really kind – they are trying their best and positive. Ideally Memory Clinics should be the first port of call in the patient pathway, however the 'lower levels' of the mental health services faces issues in escalating problems as there has initially been a lack of early intervention. This often results in a crisis'; (Llangefni June 2017)
- **34** 'Health and Social care are pushing down on the Third Sector which is already stretched to the limit and has difficulty finding volunteers'; (Llangefni June 2017)
- **31** 'There are so many parts to the care/patient pathway – but none of it is joined up'; (Llangefni June 2017)
- **31** 'Staff are under pressure to complete paperwork – they are drowning in paperwork (Mental Health Measures etc.) – but the paperwork doesn't improve care'; (Llangefni June 2017)
- **34** 'The whole system is just in meltdown/clampdown and staff don't have the flexibility to think outside of the box'; (Llangefni June 2017)
- **27** 'The clinicians on the ground work very well together – but other personal relationships are very vulnerable';
- **27** 'People do their best at work – but they are working with situations that are unsafe and unacceptable. It is a normal situation for people to leave their shifts knowing that they can't do anything about the problems. This has to change'; (Llangefni June 2017)

*“Conversations between all should continue along the pathway – but everyone is stretched to the limit – GPs are drowning”*

(Llangefni June 2017)

*“Following diagnosis – there is not much support – I think it is at crisis point in Gwynedd and Anglesey.”*

(Llangefni June 2017)

*“People do their best at work – but they are working with situations that are unsafe and unacceptable. It is a normal situation for people to leave their shifts knowing that they can't do anything about the problems. This has to change”*

(Llangefni June 2017)

- **79** 'BCU has closed far too many wards. EMI nursing homes are taking on too many patients who are high risk'; (Llangefni June 2017)
- **25** 'We have had care homes phoning 999 (asking for the police) and saying that they cannot cope with their patients';
- **34** 'In Ysbyty Cefni they were trying to re-floor the ward – there was no safe place – they also put the wrong groundwork in the garden – so there was no outside space for patients either';
- **34** 'Cefni is never fully staffed. The Matron/Ward manager is working every hour god sends'; (Llangefni June 2017)
- **30** 'I visited my dad – I saw that he had been left soiled for a long time – I was very upset'; (Llangefni June 2017)
- **30** 'Families can often end up supporting other patients with feeding and drinking'; (Llangefni June 2017)
- **9** 'The BCUHB are trying all different avenues at staffing the service but it is a 'system under siege'; (Llangefni June 2017)
- **27** 'Staff need 2 things – to be valued and to have the tools to do their job – BCU don't do any of these things'; (Llangefni June 2017)
- **31** 'There needs to be more staff in the community with an aim to keep people in their homes for longer. But there is just not enough staff. Those staff who are caring for people within their own homes are turning up to put patients in bed at 6pm. Some patients don't want to go to bed at 6pm – but it's that or nothing, There is no choice because there is no staff'; (Llangefni June 2017)
- **32** 'There is no quality to home care – it is usually a half an hour call or visit. The Welsh Governments edict of 'Voice, Choice, Control' regarding older people is being stripped'; (Llangefni June 2017)
- **25 & 26** 'We as X had to help an elderly lady who had soiled herself at home. It was easier for us to put the gloves on and help her clean herself up. Her carer wasn't due to see her for hours. I know we shouldn't be doing it, but who else would? We couldn't just leave her there like that'; (Llangefni June 2017)
- **9** 'I find everything I am hearing to be unbelievably distressing';
- **9** 'There is very little in the way of services/support in those stages following initial diagnosis and the resulting crisis of safeguarding the elderly. Everybody's responsibility – but this is not working within the BCUHB. Somebody has to be the lead'; (Llangefni June 2017)
- **9** 'There is not enough investment into early intervention and prevention. There is a need to go back to basics'; (Llangefni June 2017)
- **31** 'BCUHB and Local Authorities are commissioning services but the services are not dovetailing with the third sector. Paperwork does not necessarily improve care – it is just a tick box exercise';
- **27** 'The whole system is in clampdown – nobody is prepared to take risks';

*"Families can often end up supporting other patients with feeding and drinking"*

(Llangefni June 2017)

*"There needs to be more staff in the community with an aim to keep people in their homes for longer. But there is just not enough staff. Those staff who are caring for people within their own homes are turning up to put patients in bed at 6pm. Some patients don't want to go to bed at 6pm – but it's that or nothing, There is no choice because there is no staff"*

(Llangefni June 2017)

- **30** 'People don't have choices – no flexibility in thinking outside of the box. Feels like banging heads against a brick wall – needs high level thinking. (Model Mon/dementia strategy/Local Service Board)'; (Llangefni June 2017)

Attendees at the Llangefni Listening and engagement event said the following: (where no 'number' is provided the service user representative did not wish to be identified.)

- 'Need more money with more people on the ground – there is backlog all the time';
- 'Unacceptable, unsafe – which has to change';
- **30** 'At Ysbyty Gwynedd, food is placed in front of patients but it is never eaten as there is no staff to help make sure that patients eat their meals';

*“At Ysbyty Gwynedd, food is placed in front of patients but it is never eaten as there is no staff to help make sure that patients eat their meals”*

### Communication

- **25** 'Organisations need to talk to one another – but they are so stretched that no one had time to do so'; (Llangefni June 2017)
- **9** 'There are so many different dementia strategies and other strategies – nothing is joined up, no-one has talked to each other or made any links'; (Llangefni June 2017)
- **31** 'It's gone very quiet regarding the 'Special Measures' that have been put in place by the Welsh Government. Is the BCUHB being proactive enough?';
- **34** 'We are trying to clarify with the BCUHB the purpose of Ysbyty Cefni – but they are unable to tell us'; (Llangefni June 2017)
- **34** 'We try and have lots of input – but no-one listens to us – who are on the ground at Ysbyty Cefni';
- **27** 'Senior managers need to spend a day at the sharp end – I mean really spend a day there – not just pop in when they want to'; (Llangefni June 2017)
- **26** 'I wish I could know more about the services that are out there – I know that there is lots of excellent work going on in some places but I just don't know how I can find out anything about it. This information needs to be visible and accessible to the community'; (Llangefni June 2017)
- **26** 'Communication is good with links to Social Services and GPs in Anglesey';
- **34** 'There is a need to bring about the good news stories about the Betsi – there is so much good work being done against all the odds'; (Llangefni June 2017)

*“There are so many different dementia strategies and other strategies – nothing is joined up, no-one has talked to each other or made any links”*

(Llangefni June 2017)

*“Senior managers need to spend a day at the sharp end – I mean really spend a day there – not just pop in when they want to”*

(Llangefni June 2017)

### Comments

- **9** 'Will Donna Ockenden's report make any difference?';
- 'There is no 'quality' to care these days';
- 'Does a GP have to do a home visit if a patient is of a certain age?';

- **28** 'The new mental health strategy appears to be rushed and only as part of an 'improvement plan for special measures. What will the strategy mean – will anything change? The proof of the pudding will be in the eating. What is needed is implementation on the ground – not just a new strategy'; (Llangefni June 2017)
- **34** 'If the system isn't working – there is no point in undertaking any training';

## Ends

### 22.17 Wrexham feedback – detailed discussion and individual comments recorded 'on the day'

#### Compliments

**56** 'Positive feedback re interaction wife suffered epileptic fits, losing memory. She was admitted into a new unit 2 months ago – ie the Hafan Unit at Wrexham Maelor. I was very pleased to learn that she didn't have Alzheimers but she was experiencing fits as a result of the medication she was on. I was at Ysbyty Wrexham Maelor on a ward and it was suspected that I had had a heart attack. I was surrounded on that ward with patients with mental health problems. This was not a conducive environment for myself nor for other patients who did not experience mental health problems but who were nevertheless very ill'; (Wrexham July 2017)

**56** 'It was very difficult to sleep at night and X complained and was moved to another ward. The nurses did a magnificent job – but there are just not enough of them. Most of them were spending their time trying to calm down those patients who had mental health problems. (Wrexham July 2017) I think there were about 2 nurses looking after 3 wards. Until you see it for yourself you don't see how short staffed and under pressure the nurses are. If hospitals and wards are run properly then patients would be better assessed and put in the right wards for their care. You hear these tales but until you go until hospital and see these things first hand – you wouldn't believe it';

**56** 'I completely appreciate where the staff are coming from and am aware of the pressures that they face. It is a completely responsive system – dealing with firefighting. (Wrexham July 2017)

The 'Well-being Act' talks about the 'preventative model' – but the health service is still reactive rather than proactive':

- **55** 'My father died last year at Ysbyty Gwynedd. The care he had there was second to none';
- 'The GPOOH service is excellent;'

#### Concerns and Complaints

**57** 'Many older people are so independent and they would rather look after themselves – they only turn for help when they have reached crisis point. And

*“There is a need to bring about the good news stories about the Betsi – there is so much good work being done against all the odds”*

(Llangefni June 2017)

*“The nurses did a magnificent job – but there are just not enough of them.”*

*“I completely appreciate where the staff are coming from and am aware of the pressures that they face. It is a completely responsive system – dealing with firefighting.”*  
(Wrexham July 2017)



people are only being reached when they are at crisis point – not before'; (Wrexham July 2017)

**57** 'Can be a very 'bullying' atmosphere therefore patients and their families require the support through the complaints process;' (Wrexham July 2017)

### Care Planning

**57** 'What care packages are there? It is so frustrating that we get no answers to all the questions we are asking'; (Wrexham July 2017)

**57** Discussions seem to move away from being patient centred to being all about resources';

**57** 'Care planning – what choices are there. If you have an issue with the care provider you are left pretty much abandoned'; (Wrexham July 2017)

**57** 'Social services will go out and delegate the package – if you have issues with your provider you are pretty much left abandoned – particularly so with mental health care providers, where often care providers refuse to go into patients' homes. The patient then ends up in a residential home. Flintshire – 2 month wait for mental health advocacy service';

### Care Provision/Care Delivery

**54** 'There appears to be a divide between management and staff – the staff are isolated. Until management gets off their backsides and see for themselves what is actually happening – nothing will be done'; (Wrexham July 2017)

**54** 'Recruitment of staff – too frequently this depends on qualifications – not on whether the person is a caring person. The health service needs to look at its recruitment process. There is insufficient staff';

**56** 'There seems to be a deviance in mental health care as staff are dealing with people who cannot answer back';

**57** 'In the southern end of North Wales there is no provision of care';

**57** 'Chronic lack of facilities in places like Ruthin/Pwllheli/Towyn/Bala/Corwen – cannot get care packages. What you do get is something 'tokenistic'. The whole of North Wales is just one huge isolated area'; (Wrexham July 2017)

**57** 'There has been a constant scaling down of community provision with no replacements yet – particularly so following 'Healthcare in North Wales is Changing' which saw the closure of services in places like Prestatyn, Flint, Blaenau Ffestiniog and Llangollen – nothing yet has taken the place of those services; there is very little evidence of anything being replaced'; (Wrexham July 2017)

**57** 'Llangollen Community Care is to be closed down – no one will take this on as care packages are too expensive';

*“My father died last year at Ysbyty Gwynedd. The care he had there was second to none”*

*“Many older people are so independent and they would rather look after themselves – they only turn for help when they have reached crisis point. And people are only being reached when they are at crisis point – not before”*

(Wrexham July 2017)

*“There appears to be a divide between management and staff – the staff are isolated. Until management gets off their backsides and see for themselves what is actually happening – nothing will be done”*

(Wrexham July 2017)

**57** 'They are always talking about developing new models – but I can't see yet that anything as been developed'; (Wrexham July 2017)

**57** 'Carers get about 6 jobs to do. They get petrol money but they don't get paid for their travelling time if they are using their own vehicles. The distances between jobs can be large – but there is no payment for this. This will mean that many people will not take on the role of carer for the elderly in rural areas';

**57** 'Who cares for the carer? There is a lack of support for carers – there seems to be a lack of willingness to engage with carers. There is a fear that if carers do engage with statutory services then they may be forced to sell their homes or be separated from their loved ones';

**57** 'Social Services will signpost to organisations such as Hafal and NEWCIS – but they can only offer 17hours of carer support during a 6 month period per carer';

**55** 'Fire Services Liaison has cut fires by half. Falls assessment for BCUHB – you come across patients who need help but don't know where to go. Hoarding is an issue – there is no support. Hoarding is an issue amongst older people with mental health issues – trying to cure such people is difficult. People are aware of the issues but there is no funding and little help for them (eg from Community Mental Health teams) social services are on their knees'; (Wrexham July 2017)

**57** 'Working with carers and older people creates a lot of confusion anyway without having to try and navigate your way through complex systems. It's difficult enough with the third sector. It is affiliated to 6 different local authorities in North Wales – but the 6 different 'Third sectors' have 6 different voluntary schemes';

**57** 'Continuing Health Care – who is funding care packages? BCUHB seems to be a law unto themselves in deciding the criteria to be met. (Wrexham July 2017) For example the DST criteria can be met but BCUHB will be say that that is interpreted as a social issue and not a health issue. So the buck is passed. Individuals are not realising what support can be given to them about these issues and that they are entitled to an advocate to help them. (Wrexham July 2017)

**57** 'Continuing Health Care won't cover respite care';

**57** 'The total care that social services provide is 1 hour a week. What do people do who don't know the 'system' – it's an absolute disgrace!';

**57** 'NEWCIS has a Continuing Health Care facilitator post in Flintshire – but often it is 'all done' before the NEWCIS has become involved';

**57** 'Care providers may refuse to go into patients' homes if aggression is part of the dementia';

*“Chronic lack of facilities in places like Ruthin/Pwllheli/Towyn/Bala/Corwen – cannot get care packages. What you do get is something 'tokenistic'. The whole of North Wales is just one huge isolated area”*  
(Wrexham July 2017)

*“They are always talking about developing new models – but I can't see yet that anything as been developed”*  
(Wrexham July 2017)

*“Who cares for the carer? There is a lack of support for carers – there seems to be a lack of willingness to engage with carers. There is a fear that if carers do engage with statutory services then they may be forced to sell their homes or be separated from their loved ones”*

**57** 'Today I have been dealing with a 90 year old wife who has been told that her 90 year old husband is coming home from hospital – she has nothing planned in relation to his discharge'; (Wrexham July 2017)

### Communication

'I received a letter saying that my granddad had been on Tawel Fan – it turned out to be incorrect'; (Wrexham July 2017)

**55** 'Community Mental Health – signposting services they need – understanding the local, North Wales, BCUHB structure can be very difficult – trying to contact someone within the BCUHB can be harder still! There is so much frustration at not being able to find your way around the BCU system'; (Wrexham July 2017)

**56** 'BCUHB often speaks in jargon which leads to confusion and distress' (Wrexham July 2017)

**57** 'Following the Carers Measure (2012) we distribute surveys at Wrexham Maelor Hospital – but we get no feedback on the results of the survey and don't know where the feedback goes to';

'I often look at BCUHB website to find out what is going on – that's no good for a member of staff to have communication through the media only'; (Wrexham July 2017)

**56** 'There is no signposting to health and social services for local representatives within the community';

**56** 'As far as the general public is concerned – we hear nothing' (Wrexham July 2017)

### Comments

- **54** 'Heddfan Unit – little tiny room air-conditioning not fit for purpose – very hot. It seems to have been designed by an architect for an architect. What are the functions of this building?'
- **54** 'Politics – the emphasis is all wrong – it's all about cutting costs. Trying to get people under control rather than back in the community';
- **57** 'BCUHB 'merged' – but other organisations did not – and there is so much cross over between what the health boards and local authorities do';
- 'Berwyn Prison – it would appear that BCUHB staff are being poached to go and work there';

## 22.18 Rhyl feedback – detailed discussion and individual comments recorded 'on the day'

### Compliments

- **36** 'You do hear of some positive experiences – but there are more negatives. Parts of the system are working. You tend to hear that a particular member

*“Today I have been dealing with a 90 year old wife who has been told that her 90 year old husband is coming home from hospital – she has nothing planned in relation to his discharge”*

(Wrexham July 2017)

*“BCUHB often speaks in jargon which leads to confusion and distress”*

(Wrexham July 2017)

of staff has done a good job, for example of members of staff who are compassionate, sensitive and individually provide a good service. There are individuals within the system who are doing a very good job rather than the system as a whole working well. There is more criticism than compliments'; (Rhyl June 2017)

- **40** 'I've been racking my brains training to think of a compliment'; (Rhyl June 2017)
- **40** 'Glan Traeth – Memory Clinic – it's a bit like going into a hotel, welcoming, relaxes the person – sympathetic and very nice. People will talk to you and offer you a coffee when you walk in. Glan Traeth is the exact opposite of everything else I have experienced. Whereas Hafod – sitting in the waiting room is like visiting a prison, mainly due to inappropriately placed entrance/exit doors to other parts of the building, all with combination locks.'
- **40** You can't even get a drink of water from the water cooler as it is not in use due to cuts despite many of the patients attending Hafod suffering from a dry mouth due to medication' (Rhyl June 2017)
- **38** 'I have compliments regarding the care of elderly ward in Ysbyty Wrexham Maelor';
- **40** 'I remember meeting two nurses at the Ablett Unit who were very empathetic. I took someone I care for to see the duty GP at A&E at Ysbyty Glan Clwyd. A couple of nurses came from the Ablett unit to assess the patient – they were very nice and had a great deal of empathy. Unfortunately the issues were not followed up'; (Rhyl June 2017)
- **39** 'There is good support from Hafal however there are different arrangements across the counties of Conwy and Denbighshire and because different voluntary arrangements are in place – the service is not seamless. Voluntary agencies are doing a good job. Hafal's carer assessments were done extremely well but then Denbighshire County Council decided to give the contract to NEWCIS and this is no longer the case';
- **38** 'Ysbyty Wrexham Maelor –the dementia ward is excellent – has a great atmosphere – the manager leads the team well';
- **38** 'The carer support workers in the Ablett unit are very good for signposting and assessment'; (Rhyl June 2017)

### Concerns and Complaints

- **36** 'The new Public Services Ombudsman seems to be doing some good work – whether BCUHB takes any notice of him is something else'; (Rhyl June 2017)
- **7** 'Having made a complaint and had it escalated within the BCUHB system service user 7 found staff very unfriendly and they largely ignored service user 7 for days once service user 7 was admitted to an inpatient ward. 'Oh you're X' was the reaction from staff, 'we know about you.'

*“You do hear of some positive experiences – but there are more negatives. Parts of the system are working. You tend to hear that a particular member of staff has done a good job, for example of members of staff who are compassionate, sensitive and individually provide a good service. There are individuals within the system who are doing a very good job rather than the system as a whole working well. There is more criticism than compliments”*  
(Rhyl June 2017)

*“Ysbyty Wrexham Maelor –the dementia ward is excellent – has a great atmosphere – the manager leads the team well”*

## Care Planning

- **36** 'Are services bespoke to the patient? There are so many professionals in the system – their own self-interest seems to dominate rather than looking at the particular needs of the patient'; (Rhyl June 2017)
- 'Is it bespoke/individualised?'
- **39** 'Lack of beds in mental health hospital wards – hard to get into the mental health system. Deeply worrying for those patients who have little family and friends. Social workers seem to come and go – always changing. Reviews of older people are very rarely held';
- **36** 'There are delays in care planning – care reviews are rarely held. If you are self-funded or state funded – there will be no-one to do the necessary checks where DOLS is concerned. (Rhyl June 2017)
- Some people who have come to live in North Wales from elsewhere appear to be completely outside of the system and some have not been visited by a social worker'
- Some patients in all kinds of settings have been deprived of their liberty without independent scrutiny of the opportunity of advocates, family, friends or the service being able to question the detail on what has been imposed. (Rhyl, June 2017.)

## Care Provision/Care Delivery

- 'There is so much paperwork in a huge system – it's just too big';
- **38** 'Leaders should challenge, I'm not sure that they do'; (Rhyl June 2017)
- **36** 'DOLS – it's a complete scandal in North Wales – reference to a joint monitoring report from the Healthcare Inspectorate Wales– which appeared to just accept the scandal. In Anglesey you can have your liberty deprived and wait for up to a year to get anything done. Overall there is dire professional leadership. (Rhyl June 2017) The press in North Wales seem to be 'wilfully blind' as to the lack of leadership across the region. In the report it was suggested that the vast majority of professionals don't understand the Mental Health Act. Everybody seems to be 'wilfully blind' and colluding in the situation when it comes to dealing with fundamental human rights';
- **36** 'Most professionals do not understand the legal context of DOLS'; (Rhyl June 2017)
- **36** 'Currently there is no grip on this issue – I would not be surprised if there were weekly reports of neglect and abuse. It is not easy to close down establishments as patients have nowhere else to go. Often neglect and abuse is so fundamental that you will not change the culture'; (Rhyl June 2017)
- **36** 'Lack of professional leadership not just in BCUHB, but also in social services and in higher education. There seems to be a disrespect for basic human rights – i.e. 'these people are of less value';

*“Glan Traeth – Memory Clinic – it's a bit like going into a hotel, welcoming, relaxes the person – sympathetic and very nice. People will talk to you and offer you a coffee when you walk in. Glan Traeth is the exact opposite of everything else I have experienced. Whereas Hafod – sitting in the waiting room is like visiting a prison, mainly due to inappropriately placed entrance/ exit doors to other parts of the building, all with combination locks..”*

*“Having made a complaint and had it escalated within the BCUHB system service user 7 found staff very unfriendly and they largely ignored service user 7 for 3 days. 'Oh you're X' was the reaction from staff, 'we know about you.'”*



- **35** 'Everybody who is working within the system knows what's going on – or not going on – they just don't call it out. I retired because of poor leadership rather than speaking out. I was quite high up – I felt safer moving out of the system';
- **36** 'Your report will be significant. I hope it will show that the professional leadership is not challenging the status quo';
- **35** 'Quality of training is really poor. BCUHB are visiting jobs fairs but how they sell the jobs is important. It should be about recruiting to a vocation and instead it's along the lines of 'if you come to work for us you can work x amount of hours'. There is no compassion';
- **40** 'The framework is there, the intent is there, but it doesn't happen. There are rigid attitudes – the caring profession is just too rigid. Where is the compassion? Need to find a balance between audits – v – compassion';
- **35** 'The 'touchy –friendly' element of care has all gone – now it is all paperwork. It's becoming far too easy to tick boxes';
- **38** 'I feel very strongly for anyone elderly without a carer – everyone needs someone to fight their corner'; (Rhyl June 2017)
- **40** 'They need the right people to care for the right patients';

*“Most professionals do not understand the legal context of DOLS”*

(Rhyl June 2017)

*“I feel very strongly for anyone elderly without a carer – everyone needs someone to fight their corner”*

(Rhyl June 2017)

## Communication

- **36** 'BCUHB is saying endlessly that it is reaching the 'hard to reach' (e.g. gypsy, Romany travellers etc.) – but they are not – they don't want to and the label is used far too liberally. It is just ticking the boxes again – they are not listening and are just not respectful'; (Rhyl June 2017)
- **36** 'They get new people in to do 'engagement' – but nothing changes and then the good people leave'; (Rhyl June 2017)
- **35** 'Gren Kershaw (former Chief Executive of Conwy and Denbighshire NHS Trust) used to know all our names, who the staff on the wards were. Now there are far too many people between the ward sister and the board';
- **35** 'The leaders only tend to communicate with staff when things go wrong or there is a crisis';
- **36** 'I think that matrons are in cahoots with middle management – the only difference they make is to 'hinder' what they do'; (Rhyl June 2017)
- **38** 'I think that they have now started some 'real time compliments/ feedback' at BCUHB';
- **36** 'The framework is there, the intent is there – but it doesn't happen in practice';
- **36** 'Communications difficulties is often used as a weapon – 'I told him''; (Rhyl June 2017)
- **36** 'Donna – your report will be a 'once in a generation report' – you need to call the professionals out'; (Rhyl June 2017)

*“BCUHB is saying endlessly that it is reaching the 'hard to reach' (e.g. gypsy, Romany travellers etc.) – but they are not – they don't want to and the label is used far too liberally. It is just ticking the boxes again – they are not listening and are just not respectful”*

(Rhyl June 2017)

- 35 'I've said all of these things 5 years ago – nothing has changed';
- 'It will be really wrong if special measures comes to an end too soon';

### Comments

- 36 'The social workers at Tawel Fan – how come they didn't blow the whistle? Why haven't the social workers at Tawel Fan been interviewed?'
- 36 'Tawel Fan – did every patient have a social worker? Local Authority should have made sure that they did. How often did social workers visit patients, did they have care plans? No-one is calling it out';
- 36 'There are some massive questions to be asked about the Healthcare Inspectorate Wales – were they also being 'wilfully blind'?'
- 36 'What is the Health Inspectorate and Social Services Inspectorate doing? I think that they are part of the collusion – it just somehow seems all too cosy in North Wales';
- 35 'Why should my mother wait 8 hours in A&E for an UTI to be treated?'; (Rhyl June 2017)
- 'Special Measures appears to most citizens to have made little difference to the day to day reality for service users and patients.'
- 'There is no feeling of a sense of energy and passion'

*“Why should my mother wait 8 hours in A&E for an UTI to be treated?”*  
(Rhyl June 2017)

### Ends

## 22.19 Holywell feedback – detailed discussion and individual comments recorded 'on the day'

### Compliments

- 47 'There is some excellent care at the end of life – combinations of district nurses and the nurses at the Denbigh Infirmary, Marie Curie. My granddad died in December 2016. The system worked well and with the aid of the patients story book and family support he died peacefully at home .....This is what he wanted and what our family wanted – our needs were taken on board'; (Holywell June 2017)
- 45 'Good nurses appear to be 'stretched to the limit'. My mum was in Ysbyty Wrexham Maelor, she had vascular dementia. We kept her home for as long as possible. Standards of care are variable. The way members of staff are trained regarding dementia is also variable. I came across a ward where only one member of staff had received dementia training – but on a different ward 90% of staff had undertaken dementia training'; (Holywell June 2017)
- 'Nurses are good because they are nurses' – not because of the BCUHB';

*“There is some excellent care at the end of life – combinations of district nurses and the nurses at the Denbigh Infirmary, Marie Curie. My granddad died in December 2016. The system worked well and with the aid of the patients story book and family support he died peacefully at home .....This is what he wanted and what our family wanted – our needs were taken on board”*  
(Holywell June 2017)

- **42** 'I had a positive experience of caring. Crossroads were there for me when I really needed help at home. Although I did have the opportunity of receiving some social services, Crossroads have been excellent. Their 'sitting services' gave me the opportunity to take the dogs for a walk for 3 hours;' (Holywell June 2017)
- **47** 'There are some excellent people in the system, but they appear to have not been given the permission to do their best every day. There are some fantastic systems – but these are being closed down. 'Taith' had one member of staff (?) – but it is now closed. It had lots of people on its waiting list – I think it was closed down as that member of staff is no longer available';
- **51** 'Statutory services/Third sector/Mental health services – the third sector appears to be doing more than social services. General support for carers is by the third sector rather than the health services. (Holywell June 2017) Health services do not engage in the discussion about the way forward';
- **51** 'There are excellent staff doing their best. It is a systematic problem that staff are not given the opportunity to do their best on a daily basis'; (Holywell June 2017)

### Concerns and Complaints

- **50** 'If you bang on enough doors you will get people to listen – that's if you can find the right person'; (Holywell June 2017)
- **51** 'BCUHB is faceless – can't find colleagues and professionals. Knowing which doors to bang on – how difficult is it to get it right?'; (Holywell June 2017)
- **47** 'There is constant reorganisation'; (Holywell June 2017)
- **51** 'It seems as if they (BCUHB, Older Persons Mental Health) are throwing all the balls in the air and no-one knows where they have landed'; (Holywell June 2017)
- **48** 'If you can't find anyone then no-one is accountable'; (Holywell June 2017)
- **50** 'If you don't live with the problems day in day out – then you just don't 'get it''; (Holywell June 2017)
- **47** 'There is a fear of repercussions if you make a complaint'; (Holywell June 2017)
- 'Doctor knows best';

### Care Planning

- **44** 'In Wrexham – there doesn't appear to be any care plans at all'; (Holywell June 2017)
- **46** 'I have been totally unsupported over the last 4 years. It has been a very lonely journey as a carer and I feel really guilty because I can't get the help that we need for mum. I contacted my mums GP who told me to take mum in to see her. That's not easy, as my mum is very independent. I managed to get her an appointment, but I felt that someone somewhere was 'covering up'.

*“There is excellent staff doing their best. It is systematic problem that staff are not given the opportunity to do their best on a daily basis”*  
(Holywell June 2017)

*“If you bang on enough doors you will get people to listen – that's if you can find the right person”*  
(Holywell June 2017)

*“It seems as if they (BCUHB, Older Persons Mental Health) are throwing all the balls in the air and no-one knows where they have landed”*  
(Holywell June 2017)

*“If you don't live with the problems day in day out – then you just don't 'get it'”*  
(Holywell June 2017)

The GP said that he would think about referring mum, but after not hearing anything further, 6 months later I went back to the GP as mums mental health was becoming a real issue. The GP then said that he would refer mum to the 'Memory Service', I waited a further 4-5 months and was then told by the GP that they thought mum had a type of dementia. She was then referred for an assessment for Alzheimers. No help was forthcoming. Four years on I have still not had a full diagnosis for mum'; (Holywell June 2017)

- **51** 'There still appears to be 'prescribed disengagement' see reference below at BCUHB – i.e. when people are diagnosed with dementia.– there is no pathway for their care. You get some things from parts of the services but there is no pathway of care. This says a lot about peoples' attitudes to mental health and dementia.' (Holywell June 2017)
- <http://journals.sagepub.com/doi/pdf/10.1177/1471301214548136>
- **42** 'When the NHS is not there to help – but where you have been fortunate to have found help from Social Services – there is a huge lack of understanding as to what support services there are out there';
- **49** 'Social workers have a duty to put a package of care and support in place for the patient – it would seem that they are passing everything to the third sector to do – basically all they seem to be doing is 'signposting'. There is no follow up on what has been done – surely they should be 'assessing' and not 'signposting'?'
- **51** There are some locally and many others in the UK who campaign tirelessly and with an urgency for change and improvement....Not everyone has the tenacity or wants to be engaged in this way. It seems that the quieter voices remain seldom heard. That is why your work is so important and why I am sure that many are very appreciative that you have listened and enabled their voices and stories to be heard. It is my strongly held belief that many people are willing to engage in supporting organisations in ways that could lead to positive change. However this will only matter if the people in organisations are willing to listen deeply, hear and act. This requires humility!

*“It seems that the quieter voices remain seldom heard. That is why your work is so important and why I am sure that many are very appreciative that you have listened and enabled their voices and stories to be heard.”*

### Care Provision/Care Delivery

- **42** 'The help just isn't there. It should run alongside 'physical health' – you are left completely on your own. Is it just happening to me? I just don't know what to do'(Holywell June 2017)
- **52** 'Mum was on Onnen Ward at Ysbyty Wrexham Maelor in April 2015. Every day I had to make her bed, change her pad and wash her';
- **49** 'There is a real crisis in mental health – if a patient is 'sectionable' and an emergency – it seems that they will do something'; (Holywell June 2017)
- **51** 'There is something about the system that is not allowing good care to spread. There are too many 'pilots', but there are no learning processes following those pilots to see if the new systems work well. Learning needs to be shared. Putting Human Rights at the Heart of Nutrition and Hydration

2012 – BCUHB launched a revised programme for 12 months – supporting mealtimes. Where has this gone to?'; (Holywell June 2017)

- **52** 'Older people can often be reluctant to access Memory Services because they sit under the Mental Health umbrella – and they are stigmatised';
- **53** 'There is no support for families pre-diagnosis however NEWCIS used to offer an 8 week dementia course to carers for free';
- **47** 'There was a pilot around Advocacy for Older People in Flintshire and Wrexham which worked well. This was funded by Welsh Government and ran for 3 years. The pilot has now ended';
- 'Clinical staff do not understand the implications of a Power of Attorney';
- **46** 'Mum was taken to A&E where she was left in a cubicle from 5pm to 1am. It was explained to me that she should not be moved. I needed to go home and telephone A&E at 8am the next morning to see how mum was. I was told that she was not there and no one seemed to know where she was. At 9.30am I was told that mum had been taken to the AMU. I said that I would go over to see her then, but I was told that I was unable to as it wasn't visiting until x hrs. I told them that I had a Lasting Power of Attorney for mum. I was then told that I would be put in touch with the supervisor as I had been aggressive!'; (Holywell June 2017)
- **46** 'When I arrived at Ysbyty Glan Clwyd – the staff gave me dirty looks and were tutting in my direction. I was advised that they had not looked at mums 'presenting condition'. Mum told me that she couldn't feel her legs. She was discharged home later on Warfarin. 48 hours later mum was screaming with the pain in her legs. We phoned 999. We had a long wait at A&E but a brilliant nurse told us that she thought that mum had got a clot in her leg. She was later seen by a cardiologist and we were told that she had 4 clots in her femoral artery. (faced the option of major surgery/thrombolysis and transfer via ambulance between Bangor YGC and Wrexham Maelor';
- **46** 'I had a bad experience at Ysbyty Glan Clwyd – Ward 1. There is no 'care of the elderly' there. The nursing staff just ignored me and sat round the desk and appeared to be angry with me when I asked questions about my mum. I was told that mum had been 'wandering around for ages', I asked if she had had a wash and they told me that they had had no time to wash her. I asked if someone could direct me to the bathroom and the member of staff replied that she was new on the ward and didn't know where the bathroom was. Later I found multiple tablets under Mums pillow – I gave them to the nurse who said 'Oh we don't have time to monitor what happens here all of the time'; (Holywell June 2017)
- **46** 'Mum spent 3 months in hospital she just couldn't go home – I visited her every day and often found her food left at the end of her bed – I then felt that I needed to go to feed her. But there was a very strict visiting time – they didn't allow me to visit mum on numerous occasions';
- **46** 'When mum was in Holywell hospital I went in one day and found her sitting on a chair at the nurses' station. I asked why she was there and was told

*“There is something about the system that is not allowing good care to spread. There are too many 'pilots', but there are no learning processes following those pilots to see if the new systems work well. Learning needs to be shared. Putting Human Rights at the Heart of Nutrition and Hydration 2012 – BCUHB launched a revised programme for 12 months – supporting mealtimes. Where has this gone to?”*  
(Holywell June 2017)



by the staff that there and been an 'interaction with another patient' and that my mum and the other patient had to be separated. It was as if mum was sitting there like a naughty schoolgirl. There as a lack of dignity for mum – it felt like mum had been put on the 'naughty step'; (Holywell June 2017)

- **46** 'I have now had to give up work to look after mum – she has only got me';
- **42** 'In November last year my mum was taken into care. Whilst there she found some tablets (she had done this before). She had previously made 2 attempts at taking her life through overdosing. I went to her GP and was told to telephone the psychiatric nurse. So I did and the psychiatric nurse told me that he would go out and see mum, but he did ask me why we had telephoned him as there was nothing he could do'; (Holywell June 2017)
- **49** 'Within the last 6 months, the North Wales Dementia Network provided dementia training to 2 BCUHB housekeepers– they had done this during the housekeepers annual leave as they were desperate for dementia training'; (Holywell June 2017)
- **44** 'I went to see one of my clients one morning and was told by his carer that he had already had his breakfast. I checked his fridge and everything in it was out of date – I looked in his bin and could see no milk carton or bread. There was no food in his cupboard. He couldn't have had breakfast. He told me he was hungry. So I went shopping for him and fed him';
- **52** 'Where there is no continuity of care then how is it easier to monitor the care of the patient? Nobody appears to be giving one-to-one care';
- **42** 'There is a lack of help – or there just isn't any help. Mum has had vascular dementia. I have had to fight to get a CPN for her. I think she has been seen by a CPN 3 times over the last 9 years. Every time I ask for help I am told that her case has been closed or she has been discharged. When problems occur regarding her physical health then I can access district nurses for mum – but then you are completely on your own. I don't know how to deal with mums vascular dementia'; (Holywell June 2017)
- 'Alzheimers Society UK – cannot support patients until they are in receipt of a medical diagnosis not analysis';
- 'The most support we have had is from the third sector';

## Communication

- **51** 'BCUHB have a statutory duty to engage with users – but instead it relies on the huge efforts of service users to do the job that BCUHB should be doing'; (Holywell June 2017)
- 'I'm not sure what the 'way in' is. There are different pockets of information but the messages seem to start at the top and stop at a certain level'; (Holywell June 2017)
- 'There is a 'Health and Well-being' session that is held at Heddfan for patients. There was a lot of useful information being given there – I think this was run by the third sector';

*“Within the last 6 months, the North Wales Dementia Network provided dementia training to 2 BCUHB housekeepers– they had done this during the housekeepers annual leave as they were desperate for dementia training”*  
(Holywell June 2017)

*“I went to see one of my clients one morning and was told by his carer that he had already had his breakfast. I checked his fridge and everything in it was out of date – I looked in his bin and could see no milk carton or bread. There was no food in his cupboard. He couldn't have had breakfast. He told me he was hungry. So I went shopping for him and fed him”*

- 'There is a lack of communication – social workers seem to be closing cases, but not telling anybody about them. A social worker closed one case – they told the patient, but didn't bother telling the family';
- **42** 'There is no joined up communications between the health board and the third sector and BCUHB is not aware of what the third sector actually does'; (Holywell June 2017)
- 'Everything is separate – no one knows what the other is doing'; Why do you tell a patient with vascular dementia that they are being discharged – without telling their carer?'; (Holywell June 2017)

### Comments

- **48** 'Nothing ever changes – it's not about finance it's about the inability to change systems';
- **51** 'It is so distressing – this shouldn't be happening. It's not about resources – it's about a lack of leadership and a lack of calling out of things that are very wrong'; (Holywell June 2017)
- **47** 'There is an assumption that everyone has a family';
- 'Where are the boundaries of responsibility – is it with the health service? Localism is forgotten – nothing seems to change';
- 'The Dementia Strategy for BCUHB seems to be a massive wish list – they are not focusing on the real need of patients and its ability to change systems is questionable'; (Holywell June 2017)
- 'Following reorganisation of the BCUHB it has taken over 5 years for it to try to 'settle down' – this has disrupted teams and disrupted care. All sorts of things have 'gone away' or 'disappeared'';
- 'Things used to be better';
- 'There are still people giving good care – but the system does not allow the good care to spread';
- 'Flintshire County Council – Admiral Care – 2 dementia nurses but BCUHB would not fund these posts across the patch. There is now a campaign to get the Admiral Nurses across North Wales';

### Ends

## 22.20 Prestatyn feedback – detailed discussion and individual comments recorded 'on the day'

### Compliments

**63** 'Llandudno General Hospital – the care provided is very good. A new discharge pilot programme is underspent. In NHS England £75 million has been spent on reducing 'bed-blocking'. They are trying to do the same at Llandudno as a pilot – LLGH was the only North Wales hospital to take up this funding, Ysbyty Glan Clwyd refused to do so. The ward sister at Llandudno liaises with Colwyn Bay,

*“There is a lack of help – or there just isn't any help. Mum has had vascular dementia. I have had to fight to get a CPN for her. I think she has been seen by a CPN 3 times over the last 9 years. Every time I ask for help I am told that her case has been closed or she has been discharged. When problems occur regarding her physical health then I can access district nurses for mum – but then you are completely on your own. I don't know how to deal with mums vascular dementia”*

(Holywell June 2017)

*“The Dementia Strategy for BCUHB seems to be a massive wish list – they are not focusing on the real need of patients and its ability to change systems is questionable”*

(Holywell June 2017)

Abergele, and Ysbyty Glan Clwyd hospitals – all dealing with Conwy patients and looks for new patients who are medically fit for discharge. A pilot has been set up in November 2016 and will run until the end of August 2017. ICF has said it can be continued. So far only 3 referrals have come through – why not more?';

**20** 'Examples of good care on Tawel Fan – despite what has been said in the media – but this didn't come from where you would expect it to come from. It came from e.g. domestic staff. Some of the patients were unkempt and dishevelled – the housekeeping staff made more effort with these patients than the nursing staff. Housekeepers were very understanding. The nursing staff could be quite helpful at times but this would often come at the wrong time'; (Prestatyn July 2017)

**59** 'For the past year the Health Board has awarded contracts to the Carers Trust – which runs local services for families with dementia who are trying to keep loved ones cared for within their own homes for as long as possible. This is working well. There are some good initiatives that have been established in rural areas as well as urban. Used to be called Crossroads';

**59** 'Most of the good initiatives lie outside of Mental Health';

**60** 'The team working out of Ablett Unit seem to be committed staff. General feedback is that they are under pressure/stress with no support from management. Sickness absences due to stress places staff under pressure and hence this impacts on patient care. This seems to be occurring on a regular basis. There is a lack of engagement between managers and staff'; (Prestatyn July 2017)

**64** 'My only dealings with the NHS were solved at a GP practice level by a practice nurse, GP, my own GP and a psychiatric nurse, all within my local practice. The service I received was excellent, in terms of time allowed, (much more than I could have anticipated or deserved.) they were all listening friends, who listened much, spoke little and only then to guide me to my own solutions. They were wonderful.' (Prestatyn July 2017)

**64** 'As I am 84 years old my contacts with the NHS are increasingly frequent and I am totally satisfied and very grateful..' (Prestatyn July 2017)

### Concerns and Complaints

**60** 'We are trying to engage more with the BCUHB complaints team – but nothing changes – we feel quite drastically that things are going backwards with BCUHB. People are taken out of the county for care. I know of one case where an elderly lady was taken from Bryn Hesketh Hospital to Shrewsbury'; (Prestatyn July 2017)

**60** 'Meetings have been held with some Board members who have thanked us for bringing such issues to their attention – but no steps have been taken to rectify the situation'; (Prestatyn July 2017)

*“For the past year the Health Board has awarded contracts to the Carers Trust – which runs local services for families with dementia who are trying to keep loved ones cared for within their own homes for as long as possible. This is working well. There are some good initiatives that have been established in rural areas as well as urban. Used to be called Crossroads”*

*“As I am 84 years old my contacts with the NHS are increasingly frequent and I am totally satisfied and very grateful..”*  
(Prestatyn July 2017)

**61** 'My family have had to navigate through the whole complaints process – it is a shambolic system with no feedback. Everybody acts with a very corporate manner, very argumentative and trying to defend the undefendable. There are regulations but BCUHB don't comply with any of them. The Concerns Team are always defending the Health Board – they even argue about the definition of the word 'complaint'; (Prestatyn July 2017)

**62** 'I have had multiple individuals dealing with my complaints – no-one seems to want to take responsibility'; (Prestatyn July 2017)

**60** 'I often hear in a 'roundabout' way that a review has taken place – but never hear any feedback'; (Prestatyn July 2017)

### Care Planning

**63** 'The process within hospitals for discharge is chaotic to say the least. Our service provides independent advocacy and we very rarely get a referral – if so it is very last minute. There is no thought process about where is the best place for patients to go'; (Prestatyn July 2017)

**60** 'Discharge needs to be planned on arrival – there is no co-ordination as to what is in the best interests of the patients'; (Prestatyn July 2017)

**63** 'Care needs to be person centred/person shaped. We have to fight for a care plan. I wouldn't know who the person is based on the care plans that we get to read; (Prestatyn July 2017)

**60** 'There is also no proper process for discharge. It is very chaotic. It appears that BCUHB is reluctant to plan and involve others. Decisions are always made at the last minute – we are always hearing that patients are being discharged 'today' if patients have a lack of capacity – then the BCUHB/Social services are legally required to contact an advocate on behalf of the patient. I believe that there are often breaches of the Mental Capacity Act'; (Prestatyn July 2017)

**64** 'Care planning is very limited'; (Prestatyn July 2017)

**60** 'When patients are admitted on to the acute wards there is no communication and there is a lack of process on admittance'; (Prestatyn July 2017)

**59** 'Glantraeth and Heddfan – waiting times for diagnosis is appalling – up to a year. Families have to cope and cannot have access to services until proper diagnosis. Late diagnosis is really affecting peoples' minds. A GP diagnosis counts for nothing. People are paying for private diagnosis'; (Prestatyn July 2017)

**61** 'What is considered as proper diagnosis – people who are placed on wards need the tests before they can access services. People are being admitted without diagnosis and when they are showing aggressive symptoms; (Prestatyn July 2017)

*“We are trying to engage more with the BCUHB complaints team – but nothing changes – we feel quite drastically that things are going backwards with BCUHB. People are taken out of the county for care. I know of one case where an elderly lady was taken from Bryn Hesketh Hospital to Shrewsbury”*  
(Prestatyn July 2017)

*“Meetings have been held with some Board members who have thanked them for bringing such issues to their attention – but no steps have been taken to rectify the situation”*  
(Prestatyn July 2017)

*“I have had multiple individuals dealing with my complaints – no-one seems to want to take responsibility”*  
(Prestatyn July 2017)

**2** 'Our impression of using services – is that once a relative has got a diagnosis then the health services appears to ask 'what do you expect us to do?''; (Prestatyn July 2017)

**64** 'No assessments for frailty'; (Prestatyn July 2017)

### Care Provision/Care Delivery

**65** 'There is a lack of consideration from Social Services as well as the NHS. There are people in their late 50s living in older peoples residential homes – whereas they could be living in family homes. How do people find out about what is available to them?';

**64** 'I've undertaken hospital inspections in the past for an inspectorate. We found that care records are often generic and not personalised. Just another patient – not customised to individual needs';

**60** 'The 'Sofa System' option is offered to patients – ie a sofa or mattress on the floor rather than a bed in a hospital ward. The BCUHB knows about this. This is not an issue at the moment – but last winter this was happening on a very regular basis. I still feel that BCUHB has gone backward over the last 6 months. Patients from North Wales are offered beds out of area on a very regular basis – places as far as Southampton, Essex, Birmingham, Manchester, Coventry, Shrewsbury, Bradford and Newcastle are offered to patients. There is a real gap between management and what is actually happening to patients on the front line. I've raised these issues with the Vice-Chair of the Board – who has told me that they are 'looking into it'. I still have not received any feedback; (Prestatyn July 2017)

**63** 'Someone who was in A&E for 2 days and was then given the option to go to Southampton – others under police care for 2 days – that is not uncommon. A&E is being used like a waiting room at Ysbyty Glan Clwyd. The person who was waiting for 2 days had made attempts to take their own life during that time; (Prestatyn July 2017)

**60** 'There was one lady who required a 'specialist bed' – the only one that was available was in Essex – when the patient arrived in Essex the bed had gone; (Prestatyn July 2017)

**62** 'My mum's continence deteriorated significantly after she was admitted to Ysbyty Glan Clwyd. Mum has dementia. After a week of being in Ysbyty Glan Clwyd she was using continence pads. People kept asking her questions she couldn't answer. She was woken up once to have her bloods taken and she lashed out – because of this she was labelled 'aggressive' My mum was at Ysbyty Glan Clwyd – in a side-room to a ward. I always felt that I was overstepping the mark when I was there. There was no process for her discharge. She went from being completely continent to incontinent and deteriorated over a period of a week after being admitted to YGC. No dignity and no respect – no-one seems to understand the knock on effect. She is now in a residential home'; (Prestatyn July 2017)

*"Our impression of using services – is that once a relative has got a diagnosis then the health services appears to ask 'what do you expect us to do?'"*

(Prestatyn July 2017)

*"Someone who was in A&E for 2 days and was then given the option to go to Southampton – others under police care for 2 days – that is not uncommon. A&E is being used like a waiting room at Ysbyty Glan Clwyd. The person who was waiting for 2 days had made attempts to take their own life during that time"*

(Prestatyn July 2017)



**62** 'Mum who has OPMH has frequent falls – kept on presenting at A&E over 3 days. It was noted that she was 'challenging'';

**62** 'People don't seem to be much better following their discharge from hospital';

**62** 'On the Dinerth ward – there were no activities or holistic care. Ethical care should be at the heart of everything we do – rather than a 'what do you expect me to do' approach';

'There is a gap between management and frontline staff'; (Prestatyn July 2017)

**61** 'There is talk about the dementia butterfly scheme – but it is not really there in practice. Some say that they shouldn't be using this scheme. In one community hospital this was stopped as relatives felt that it was stigmatising patients. In others the system was chaotic and staff had received no training on how to use it. It doesn't seem to mean a thing – I think it is now 'yesterday's flavour'; (Prestatyn July 2017)

**61** 'Johns Campaign would have been so much more use to us as families in Tawel Fan. We were told that it has been rolled out across the BCUHB. The patients were supposed to have protected mealtimes – but this shouldn't be from relatives';

**62** 'I was able to visit mum at any time – but her food had just been left there so I needed to help her with eating her food. You feel as if you are overstepping the mark'; (Prestatyn July 2017)

**63** 'Dignity and respect seems to be very low on the BCUHB's horizon – when no families are involved it is down to the nurses. There are huge clumps of people who don't talk to one another and a reluctance to try new services. Often people are not given any options'; (Prestatyn July 2017)

**60** 'Patients' notes are not filled in around the person – they are just filled in automatically as a tick-box exercise'; (Prestatyn July 2017)

**61** 'Medical records – don't even record accurately the medication – not alone the care-plans. Medication is often left on the side of patient beds. Amoxycillin wasn't even available in one hospital!';

**60** 'My wife works as front line staff – they are being squeezed and squeezed – they have had no pay rise in the last 5-6 years. They are under relentless pressure, are disillusioned and stressed. There has been re-organisation after re-organisation. They are facing having their positions downgraded and are so disillusioned with it all'; (Prestatyn July 2017)

**65** The way patients are treated is the same as the way staff are treated – with a lack of humanity/lack of respect and a lack of dignity'; (Prestatyn July 2017)

*“I was able to visit mum at any time – but her food had just been left there so I needed to help her with eating her food. You feel as if you are overstepping the mark”*

(Prestatyn July 2017)

**61** 'You need to stay balanced – we've had some experiences of cultural issues in mental health and it can be seen that they are all to do with matters such as lack of candour, lack of transparency, lack of trust in management and in staff – in the corporate body. Lack of empowerment – you feel as if you are in a strait jacket';

**60** 'There is very little for the younger people with onset dementia. There was a 35 year old who had Alzheimer's but was unable to access services for years';

### Communication

'Communication is poor. People aren't informed of their rights';

**60** 'I understand that CANIAD undertook a recent survey of inpatients and had about 15-18 responses';

**80** 'Communication with the Health Board is difficult. There is very rarely somebody to contact if you have questions about anything'; (Prestatyn July 2017)

**80** 'Whenever you read something about the Health Board in the press – there is always mention of a 'spokesperson' – it's as if no-one wants to stand up and take ownership when there is bad news. It is faceless'; (Prestatyn July 2017)

**61** 'Letters from the Health Board always arrive on a Saturday. You are left to wait over the weekend until you can contact someone if you have any questions about what is said within the letter as offices are closed. When you do phone up on a Monday it's as if no one wants to talk to you or no one is aware of the matter'; (Prestatyn July 2017)

**65** 'There is just this sense of secrecy about everything it does'; (Prestatyn July 2017)

**60** 'A rosy picture is painted that the board wants to portray regarding 'wonderful services' – different projects, different press releases. The background is chaotic. What is going on behind the scenes doesn't match the rosy picture that is portrayed. Communication is dreadful. We asked for information about mortality rates – the Health Board didn't provide us with this for 12 months'; (Prestatyn July 2017)

**61** 'It is all spin'; (Prestatyn July 2017)

**80** 'Health Board always gives the impression that 'it knows best'';

**64** 'There is a one way traffic system – the doctor knows best if it is a patient issue, the health board knows best if it is a staff issue';

*“My wife works as front line staff – they are being squeezed and squeezed – they have had no pay rise in the last 5-6 years. They are under relentless pressure, are disillusioned and stressed. There has been re-organisation after re-organisation. They are facing having their positions downgraded and are so disillusioned with it all”*  
(Prestatyn July 2017)

*“Whenever you read something about the Health Board in the press – there is always mention of a 'spokesperson' – it's as if no-one wants to stand up and take ownership when there is bad news. It is faceless”*  
(Prestatyn July 2017)

65 'It is has dark sinister methods of communication. BCUHB ignored me – I went private –it was money well spent as I ended up having a proper diagnosis for my husband. On the Ablett Unit– they changed records/lost notes. I made complaints but this fell on deaf ears. I know that they were sending people out of area. This to me is dark and sinister – is so that patients are out of sight out of mind – is that why patients are being sent out of area?';

65 'I feel as if I have to keep my mouth shut or they might remove me as a carer'; (Prestatyn July 2017)

#### Comments

61 'I've seen the final draft of the so called Dementia Strategy. It looks like a wish list and some are just a list of basic human rights. There is no mention about raising an awareness of dementia and evidence that BCUH have considered the outcomes for patients. There is no evidence of any milestones set down in the strategy'; (Prestatyn July 2017)

64 'BCUHB just comes up with a mish-mash of strategies – which don't dovetail';

60 'There is very much a defensive mentality at Board level – they are not allowing staff to use any initiatives in improving individual wards'; (Prestatyn July 2017)

64 'There is a lack of imagination on the part of the Board – criticism of the Board is always taken as an 'unfair' approach'; (Prestatyn July 2017)

61 'There doesn't seem to be any improvements relating to care since Tawel Fan – although some staff are conscientious'; (Prestatyn July 2017)

60 'Everything we do as an organisation is outcome based. We can demonstrate and justify our service. BCUHB just don't do that';

61 'There are cultural issues seen in the Mental Health services at BCUHB that can be seen across the health board. A lack of transparency, a lack of candour and a lack of trust in the ability of staff to improve services. Because the BCUHB is very corporate it has very much a strait jacket approach'; (Prestatyn July 2017)

60 'Our contracts are longer than the dementia strategy! Dementia should be treated in the same way as a cancer diagnosis';

64 'If you're not a person who can push back against the system – you just get covered in the noise'; (Prestatyn July 2017)

61 'BCUHB – some members of the Board have been there so long. There is a lack of humanity, dignity and respect. We have a lack of trust in the Health Board and its top down/doctor knows best approach';

*“It is all spin”*

(Prestatyn July 2017)

*“BCUHB just comes up with a mish-mash of strategies – which don't dovetail”*

*“If you're not a person who can push back against the system – you just get covered in the noise”*

(Prestatyn July 2017)

64 'BCUHB is always in defensive mode – not looking to change and how it can improve patients' experiences'; (Prestatyn July 2017)

64 'They are incompetent and lacking in imagination – just reinventing themselves. (Prestatyn July 2017)

64 'No imagination, no flair, dead-hand on the tiller'; (Prestatyn July 2017)

60 'So much negativity – staff won't come to North Wales – there is nobody brave enough to take it on';

64 'When Donna Ockenden submits her report to BCUHB – will they be able to accept it? Will they accept what is being said within it? Can the BCUHB challenge the opinions provided within the report; (Prestatyn July 2017)

Overview of compliments received about the provision of Mental Health services across North Wales

### Compliments:

Praise for an Independent Advocate with MIND, local Assembly member, specialist cardiology nurses and some Doctors on Dinas Ward. (Family 65)

### Compliments (Family 65)

- 'My husband got help from an independent advocate from MIND she was excellent, she was brilliant in presenting the case for the abuse that he was receiving';
- 'Our AM. She was brilliant';
- 'The Heart Failure Nurses were brilliant they didn't mess about.';
- 'A couple of the Doctors on Dinas Ward were excellent';
- 'They were brilliant at Bryn y Neuadd in Llanfairfechan';

### Compliments (Family 74)

- 'My husband received good care at the Memory Clinic at Bryn Hesketh hospital';
- 'Ward 12 at Glan Clwyd were really good I can't complain about them at all';
- 'Everything I've got to say about the Community Health Council is positive – you need that personal touch because if it becomes like a call centre people don't know you from Adam when you ring up. Well, when I ring I don't have to';
- **Compliments:** Praise for the Memory Clinic at Bryn Hesketh Hospital, Ward 12 at Ysbyty Glan Clwyd and the North Wales Community Health Council. (74)
- The Alzheimer's Society is brilliant. It's somebody to talk to who understands the problems';

*“They are incompetent and lacking in imagination – just reinventing themselves.”*  
(Prestatyn July 2017)

*“No imagination, no flair, dead-hand on the tiller”*  
(Prestatyn July 2017)

*“My husband got help from an independent advocate from MIND she was excellent, she was brilliant in presenting the case for the abuse that he was receiving”*

- A Psychiatrist, I think he's quite new in post he was very good with my Dad to be fair, very very good. The atmosphere in the appointment was very relaxed, very informal and he spoke to my Dad and asked my Dad questions. He didn't just address them to me, he spoke to Dad, you know he made my Dad feel very included in the conversation';
- 'They are brilliant at the Dolgellau Hospital and at the Minor Injuries Unit, I don't know what I would do if that went because dad's prone to falling. The staff at the hospital, the Nursing Staff and the Healthcare Assistants Donna are absolutely fantastic – they know my Dad, they know the issues, they know exactly how to treat him, exactly how to talk to him. It's just the care that they give is absolutely amazing'; (71 and 72)
- 'I work closely with CPNs and up here I think they are brilliant, but there is not enough of them and I think they are under tremendous pressure. They are doing the best they can. I am only criticising the fact that there's not enough of them and the process of accessing them';
- 'At the Bodnant in Llandudno Hospital and at Bryn Hesketh Hospital and at Glan Traeth. On a personal level, I get on really well with the Staff there'; (3)

*“I work closely with CPNs and up here I think they are brilliant, but there is not enough of them and I think they are under tremendous pressure. They are doing the best they can. I am only criticising the fact that there's not enough of them and the process of accessing them”*

## 22.21 Timeline for case study 1 – Family 21

Date	Details
21st to 23rd August 2012	Healthcare Inspectorate Wales (HIW) Mental Health Act monitoring visit at the Hergest unit. HIW says 'there was limited time for staff – patient interaction. Staff acknowledged that due to pressures on their time that occasionally they were required to prioritise patients and felt that they may respond to patients that were more demanding rather than those patients that required the assistance.' (HIW, 2012 page 20.)
July 2013	Patient admitted to Hergest Unit.
4th September 2013	Letter from staff F in response to a request from staff Z to assess the patient. The letter explains staff F visited the patient on three occasions (25th August 2013, 28th August 2013 and 2nd September 2013). Staff letter F details that the patient presented differently on each of the three occasions and gave an outline of the patient as presenting with fairly acute onset of mental health problems, mental state and cognitive functions which fluctuate, can present as anxious and depressed, and may have cognitive impairment as well as organic mood disorder. Staff F also added 'a more detailed repeat neuropsychological assessment could be useful to help identify possible early dementia'.



Date	Details
27th November 2013	Patient discharged from Hergest Unit, not under section 117 of the Mental Health Act or with NHS Continuing Healthcare, resulting in the patient's spouse being liable for the costs of the detained patient. BCUHB confirmed to the family 26/6/17 there were "gaps in the notes/" "no records of assessment by EMI staff", "surprised that arrangements had been made" in absence of other key professionals. "There was no discharge plan" "there was no record of a discharge meeting or MDT" the family were not asked to attend one. The Family was told at the time that this was not irregular, "anyone could have removed her" because she was an informal patient, a "voluntary Patient" though it was recorded she did not have capacity and "her begging "to take me home" was in there".
27th November 2013	Patient detained in X EMI.
January 2014	Robin Holden Hergest Report (commissioned following staff concerns/ whistleblowing policy), completed.
March 2015	At an MDT meeting staff AA who worked under staff Z attended and confirmed the patient now had 'advanced dementia'. Those present and staff at X had not previously had a diagnosis of dementia and the manager of X EMI questioned this diagnosis as it was the first time they had been notified, and confirmed they had associated the patient's most challenging behaviour with frontal lobe damage from a car collision in 1980 and queried if staff letter AA understood the significance of this?
19th March 2015	A telephone call took place between staff AD and the patient's son during which staff AD was asked to confirm if the patient would be moved if funding was successfully obtained,. Staff AD confirmed this but when referred to the WAG guidance acknowledged she had contradicted the notes with which she was familiar. Staff AD is said by the family to have closed the patient's case never having met the patient or patient's family.
16th March 2016 16.18	Staff Y sent an email to patient's son following the telephone conversation (15th March 2016), giving apologies for the response which did not answer all of your questions.  Further questions have been forwarded to those involved in the initial investigation of your concerns with a request that they address these, and have also requested a copy of the letter you have asked for and dates of cancelled meetings, and will contact you again shortly.
16th March 2016 18.28	Patient's son sent an email to staff Y confirming the family did attend some meetings to find some had been cancelled, but also key members of the team were not in attendance sometimes only the family were in attendance. The family were not informed when some team members changed and therefore would appreciate a list of meetings which took place and who attended.
17th March 2016	Staff Y sent an email to patient's son confirming email has been passed to the relevant team for response.

Date	Details
24th March 2016 16.08	<p>Patient's son sent an email to staff Y explaining during a conversation with Concerns Team, we have been told there is nothing more the team can do regarding this matter until a copy of the letter, dates of meetings and attendees/non-attendees are provided by other departments. Son also requested that there must be something the team can do to prompt a response?</p> <p>Son said – we have waited four months for a response, then following that response three weeks for a promised call from staff T and a week since a copy of a letter quoted in staff T's response was also promised.</p>
29th March 2016 11.08	Concerns Team sent email to patient's son confirming email has been passed to the relevant team for response.
29th March 2016 12.24	Patient's son sent email to Concerns Team requesting copy of the letter promised two weeks ago, the dates of meetings and who was/was not present and still awaiting a call from staff T promised on 3rd March 2016.
13th April 2016	An MDT meeting took place at which the team used the NHS Continuing Healthcare Decision Support Tool to assess the patient. A copy of this has now been passed to the family, the patient, though judged not as she presented but given what all agreed was an improved drug regime, scored two 'severe' and a High, when asked if this indicated eligibility a senior member of staff confirmed this at the time but stated "it does not matter what we put down They (NHSCHC) won't pay it"
27th April 2016 12.42	<p>Patient's son sent email explaining it is now a month since we requested a chronology of assigned team members to the patient. Not all meetings attended by the family were attended by the full team members.</p> <p>The Concerns Team referred to a letter of 5th November 2015 confirming the patient's case was closed, but the family have seen this letter.</p> <p>Further explaining the details of the discussion at the MDT meeting on 13th April 2016 at which the patient's team (querying if case has been re-opened?) used the NHS Continuing Healthcare Decision Support Tool to assess the patient. Most of the participants present were not familiar with this, and its purpose was not explained. Following this meeting a member of the team confirmed it was being used out of context and informally, to assess if X EMI was meeting patient's needs, which the family and X EMI staff have confirmed. The MDT agreed, the patient can remain at X EMI, the patient scored two high and one severe using the Decision Support Tool (and the care and medication the patient is receiving is now resulting in lower scores), staff AC and staff L agreed had an assessment been completed correctly in October 2013, the patient's score would have justified NHS Continuing Healthcare funding.</p>

Date	Details
4th May 2016 10.16	<p>Patient's son sent email to Concerns Team explaining legal advice is being sought and therefore require information regarding patient's assigned team members (including dates) and meetings attended/not attended. The family were not contacted by some team members or notified when they changed. It is also unclear if some team members ever met the patient.</p> <p>Noted it is two months since this information was requested.</p>
30th May 2016	<p>A further MDT meeting took place at which staff AI stated with reference to the patient being eligible for funding, 'water under the bridge', because staff had not followed assessment procedures at discharge there would be no funding' and "her weakness now means she is less able to inflict harm, she is easier to control so her score would go down another NHSCHC would be pointless". Staff AI also stated there would be no retrospective review of funding as "BCUHB do not carry out such reviews".</p>
19th June 2016	<p>Patient died in X EMI.</p>
23rd June 2016 10.53	<p>Patient's son sent an email to the BCUHB Concerns Team explaining it is four months since information was requested, and patient has now died.</p> <p>Requesting information regarding the patient's discharge from Hergest, the patient's weight loss, feeding not being monitored, and as agreed by all members of the MDT meeting at X EMI that the patient should have qualified for NHS Continuing Healthcare funding.</p>
23rd June 2016 11.43	<p>Patient's son sent an email to staff H and staff AG at BCUHB citing the email sent on 23rd June 2016 to the Concerns team, explaining failure to implement NHS Continuing Healthcare, failure to follow protocols, assumptions made within BCUHB that only people in nursing homes could qualify and qualifying would result in a patient having to be moved from current home regardless of the patient's best interests. Further explaining that in February 2016, staff AA said that there was no point in applying as patient would not score high in any category used on the Decision Support Tool, when it was applied the patient had to be scored down in order to remain in current home and it was confirmed that patient would have qualified for NHS Continuing Healthcare.</p> <p>The patient's family have asked for more details regarding letters and associated staff but this request has gone four months without a response. The email ends explaining the patient has died.</p> <p>No response received</p>
14th February 2017 14.47	<p>Patient's son and sent email to staff G, staff S and staff AB providing an attached precis of all concerns. Significant issue cited is that the patient had acute mental illness, not dementia and therefore the patients need should have been met under NHS Continuing Healthcare.</p>

Date	Details
3rd May 2017	Staff Q sent an email to patient's son confirming have been searching for 2012 Hergest Inspection report and that there has been redevelopment work on the website and cannot find the report, and asking if patient's son has seen it and could provide the month in which it took place?
3rd May 2017 12.32	Patient's son sent an email to staff Q providing month of HIW inspection, (August 2012). This is known because a subsequent report refers to unresolved matters from the August 2012 inspection and explaining reasons for requesting it.
8th May 2017 10.01	Patient's son sent an email to staff N explaining awaiting promised phone contact from your team. Staff upset to discover that the 2013 HIW inspection highlights issues raised in the Hergest unit which had been highlighted in 2012
9th May 2017 7.47	Patient's son sent an email to staff AE requesting a copy of 2012 inspection of Hergest Unit which has been removed from HIW website, which was promised two weeks ago, and also explaining none of his calls have been answered.
9th May 2017 9.01	Patient's son sent an email to staff U urgently requesting copies of 2012 Hergest Healthcare Inspectorate Wales Inspection Report, 2013 audits and Robin Holden 2014 Hergest Report prior to meeting Donna Ockenden the following day.  Also explaining the issues with the patient's discharge from Hergest which consequently resulted in the patient becoming self-funding and the impact of this on the patient's spouse.
9th May 2017 10.56	Staff AE sent an email to patient's son explaining understand that staff Q has responded to your request this morning.
10th May 2017 8.16	Patient's son sent an email to staff U and staff E requesting copies of 2012 Hergest Unit HIW Inspection Report, 2013 audits and Robin Holden 2014 Hergest Report.
12th May 2017 17.52	Email sent from staff E to patient's son apologising for not responding within the requested timescales and explaining the 2012 Hergest Inspection Report was marked as 'restricted' by HIW as was their practice at the time as reports could contain information which could identify individual patients. Also explaining BCUHB have made a decision to withhold the full Holden investigation under Section 14 of the Freedom of Information Act and providing a redacted version of the summary and recommendations.

Date	Details
22nd May 2017 9.22	<p>Patient's son sent an email to staff G, staff S and staff AB explaining it is approaching a year since patient died and that staff AB had made contact after patient's son had written to staff AG.</p> <p>It is now ten months since submitting the NHS CHC request and 14 weeks since submitting attached complaint. Wish to expedite this matter. Providing dates when staff K is able to attend a meetings. Also reiterating patient was not a dementia patient but acutely mentally ill. Staff R, has explained to the patient's son the decision to section or not to section the patient would have been made by Hergest staff.</p>
22nd May 2017 14.47	<p>Patient's son sent an email to staff G, staff S and staff AB providing an attached letter detailing (over 16 pages) all concerns with photographs and the letter from staff F to staff Z dated 4th September 2013 providing her assessment and opinion of patient's mental health.</p>
23rd May 2017	<p>Staff B sent a letter, to staff K explaining a request had been received from staff W for patient's family to complete a form to give consent for GP records to be obtained and requesting that staff K arrange for the form to be completed.</p>
23rd May 2017 15.41	<p>Patient's son sent an email to staff E and staff U thanking staff E for response of 12th May 2017 and confirming family understanding the necessity of confidentiality in reports, and that only requires to them as unable to resolve past issues because BCUHB have not recognised or resolved the consequences of failing highlighted in those reports. On seeing reports and redacted summary 'they painted a picture of Hergest Unit at a time when (the patient's) stay on the Hergest unit was a matter of deep concern', and reiterating that the patient lost weight (was not weighed whilst on the unit), other patients (not staff) informed the family the patient had made a suicide attempt with window blind cords, the patient deteriorated significantly physically, and the Unit had an 'environment and demanding patient mix' which did not meet the patient's needs.</p> <p>The patient should have received on-going funding but processes were not followed on discharge.</p>
26th May 2017	<p>Patient's son received a consent form to complete from BCUHB CHC team in order to gain permission from the family to access patient's medical records.</p>
26th May 2017	<p>Staff A sent a letter to patient's son providing clarification regarding Hergest Inspection Report following Mental Health Act monitoring visit 21st to 23rd August 2012.</p>



Date	Details
29th May 2017	<p>Patient's son sent email to staff E explaining this is to provide an update on developments: on 26th May 2017, received a request from staff W via Concerns Team, via Community Health Council to again complete and submit a consent form, (already completed last year) in order, at that time for BCUHB to look into a three year old case. It is now a year since patient died, so were able to submit form 'without the threat' of the patient being returned to Hergest.</p> <p>It is now ten months since the application was made and was promised an update on progress which has not been received, and also await confirmation of meeting with staff AB and staff G promised by email on 16th December 2016.</p> <p>Son compared dealing with BCUHB as 'a Kafkaesque nightmare'.</p>
11th June 2017 12.49	<p>Patient's son sent an email to staff E and staff U, stating that it is three weeks since writing to you and would appreciate a response. Providing the following timeline to date:</p> <ul style="list-style-type: none"> <li>• Three years since funding for first requested, 22 months since the Older Persons Commissioner wrote to BCUHB, 17 months since requesting Concerns Team provide for timeline and responsible personnel, ten months since submitting a request for a NHS Continuing Healthcare review, four months since resubmitting a complaint summary.</li> </ul>
13th June 2017 10.20	<p>Staff V sent an email to patient's son confirming as per telephone conversation today, on-going concerns are being dealt with by the Concerns team and as per the 'Putting Things Right' process.</p>
13th June 2017 11.23	<p>Patient's son sent an email to staff V explaining 'we did not have a conversation' you just repeated the phrase 'I can confirm that your on-going concerns are being dealt with via our Concerns Team and per our 'Putting Things Right' process', to each question asked and then 'hung the phone up on me'.</p>
13th June 2017 11.25	<p>Patient's son sent an email to staff E explaining the family's experience on Hergest Unit the day they were informed of the patient's suicide attempt. Another patient told the patient's son and his wife that the patient had tried to hang them self and a second patient gestured across their throat. They explained that the patient had tried to use the window blind cords in the dining room as a ligature. Not knowing whether to take this information seriously initially, the family later discovered this account to be correct and that "her suicidal intent was recorded" this incident appears to have been addressed by staff F in her assessment. Although it would not have been easy for staff to tell the family about the incident, hearing about it from other patients, and not knowing whether to believe the information to be correct, caused the family deep distress.</p>

Date	Details
18th June 2017 15.37	<p>Patient's son sent an email to staff J explaining has been given a message by staff V, that after his first response, staff E's intention is not to reply to my emails, which ask legitimate questions.</p> <p>Was also promised a call back by the Corporate Management Office, (BCUHB) but this has not happened.</p> <p>Explaining the patient's history from their time in Dryll Y Car and four months spent on Hergest Unit including the patient's drop in weight to just over six stones and suicide attempt with window blind cords.</p>
26th June 2017	<p>At a meeting with son and spouse were told:</p> <p>BCUHB confirmed to the family 26/6/17 that the discharge had been improper</p> <p>There were "gaps in the notes" "no records of assessment by EMI staff", professional involved was "unaware that the transfer had been arranged without necessary discussions" and was "surprised that arrangements had been made" in their absence. "There was no discharge plan" "there was no record of a discharge meeting or MDT" the family were not asked to attend one. The Family was told at the time that this was not irregular, "anyone could have removed her" because she was "an informal patient", a "voluntary Patient" though it was recorded she did not have capacity and "her begging "to take me home" was (recorded in writing) in there".</p> <p>There was no record of decisions many notes were missing including District Nurse and Social Services and the EMI home records.</p> <p>The Investigator simply could not find records of decisions or assessments</p> <p>Told at meeting 'if it is not written it is not given'</p> <p>There is no record of why she was being discharged. One member of staff claimed family collected patient without agreement, In fact Staff at Hergest had actually taken her the next day to the EMI home as when family arrived "as agreed" staff had not completed procedures and asked family to collect her the next day which they could not do</p> <p>Staff confirmed MUST<sup>261</sup> Procedures and "plate" records were done at Dryll Y Car but not in Hergest (intake of food or refusal was a fundamental agreed and understood by all as manifestation of the patient's condition.)</p> <p>It was stated by a staff member 'Someone had "written all the weights down on one sheet of paper in the one biro in the one handwriting"</p>

<sup>259</sup> See Glossary

Date	Details
10th July 2017 12.38	Patient's son sent an email to staff G, requesting that an included email is forwarded to staff F. The email explains the history of the patient's illness, their time in X and Hergest, and that the patient's family did not consider the patient symptoms and behaviours to be similar to other family members who had been diagnosed with dementia. Therefore, was staff F of the opinion that the patient had dementia and was not eligible for funding?
25th July 2017 11.43	Patient's son sent an email to staff G explaining have spoken to staff F's secretary who has confirmed they had not received this email, and asking for it to be forwarded.
30th July 2017 16.00	Patient's son sent an email to staff F explaining as you do not appear to have received the email staff G was requested to forward, now writing directly to you. Citing what had taken place regarding the patient and the first diagnosis of dementia was in March 2015. All parties now agree that procedures and assessments were not followed and as a consequence the patient became self-funding and asking if staff number F assessed the patient as having dementia?
15th August 2017 9.30	Patient's son sent an email to staff E asking why staff F has not responded to his email of 30th July 2017?
16th August 2017	<p>From patient's son to staff E explaining was informed 'notes would not be brought to the meeting' and requesting clarification as at meeting 26th June 2016 BCUHB investigators stated they could not answer specific questions as they had not been able to access notes, were they not available?</p> <p>None of staff actions from 26/6/were completed – they were to report on weight loss and on all records not gathered for original meeting</p> <p>On 15th son was told "would not be a meeting the following Day" there would not be discussion staff would tell Family what the outcome was and what actions would be.</p> <p>She gave notes "exonerating" records to CHC rep in fact they showed untenable weight changes at time of admission when family originally were told she wasn't weighed and then records "appeared".</p> <p>Son attended meeting waited 40 minutes after scheduled start time outside room allocated and he was told to attend night before. Established the venue had been changed that morning but no note was posted at the meeting room where he was on time and for forty minutes after scheduled start.</p>

Date	Details
24th August 2017	<p>Staff K sent an email to patient's son stating that they had sent a text to staff G to check if response was on track? Also confirmed by staff G to staff K that there were conversations between patient's son and staff M, and that staff number M had only contacted staff F yesterday (23rd August 2017) which was the earliest opportunity.</p> <p>BCUHB withheld "wholly inappropriate response drafted by staff" Family later told not to contact staff.</p>
7th September 2017 8.02	<p>Patient's son sent an email to staff AB explaining it is now ten weeks since we met, three weeks since our last scheduled meeting and two weeks since a delayed response was promised to the original complaint submitted in September 2015.</p> <p>Family originally asked for NHS Continuing Healthcare in October 2014 and repeatedly stressed the urgency was due to the patient's spouse's mental and physical decline, and anxiety about money. The patient's spouse has since died.</p> <p>Staff had been unable to complete the procedure as there was no formal discharge from Hergest, although the patient was taken to X by BCUHB staff. The family have been told if procedures had been followed that claim would be deemed valid, but the review team would base their decision on the patient's medical records, but reviews were not completed, other than the review undertaken on 13th April 2016 which has now been mislaid.</p> <p>The son responded by saying that as records of weight etc. from the Hergest unit were (the family believed) inaccurate, then were the remaining patient records inaccurate and may have been amended. Therefore no review of the CHC funding should proceed pending investigation of that matter.</p>
7th September 2017 8.39	<p>Patient's son sent an email to staff M stating it is now ten weeks since meeting with staff AB and staff G.</p> <p>On 15th August 2017 Patient's son had asked staff E's office if an information request to staff F was being 'refused or ignored' but have not yet received a response.</p> <p>Also stated is the belief that adherence to 'Duty of Candour' should have resolved this issue years ago, but staff M indicated that this, (Duty of Candour,) is not a legal requirement in Wales.</p> <p>Further explaining that has asked for matter not to be passed to the 'Putting Things Right' team as their failures have added to the issues, and had only requested a 'watching brief' so progress could be monitored without interference and citing the email sent by staff K on 24th August 2017.</p>

Date	Details
7th September 2017 10.32	Staff M sent an email to patient's son explaining BCUHB will send response shortly and once this is received a meeting will be arranged for you to meet with the Nurse Director or her deputy to discuss concerns.
7th September 2017 11.28	<p>Patient's son sent email to staff M and staff AF requesting senior staff member is made aware of concerns, attaching a weight chart for patient which had been given to staff K and explaining that have been trying to secure patient's spouses money (having paid for the patient who qualified for NHS Continuing Healthcare) for four years and now dealing with this as an executor to the patient's spouse's estate following his death.</p> <p>Confirming a complaint was sent to the Older Persons Commissioner in 2015, and requesting a meeting with staff M.</p>
7th September 2017 11.53	Staff M sent an email to patient's son explaining the Nurse Director is aware and staff AF will be in touch to arrange a meeting.
8th September 2017 9.32	Patient's son sent an email to staff D thanking them for telephone call yesterday which was reassuring and looking forward to meeting you. Further explaining that had a similar reassuring conversation with staff AB nearly 15 months ago, but written communication from staff AB has been minimal.
11th September 2017 9.06	<p>Staff AB sent an email to patient's son explaining that their understanding is that Concerns department are preparing a full response and the retrospective view has been expedited by the Continuing Healthcare Retrospective Team.</p> <p>Also giving apologies for the confusion regarding the meeting room, and also giving condolences for the loss of both parents in such a short space of time.</p>
11th September 2017 9.37	Patient's son sent an email to staff AB, requesting details of a contact in the Continuing Healthcare Retrospective Team, as cannot agree with their commencing using methodology you advised as the significance of information wasn't recognised given its context.
11th September 2017 10.03	Staff I sent an email to patient's son explaining further to your conversation with my deputy (staff D) now looking to reassure you on the actions now being taken which include connecting you with the most senior member of staff, staff AH, who intends to meet you and apologising for distress caused.



Date	Details
11th September 2017 11.04	<p>Staff AH sent email to patient's son, stating staff I and staff AB wish to offer sincere apologies for any distress the process has caused to the patient's family and explaining having reviewed the evidence, Staff AH believes we must concede our failure to apply the Continuing Healthcare process correctly and confirming 'I would concur with your observation that there was evidence in this case of a real cultural misunderstanding around CHC'.</p> <p>Also requesting a meeting with the patient's son and Community Health Council representatives to provide an apology and information about the changes which have been put in place, and to seek valuable feedback from your experiences to inform further improvements and confirming staff S will be in touch with you.</p> <p>Also explaining that understands that patient's son has raised concerns with staff AB regarding 'quality, type and robustness of the evidence that would be reviewed as part of the retrospective process.</p>
11th September 2017 12.32	<p>Patient's son sent an email to staff AH, staff I, and staff AB explaining had been in contact with staff S and had agreed with them regarding rules and implementation of NHS Continuing Healthcare.</p> <p>Also attaching information about patient's weight and requesting a reconvening, to include staff K.</p>
24th November 2017	<p>Staff D sent email to patient's son explaining currently in a meeting, will call during a break, further explaining that the concerns letter has been paused from being sent as currently awaiting a meeting with staff AH, and suggesting a meeting with staff I and Staff AM, and will request that staff AF organises this.</p>
24th November 2017	<p>Staff AF sent email to patient's son providing potential dates for a meeting and requesting confirmation regarding if either are convenient?</p>
24th November 2017	<p>Staff K sent email to staff AF, staff D, patient's son, and copied to staff I, Staff AM and Staff AL suggesting their availability on one of the dates.</p>
24th November 2017	<p>Patient's son sent email to staff K, staff D, and staff AF, copied to staff AL, staff AM and staff I explaining concerns regarding the length of the meeting being insufficient and suggesting he provides a brief agenda.</p>
27th November 2017	<p>Staff AF sent email to patient's son and staff K confirming date of meeting.</p>
27th November 2017	<p>Patient's son sent email to staff AF and staff K copied to staff AM and staff D confirming he is free to attend either of the days suggested and understands the difficulties of time available and will leave it to staff D and staff I to say how much time they will set aside.</p>
18th December 2017	<p>Staff AF sent email to patient's son and staff K copied to staff AM, staff I, staff AS and staff AL explaining both staff D and staff I are ill, so will need to rearrange meeting in the New Year and offering the date of 8th January 2018.</p>

Date	Details
18th December 2017	Patient's son sent an email to staff AF expressing disappointment and asking if the meeting could be organised to take place nearer to Bangor.
5th December 2017	Patient's son sent an email to staff D copied to Staff I and Staff K regarding minutes of meeting held on 31/5/16 recently given to him by BCUHB which the patient's son believes to be wholly incorrect/untrue record of care and treatment patient received and expressed significant feelings of anger with regard to these minutes.
5th December 2017	Staff D sent an email copied to staff M and Staff K explaining will call patient's son later today.
5th December 2017	Patient's son sent an email to staff D copied to Staff I and Staff K outlining each key point and paragraph of the minutes of 31/5/16 regarding care and treatment patient received and how these minutes are not a correct/true record of the care and treatment patient received.

The record of interaction between the family and anonymized staff within BCUHB ends as of December 2017 but the family concerns has not yet been investigated, although BCUHB have recently, (May 2018) agreed to an external investigation outside of the Health Board which is yet to commence.

The family have had interaction with more than 35 members of staff in BCUHB in trying to get answers to their concerns and are deeply distressed by the way they have been treated by BCUHB over a period of several years.

## 22.22 Case study 2 Concerns and Complaints in DoLS: (2 of the '7' C's)

With reference to the DoLS process, service user representative number 42 told the review team that the review into the formal complaint made by the family and the next of kin failed to include relevant information from the complainant pertaining to the complaint. 'Can you imagine my absolute horror when I had time to sit and read the assessment in its entirety to find information that is shown to have been given by me, which I had not given, outdated information that had been made to appear relevant to the current situation and a lot of statements that said, I was not able to cope with or look after my mum?' (Service User Representative number 42, in conversation Holywell June 2017.) Service user representative 42 explained that there were significant delays in the complaint resolution process and inaccuracies in information relating to the complainant and a continued lack of communication with the carer and wider family.

*“Can you imagine my absolute horror when I had time to sit and read the assessment in its entirety to find information that is shown to have been given by me, which I had not given, outdated information that had been made to appear relevant to the current situation and a lot of statements that said, I was not able to cope with or look after my mum?”*

## 22.23 Care Planning and Care Delivery, (the 3rd and 4th of the 7 C's)

Service user representative number 42 described to the Ockenden review team a complete lack of planning once it had been decided to establishment where her elderly mother was living. Service user 42 described no consideration of the impact upon residents and their families and there was no involvement of families and carers. I was told *'that all the residents would have to leave by tomorrow.... that a new placement had been arranged for my mother. It would have been devastating for mum to have been moved into another home at such short notice. I have since learned that visits had been made to residents at the home the week before. It appears that they had been assessing all the residents and checking room vacancies at other homes.'*

Service user representative number 42 explained that no information had been shared with the family regarding the DOLS process, assumptions were made with no consultation with the family. There was a rushed assessment process with no consultation with others involved in the elderly person's care – such as community nurses and the elderly person's own Community Psychiatric Nurse (or CPN.) 'No other less restrictive options were considered. The care home had never informed me that they had applied for a DOLS, so the first I knew was when mum told me a psychiatrist had been. I found it incomprehensible that I really was not being listened to. I still did not know the full content of the report and statements were still being made 'you are not appropriate', 'it's the law'; 'you can't cope with your mother'; 'your views differ.' Why wasn't I listened to when I tried to give correct information?' (Service user representative number 42, in conversation Holywell, June 2017.)

A paid Relevant Persons Representative (or RPR – see glossary) was appointed without prior discussion and involvement of the family. The elderly person became distressed and confused by the visits undertaken by the appointed and paid RPR. She kept asking me why 'the man with the beard' keeps coming. I had to explain that I could do nothing. (Service user representative number 42, in conversation Holywell, June 2017.)

## 22.24 Care Provision/Care Delivery: (the 5th and 6th of the 7 C's)

Service user representative number 42 described the 'removal' of residents from a care home that was being 'closed' in a distressing and unthoughtful manner – with no consideration of the impact caused to the residents. 'I was stunned by what was happening. I have never seen such a distressing sight. I saw one lady sitting in the middle of her room with the door open – she was surrounded by staff who were taking flat packed boxes and building them in front of her. Some residents were sitting in chairs surrounded by packed bags and looking bewildered and frightened. Some had no idea that they would not be there by lunch time. There was no regard whatsoever for the feelings of residents. (The home owner)

*"I was told 'that all the residents would have to leave by tomorrow.... that a new placement had been arranged for my mother. It would have been devastating for mum to have been moved into another home at such short notice. I have since learned that visits had been made to residents at the home the week before. It appears that they had been assessing all the residents and checking room vacancies at other homes.'"*

*"Why wasn't I listened to when I tried to give correct information?"*  
(Service user representative number 42, in conversation Holywell, June 2017.)

had no control over what was happening because of the sheer number of external staff taking over the whole operation throughout every area of the premises.'

The home owner wasn't able to give support to her residents or her staff who, in law, she remained responsible for. I saw elderly people taken out of their chairs and putting them in the back of cars to drive them to homes all over the county. I saw one who thought she was going for a little outing in the car. She had no idea that she was going to live elsewhere on her own, without any of her friends. I saw relatives who could not find where their family members were once they had been taken. The confusion was shocking. Many residents suffered from dementia; It appeared to me that their human rights were not considered and that the Mental Capacity Act was disregarded. Friends that had lived together as family were split up and shifted out without them or their relatives having any say. None of them even got to say goodbye to their friends or to the staff who had become a very important part of their lives'; (service user representative number 42, In conversation Holywell, June 2017.)

In conclusion service user representative told the Ockenden governance review 'Such action must never be allowed to happen again. I have seen first-hand, the distress, the fear and the heartbreak caused, not only for the residents but also the impact on family and friends.'

## 22.25 There was poor Communication, (the 7 of the 7'Cs')

There was a lack of prior information given to the family regarding the instigation of the DOLS process. The family and clinical staff who had been caring for the elderly lady for over two years were not involved from the outset and when involved felt as if they were not listened to. There was a lack of information given surrounding the DOLS process. The family had to seek external advice and support. 'During the independent review I gave my information as clearly as possible stating the facts in chronological order and without embellishment. I also showed the investigator the 'challenges' I had made to the accuracy of the assessment document. The investigator passed that information to the complaints department for consideration within the complaint. That information has not been referred to in the review report. (Service user representative number 42, in conversation, Holywell June 2017),

'The Best Interest Assessor (or BIA) rushed the assessment process – the BIA would have had a very different picture had she spoken with any member of the family. The BIA did not ask for information from the BCUHB CPN or Community Nurse both of whom had known mum for two years and had been to visit her, both had reported that she was settled and doing very well. The BIA said we would not need to meet, she had all the information she required from electronic case notes, care plans and her meeting with mum. She went on to say that she had appointed a paid Relevant Persons Representative who would visit mum on a regular basis. I was told that I was not appropriate as it was me who 'put her there'. I was very shocked by the conversation and the realisations that mums future could be decided for her. The main points the BIA kept making were 1) I've

*"I saw elderly people taken out of their chairs and putting them in the back of cars to drive them to homes all over the county. I saw one who thought she was going for a little outing in the car. She had no idea that she was going to live elsewhere on her own, without any of her friends. I saw relatives who could not find where their family members were once they had been taken. The confusion was shocking."*

*"Friends that had lived together as family were split up and shifted out without them or their relatives having any say. None of them even got to say goodbye to their friends or to the staff who had become a very important part of their lives'."*

(service user representative number 42, In conversation Holywell, June 2017.)

got all the information I need from her Social Services case notes, her care plan and assessments; 2) It's clear you can't deal with her behaviour; 3) I have appointed an independent paid RPR because 'you are not appropriate'; 4) The judge will make the decision; 5) She can go home to her flat with carers. (Service user representative number 42, in conversation Holywell, June 2017.)

'My main concerns were that the BIA said that she had all the information she needed, but from the scant details she told me, it was obvious that the information she had was outdated, was only relevant to a short period of time, it was in the wrong chronological order and out of context. The BIA said that she had all the information she needed and that she can only take a 'snap shot' on the days she visited mum';

## 22.26 What happened next?

'I felt I needed independent support from an organisation that would be able to give me clear guidance relevant to the DoLS process. I had found a leaflet produced by Social Care Institute of Excellence' (or SCIE) The (SCIE) told me that the court ruling through the Supreme Court changes nothing in regard to the Code of Practice and as far as she could see the Code had not been followed and that was unlawful. I telephoned a solicitor who deals with Court of Protection cases and asked for advice. She advised me that it sounded like the process had not been 'dealt well with so far'. She assured me that there was no reason why I could not be the RPR and my views should be listened to. I telephoned Age Concern in Cardiff to ask if they could help, they gave me the same information as everyone else, the family should be involved and that there is no reason why I cannot be the RPR if I am willing'; (Service user representative number 42, In conversation Holywell, June 2017.)

*“The Best Interest Assessor (or BIA) rushed the assessment process – the BIA would have had a very different picture had she spoken with any member of the family. The BIA did not ask for information from the BCUHB CPN or Community Nurse both of whom had known mum for two years and had been to visit her, both had reported that she was settled and doing very well.”*

## 22.27 Case study 3 from service user representative Number 65 – out of area placement due to lack of beds

### Summary of issues discussed:

#### Concerns and Complaints:

- BCUHB staff were described as acting as 'sinister' once a complaint is raised. (Prestatyn July 2017.) Meetings with BCUHB staff were described as 'intimidating' with 'unfamiliar faces'. Service user representative 65 stated that 'threats' were made to place the patient in a 'more secure unit' if the family complained. The complainant (Service user number 65, Prestatyn July 2017) described being ignored during a lengthy complaints process.

#### Care Planning:

- Service user number 65, (Prestatyn July 2017) described as a family being passed from pillar to post. They described a 'constant referral for need to involve the Police' as there was an inability by the BCUHB system to cope with the patients condition. Carers in Prestatyn (July 2017) described being overwhelmed with the burden of responsibilities placed upon them and



struggling to cope. Carers described (Prestatyn July 2017) having to intervene continuously in the care planning process by BCUHB to ensure that individual needs were considered.

#### Care Provision/Care Delivery:

- Carer described patients not being treated holistically and described a patient sent to an out of area placement more than 160 miles away from home. The carer described that the patient spent over a year at the out of area placement. No consideration was given to caring for the patient in their own home/community.

#### Communication:

- Carers described a 'listening' problem and a 'communication' problem within the BCUHB Mental Health Service. Carers stated that there was no integrated care. Carers are not being listened to. (Prestatyn July 2017) Doctors are not communicating across 'speciality areas'.

#### Comments:

- Hope that as a result of Donna Ockenden's report systems will change.

#### Part B

#### Concerns and Complaints:

- **65** 'I don't know what all the answers are – we have professionals that are paid to do that and to be helpful. They are not helpful and I've said this before and I'll keep on saying it until the day I die. They can be very sinister, if you complain'; (Prestatyn July 2017)
- 'I said there was something very sinister going on and there was and it was proven by the investigator. When you go to MDT meetings they've already had the meeting before you walk in and they literally try to wind you up before you go into the room which has huge table, with lots of people you don't know, there's probably only one familiar face'; (Prestatyn July 2017)
- 'I think they probably thought well he is going to die you know because he needed oxygen, he needed all sorts, but they couldn't see that he was ringing a bell because he was throwing up. He didn't have a proper diet, they were threatening him with a more secure placement if he complained';
- 'I can't believe basically that I didn't kick up more of a fuss. I tried to do it sort of professionally and the only thing I could think of was grasping at straws really. He'd shout at me and point with his finger and say 'why are you doing this to your husband?';
- **75** 'From 2015 to date, we have sent numerous letters. The complaints investigator at BCUHB is basically ignoring me. They are denying everything';

*“You're like a tennis ball, you're thrown to one person and then back again. They use the police instead of their own people (it's a cheap option I suppose for them) 'oh it's a police matter, it's a police matter', 'we can't deal with it, oh well if you're having problems, if he's in crisis call the police'. That's not appropriate”*

### Care Planning:

- 'You're like a tennis ball, you're thrown to one person and then back again. They use the police instead of their own people (it's a cheap option I suppose for them) 'oh it's a police matter, it's a police matter', 'we can't deal with it, oh well if you're having problems, if he's in crisis call the police'. That's not appropriate';

### Care Provision/Care Delivery:

- 'Patients in Mental Health are not treated. They've got co-morbidities, they are not treated holistically';
- **75** 'Sometimes, it's one step forward and thirty back and you feel as if you are drowning. I think all carers deserve to be able to carry on the work themselves – if they're working during the day and they are caring, they should be able to have time off, not say 'oh I'm going to have to give up my career because nobody's helping here or nobody's listening''; (Prestatyn July 2015)
- They didn't have a bed space for him here in BCUHB's catchment area and they sent him out of area to X it was a (more than 300 mile and more than seven hour round trip by car or train). You see what they (BCUHB) do is 'out of sight out of mind.' As soon as he got there the doctors said that he could have been cared for in the Community'; (Prestatyn July 2017)
- 'You see the problem was they (BCUHB) never ever considered helping me at home with him, you know Community Care at home. They never considered a longer spell of rehabilitation in the area, (Prestatyn July 2017)
- 'At Dinas Ward the Sister said to me that 'he's just renting a bed here, we're not doing anything for him'(Prestatyn July 2017)'
- Why didn't they bring him back home to BCUHB's territory so that he could be looked after?' (Prestatyn July 2017)'
- 'They put people in boxes, we're not boxes, people have global problems if you like, they have problems with their brain, they have problems with their physical needs. You can't just place somebody in an unsuitable placement more than 150 miles away. You might as well put them in a jail and say okay you'll be out in 4 months.. You'd probably get better care there'; (Prestatyn July 2017)'

### Communication:

- 'The care system in elderly Mental Health care is not working. It's failing miserably. There's a listening problem, there is a communication problem with Mental Health, the whole of Mental Health and Social Services. There is no integrated care, carers are not listened to although carers are best placed to understand – they are in a unique place to understand the problems of their cared for. They are not given that authority to access care, appropriate care, speedy care and ethical care'; (Prestatyn July 2017)'

*“They didn't have a bed space for him here in BCUHB's catchment area and they sent him out of area to X it was a (more than 300 mile and more than seven hour round trip by car or train). You see what they (BCUHB) do is 'out of sight out of mind.' As soon as he got there the doctors said that he could have been cared for in the Community.”*

(Prestatyn July 2017)

*“Carers are not listened to although carers are best placed to understand – they are in a unique place to understand the problems of their cared for. They are not given that authority to access care, appropriate care, speedy care and ethical care’.”*

(Prestatyn July 2017)

*“At Dinas Ward the Sister said to me that 'he's just renting a bed here, we're not doing anything for him.’”*

(Prestatyn July 2017)

- 'Doctors don't talk to other doctors, if you've got a Mental Health patient with say a heart problem or a stomach problem, a serious heart problem, a serious stomach problem they've no integrated care, none whatsoever and this is why you end up with the patient in crisis. There was none from 2004 to 2017 nothing has changed'; (Long term carer Prestatyn July 2017)

**Comments:**

- 'When you came on the scene Donna Ockenden, I thought oh my God, people are going to find out the truth now. It's going to change, this is going to change for everyone for all the people that have suffered like me financially, emotionally, health wise'. (Prestatyn July 2017)'

## 22.28 Case study 4

### Service user representative number 74

#### Summary of issues discussed:

Compliments: Praise for the Memory Clinic at Bryn Hesketh Hospital, Ward 12 at Ysbyty Glan Clwyd and the North Wales Community Health Council.

## 22.29 Concerns and Complaints from service user 74

No-one was available at Bryn Hesketh ward to raise verbal concerns in the summer of 2015. The complaints review was based on inaccuracies and it took several meetings with BCUHB, supported by NWCHC to establish that the concerns of the service user representative were accurate. There were very lengthy delays in the complaints process which ran from 2015 until the end of 2017 and no response had been received eight weeks following the 'final' meeting with a senior manager within Older Persons Mental Health service. (Colwyn Bay August 2017). Eventually the final response was received several months later and was of such poor quality it was escalated to the Director of Nursing by the Ockenden review team. (Colwyn Bay December 2017) Service user representative number 74 stated that no-one within Older Persons Mental Health had taken responsibility for the incidences leading to the complaint. (Colwyn Bay August 2017) The complainant was given no explanation of the BCUHB complaints process and sought support from NWCHC. Service user representative number 74 was well supported NWCHC and her Assembly Member, (AM) and overall found both to be significantly more helpful than the Health Board. (Colwyn Bay August 2017)

#### Care Planning:

The family was given no explanation or information about the care plans for the patient at Bryn Hesketh. (Service user representative number 74, Colwyn Bay August 2017) No explanation was given to the family regarding the POVA process. The complaints process revealed inaccuracies in patients' notes. (Colwyn Bay August 2017)

*"The family was given no explanation or information about the care plans for the patient at Bryn Hesketh. (Service user representative number 74, Colwyn Bay August 2017) No explanation was given to the family regarding the POVA process. The complaints process revealed inaccuracies in patients' notes."*  
(Colwyn Bay August 2017)

*"In his short stay at Bryn Hesketh he suffered rapid weight loss, became doubly incontinent, stopped eating and no mouth care or oral hygiene was provided by the ward staff."*

### Care Provision/Care Delivery:

The patient's condition deteriorated rapidly very shortly after being admitted to Bryn Hesketh. He had been physically well at home and had only been admitted to Bryn Hesketh for respite care to allow service user representative number 74 – (his wife and main carer) the opportunity to have surgery and recover from it. In his short stay at Bryn Hesketh he suffered rapid weight loss, became doubly incontinent, stopped eating and no mouth care or oral hygiene was provided by the ward staff. Families were not encouraged to stay after visiting to provide assistance with eating meals – there were no protected mealtimes. (Colwyn Bay August 2017 describing events at Bryn Hesketh ward in the summer of 2015)

*“My husband received good care at the Memory Clinic at Bryn Hesketh Hospital”*

### Communication:

There was a general lack of communication with the family at all times.

*“Everything I've got to say about the Community Health Council is positive – you need that personal touch because if it becomes like a call centre people don't know you from Adam when you ring up. Well, when I ring I don't have to”*

### Part B

#### 22.30 Compliments from Service User representative number 74 (Colwyn Bay August 2017)

- ‘My husband received good care at the Memory Clinic at Bryn Hesketh Hospital’;
- ‘Ward 12 at Glan Clwyd were really good I can't complain about them at all’;
- ‘Everything I've got to say about the Community Health Council is positive – you need that personal touch because in BCUHB it becomes like a call centre people don't know you from Adam when you ring up. Well, when I ring the Community Health Council I don't have to worry.’

#### 22.31 Concerns from service user 74

(Concerning an incident in Summer 2015 as described to the Ockenden team in August 2017 but the complaint remained unresolved as of December 2017)

- ‘I had no-one I could ask questions to, to raise verbal concerns. I felt that I could not talk to people. There wasn't a way of speaking to someone on the ward about my concerns and raising them’; (Service user representative 75, Colwyn Bay August 2017)
- ‘My husband wasn't incontinent on admission but according to them, well part of my complaint was that I had allegedly said he was doubly incontinent on admittance – I did not!’;
- ‘They couldn't reply to what was said in my letter of complaint as they can't find this nurse, they can't trace her’;
- ‘No-one has taken responsibility overall for what happened to my husband’; (Service user representative 75, Colwyn Bay August 2017)
- ‘They haven't got in place the systems and the structures to get a high quality response to people's concerns, they think that the investigator was working on two cases at the same time and got mixed up – nobody seems to

*“I had no-one I could ask questions to, to raise verbal concerns. I felt that I could not talk to people. There wasn't a way of speaking to someone on the ward about my concerns and raising them”*  
(Service user representative 75, Colwyn Bay August 2017)

get to grips with why the report was so wrong'; (Service user representative 75, Colwyn Bay August 2017)

- 'No-one at BCUHB has given me any information about any next steps I could take';
- 'In terms of sorting out my complaint, it's been the CHC that's helped me, rather than BCUHB'; (Service user representative 75, Colwyn Bay August 2017)

*"In terms of sorting out my complaint, it's been the CHC that's helped me, rather than BCUHB"*

#### Care Planning:

- 'He went in to Bryn Hesketh for assessment, prior to me going in for surgery, they took him in as an in-patient. I thought it was only going to be for a couple of days or a week but, unfortunately, he never came home'; (Service user representative 75, Colwyn Bay August 2017)
- 'Nobody gave me that information nobody sat with me and explained and said this is how it works, this is for you to understand, I didn't get anyone to talk to. I didn't know really what was happening I just noticed that he started to look frail. I didn't have any doctors' meeting to say how long they were going to keep him there or what they were doing, this was all a relatively new experience to me, and then I got the impression that they were thinking that, he'd deteriorated so much in there that you start to look for somewhere for him permanently'; (Service user representative 75, Colwyn Bay August 2017)
- 'At no point did anyone sit with me as X's wife and say we need to put a plan in place, these are our thoughts, what do you think, I didn't get involved in a plan, making a plan';
- Anyway the next thing was she rang and she said that she'd spoken to her seniors and they were applying for a POVA. Well, at that time, I didn't even know what a POVA was, that was nothing to do with me that was Social Services that applied for the POVA. (Service user representative 75, Colwyn Bay August 2017)
- 'I was in floods of tears, thinking God, what a place, I just wish I could just take him home, but if I did I knew that I would probably have no support'; (Service user representative 75, Colwyn Bay August 2017)
- 'When I went to the POVA meeting, I asked the independent investigator I asked who was the doctor that had given my husband the 'once-over' on the Thursday morning. She replied 'Oh, I don't know, I've not got that with me'. And what was his diagnosis? 'Don't know' she said'; (Service user representative 75, Colwyn Bay August 2017)
- 'notes were not dated and timed'; (Service user representative 75, Colwyn Bay August 2017)

*"He went in to Bryn Hesketh for assessment, prior to me going in for surgery, they took him in as an in-patient. I thought it was only going to be for a couple of days or a week but, unfortunately, he never came home"*

*"I was in floods of tears, thinking God, what a place, I just wish I could just take him home, but if I did I knew that I would probably have no support"*

(Service user representative 75, Colwyn Bay August 2017)

#### Care Provision/Care Delivery:

- 'He just seemed to deteriorate so quickly while he was in there';
- 'He went in just for assessment so I could plan when to have my surgery, with a view to him being cared for whilst I recovered from my surgery. On the second day he was there I got a phone call from one of the sisters to say,



it was late, that we're having to put a Section 2 on your husband because he's trying to get out the doors, and obviously we can't keep him here against his will unless we put a Section on him, because if he decides to leave at one o'clock in the morning there's nothing we can do about it. So, of course, you agree to it, you say yes okay, yes that's fine'; (Service user representative 75, Colwyn Bay August 2017)

- 'I said to the Staff Nurse, do you realise that my husband has had nothing to eat or drink for three days? So he said oh, is it three days? So I said yes, according to the staff on the ward he's not had anything all that time... I said I've asked the staff on the ward what does he weigh and they said that they didn't think he'd been weighed'; (Service user representative 75, Colwyn Bay August 2017)
- 'He'd lost a stone – it was sudden. You could see he had this mouth infection, his mouth was very dry, so when I said to the staff, have you seen his mouth, is nobody doing any mouth care? They said 'oh well we're not allowed to do it anymore, we're not allowed to use those sticks with orange things on'; (Service user representative 75, Colwyn Bay August 2017)
- 'At that time you're thinking well, is he in bed because they've sedated him or is he in bed because he's poorly? How do I know?';
- 'At one point I actually took his teeth out because they'd not been taken out for god knows how long, they were absolutely stuck and they were absolutely filthy, I took them to his room and scrubbed them and left them to soak because I thought there's no way he'll put his teeth back in because his mouth was just so sore'; (Service user representative 75, Colwyn Bay August 2017)
- 'There was no explanation as to why they weren't providing basic nursing care'; (Service user representative 75, Colwyn Bay August 2017)
- 'When I get to A&E, nobody was with him from Bryn Hesketh, all he had with him was with whatever they dragged him out of bed in – a t-shirt and a pad and pants, no dressing gown, no slippers, nothing'; (Service user representative 75, Colwyn Bay August 2017)
- 'He became incontinent really quickly when he was in there. He didn't have to have pads and pants at home, just normal'; (Service user representative 75, Colwyn Bay August 2017)
- 'I heard one nurse in A and E say to the other 'This man's been admitted from a EMI care home, they don't look after them very well, do they?'; He hadn't come from an EMI Nursing Home, he'd come from one of the BCUHB hospitals! (Service user representative 75, Colwyn Bay August 2017)
- 'This was late Summer 2015 and, at this point, they still hadn't introduced in Bryn Hesketh the idea that families could sit for mealtimes to encourage people to eat their meals';
- 'I went in he'd still got no socks on, so I looked and his feet looked worse, I pushed his trouser legs up, and his legs were like tree trunks. I said to the staff – have you seen the state of his legs, did you not notice it when you got

*“At one point I actually took his teeth out because they'd not been taken out for god knows how long, they were absolutely stuck and they were absolutely filthy, I took them to his room and scrubbed them and left them to soak because I thought there's no way he'll put his teeth back in because his mouth was just so sore”*

(Service user representative 75, Colwyn Bay August 2017)

*“I heard one nurse in A and E say to the other 'This man's been admitted from a EMI care home, they don't look after them very well, do they?'; He hadn't come from an EMI Nursing Home, he'd come from one of the BCUHB hospitals!”*

him dressed this morning? They replied, we didn't get him up, the night staff got him up'; (Service user representative 75, Colwyn Bay August 2017)

- 'People were very early getting people out of bed, because the night staff go off before eight o'clock, so there's no handover'; (Service user representative 75, Colwyn Bay August 2017)
- 'You didn't see a doctor, unless you went to seek one out'; (Service user representative 75, Colwyn Bay August 2017)
- 'He said nobody could have looked after my husband better than I did, he said in fact we didn't realise how poorly your husband was until he came in here and that was down to you';
- 'If I'd have known that he was not going to come home he would have never have gone to Bryn Hesketh'; (Service user representative 75, Colwyn Bay August 2017)

*"If I'd have known that he was not going to come home he would have never have gone to Bryn Hesketh"*

#### Communication:

- 'They'd obviously given him medication to calm him down or whatever, so when I eventually visited he was quite down. When he saw me he started crying and I really wanted to take him home but I knew at that point I couldn't, well I didn't know what to do'(Service user representative 75, Colwyn Bay August 2017)
- 'They were not communicating to me about my husband getting more poorly and then I said something about the notes were not dated and timed, they could have been written anywhere and at any time'; (Service user representative 75, Colwyn Bay August 2017)

*"The family described a 'scattergun' approach to the planning of care. Patient had no named CPN and no follow up/communication for 8 weeks following their appointment with the psychiatrist. They subsequently found out the psychiatrist had left BCUHB and no one had (at the time) picked up that work due to medical staff vacancies"*

(Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

## 22.32 Case study 5 – Lack of coordination and individuality in the planning of care and lack of BCUHB staff to be able to deliver care

### Service users 71 and 72

#### Summary of issues:

The family described no co-ordination in planning 'day care' – and a complete lack of communication with family. Activities were not planned and tailored to meet the individual needs of the patient and included colouring books. The family described a 'scattergun' approach to the planning of care. Patient had no named CPN and no follow up/communication for 8 weeks following their appointment with the psychiatrist. They subsequently found out the psychiatrist had left BCUHB and no one had (at the time) picked up that work due to medical staff vacancies (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

#### Care Provision/Care Delivery:

Staff at the Day Centre in Dolgellau Hospital were described as not engaging with patients and not being attentive to the needs of patients. There was a lack of appropriate activities provided to meet patients needs. (The family gave the

example of colouring books and jigsaws for men who has spent their working lives engaged in manual labour.) Patients and their families are expected to travel long distances to access places that provide appropriate activities. The family described a current and complete lack of co-ordination between health care services provided by BCUHB and social services locally. (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

## Part B

### 22.33 Compliments from service user representative 71 and 72

'The Alzheimer's Society is brilliant. It's somebody to talk to who understands the problems.'

'A Psychiatrist, I think he's quite new in post he was very good with my Dad to be fair, very very good. The atmosphere in the appointment was very relaxed, very informal and he spoke to my Dad and asked my Dad questions. He didn't just address them to me, he spoke to Dad, you know he made my Dad feel very included in the conversation'; (the family later found out that the 'new' psychiatrist left the service and at the time of the interview had not received any notification as to who would be picking up their family member's care.)

'They are brilliant at the Dolgellau Hospital and at the Minor Injuries Unit, I don't know what I would do if that went because dad's prone to falling. The staff at the hospital, the Nursing Staff and the Healthcare Assistants Donna are absolutely fantastic – they know my Dad, they know the issues, they know exactly how to treat him, exactly how to talk to him. It's just the care that they give is absolutely amazing'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

### 22.34 Lack of care in care Planning

'I had a phone call from the Day Centre and they said they were coming to pick up my husband in a quarter of an hour. I said what for? She said oh I'm coming to take him out, I said well it's very good of you to have let me know. She said oh I'll be there in quarter of an hour, you've got time to get him ready. I said I haven't, because I usually let him know the day before when he's going out so he can get himself ready. I said it's too much for him, he can't cope with too much all in one day'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'There seems to be no co-ordination to anything. My Dad needs routine. He's always been a creature of habit and he's even more so a creature of habit now. Dad needs structure, he needs routine and he needs to be aware of what he is doing and when he's doing it and this is not what's happening. I don't doubt they're trying their best, but to my mind their best is not good enough for my Dad and if it's not good enough for my Dad then it may well not be the best for other patients'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

*“There was a lack of appropriate activities provided to meet patients needs. (The family gave the example of colouring books and jigsaws for men who has spent their working lives engaged in manual labour.)”*

*“The Alzheimer's Society is brilliant. It's somebody to talk to who understands the problems.”*

'Dad's care is just completely random, well there isn't any. It's just a complete scattergun effect and I just don't understand how that works. Why one works so well and this doesn't work at all'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'The Consultant Psychiatrist was supposed to be sorting things about getting a CPN for dad, but we've not heard back from him. He said he would write to us but that was 8 weeks ago and we have heard nothing further'; (The family later found out that the 'new' psychiatrist had left BCUHB and at the time of the interview had not received any notification as to who would be picking up their family member's care.)

'The Support Workers didn't turn up for 2 weeks and Dad was standing there at the window with his coat on waiting for them and he said to me have I been a naughty boy because they don't want me anymore. There's been no thought, no planning, no what are we going to do with X if we don't take him out on a Monday'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'It's the poor co-ordination side of it, I don't understand how they can organise their workload if there's no proper planning going into it. It all just seems to be a kneejerk reaction to. Oh give them a quick ring to see if they're up for it, so it can't be co-ordinated'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'There is no care package to speak of as such. Dad wouldn't know what questions were being asked of him and he wouldn't know what decisions to make'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'I get the impression that they are trying to put these people in boxes and if you don't fit a box, they don't know what to do with you'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

### Care Provision/Care Delivery:

'The psychiatrist was concerned that Dad didn't have a named CPN'; (Nothing was put in place following this Consultant appointment as the Consultant left BCUHB shortly afterwards. The family then made a complaint to BCUHB and copied in the Ockenden team. The family were then copied into the following internal email between senior staff in Older Persons Mental Health provision in BCUHB in error.)

'X – Could you look into this email trail as a matter of some urgency and can we try to answer the questions raised as soon as possible please. I think given the involvement of Donna Ockenden we should regard it as a priority.' (BCUHB August 2017)

*"The Support Workers didn't turn up for 2 weeks and Dad was standing there at the window with his coat on waiting for them and he said to me have I been a naughty boy because they don't want me anymore. There's been no thought, no planning, no what are we going to do with X if we don't take him out on a Monday"*

(Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

*"X – Could you look into this email trail as a matter of some urgency and can we try to answer the questions raised as soon as possible please. I think given the involvement of Donna Ockenden we should regard it as a priority."*

(BCUHB August 2017)

## 22.35 Poor facilities at the Day Centre

'At Dolgellau Hospital they have a Day Centre for dementia patients. Dad has been there but walked out because they had colouring and things and he didn't want to do it'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'We went into the room at Dolgellau Hospital where the Day Centre is for the patients with dementia. I was horrified, absolutely horrified. It was a roasting hot day, so they had got all the windows open and they happened to be having the central heating system replaced that day as well. It was just so institutionalised. I couldn't believe it. They were all sitting round in what I would call old people's chairs you know the high backed and the high winged ones? The sun's blaring. The gentlemen who were sitting there were sitting there in their vests because they were that hot which I didn't think was very dignified, but if they were hot then fair enough, but the support staff who were supposed to be there looking after these people and taking care of them were sitting fiddling on their mobile phones and I just thought hang on a minute that doesn't seem quite right to me, so no wonder Dad didn't want to go if the staff weren't engaging with the patients which they certainly weren't doing that day then you know I just thought – is this how it always is?';

'Well you think when their job is to look after people with dementia they would understand and I don't think they do'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'At the Day Centre currently at Dolgellau Hospital there is no sense about what activities they're actually doing with patients to make their day a pleasant one, a productive one, one that the patients enjoy. Dad said that there's nothing for me to do there, I'm wasting my time going. From what I understand there's stuff like jigsaw puzzles for them to do, there's colouring and there's a craft activity but that's not the sort of thing Dad wants to do. He can't see because he's got macular degeneration and he's got another issue that's being addressed, so he can't see to sit down and colour, he doesn't have the patience to do that'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'When I've spoken to other people who have said that their fathers or fathers-in-law were referred to the unit and they said I'm not going there, there's nothing to do'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

'There's a Men's Shed in Blaenau Ffestiniog – 26 miles away – a 52 mile round trip –When I mentioned it to the social worker, she said they couldn't take him there, we'd have to take him. I said well that's defeating the object isn't it? I took him to Blaenau, I wouldn't have time to come back and go back again for him, I'd have to stay in Blaenau. So if they managed to get an activity for my husband there they'd be expecting me to do the round trip of 52 miles'; (Service user representatives 71 and 72, in interview, Dolgellau, July 2017)

*“The gentlemen who were sitting there were sitting there in their vests because they were that hot which I didn't think was very dignified, but if they were hot then fair enough, but the support staff who were supposed to be there looking after these people and taking care of them were sitting fiddling on their mobile phones and I just thought hang on a minute that doesn't seem quite right to me, so no wonder Dad didn't want to go if the staff weren't engaging with the patients which they certainly weren't doing that day then you know I just thought – is this how it always is?”*



## 22.36 Case study 6 Service user representative Number 3, representing a local organisation supporting carers

This person represents a local organisation providing support to those with Alzheimer's and carers of people with dementia and was interviewed by the Ockenden team in April 2017)

### Summary of issues discussed:

Concerns and Complaints: Echoing the views of many service user representatives who met the Ockenden governance review team including 7,9, 15, 21, 24, 60, 65,68,74,76, 81, 84, 101 and 103 service user representative number 3 in interview said that people are still reluctant to raise concerns and complaints with BCUHB. Again, echoing feedback from a number of service user representatives service user representative 3 told the Ockenden review team that complaints that have been raised with BCUHB have not been responded to over a lengthy period of time. Many carers and service user representatives told the Ockenden review are in fear of repercussions that may affect the care of loved ones. In addition when taking into account the caring responsibilities they had many carers stated they simply did not have the time or energy to follow up on complaints and concerns with BCUHB.

### Care Planning:

Service user representative number 3 said in interview that there were very few referrals to the support organisation received from GPs and there is a reluctance of GPs to share information about patients with carers and advocates. This was despite the organisation having an excellent local reputation and a relatively high profile. The organisation finds that discharges from hospital are late in the day having little regard to the needs of the patient and often with poor planning. It also appears that patients are being discharged at inappropriate times and with insufficient planning due to bed shortages. (Service user representative number 3 Llandudno April 2017). This theme of insufficient planning for discharge was echoed in interview by multiple service user representatives met across North Wales.

### Care Provision/Care Delivery:

Echoing the feedback from multiple carers the representative of the support organisation reported that there was no consideration given to needs of dementia patients when arranging out-patient appointments. The organisation reported insufficient funding and insufficient staff to provide the care needed by elderly people with mental health needs. Echoing the concerns of other carers and service user representatives including 9, 24, 76, 86, 102, 60, 65, 51 and 68 service user representative number 3 stated that patients are frequently having to travel long distances and often to England to receive the care they need. (Service user representative number 3 Llandudno April 2017).

*“There’s a Men’s Shed in Blaenau Ffestiniog – 26 miles away – a 52 mile round trip –When I mentioned it to the social worker, she said they couldn’t take him there, we’d have to take him. I said well that’s defeating the object isn’t it? I took him to Blaenau, I wouldn’t have time to come back and go back again for him, I’d have to stay in Blaenau. So if they managed to get an activity for my husband there they’d be expecting me to do the round trip of 52 miles”*

### Communication:

Service user representative number 3 who was interviewed by the Ockenden team in Llandudno in April 2017 described a lack of communication with families or carers following a diagnosis of dementia. Echoing the concerns of other families the Ockenden review team service user representative number 3 described little feedback following meetings with consultants.

### Part B

#### 22.37 Compliments from service user representative 3 – the BCUHB CPNs

'I work closely with BCUHB CPNs and up here I think they are brilliant, but there is not enough of them and I think they are under tremendous pressure. They are doing the best they can. I am only criticising the fact that there's not enough of them and the process of accessing them'; (Service user representative number 3 Llandudno April 2017)

#### 22.38 Concerns and Complaints – the perspective of service user representative 3

'With complaining people are always a bit like – will they take it out on my mother or whatever aren't they?'; (Service user representative number 3 Llandudno, April 2017)

'I have supported people who have made complaints. Neither have been particularly positive. One gentleman complained about his wife's care – she was in hospital and he complained about how she was treated. His wife passed away and he would not let it go and it took him a year to get any response really. He is still fighting this because he is not getting the response that he wants and his wife passed away 18 months ago'; (Service user representative number 3 Llandudno, April 2017)

### Care Provision/Care Delivery:

'I am not aware of anything that's happened in the hospital setting around consideration for outpatient appointment times for example for people with dementia'; (Service user representative number 3, Llandudno, April 2017)

'There aren't many advocates about, so we feel that there should be more emphasis on that as well'; (Service user representative number 3, Llandudno, April 2017)

### Communication:

'Sometimes people are still not being told or are not being told in a way that they understand'; (Service user representative number 3 Llandudno April 2017)

*"I work closely with BCUHB CPNs and up here I think they are brilliant, but there is not enough of them and I think they are under tremendous pressure. They are doing the best they can. I am only criticising the fact that there's not enough of them and the process of accessing them"*

(Service user representative number 3 Llandudno April 2017)

'The feedback we often get from carers after patients have been discharged from the Memory Clinics is that they don't know what to do'; (Service user representative number 3 Llandudno April 2017)

'There have been occasions when people have said that the consultant never speaks to their husband, he speaks to me and my husband won't go now because he says 'what's the point he ignores me?'' (Service user representative number 3, Llandudno, April 2017)

'Feedback from consultations is sometimes is poor'; (Service user representative number 3 Llandudno April 2017)

## 22.39 Case study 7 – the independent care sector in older peoples mental health

**Service user representative number 5 (Llandudno, April 2017)**

**Summary of issues discussed:**

### 22.40 Care Planning:

Service user representative number 5 works within the independent elderly care sector alongside BCUHB and plans and delivers care to elderly patients with mental health problems discharged from BCUHB hospitals on a daily basis.

In interview with the Ockenden review team in April 2017 at Llandudno service user representative number 5 echoed service user number 3 and described a lack of 'detailed assessments when discharging patients from hospitals.' and 'no urgency in care planning.' Service user representative number 5 described elderly patients often not being placed on the right wards to meet their needs and therefore nursing staff were not able to understand their specific dementia needs. Service user representative number 5 described no integration between the health services provided by BCUHB and social services. Overall, service user representative number 5 described poor information about the availability of services, echoing a range of other service users including 3, 71, and 72. Information (when available) was spread across a number of places and sources and there was no central point for families and carers to access support and advice.

### 22.41 Concerns with Care Provision/Care Delivery from service user representative 5

Service user representative number 5 described a lack of communication and continuity of care from the BCUHB district nursing service when caring for elderly people and that overall BCUHB was not open to accepting new ideas or to embrace a change of their systems. Service user representative number 5 stated that patients with dementia at Ysbyty Glan Clwyd were not having their nutritional needs met meaning that families were having to help with feeding and drinking. Service user representative number 5 stated that there is a significant over reliance by BCUHB on unpaid carers and families in the care of elderly patients

*“The feedback we often get from carers after patients have been discharged from the Memory Clinics is that they don't know what to do”*

(Service user representative number 3 Llandudno April 2017)

*“A lack of 'detailed assessments when discharging patients from hospitals.' and 'no urgency in care planning.'”*

with mental health problems. All of the feedback from service user representative number 5 was echoed by a range of current and recent service user representatives. Service user representative number 5 said at interview 'There are some very hard working people in the BCUHB who really do go above and beyond, but also there are some huge loopholes and gaps'; (Service user representative number 5 Llandudno April 2017)

## 22.42 Concerns with Care Planning – service user representative 5

The assessments that we get are so vague, it's like a cut and paste thing'; (Service user representative number 5 Llandudno April 2017)

Discussing the lack of information available to carers and families service user representative number 5 said 'It's not always clear what is available and there is only sort of like Citizen's Advice and people like that that are willing to help people understand what they are entitled to, their benefits, whether there's memory clinics. Nothing ever gels and there are so many little bits like the dementia coffee place in the middle of Llangefni'; (Service user representative number 5 Llandudno April 2017)

Echoing the feedback from multiple other service user representatives 'service user representative number 5 said 'I just think that everything needs to be brought to a centre point – I am very concerned ....where people are just left to get on with it where family members are very anxious about their safety, about how they are dealing with it, how frustrated they get. What impact does it have on their general day to day life?'; (Service user representative number 5 Llandudno April 2017)

## 22.43 Concerns with Care Provision/Care Delivery – service user representative 5

'I think generally the weaknesses that we find is the lack of communication, the lack of continuity, so you might have a District Nurse going into one person, but with 2 or 3 different District Nurses going each week'; (Service user representative number 5 Llandudno April 2017)

'I understand what they, [BCUHB]; are up against. I really do, but I also believe that if there are people like myself to be able to offer and to help that they should be embracing it, not making it difficult'; (Service user representative number 5 Llandudno April 2017)

'I know of one patient who had dementia, ended up going into Ysbyty Bangor and was extremely disorientated. The daughter was in there literally all the time, the nursing staff told her to go home. She didn't want to leave her mum, she wanted to sleep in the chair by her mum's bed because she realised how disorientated her mother was. Her mother came home and died with us. Patients are not on the right wards, they go to the one bed that's available. They might

*“There are some very hard working people in the BCUHB who really do go above and beyond, but also there are some huge loopholes and gaps”*

(Service user representative number 5 Llandudno April 2017)

*“The assessments that we get are so vague, it's like a cut and paste thing”*

(Service user representative number 5 Llandudno April 2017)

*“I just think that everything needs to be brought to a centre point – I am very concerned ....where people are just left to get on with it where family members are very anxious about their safety, about how they are dealing with it, how frustrated they get. What impact does it have on their general day to day life?”*

end up on the orthopaedic ward. They haven't got time to be focusing all that care on that specific need'; (Service user representative number 5 Llandudno April 2017)

'There needs to be a little bit more flexibility, because surely that's more helpful to the nursing staff. I know that people get in the way and I know that family can interfere in the wrong ways, but I think there needs to be a little bit more give and take with that'; (Service user representative number 5 Llandudno April 2017)

'I know of somebody else has just told me at the weekend about having to go in to Ysbyty Glan Clwyd and feed her mother who has dementia, because they are dumping the food in front of them and people with dementia not getting the care they need because they may well be in an inappropriate ward. When they are dumping the food in front of them and they don't know whether it's a fork or what and because they haven't eaten it they just take it away. As far as I know, that person hadn't had the nutrition they needed or the fluids'; Is it fair to say that there is a lack of individualised care for people with dementia? Yes (Service user representative number 5 Llandudno April 2017)

Service user 5 described the lack of provision in one specific area – Anglesey and stated in interview 'There are very few links on Anglesey such as Older People's Mental Health, the Community Psychiatric Nurses. You just tend to take whoever or whatever is available at the time; (Service user representative number 5 Llandudno April 2017)

Echoing feedback from across all of the service user representative listening and engagement events service user representative number 5 said 'We rely so much on unpaid carers and family members and friends and they're not supported'; (Service user representative number 5 Llandudno April 2017)

### **Communication:**

Describing the still unsatisfactory levels of communication between BCUHB and care agencies providing care to elderly vulnerable patients on discharge from hospital service user representative said 'We want to try to build better links so that we all share the right communication. We all work all together, but I want that a bit tighter and a bit firmer and a bit more shared communication..... 'They basically just fax through this information, then we need to check with the social worker and with the family. It's a right rigmarole so we don't know what we are doing. There are no proper contact details'; (Service user representative number 5 Llandudno April 2017)

*"I know of somebody else has just told me at the weekend about having to go in to Ysbyty Glan Clwyd and feed her mother who has dementia, because they are dumping the food in front of them and people with dementia not getting the care they need because they may well be in an inappropriate ward."*

(Service user representative number 5, April 2017.)

*"We rely so much on unpaid carers and family members and friends and they're not supported."*



## 22.44 Case study 7 – Example of a 'historic' (2010) complaint that did not receive a response

### Service user representative Number 4, Llandudno April 2017

#### Summary of issues discussed:

##### Concerns and Complaints:

No reply to formal complaint raised with BCUHB in 2010.

##### Care Provision/Care Delivery:

Concern raised regarding the variable quality of care delivered by carers in 2010. The care provided was poor at Colwyn Bay Hospital. The harm service user representative believed to have been caused to mother had not been seen by nursing staff. The 'Butterfly' scheme was not understood. There was no consistency to the quality of care.

## 22.45 Compliments from service user representative 4

'The main provision of my mothers' care was based in Llandudno General Hospital, the Bodnant Day Centre which held a memory clinic and had a day centre for people with dementia twice a week. Overall, I felt that this was an excellent service'; (Service user representative number 4, Llandudno April 2017)

## 22.46 Concerns and Complaints from 2009-10 – not answered at the time

Describing historic events from 2009-10 service user representative stated 'I remember raising concerns on behalf of my mother in the form a complaint, but no one ever responded'; (Service user representative number 4, Llandudno April 2017)

#### Care Provision/Care Delivery in 2009/10:

With reference to events in 2009/2010) service user representative number 4 said 'The care at Colwyn Bay Hospital was not good. I recall taking in all meals for my mother. There was also an issue with medicines not being administered....; One day I noticed Mum's hand to be completely "black and blue" and at this point Mum showed me a gentleman who she said had lifted her up in her chair and then pushed her back very hard which had caused the bruising to her hand. I observed the nurses to be standing by the desk and chatting and the nurses had not noticed this event taking place'; (Service user representative number 4, Llandudno April 2017)

Today service user representative number 4, said 'There is no continuity of care. People comment on the rapidity of the visits which are for minimal care purposes';

*“There is no continuity of care. People comment on the rapidity of the visits which are for minimal care purposes.”*

## 22.47 Case study 8 Service user representative number 6 (Llandudno April 2017)

### 22.48 Lack of care planning with family representatives

Describing care that was delivered in late 2015 service user 6 noted that the advice of the patients family who were her long term carers was not sought. There was no real approach made to discuss a care plan. Service user representative number 6 (Llandudno April 2017)

#### Care Provision/Care Delivery:

Echoing service user representative number 1 and others who are very recent BCUHB service users (within the last year) Service user representative noted the lack of continuity of care at the AMU in Ysbyty Glan Clwyd (circa 2014/15). Service user representative number 6, again echoing service user representative number 1 noted a lack of awareness of dementia issues amongst staff at the AMU Ysbyty Glan Clwyd. Echoing service user representatives including 3 and 5 service user representative 1 noted patients remaining on AMU recently because of the shortage of appropriate beds in the main hospital.

Clinical staff were said to have described patients being 'scattered' throughout a main hospital. (Service user representative number 6, Llandudno April 2017) Concerns were expressed regarding the level of care on Care of Elderly Ward at Ysbyty Glan Clwyd. Families were reported as staying with patients to ensure that they were taking sufficient fluids and were not confident that ward staff would do this. Service user representatives reported a lack of understanding on the Care of the Elderly Ward of dementia issues.

#### Communication:

The service user representative experienced poor integration between Health Services and Social Services.

### 22.49 Compliments from service user 6

'Before Christmas last year mum was again taken to the AMU at Ysbyty Glan Clwyd. On this occasion the care in the AMU was chalk and cheese to the first occasion. It was absolutely fantastic, that she was well looked after whilst she was in there. There was a great deal of understanding of her dementia issues as well as her illnesses and I couldn't have been more impressed frankly with the way in which Mum was looked after':

- 'We weren't thrown out and we spent a lot of time with my Mum, because we felt it was the only way that we could get some liquids into her so we spent a lot of time, so they were generous with that';
- 'From the moment that we/through the GP spoke to Social Services they were very quick to get her a Memory Clinic assessment, very quick to sort out help and assistance. Through Conwy Social Services she went to a Day Centre who were fantastic';

*"Before Christmas last year mum was again taken to the AMU at Ysbyty Glan Clwyd. On this occasion the care in the AMU was chalk and cheese to the first occasion. It was absolutely fantastic, that she was well looked after whilst she was in there. There was a great deal of understanding of her dementia issues as well as her illnesses and I couldn't have been more impressed frankly with the way in which Mum was looked after."*

- 'A scheme called Trio<sup>260</sup> started in North Wales' where elderly people with dementia are taken out on a 1:2 basis with a carer and they are taken out for the day and they go shopping or for a walk around town or a walk on the beach/on the prom if the weather is nice and they have lunch out and are brought back in the late afternoon. Mum was put on that scheme, I could not speak more highly of it';
- 'I could not speak more highly of Pembroke House';
- 'There's a lot of good, there's a lot of good and I think within Conwy we were led into the system superbly once we were put in touch with the memory clinic that bit all worked whilst Mum wasn't too bad and the Trio bit worked fantastically well'.

#### Care Planning:

- 'Were we involved in her care? I don't think our advice was sought which perhaps it should have been given that we were/my wife and I were principal carers and we know my Mother and know her issues so perhaps not in those terms';
- 'A care plan was only discussed only on the basis that we were asked how are things, how are you coping, what do you need and in essence for us it was well what do we need?'

#### Care Provision/Care Delivery:

- 'At that time (2-3 years ago) we found the AMU at Ysbyty Glan Clwyd to be a shambles and we found staff there to lack an understanding of issues in Older People suffering from dementia. There was certainly an issue about continuity of care because of the way in which the staff rotated around the bays in that a member of staff/ a nurse would seem to be on one bay today and on a different bay tomorrow, so was never building up any kind of relationship or understanding of the needs of patients';
- 'Mum stayed in the AMU for 3 nights. There was no bed to be had. I can remember speaking to her Consultant (I think it was an Older Persons Consultant) and I raised issues and the Consultant was virtually in tears saying well yes but I have got patients scattered around the Hospital, I can't find them';
- 'Mum did end up on the Care of the Elderly ward where we weren't entirely happy with the level of care that she was getting. We had a conversation and decided that she was safer at home, so we in the end took her home';
- 'She couldn't be moved because she was dehydrated and they were going to try and put a line in. Well they did try and put a line in and my Mother pulled it out immediately and so that failed. They then said they were going to try and put a line into her foot. We pointed out that she had compromised vascular systems in her legs that if they had read the notes they would discover that';

*"Were we involved in her care? I don't think our advice was sought which perhaps it should have been given that we were/my wife and I were principal carers and we know my Mother and know her issues so perhaps not in those terms."*

*"Mum did end up on the Care of the Elderly ward where we weren't entirely happy with the level of care that she was getting. We had a conversation and decided that she was safer at home, so we in the end took her home."*

*"We are sitting with her trying to get her to drink because we know that if she hadn't drunk in that time the cup of water would be left with her and then an hour later someone would take that cup away and mark on her notes that she hadn't drunk it."*

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<sup>260</sup> See glossary

- 'We are sitting with her trying to get her to drink because we know that if she hadn't drunk in that time the cup of water would be left with her and then an hour later someone would take that cup away and mark on her notes that she hadn't drunk it';
- 'I would have expected on a Care of the Elderly ward a greater understanding of some of these issues around dementia and a greater understanding about where she was in terms of her life as well. She actually died a few weeks later';
- 'From my experience I was surprised by the lack of understanding in a Care of the Elderly ward. You would have thought that every member of staff working on a Care of the Elderly ward would be dementia trained and I am not sure they are';
- 'Well anybody dealing with somebody of that age should be dementia trained, every member of Staff at AMU should be dementia trained';
- 'The truth is that people are spending longer in AMU, so staff rotations between bays does not help because people with dementia have issues which take time to be understood';
- 'When you are busy, the temptation is to pull the curtains around the bed and forget about them and if you are dementia trained you don't do that, so I would expect particularly those units where they are likely to come into contact with elderly patients that dementia training would be essential';
- I think there are signs up saying Butterfly or whatever it is called, but nothing we came in touch with. I think there were individual members of staff who got it. I didn't find that from nursing staff, there were individual nursing staff who I did feel were understanding and actually I felt there was a degree of a lack of understanding amongst the members of staff that we dealt with';
- 'On the first occasion my wife took issue with things that messes weren't cleaned up quite as quickly as they should have been had she been and she was concerned that whilst fluid inputs were being measured, fluid outputs weren't being measured';
- 'The Nurse said to my wife 'oh did you notice any bedsores or any marks on her' and my wife said well actually you shouldn't be asking me that, you should be knowing that anyway';
- 'District Nurses went from being superb to being pretty poor when they reorganised it';
- 'There was some kind of reorganisation and suddenly you noticed that the District Nurses were seeming to be under more stress and sometimes didn't turn up at all, would turn up at the wrong time when we weren't expecting. That was probably 18 months ago and it just seemed to change quite quickly from being functioning to being difficult, but it became difficult to contact and difficult to ring the numbers that were published on the Trust/Board website as they didn't seem to work. I'm not blaming the District Nurses because when we saw them they were really really good, but they seemed more stressed and more stretched than they had been prior to the reorganisation';

*"I would have expected on a Care of the Elderly ward a greater understanding of some of these issues around dementia and a greater understanding about where she was in terms of her life as well. She actually died a few weeks later."*

*"Well anybody dealing with somebody of that age should be dementia trained, every member of staff at AMU should be dementia trained."*

*"Whilst fluid inputs were being measured, fluid outputs weren't being measured."*

*"The truth is that people are spending longer in AMU, so Staff rotations between bays does not help because people with dementia have issues which take time to be understood."*

- 'Mum went first of all to a place called The XX and they threw her out in 24 hours, despite the fact that it was registered for dementia and Mum had had an assessment. On the first night she fell down some stairs, well we had warned them about that and then she struck out at staff and another resident and I had a letter within 24 hours saying that they wanted to move her, we had to move her out. I don't think they had dealt with it at all well';
- 'It strikes me that some of these care homes – even with the ones that get a dementia registration – actually want a bunch of little old ladies who will sit in a chair twiddling their thumbs all day, will say yes or no to teas and coffees and will go to the loo and then go to bed because it doesn't cause them any problems and it means that when there are inspections there's no issues going on that rock the boat. They don't want people who are difficult'.

## 22.50 Case study 9

### Service user representative Number 73

#### 22.51 Compliments: Good working relationships between Caniad and BCUHB. Praise for Single Point of Access system in Denbighshire

##### Care Provision/Care Delivery:

Recognition that care provided in the past must not continue. Lack of help, support and information for carers. Shortage of beds since closure of Tawel Fan and Ablett being a very busy unit. Patients being transferred out of Wales for care in settings very far away.

##### Part B

##### Compliments:

- 'Caniad's working relationships with the BCUHB are very good indeed
- 'Single point of access, if somebody's in desperate need, it's twenty four hours a day and we've got a system in Denbighshire now, the SPOA system where you ring up, somebody comes to your house within twenty four hours and assesses you and within forty eight hours, between forty eight hours and the third day they have something in place that needs to be, you're addressed and they move forward with social services then, and it's a very, very good system. We are starting to see a difference with the SPOA as well';
- 'That is a freephone number and it's twenty four hours a day. All Councillors have got it, all service users have got cards now and that, so every meeting we go to we take cards with us to make sure they're getting the help that they need'.

##### Care Provision/Care Delivery:

- 'Care that has gone on in the past can't go on, it has to move forward'

*“There was some kind of reorganisation and suddenly you noticed that the District Nurses were seeming to be under more stress and sometimes didn't turn up at all, would turn up at the wrong time when we weren't expecting. That was probably 18 months ago and it just seemed to change quite quickly from being functioning to being difficult.”*

*“We've got a system in Denbighshire now, the SPOA system where you ring up, somebody comes to your house within twenty four hours and assesses you and within forty eight hours, between forty eight hours and the third day they have something in place that needs to be, you're addressed and they move forward with social services then, and it's a very, very good system.”*



- 'It's nice to see something's being done because you know it's just been left on the side lines for the time being and we need to move forward, because there's not many beds now, we have to transfer them over to Wrexham, I mean they are local people at the end of the day, we shouldn't be sending them to Wrexham, we should have them in this area';
- 'We are short of beds, we've had a chap in Ruthin, he had to go to Essex because we didn't have the beds. He's not the first one, they've had two or three go down from North Wales to Essex, unfortunately no beds, no money, you know, most of them were private. We are hearing a lot of this at the moment';
- 'It's just recently started to happen, with Tawel Fan closing, no beds in the Ablett ward, over the past eighteen months, it's not regularly been happening but the past eighteen months it's just gone downhill, there's no beds anywhere';
- 'There's no help out there for the carers but it is improving slowly. The more awareness they have for help the better really'.

*"We are short of beds, we've had a chap in Ruthin, he had to go to Essex because we didn't have the beds. He's not the first one, they've had two or three go down from North Wales to Essex, unfortunately no beds, no money, you know, most of them were private. We are hearing a lot of this at the moment."*

## 22.52 Case study 9 A Timeline from Service user 1

Example of attempts to resolve a complaint regarding care provided to a dementia sufferer in a main BCUHB Hospital site in 2017. Service user 1 has liaised with twelve members of BCUHB staff trying to resolve a complaint over the time span of a year.

### Chronology of a patient's spouse submitting concerns, and responses from BCUHB

Date	Details
18th November 2016	Patient admitted from nursing home with acute chest infection as an emergency. During hospital stay patient transferred to Ward 7 at Ysbyty Glan Clwyd.
28th November 2016	<p>Patient sent to Discharge Lounge and waited for an ambulance for more than three hours with only a hard chair to sit on.</p> <p>Patient had not been shaved for a number of days, a catheter remained in situ (patient did not have a catheter prior to the hospital stay), a bag of medication had been given to patient, and the patient did not have any hospital notes.</p> <p>On arrival at the nursing home, a nurse commented that the patient was in an 'appalling state' and also found the patient had a pressure sore.</p> <p>The patient's spouse sent an email to staff J, BCU Health Board (also copied to staff E, and staff I, listing concerns regarding the experience of the patient in the Discharge Lounge and the state the patient was in when returned to the nursing home.</p>

Date	Details
29th November 2016	Staff J sent an email apologising to patient's spouse and explaining the email of 28th November had been passed to staff E and staff I for investigation and response.
2nd December 2016	Concerns Team acknowledge email of 28th November 2016 with a letter and list points for investigation, providing a 'Putting Things Right' leaflet, a Community Health Council leaflet and a consent form to be signed by the patient's spouse to allow team to access the patient's records.
5th December 2016	Consent form signed by patient's spouse and returned.
8th December 2016	Concerns Team sent a letter thanking patient's spouse for the signed consent form and requesting proof that patient's spouse has authority to act on patient's behalf.
Around 8th December 2016	Patient's spouse contacted by staff letter AJ to arrange a meeting to discuss concerns who also explained POVA Committee consider nursing homes concerns to be so serious, a POVA may be issued against hospital. Hospital notes when arrived at nursing home stated patient had pneumonia, but hospital consultant had told patient's spouse that the patient had a chest infection. The patient is now very ill.
12th December 2016	Patient died at X Dementia Care Centre. The Death Certificate states cause of death to be Mixed Alzheimer's and Cerebrovascular Dementia.
20th December 2016	Patient's spouse informs staff J that the patient has died.
21st December 2016	Staff J sent an email to patient's spouse giving their condolences and stating to let them know if they can be of any help after the meeting to discuss concerns to be held on 4th January 2017.
4th January 2017	Meeting took place to discuss concerns at which patient's spouse given a verbal apology for lack of care. Patient's spouse requested apology be provided in writing and to be kept informed of what will be done to help other patients in a similar situation.
9th January 2017	POVA meeting held.
9th January 2017	Patient's spouse informed Staff J by email of verbal apology given at meeting on 4th January 2017 for lack of care.
15th January 2017	Staff J sent an email to patient's spouse asking if they would like a separate meeting with them and staff E.
15th January 2017	Patient's spouse sent an email to staff J explaining they were still awaiting letter of apology as promised by Concerns Team at the meeting on 4th January 2017 and will consider the offer of a meeting once the written apology is received.
3rd February 2017	Patient's spouse sent an email to staff J explaining the letter of apology has still not been received and asking staff J to look into this.
3rd February 2017	Staff J sent an email apologising to patient's spouse and explaining will forward this information to staff E for urgent follow-up.

Date	Details
13th February 2017	Patient's spouse sent an email to staff J and copied to staff E explaining still awaiting letter of apology the purpose of which was to hold the hospital to account and confirming that they do now not want written apology as it is too late.
13th February 2017	Staff E sent an email to patient's spouse apologising for the delay in sending out letter of apology which is now ready for signature and noting patient's spouse does not wish to receive it and offering a meeting
13th February 2017	Patient's spouse sent email to staff E confirming would like a meeting.
21st February 2017	Staff letter V emails patient's spouse to request availability to meet with staff J and staff E.
24th February 2017	Patient's spouse sent email to staff letter V to request directions for meeting with staff J and staff E to be held on 2nd March 2017.
27th February 2017	Patient's spouse sent email to staff letter V and copied to staff J and staff E requesting that the meeting is cancelled as meeting regarding the days before patient's death as this would be too upsetting and asking if the letter of apology due to be provided at the meeting on 2nd March 2017 is now sent by post.
8th March 2017	Staff E sent a letter to patient's spouse acknowledging the relevant dates and explaining concerns have been investigated in accordance with regulations and a meeting held on 4th January 2017 and a POVA meeting held on 9th January 2017. Addressing all points and providing apologies for a number of instances when care fell below standards including lack of documentation for use of catheter and of intentional rounding, issues with personal care, lack of information regarding medication and delay in transfer to nursing home. Concluding care fell below standard of expected care, apologising for this but giving assurance that breach did not cause harm, and giving condolences for loss of patient.
12th March 2017	Patient's spouse sent email to staff E and staff J explaining that of particular concern is treatment of transfer from Ward 7 to Discharge Lounge and disagreeing with assurance that breach did not cause harm, and requesting that facts relating to events in Discharge Lounge are reviewed.
14th March 2017	Staff letter C sent email to patient's spouse copied to staff E and staff J explaining further to email of 12th March 2017 the comments have been noted and sincerely apologising for BCUHB response of 8th March 2017 not addressing concerns and further concerns will be logged and Investigation Officer will be informed.

Date	Details
21st March 2017	<p>Staff E sent an email to patient's spouse, copied to staff J, staff letter V and staff I) apologising for delay in responding and agreeing that spouse should not have spent hours on a hard chair in discharge lounge and also confirming staff did not do skin integrity checks or document them. Explaining use of word 'harm' as per definition in 'Putting Things Right' policy and confirming belief that due to the hard chair and lack of paperwork, physical harm was caused whether or not it meets formal definition. Health Board needs better procedures for caring end of life patients, especially those with dementia and further explaining staff I can provide details of improvement plans, if helpful.</p>
22nd March 2017	<p>Staff I sent an email to patient's spouse and staff E, copied to staff J, staff letter X, and staff letter AF apologising for quality of care spouse received and confirming work is being undertaken to revise approach to end of life care and people with dementia, and offering a meeting and requesting any contributions you feel able to offer.</p>
29th March 2017	<p>POVA meeting reconvened to provide patient's spouse with feedback from POVA investigation. POVA meeting was originally held on 9th January 2017 following referral made concerning allegation of neglect received on 7th December 2016.</p> <p>Feedback included the catheter being left in situ and there was incorrect paperwork regarding this. The patient being resistive to care, although this was not the case but patient did not want to be shaved. The patient's spouse explained the patient required two staff to assist with personal care, the patient being sent to the discharge lounge looking unkempt. There was no intentional rounding system in place regarding body checks whilst patients were waiting in the discharge lounge. A nurse (patient's spouse stated this was a Healthcare Assistant) assisted patient to go to the toilet; the nurse checked and noticed there were no pressure sores but a full body map was not completed.</p> <p>In regards to lessons learnt, the patient's spouse stated they would encourage staff to liaise with care homes at any point; as everyone's journey is different due to their level of dementia.</p> <p>Feedback will be provided to the patient's spouse by 18th April 2017.</p>
3rd May 2017	<p>Staff letter AK sent a letter to patient's spouse apologising for letter which stated 'no harm had been caused', initial investigation had come to a different conclusion, but reflected incorrectly in letter, explaining requirements under legislation for a qualifying liability, what the Health Board must then do/offer including a report of financial compensation and offer the latter of 2,000 pounds. Also explaining if compensation is accepted, patient's spouse will be 'required to waive any right to civil proceedings' by signing a 'Form of Indemnity Settlement' under 'Putting Things Right' enclosed with the letter.</p>

Date	Details
13th May 2017	Patient's spouse sent an email to staff letter AK acknowledging receipt of letter dated 3rd May 2017 and confirming will not accept financial compensation but requesting a report on what actions will be taken to prevent failing with patient's care happening again.
25th May 2017	Staff letter P sent a letter to patient's spouse offering a meeting with staff I.
27th May 2017	Patient's spouse sent email to staff letter P confirming request for a written report.
26th June 2017	Staff I sent a letter to patient's spouse further to letter of 25th May 2017, apologising for offering a meeting to discuss plans to improve care for patients at end of life when you had said you would prefer a report, and providing an 'Action Plan'.
28th June 2017	Staff E sent a letter to patient's spouse to update on investigation into care and treatment of patients whilst on Tawel Fan and requesting TF1B Confirmation of Role of Personal Representative form is completed and returned to allow Health Board to correspond with you.
26th July 2017	Patient's spouse sent email to staff I, staff letter AK in response to letter from staff I dated 26th June 2017 explaining originally accepted option of a report but was offered a meeting, report not received but an Action Plan, which did not provide reassurance the issues would not reoccur and listing observations including staffing training needs, documentation issues, and number of staff posts.
26th July 2017	Concerns Team sent letter to patient's spouse explaining further concern has been uploaded to Datix system, lead investigator notified, and have requested someone from the services makes contact shortly.
9th August 2017	Patient's spouse sent email to Concerns Team regarding email received on 26th July 2017 explaining no one has made contact.
9th August 2017	Concerns Team sent email to patient's spouse apologising for not having been in contact and informing that Lead Investigator will make contact.
4th September 2017	Patient's spouse sent email to Concerns Team reiterating that they would like a report not a meeting.
4th September 2017	Concerns Team sent an email to patient's spouse confirming will forward email to investigating officer.
5th September 2017	Concerns Team sent an email to patient's spouse confirming that staff letter AJ is working on report and it will be with them in due course.
19th September 2017	Patient's spouse sent email to Concerns Team explaining has still not received the report offered by staff letter AK on 3rd May 2017 and requesting this is looked into.
20th September 2017	Concerns Team sent an email to patient's spouse apologising for not having received a 'response letter', and explaining will contact Investigating Officer and ask what stage they have reached.



Date	Details
20th September 2017	Concerns Team sent an email to patient's spouse confirming that the Investigating Officer is still preparing the report, requires further information to complete it and to be assured a thorough investigation is being undertaken.
28th September 2017	Concerns team telephoned patient's spouse to explain have met with staff letter AJ and explained report is almost finished. Concerns Team offered patient's spouse a meeting to review the report and patient's spouse declined meeting and asked if the report is about what will be done to help future dementia patients, which it was confirmed as such.
1st December 2017	Staff letter AL sent an email to patient's spouse providing the report, acknowledging how difficult this time must have been and confirming a hard copy will be sent with a letter apologising for the delay and explaining a password will be emailed shortly.
1st December 2017	Staff letter D sent an email to patient's spouse explaining Donna Ockenden has chased for the report and that a letter of apology regarding the delay and a hard copy of the report will be sent shortly.
4th December 2017	Staff letter AL sent an email to patient's spouse apologising for an incorrect date in the report and providing correct date and confirming that the report and letter have been posted.
5th December 2017	Report received from staff letter Staff letter AJ, expressing sorrow for delay in sending the report which has been due to work constraints, and providing a phone number should further discussion regarding the report be required.

As of the end of December 2017, a year after the death of their spouse had still not received the report requested into improvements into 'end of life' care for those people with dementia. In trying to receive that report Family 1 had contact with twelve different members of BCUHB staff but this has not led to success in getting important issues resolved.

## 23 GLOSSARY of Terms used in the Ockenden review

### A

Agency Staff	Refers to an employment situation where the working arrangement is limited to a certain period of time based on the needs of the employing organization. These are temporary staff and not part of the permanent workforce of the organization.
Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.
Assessment for the purpose of the Deprivation of Liberty Safeguards	Six assessments have to be successfully conducted before a local authority (supervisory body) can authorise the deprivation of an individual's liberty in a hospital or a care home. These assessments must be carried out by appropriately qualified assessors appointed by the supervisory body. (See Glossary for supervisory body.)
Abbey Pain Scale	A recognised observational tool used to measure pain in people with who cannot verbalise discomfort.
Ablett Unit	BCUHB mental health unit at the site of Ysbyty Glan Clwyd Hospital.
Accountable Care Organisations (ACOs)	Groups of health care providers that work as a team to coordinate care for a group of patients, with the goals of providing high-quality, patient-centred care and reducing costs.
Age	An assessment of whether the Relevant Person has reached age 18 (See Glossary for 'Relevant Person.')
AIMS	Accreditation for Inpatient Mental Health Services at The Royal College of Psychiatrists.
Assurance Framework	Provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support any Statement on internal controls in place.
Accountability	The fact or condition of being accountable; responsibility.
AM	Assembly Member of the National Assembly of Wales

### B

BCUHB	Betsi Cadwaladr University Health Board
Best interests assessment	An assessment of whether deprivation of liberty is in the relevant person's best interests is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm. This must be decided by a Best Interests Assessor.
Bucket Chair	A single, low and deep seat, with a contoured back

Bank Staff	A nurse bank is a group of flexible employees, contracted to work on an as-and-when-required basis, often at short notice, to cover for planned and unplanned shortfalls in staffing. The employees are referred to as 'bank nurses' and are NHS employees, recruited and trained within the parent NHS organisation. Other professionals can also be utilised via a bank, e.g. occupational therapist, physiotherapist.
Best Interest Assessor	A person who carries out a deprivation of liberty safeguards assessment.
<b>C</b>	
CAMHS	Abbreviation for Children and Adolescent Mental Health Services.
CO3 Form	Certificate of Second opinion, under the Mental health act 1983 concerning medicine administration.
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.
Carers Passport	This is a way of identifying relatives of patients who are regarded as their main carers so that they can be supported and enabled to visit at almost any time to assist with feeding, dressing or just keeping patients company.
Care Home	A care facility registered under the Care Standards Act 2000.
Care and Social Services Inspectorate Wales (CSSIW)	Care and Social Services Inspectorate Wales is the body responsible for making professional assessments and judgements about social care, early years and social services and to encourage improvement by the service providers.
Carer	People who provide unpaid care and support to relatives, friends or neighbours who are frail, sick or otherwise in vulnerable situations.
CHC	Community Health Council (also see NWCHC North Wales Community Health Council)
COO	Chief Operating Officer, usually an Executive Director of the Board
Contemporaneous	Existing at or occurring in the same period of time. This means taking place at the same time as another occurrence.
Conditions	Requirements that a Supervisory Body, (See Glossary); may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the Best Interests Assessor. (See Glossary)
Continuing Healthcare (or CHC)	When a person (adult) with long term and complex health needs qualify for free social and health care arranged and funded by the NHS.

Consent	Agreeing to a course of action – specifically in this report to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision known as informed consent and not have been under any duress or inappropriate pressure.
Corporate risk register	A means by which an organisation records and manages the high level risks facing its organisation. These are usually considered and calculated by the likelihood rating, (how often something might happen) multiplied by the impact rating – (i.e. low, medium or high risk.) The combined score likelihood multiplied by impact with give a risk score. Each risk should be calculated individually and would usually be 'owned' by named senior individuals within an organisation who will report back to the organisation on mitigating actions put in place to reduce the risk at agreed times.
Cheshire West Judgement (date 2014)	This judgment clarified the test and definition for Deprivation of Liberty for adults who lack capacity to make decisions about whether to be accommodated in care.
CPG	Clinical Programme Groups – The clinically led structure set up at the creation of BCUHB in 2009.
Court of Protection	The specialist court for all issues relating to people who lack mental capacity to make specific decisions. It is the ultimate decision maker with the same rights, privileges, powers and authority as the High Court. It can establish case law which gives examples of how the law should be put into practice.
Clostridium Difficile	A bacterium that is one of the most common causes of infection of the colon. Patients taking antibiotics are at risk of becoming infected with C. difficile as antibiotics can disrupt the normal bacteria of the bowel, allowing C. difficile to become established in the colon. In some people, a toxin produced by C. difficile causes diarrhoea, abdominal pain, severe inflammation of the colon (colitis), fever, an elevated white blood cell count, vomiting, and dehydration. In severely affected patients, the inner lining of the colon becomes severely inflamed (pseudomembranous colitis) with the potential to perforate. There was a clostridium difficile out break at Ysbyty Glan Clwyd Hospital of BCUHB in 2013.

## D

Datix	A patient safety organisation that produces web-based incident reporting and risk management software for healthcare and social care organizations. Datix is the system of risk management in BCUHB
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Delayed Transfer of Care	<p>A situation where a 'delayed transfer of care' exists is when transfer from either acute or non acute care to a proposed destination – for example home, nursing home or hospice is delayed.</p> <p>A delayed transfer of care is said to exist when:</p> <p>A clinical decision has been made that a patient is ready for transfer AND A multi disciplinary team decision has been made that a patient is ready for transfer AND</p> <p>The patient is safe to transfer/discharge BUT the receiving organisation is not ready to receive that patient. Examples can include a former carer at home now too frail to care for the patient/relative or a suitable residential or nursing home placement not being able to be found.</p>
Deprivation of Liberty	<p>Deprivation of Liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away.</p>
Delirium	<p>An acutely disturbed state of mind characterised by restlessness, illusions, and incoherence, occurring in fever or infection.</p>
Deprivation of Liberty Safeguards (DoLS)	<p>The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.</p>
Dementia Care Mapping	<p>Is an established approach to achieving and embedding person-centred care for people with dementia, recognised by the National Institute for Health and Clinical Excellence.</p>
<b>E</b>	
Eligibility assessment	<p>An assessment of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.</p>
<b>F</b>	
FD or DOF	<p>Finance Director or Executive Director of Finance (Usually an Executive Member of the Health Board)</p>



**Fish bone analysis** Linked to the Five Whys technique. This is known as a fish bone diagram or Ishikawa diagram. The defect or problem is shown as the fish's head on the right of the diagram. The causes are extended to the left in a fish bone pattern, with the ribs, (or main bones) representing main causes of the defect or problem and other 'minor bones' on the diagram presented as sub causes. The purpose of a fish bone diagram is to break down in an organised fashion the detail or root causes that potentially contribute to a particular outcome or problem; (the 'fish head'.)

**Functional Mental Illness** A physical disorder in which the symptoms have no known or detectable organic basis but are believed to be the result of psychological factors such as emotional conflicts or stress.

## G

**GP** General Practitioner: A person who provides general medical care.

## H

**Healthcare Inspectorate Wales (HIW)** The independent inspectorate and regulator of health care in Wales.

**Heddfan** A Betsi Cadwaladr Health Board mental health unit at Wrexham Maelor Hospital.

**HASCAS (Health and Social Care Advisory Service)** HASCAS is an organisation which works in all aspects of mental health and older people's services across the health and social care continuum. Authors of the 2018 'Independent Investigation: Tawel Fan Lessons for Learning Report'

**Healthcare in North Wales is Changing** The Health Board (Betsi Cadwaladr University Health Board) for North Wales, published consultation in 2012.

**Hospital Managers reviews (Mental Health Act 1983)** The term 'Hospital Managers' refers to the Board of the NHS Trust with responsibility for detained patients. Legislation allows the Trust to establish a Committee comprising of Non-Executive Directors of the Trust and Associate Managers. The day-to-day duties are delegated to specific officers of the Trust, but only the Committee members are able to exercise the power of discharge.

**Hafal** An organisation in Wales working with individuals recovering from serious mental illness and their families.

## I

**Independent Hospital** As defined by the Care Standards Act 2000 – a hospital, the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care or any other establishment, not being defined as a health service hospital, in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983.

Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health

Interim matron Role	An interim role is usually a temporary role of short duration.
Independent Mental Health Advocate (IMHA)	Access to an IMHA is a statutory right for people detained under most sections of the Mental Health Act, subject to Guardianship or on a community treatment order (CTO). IMHAs are independent of mental health services and can help people get their opinions heard and make sure they know their rights under the law.
Independent Mental Capacity Advocate (IMCA)	A trained advocate who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 whose functions are defined within it.
Independent Members	The role of a Non Officer Member in Local Health Boards and Non-Executive Directors in NHS Trust in Wales. With no direct executive portfolio, independent members have full director responsibility and the additional responsibility of ensuring the best quality decision taking through holding the executive to account.
Internal Audit	An independent, objective assurance and consulting activity designed to add value and improve an organization's operations. Professionals called internal auditors are employed by organisations to perform the internal auditing activity.

## J

Johns Campaign	A Campaign named after Dr John Gerrard, who died in November 2014 after a catastrophic stay in hospital. The focus of John's Campaign is for the right to stay with people with dementia and for the right of people with dementia to be supported by their family and/or known carers.
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## L

Ligature Risk	Monitoring the risk of persons/patients causing harm or death to themselves accidentally or purposefully by suspension or hanging. Ligature risks should be monitored on an ongoing basis and alternatives should be introduced to reduce the risk of harm. For example – through the use of the use of collapsible rails (not fixed), ensuring that persons cannot harm themselves.
Local Health Board (LHB)	<p>Local Health Boards fulfil the Supervisory Body function for health care services and work alongside partner local authorities, usually in the same geographical area, in planning long-term strategies for dealing with issues of health and well-being.</p> <p>They separately manage NHS hospitals and in-patient beds, when they are managing authorities.</p>

Labelling	The act of describing the person as or by a behaviour suggesting that the person is to blame for their behaviour. Labelling creates stigma which threatens the delivery of person centred care.
Local Authority/Council	The local council responsible for commissioning social care services in any particular area of the country. Senior managers in social services fulfil the Supervisory Body function for social care services.
Lymphoedema	Lymphoedema is a long-term (chronic) condition that causes swelling in the body's tissues. It can affect any part of the body, but usually develops in the arms or legs.
<b>M</b>	
Managing Authority	<p>The person or body with management responsibility for the particular hospital or care home in which a person is, or may become, deprived of their liberty. They are accountable for the direct care given in that setting.</p> <p>Care homes run by the council will have designated managing authorities.</p>
MAU or Medical Assessment Unit	Usually the first point of entry to a hospital where patients can be referred by GPs or the next 'port of call' within a hospital where patients are admitted via A and E and may require longer than an A and E stay to fully ascertain a presenting problem.
Maximum authorisation period	The maximum period for which a Supervisory Body may give a standard deprivation of liberty authorisation, which cannot be for more than 12 months. It must not exceed the period recommended by the Best Interests Assessor, and it may end sooner with the agreement of the Supervisory Body.
Mental Health and Learning Disabilities (MHLDD)	The service configuration found within BCUHB first in a CPG, latterly in a Division where both mental health and learning disabilities services are led and managed by one senior management team. Also the provision of mental health services for adults with learning disabilities. Central to their aim is that people with a learning disability must be able to access mainstream mental health services where these can meet their needs. They should also be able to be seen by specialist learning disability services where their learning disability means that mainstream services are unable to support their difficulties.
Maelor Assessment	A tool used for the risk assessment, reduction and management of pressure damage/ulcers on a patient.
MD	Executive Medical Director – part of the Health Board. An Executive member of the Board.
Mental Disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs.

Mental Capacity Act 2005 (MCA 2005)	<p>The Mental Capacity Act 2005 provides a framework to empower and protect people who may lack capacity to make some decisions for themselves. The five key principles in the Act are:</p> <p>Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.</p> <p>A person must be given all practicable help before anyone treats them as not being able to make their own decisions.</p> <p>Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.</p> <p>Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.</p> <p>Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.</p>
Mental Capacity Act Code of Practice	<p>The Code of Practice supports the MCA and provides guidance to all those who care for and/or make decisions on behalf of adults who lack capacity. The code includes case studies and clearly explains in more detail the key features of the MCA.</p>
Mental Health Act 1983	<p>Legislation mainly about the compulsory care and treatment of patients with mental health problems. It includes detention in hospital for mental health treatment, supervised community treatment and guardianship.</p>
Mental Health Tribunal	<p>An independent body established to safeguard the rights of persons subject to the Mental Health Act 1983. It provides for consideration of appeals against the medical detention or forced treatment of a person who was deemed to be suffering from a mental disorder that was associated with a risk to the health or safety of that person or others.</p>
Mental Health Measure 2010	<p>A law made by the National Assembly for Wales which will help people with mental health problems in four different ways. The Measure aims to ensure that appropriate care is in place across Wales which focuses on people's mental health needs.</p>
Mental capacity assessment	<p>An assessment of whether or not a person has capacity to decide if they should be accommodated in a particular hospital or care home for the purpose of being given care or treatment.</p>
Management of continuing Health Care	<p>This definition of NHS Continuing Healthcare has been taken from the National Framework and establishes the principle that someone with a 'primary health need' is entitled to NHS funded care which is free at the point of delivery.</p>

Mental Health review	It provides for consideration of appeals against the medical detention or forced treatment of a person who was deemed to be suffering from a mental disorder that was associated with a risk to the health or safety of that person or others.
Medication Reconciliation	Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking, including; drug name, dosage, frequency, and route. Comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.
Mental health assessment	An assessment of whether or not a person has a mental disorder. This must be decided by a medical practitioner.
MUST or Malnutrition Universal Screening Tool	A five step screening tool to identify adults who are malnourished or at risk of developing malnutrition or are obese. All five steps must be followed to ascertain a MUST score which is then managed according to management guidelines or local policies.

## N

National Assembly for Wales	The National Assembly for Wales is a democratically elected body. It is a devolved parliament with power to make legislation in Wales. The Assembly comprises 60 elected members, who are known as Assembly Members, or AMs (Aelodau y Cynulliad). It holds the Welsh Government to account).
National Institute of Health and Care Excellence (NICE)	<p>Providing national guidance and advice to improve health and social care. A primary legislation was established in April 2013, for NICE to becoming a Non Departmental Public Body (NDPB). As an NDPB, they are accountable to their sponsor department, the Department of Health and Social Care, but operationally independent of government.</p> <p>The way NICE was established in legislation means that their guidance is officially England-only, but they do have agreements to provide certain NICE products and services to Wales, Scotland and Northern Ireland.</p>
NHS Wales Shared Services Partnership (NHSWSSP)	An independent organisation, owned and directed by NHS Wales. NWSSP supports NHS Wales through the provision of a comprehensive range of high quality, customer focused support functions and services. Examples include provision of legal and risk services to Health Boards in Wales.

ND	Executive Director of Nursing – Member of the Health Board
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Nursing and Midwifery Council (NMC)	The regulator for nursing and midwifery professions in the UK. The NMC maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise. It sets and reviews standards for their education, training, conduct and performance. The NMC also investigates allegations of impaired fitness to practise (i.e. where these standards are alleged to have not been met.)
NHS Delivery Unit (Wales)	Tasked with achieving policy outcomes across Government portfolios.
No refusals assessment	An assessment of whether there is any other existing authority for decision making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or donee appointed under a Lasting Power of Attorney.
NWCHC	North Wales Community Health Council
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

## O

'One Wales' 2007	A document published by Welsh Government setting out 228 specific commitments in One Wales to be delivered by April 2011. Each section of the plan included a vision statement and success criteria.
Organic Mental Illness (OMI)	Also known as organic brain syndrome or chronic organic brain syndrome, is a form of decreased mental function due to a medical or physical disease, rather than a psychiatric illness.
Ombudsman	An ombudsman is a person who has been appointed to look into complaints about companies and organisations. Ombudsmen are independent, free of charge and impartial – that is, they don't take sides with either the person who is complaining or the organisation being complained about. Using an ombudsman is a way of trying to resolve a complaint without going to court.
Oversight Panel	A panel of appointed independent people reporting in the case of this governance review to Welsh Government.
Older People's Mental Health Service (OPMH)	A service helping older people who require care as a result of their mental illness.
Out of Hours Services	These are services that are provided outside of those provided between 9:00am to 5:00pm Monday to Friday.

## P

PALS	Patient advice and liaison services. This offers confidential advice, support and information on health related matters. It offers a single point of contact for patients, families or carers.
PICU	Psychiatric intensive care units provide mental health care and treatment for people whose acute distress, absconding risk and suicidal or challenging behaviour needs a secure environment beyond that which can normally be provided on an open psychiatric ward. High staffing ratios allow for intensive input to resolve issues quickly.
PTR	Putting Things Right (2011) – The legislation and systems, structures and processes underpinning the concerns process in Wales.
Primary Care	Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.
PoVA	The Protection of Vulnerable Adults.
PADR	Personal Appraisal and Development review
Patient Acuity	<p>Patient acuity is a concept that is very important to patient safety. As acuity rises, more nursing resources are needed to provide safe care.</p> <p>Two main attributes are to be considered; severity that indicates the physical and psychological status of the patient and the intensity of which indicates the nursing needs, complexity of care and corresponding workload.</p>
Pressure ulcer/pressure damage	A localised injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure or pressure combined with shearing force.

## Q

Qualifying requirement	Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.
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## R

Relevant hospital or care home	The particular hospital or care home in which the person is, or may become deprived of their liberty.
Responsible Clinician	The Responsible Clinician has overall responsibility for care and treatment for service users being assessed and treated under the Mental Health Act.

Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.
Relevant person's representative	A person, independent of the particular hospital or care home, appointed to maintain contact with the relevant person and to represent and give support in all matters relating to the operation of the deprivation of liberty safeguards.
RAG rated risk register	RAG stands for Red, Amber and Green. Each colour indicates the level of risk identified. Green indicates low or no risk, through to red indicating a very high level of risk. Amber would be regarded as a medium risk.
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.
Root Cause Analysis (RCA)	Investigations to identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients. See the 'Five Whys' and the 'fish bone diagram' for further info.
Restrictive Physical Intervention (RPI)	Are defined as a deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and end or reduce significantly the danger to the person or others; and contain or limit the person's freedom for no longer than is necessary.
Royal College of Psychiatrists (RCPsych)	A professional body responsible for education and training, and setting and raising standards in psychiatry.
Risk Mitigation	Actions put in place to reduce risk.
Risk Register	A log of risks of all kinds that threaten an organisations success in achieving its declared aims and objectives. It is a dynamic living document, which is populated through the organisation's risk assessment and evaluation process.
RTT	Referral to Treatment Waiting Times

## S

Salmon Principle	<p>Official letters sent out by a public inquiry or before a public facing report is released to people who will be potentially subject subject to criticism when an inquiry report is released.</p> <p>The aim of the letter is to give the person a chance to prepare for the resultant exposure and possible legal recourse which may need to be taken when allegations against them become public.</p>
Scott Principle	<p>A principle set out in order to create fair play. These principles are introduce within reason, and where it is appropriate.</p>
Section 17 Leave Policy	<p>This is a Section of the Mental Health Act (1983) which allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave the hospital site.</p>
Service line reporting	<p>A system where an organisation aims to improve the level of financial and performance information available to managers of services. It brings together information generated by services and the costs associated with providing that service and reports this for each operational unit.</p>
Star Wards	<p>Founded in 2006, Star Wards works in partnership with mental health wards to improve everyone's experiences and outcomes – patients, staff, family, friends and carers.</p>
SMT	<p>Senior Management Team (one example is within the Mental Health and Learning Disabilities Division)</p>
Safe wards	<p>Safe ward is an internationally recognised model of conflict and containment. The Safe wards model identifies set factors which can act as a trigger to conflict. This model uses a set of interventions to reduce the conflict triggers and prevent flashpoints arising from them. This intervention has been proven effective through Randomised Controlled Trials.</p>
SUI or SI	<p>Serious Untoward Incidents (also known as SI's – Serious Incidents.) These are usually reported outside an organisation.</p>
Section 62	<p>Of the Mental Health Act 1983, makes it an offence to possess a prohibited image of a child.</p>
Standing Orders	<p>Standing Orders regulate the conduct of meetings of the Board and its sub-committees. They fulfil the dual role of protecting interests and protecting officers from possible accusation that they have acted less than properly.</p>
Scheme of Delegation	<p>To provide an 'at a glance' framework outlining where it makes decisions and on what issues, and whether it wishes to delegate more decision-making authority, for example to the chief executive.</p>

Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health

Standing Financial Instructions	Financial transactions that are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.
Special Measures	<p>In exceptional circumstances, officials of the Welsh Government (including the Chief Executive of Healthcare Inspectorate Wales) and the Auditor General for Wales may identify concerns in relation to an NHS body in response to which the Welsh Ministers may take Intervention as set out in the NHS (Wales) Act 2006 [sections 26-28] and associated regulations.</p> <p>The circumstances for special measures are set out in the Welsh Government NHS Wales Escalation and Intervention Arrangements (March 2014)</p>
Section 12 Doctors	Doctors approved under Section 12(2) of the Mental Health Act 1983
Standard authorisation	An authorisation given by a Supervisory Body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in a particular hospital or care home.
Supervisory Body	A local authority social services or a local health board that is responsible for considering a deprivation of liberty application received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.
Supreme Court	The Supreme Court is the final court of appeal in the UK for civil cases, and for criminal cases in England, Wales and Northern Ireland. It hears cases of the greatest public or constitutional importance affecting the whole population.
Section 136	Part of the Mental Health Act. This means that the police have the power to remove an individual from a public place, and take an individual to a place of safety, for instance within a hospital. This is commonly referred to as a Section 136 suite.
Second Opinion	An opinion from a second qualified person on something such as a health or legal problem.
Secondary Care	<p>A patient who has been provided with primary care may go on to need a secondary care referral. This is usually because input from a specialist with additional expertise is required. Secondary care services relevant to this governance review are usually consultant-led services which include psychology and psychiatry.</p> <p>Secondary care is usually delivered in a hospital or clinic with the referral being made by a primary care professional.</p>
SMART	<i>SMART</i> is a best practice framework for setting goals. A <i>SMART</i> goal should be Specific, Measurable, Achievable, Relevant and Timely.



## **T**

'This is Me'	A simple form, found at <a href="http://www.alzheimers.org.uk">www.alzheimers.org.uk</a> , for anyone receiving professional care who is living with dementia or is experiencing delirium or other communication difficulties. It is suitable for use in any setting – at home, in hospital, in respite care or a care home and provides a valuable way of integrating person-centred care.
Third Sector	The part of an economy or society comprising non-governmental and non-profit-making organisations or associations, including charities, voluntary and community groups, cooperatives, etc.
A scheme called 'Trio'	TRIO is a unique Shared Lives project based in Wales to support older people with dementia to take an active part in their communities with the support of Shared Lives Carers known as TRIO Companions.
Temporary Staff	A term used for staff who have been employed by the Health Board who work as required, or staff who have been employed via a third party (an agency) to work as required.

## **U**

Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.
Urgent authorisation	An authorisation given by a managing authority for a maximum of seven days, which subsequently may be extended by a maximum of a further seven days by a Supervisory Body. This gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.

## **V**

Vacancy Control Panel	With reference to this governance review – a process whereby vacancies that were approved as essential by the CPG then had to go through a process of further Executive scrutiny prior to approval.
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## **W**

The Welsh Audit Office (WAO)	An independent public body which was established by the National Assembly for Wales on 1 April 2005. It has overall responsibility for auditing on behalf of the Auditor General for Wales, across all sectors of government in Wales, except those reserved to the UK government.
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## Y

### YGC

Ysbyty Glan Clwyd Hospital in Bodelwyddan.

Glan Clwyd Hospital (Ysbyty Glan Clwyd) is the district general hospital for the central area of North Wales.

It was built in 1980 and it is situated in rural surroundings at Bodelwyddan, a small community that lies 4 miles south of Rhyl.

The hospital serves a population of approximately 195,000. The acute hospital service has a total of circa 680 beds, with a full range of specialties.

### 23.1 Bibliography: Key references for review of the governance arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 19th December 2013 and current governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB) from December 2013 to the current time

### 23.2 Primary Literature

1. Interviews – carers, service user representatives and former and current BCUHB staff, (200 interviews in total)
2. A database of documents supplied electronically by BCUHB, via a secure portal – 3265 in number. These are saved electronically due to the size of the record with no separate written list created. This database will be provided back to BCUHB at the end of the Ockenden governance review.

### 23.3 Secondary Literature (in unit and date order and the order they appear in the report)

### 23.4 The Hergest unit – literature considered

1. HIW 2009 Letter dated 1 September 2009 Re: Healthcare Inspectorate Wales Mental Health Act visit to Hergest unit
2. HIW 2010 Letter dated 26 November 2010 Re: Healthcare Inspectorate Wales Mental Health Act visit to Hergest Unit
3. HIW 2011 Letter dated 27 June 2011 Re: Healthcare Inspectorate Wales Mental Health Act visit to Hergest Unit
4. HIW 2012 Betsi Cadwaladr University Local Health Board – Mental Health Act Monitoring Visit, Hergest Unit, Ysbyty Gwynedd Date of visit: 21 to 23 August 2012 report
5. Letter dated 31 December 2012 Re: review of the Hergest unit

6. HIW 2013 Letter dated 10 January 2013 Re: Healthcare Inspectorate Wales Visit to the Hergest Unit, BCU Health Board
7. HIW 2014 Letter dated 4 February 2014 Re: Healthcare Inspectorate Wales visit to Hergest Unit in December 2013
8. BCUHB 2013 Mental Health & Learning Disability Clinical Programme Group – Hergest Improvement Group – Minutes of meeting held on Monday 4 February 2013
9. NHS Delivery and Support Unit 2013 – Hergest Inpatient review 3 June 2013
10. HIW 2013, letter dated 26 July 2013 Re: Healthcare Inspectorate Wales MHA visit to the Hergest Unit
11. BCUHB Mental Health & Learning Disability Clinical Programme Group – Senior Management Team – Minutes of Meeting held on Friday 2 August 2013
12. BCUHB – Senior Management Team Meeting – minutes of meeting held on Friday 13 September 2013
13. HIW 2013 Letter dated 17 December 2013 Re: Visit undertaken to the Hergest Unit on the 2, 3 and 4 December 2013
14. Mental Health and Learning Disability Clinical Programme Group – Senior Management Team – Minutes of meeting held F2F Friday 17 January 2014
15. Raising Staff Concern/Whistleblowing Policy – WP4 – Investigation Report – into the concerns raised about the “Management of the Mental Health Clinical Programme Group in their dealings with the Hergest Unit and a variety of other issues relating to the Hergest Unit” Author – Robin Holden 17 January 2014
16. Betsi Cadwaladr University Health Board – Hergest HIW Action Plan 2014 – Visit to Hergest Unit 12 May 2014 – Version 2
17. Letter dated 2 June 2014 Re: Visit undertaken to the Hergest Unit, Ysbyty Gwynedd on the 12, 13 and 14 May 2014
18. HIW 2014 Letter dated 30 June 2014 Re: Healthcare Inspectorate Wales Visit to the Hergest Unit, BCU Health Board – 12 May 2014
19. HIW 2014 Letter dated 31 July 2014 Re: Matters arising during our visit to the Hergest Unit, Ysbyty Gwynedd on the 12, 13 and 14 May and to the Ablett Unit on 23, 24 and 25 June 2014
20. BCUHB 2013 Mental Health & Learning Disability Clinical Programme Group – Senior Management Team – Minutes of meeting held via VC on Friday 26 July 2013
21. BCUHB 2016 Mental Health/Learning Disability Inspection (Unannounced) Ysbyty Gwynedd: Hergest Unit: Betsi Cadwaladr UHB 6-8 January 2016

22. HIW 2016 Letter dated 11 January 2016 Re: Mental Health & Learning Disability Inspection, Hergest Unit, Ysbyty Gwynedd: Immediate Assurance Required
23. HIW 2016 Email dated 26 January 2016 Re: Hergest HIW Inspection Jan 2016 Immediate Improvement Plan v2.doc; 303 5601
24. HIW 2016 Letter dated 1 September 2016 Re: Hergest Unit – Improvement Plans
25. HIW 2016 Letter dated 26 October 2016 Re: Hergest Unit – Improvement Plans

### 23.5 Bryn Hesketh unit

1. HIW 2010 Letter dated 17 June 2010 Re: Unannounced Dignity and Respect Visit: Glan Traeth and Bryn Hesketh Units
2. Action Plan for Bryn Hesketh Unit – Visit 18 June 2013
3. Aneurin Bevan University Health Board (2016), Adult Protection Investigation at Bryn Hesketh, October 2016
4. HIW 2017 Unannounced NHS Mental Health Service Inspection to Bryn Hesketh, 8 – 10 November 2017
5. North Wales Community Health Council, reports of visits to Bryn Hesketh in October 2016, February 2017, May 2017

### 23.6 Ysbyty Cefni

1. HIW 2017 Unannounced NHS Mental Health Service Inspection to Ysbyty Cefni, published May 2017

### 23.7 Heddfan unit

1. Letter dated 23 April 2015 Re: Mental Health & Learning Disability Inspection, Heddfan Unit, Wrexham: Immediate Assurance Required
2. Letter dated 20 April 2015 Re: Mental Health & Learning Disability Inspection, Heddfan Unit Wrexham: Immediate Assurance Required
3. Email dated 2 June 2015 Re: Amended Draft Report from HIW – Heddfan Unit Wrexham – April 2015 following concerns
4. Mental Health & Learning Disability Division – Senior Management Team – Operational – Minutes of the meeting held on 24 April 2015
5. NHS Mental Health Service Inspection (Unannounced) Heddfan Psychiatric Unit – Betsi Cadwaladr University Health Board – Inspection date: 12-14 June 2017 – Publication date: 13 September 2017

## 23.8 Ysbyty Glan Clwyd

1. HIW 2017 Healthcare Inspectorate Wales – Hospital Inspection (Unannounced) Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board, Ward 1 and Ward 2B – Inspection date: 4,5,6 July Publication date: 9 October 2017
2. HIW 2017 Healthcare Inspectorate Wales – Hospital Inspection (Unannounced) Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board, Cynnydd and Dinas ward, published 22nd February 2018
3. Letter dated 14 July 2014 Re: Visit undertaken to the Ablett Unit, Glan Clwyd Hospital on the 23, 24 and 25 June 2014
4. Mental Health and Learning Disabilities Clinical Programme Group – HIW Action Plan in Response to visit to the Ablett Unit, Glan Clwyd Hospital 23/24/25 June 2014
5. HIW Mental Health/Learning Disability Inspection (Unannounced) Glan Clwyd: Ablett Unit: Betsi Cadwaladr UHB 6-8 July 2015 Report
6. Letter dated 21 April 2011 Re: Healthcare Inspectorate Wales Mental Health Act visit to Ablett Unit, Dinas Ward
7. Letter dated 9 December 2009 Re: Healthcare Inspectorate Wales Mental Health Act visit to Tegid & Tawe Fan Wards, Ablett Unit
8. Letter dated 22 August 2013 Re: Healthcare Inspectorate Wales Mental Health Act Monitoring visit to Ablett Unit, Tegid Ward
9. Action Plan for Tawel Fan Ward, Ablett Unit – 17 July 2013
10. Letter dated 10 October 2013 Re: Healthcare Inspectorate Wales Mental Health Act Monitoring visit to Ablett Unit, Tawel-Fan Ward
11. Letter dated 25 January 2017 Re: Hospital Inspection – Emergency Department, Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board
12. Betsi Cadwaladr University Health Board – Tawel Fan Ward – Ysbyty Glan Clwyd – Dementia Care Mapping Report – 30 October 2013
13. Ockenden D 2017 Letter dated 2 February 2017 Re: Independent Governance review Relating to the Care of Patients on Tawel Far Ward Prior to its Closure on the 19 December 2013 and Current Governance Arrangements in Older People's Mental Health (OPMH)
14. HIW 2017 Letter dated 28 February 2017 Re: Independent governance review you are undertaking into the care of patients on Tawel Fan Ward and current governance arrangements in older people's mental health
15. HIW 2017 Letter dated 30 October 2017 Re: Request for copies unpublished management letters and reports relating Betsi Cadwaladr University Local Health Board



## 23.9 Ty Llewellyn

1. Letter dated 22 August 2013 Re: Healthcare Inspectorate Wales Mental Health Act Monitoring Visit to Ty Llewellyn Hospital
2. Letter dated 15 November 2014 Re: Visit undertaken to Ty Llewellyn unit, Bryn y Neuadd hospital, Llanfairfechen on the 4, 5 and 6 November 2014
3. Letter dated 15 December 2014 Re: Two Action Plans prepared to address the issues reported following your visit to Ty Llewellyn on 4, 5 and 6 November 2014
4. Letter dated 18 August 2016 Re: Healthcare Inspectorate Wales Visit to Learning Disability Services: Bryn y Neuadd Hospital, Llanfairfechan – 22 and 23 June 2016

## 23.10 Community Hospitals

1. Letter dated 21 November 2016 Re: Inspection of Holywell (Ffynnon A) and Deeside (Gladstone, Branwen) Community Hospitals
2. Letter dated 28 November 2016 Re: Immediate Assurance required (Holywell Community Hospital)
3. Letter dated 20 December 2016 Re: Holywell Hospital (Ffynnon A ward) – Improvement Plan (Immediate Assurance Required)
4. Email dated 13 February 2017 Re: HIW Draft report
5. Letter dated 10 February 2017 Re: Hospital Inspection Report – Holywell & Deeside Community Hospitals
6. Letter dated 3 August 2015 Re: HIW Inspections – Improvement plans Update
7. Letter dated 3 September 2015 Re: HIW Inspections – Improvement Plans Update (Improvement plans attached)
8. Letter dated 27 November 2015 Re: HIW Hospital Inspections – Improvement plans update – evaluation of health board response
9. Letter dated 10 December 2015 Re: HIW Inspection: Improvement plans update – evaluation of Health Board responses
10. Letter dated 27 November 2015 Re: HIW Inspection: Immediate Assurance required
11. Letter dated 4 December 2015 Re: HIW Inspection: Immediate Assurance Required – Penrhos Stanley and Mold
12. Letter dated 18 December 2015 Re: Penrhos Stanley Hospital and Mold Community Hospital – Improvement Plan (Immediate Assurance Letter)
13. Letter dated 4 January 2015 Re: Ysbyty Penrhos Stanley (YPS)

14. Letter dated 12 January 2016 Re: Penrhos Stanley Hospital and Mold Community Hospital – Improvement Plan (Immediate Assurance Letter and Improvement Plan dated 27 November 2015)
15. Letter dated 20 January 2016 Re: Penrhos Stanley Hospital and Mold Community Hospital – Improvement Plan (Immediate Assurance Letter and Improvement Plan dated 27 November 2015)
16. Letter dated 29 January 2016 Re: HIW Inspection: Further Immediate Assurance Required – Penrhos Stanley
17. Letter dated 8 February 2016 Re: HIW Inspection: Action plan and report – Penrhos Stanley, Mold and Denbigh
18. Letter dated 21 April 2016 Re: March 2016 update – Penrhos Stanley
19. Letter dated 27 October 2016 Re: Ysbyty Penrhos Stanley Unannounced Inspection – 23 & 24 November 2015
20. Email dated 29 April 2016 Re: HIW Hospital Inspections – Improvement plans update
21. Letter dated 18 November 2016 Re: Hospital Inspection: Immediate Improvement Plan Required
22. Letter dated 2 December 2016 Re: Hospital Inspection: Immediate Improvement Plan Required
23. WAO/HIW Joint review – Strictly Embargoed Until 00.01 27 June 2013 – Chairman of the Board resignation notice
24. Letter dated 19 October 2015 Re: Evidence of positive or negative assurance against the 12 key standards identified by the Older People's Commissioner (OPC)
25. Letter dated 16 December 2014 Re: Dignity and Essential Care Inspection: Immediate Assurance Required
26. Letter dated 26 August 2016 Re: Foelas Assessment and Treatment Unit and Tan y Coed Residential Unit – Improvement Plans
27. Betsi Cadwaladr University Health Board Older Persons Mental Health In-Patient Services Delivery Unit Assurance review Final Report

## 23.11 Other external documents

1. Allegra Report – BCUHB External review in accordance with terms of reference dated 12 October 2012. Internal BCUHB summary document provided by BCUHB.
2. Andrews J and Butler M (2014) Trusted to Care: An Independent review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board
3. Burrows M (2009) Clinical Programme Groups – a briefing

4. Care Quality Commission (2014) Cracks in the Pathway, people's experiences of dementia care as they move between care homes and hospitals
5. Care Quality Commission (2014) Quality report, Nottinghamshire Healthcare NHS Trust, services for older people (Mental Health)
6. Care Quality Commission (2014) Quality report, Nottinghamshire Healthcare NHS Trust, crisis resolution and community services
7. Care Quality Commission (2015) Quality report, Mersey Care NHS Trust
8. Care Quality Commission (2015) How CQC regulates: Specialist mental health services Provider handbook
9. Care Quality Commission (2016) Quality report, South London and Maudsley NHS Foundation Trust
10. Care Quality Commission (2016) Building bridges, breaking barriers
11. Care Quality Commission (2016) Better care in my hands
12. Duerden 2013 review of Governance Arrangements, Structures and Systems for the Prevention and Control of Healthcare Associated Infections in the Betsi Cadwaladr University Health Board – Report by Professor Brian I. Duerden CBE, BSc, MD, FRCPath, FRCPE *Emeritus Professor of Medical Microbiology, Cardiff University*
13. Flynn M and Eley R (2014) Strategic review of Older People's Mental Health services, (OPMH) at BCUHB
14. Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
15. Good Governance Institute (2014) A review of the Governance systems at Betsi Cadwaladr University Health Board (BCUHB)
16. HIW Healthcare Inspectorate Wales Annual Report 2008 – 2009 – January 2010
17. HIW 2013 An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board – Joint review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office – June 2013
18. HIW 2014 An Overview of Governance Arrangements – Betsi Cadwaladr University Health Board – A Summary of Progress – Joint review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office.
19. HIW 2017 An Overview of Governance Arrangements
20. HIW 2015 Dignity and Care Inspections 2014-15
21. Hurst Report – Betsi Cadwaladr UHB review on April 4 and 5 2012. Internal briefing document provided by BCUHB.
22. Lloyd A 2015 Betsi Cadwaladr University Health Board Targeted Intervention, January/February 2015

23. Marks R 2014 An Independent review of the work of Healthcare Inspectorate Wales – The way ahead: to become an inspection and improvement body Executive Summary – Ruth Marks – November 2014
24. Nottinghamshire County Council (2014) Draft Mental Health Strategy for Nottinghamshire
25. Older Persons Commissioner for Wales 2013
26. Older Persons Framework for Action 2013-2017
27. Royal College of Nursing 2012 Safe staffing for older people's wards
28. Royal College of Psychiatrists Inpatient care for older people within mental health services faculty report FR/OA/1
29. Welsh Government 2011 'Putting Things Right'
30. Welsh Government 2012 'Together for Mental Health: A strategy for Mental Health and wellbeing in Wales'
31. Welsh Government 2013 Safe Care, Compassionate Care. National Governance Framework to enable high quality care in the NHS in Wales
32. Welsh Government (2014) NHS Wales Escalation and Intervention Arrangements
33. National Assembly for Wales, Public Accounts Committee (2013) Governance arrangements at Betsi Cadwaladr University Health Board
34. Welsh Government (2014) NHS Wales Escalation and Intervention Arrangements
35. Welsh Government (2016) Together for Mental Health: Delivery Plan 2016-19

### 23.12 Other references and useful links (in alphabetical order)

City of Bradford Mental wellbeing in Bradford District and Craven, a strategy 2016 to 2021, found at [www.bradford.gov.uk](http://www.bradford.gov.uk)

**Deprivation of Liberty Safeguards:** Annual Monitoring Report for Health and Social Care <http://cssiw.org.uk/docs/cssiw/report/140224dolsreporten.pdf>

**Mental Capacity Act** – The Mental Capacity Act 2005 provides a framework to empower and protect people who may lack capacity to make some decisions for themselves. <http://www.legislation.gov.uk/ukpga/2005/9/contents>

#### **Mental Capacity Act Code of Practice**

<http://wales.gov.uk/topics/health/publications/health/guidance/mcaconsent/?lang=en>

NHS Bradford Districts CCG 2017 'Commissioning for value, Mental Health and dementia pack.'

Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health

**The Supreme Court judgment P** (by his litigation friend the Official Solicitor) (FC) (Appellant) v Cheshire West and Chester Council and another (Respondents)

[http://supremecourt.uk/decided-cases/docs/UKSC\\_2012\\_0068\\_Judgment.pdf](http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf)

WHO 2015 Ensuring a Human Rights based approach for people living with dementia

<http://www.who.int/mental-health/neurology/dementia/en>





