Health Board

24.1.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	HASCAS independent investigation and Ockenden governance review: progress report
Report Author:	Mrs Deborah Carter, Associate Director Quality Assurance
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The paper provides the progress updates as at the end of Q3 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	The Improvement Group and Stakeholder Group meetings review, monitor and scrutinise the work and progress of the recommendations. This paper will also have been reviewed by the Quality, Safety & Experience Committee on the 22.1.19.
Governance issues / risks:	Work is underway to identify any additional resources required to progress the work identified to deliver improvements and address the recommendations.
Financial Implications:	A paper will be submitted to Executive Team setting out the additional resources and any related costings, including any additional workforce requirements, for their approval.
Recommendation:	To note the progress of the HASCAS & Ockenden recommendations

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

3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Mental Health Leadership and Governance			
Equality Impact Assessment			

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 1

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

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

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

Recommendations updates

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

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

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

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

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

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

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

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

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

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

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

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

Risks and Issues

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

HASCAS 2 & Ockenden 2: Dementia Strategy

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

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

HASCAS 13: Restrictive Practice Guidance

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

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

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

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

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

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

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

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

Ockenden 2d: Consultant Nurse in Dementia

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HASCAS 10: Prescribing & Monitoring of Anti-Psychotic medication

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

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

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

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

Monitoring

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

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

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

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

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

Audit

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

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

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

Implementation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ockenden 5: Partnership working

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

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

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

Ockenden 7: Concerns Management

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

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

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

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

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

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

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

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

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

Ockenden 11: Estates – Older Persons Mental Health

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

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

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

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

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

Appendix 1

Improvement Group (HASCAS and Ockenden)

Terms of Reference

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

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

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

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

Remit

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

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

Improvement Group Structure

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

Membership

Membership of the Improvement Group shall comprise of the following;

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

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

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

Nominated deputies will be permitted

Meetings

Quorum

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

Frequency of meetings

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

Agendas and Papers

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

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

Reporting and Assurance Arrangements

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

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

1.14 The Improvement Group will:

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

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

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

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

Date Terms of Reference Approved:.....

Review date: August 2019

Stakeholders Group

Terms of Reference

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

Remit

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

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

Membership

Membership of the Stakeholder Group shall comprise of the following;

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

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

Meetings

Quorum

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

Frequency of meetings

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

Agendas and Papers

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

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

Reporting and Assurance Arrangements

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

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

1.21 The Stakeholder Group will:

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

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

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

Date Terms of Reference Approved:.....

Review date: August 2019