

Health Board 1.11.18	 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board <i>To improve health and provide excellent care</i>
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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 Quarter 2 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	The Quality Safety & Experience Committee
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 recommendations

Health Board's Well-being Objectives <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	<input checked="" type="checkbox"/>	WFGA Sustainable Development Principle <i>(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.)</i>	<input checked="" type="checkbox"/>
1.To improve physical, emotional and mental health and well-being for all	<input checked="" type="checkbox"/>	1.Balancing short term need with long term planning for the future	<input checked="" type="checkbox"/>
2.To target our resources to those with the greatest needs and reduce inequalities	<input checked="" type="checkbox"/>	2.Working together with other partners to deliver objectives	<input checked="" type="checkbox"/>
3.To support children to have the best start in life	<input type="checkbox"/>	3. Involving those with an interest and seeking their views	<input checked="" type="checkbox"/>
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	<input checked="" type="checkbox"/>	4.Putting resources into preventing problems occurring or getting worse	<input checked="" type="checkbox"/>

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 Governance & Leadership Mental Health Services http://www.wales.nhs.uk/sitesplus/861/page/81806			
Equality Impact Assessment All equality and rights issues will be addressed as part of activity to deliver the recommendations where relevant. (http://howis.wales.nhs.uk/sitesplus/861/page/47193)			

Disclosure:

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

Board/Committee Coversheet v10.0

HASCAS Investigation and Ockenden Governance Review Progress Report

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_interim_report.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 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 (attached at Appendix 1).

The inaugural meeting of the Improvement Group was held on 16th August 2018, chaired by the Executive Director of Nursing & Midwifery, where the Group received status and progress updates from the operational leads responsible for each of the recommendations, including metrics and milestones identified to demonstrate progress towards achieving the outcomes of the recommendations. A paper will be submitted to the Executive Team in October setting out capacity and workforce requirements to support the delivery of the recommendations.

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 Monday 8th October 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 will also review the terms of reference to consider their role in terms 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.

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 2, September 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
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	Chief Information	Health Records Group

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
		Director	Officer	
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
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

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
	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 and Safety	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

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 for the strategy has been agreed in partnership detailing key engagement events along with attendance at partner organisations. The programme plan will outline proposals for improvement in patient pathways, systems, structures and processes of governance.

Appointments have been made to take forward the review and service redesign projects to the roles of Clinical lead for Older Peoples Mental Health OPMH and Older Persons Programme Manager within the CHC Commissioning Corporate Team, on a secondment basis.

The work of the existing Older Persons Group is under review along with the strategic objectives to ensure the review, redesign and development of a new service model, for older people and those with dementia, across the six counties of North Wales.

This work will be progressed in partnership with our north Wales wide partner organisations, in particular ensuring engagement with the North Wales Regional Partnership (Part 9) Board, alongside their remit to develop a work programme for the older person with complex care. The scope and methodology for this partnership work is to be developed further with partners, such that this is a jointly owned approach from the outset.

The Older Peoples Strategy, will be developed in partnership and a delivery plan for agreement will be submitted to the Part 9 Board, by March 2019.

In addition, a Quality & Workforce group for OPMH has been established to take forward the development of the service models and care pathways.

Work will also be undertaken to review and redesign the service model for the older person and those with living with dementia.

Other priority areas of focus have been identified as staff knowledge, skills and education and service user experience for the older person.

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.

HASCAS 13: Restrictive Practice Guidance

Relevant guidance has been reviewed by the operational lead and the Improvement Group acknowledged 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. Physical restraint guidelines are being reviewed internally through the Professional Advisory Group (PAG) meeting.

The Health Board Area Directors and Secondary Care Nurse Directors will undertake a scoping exercise for restraint training and review the scoping of restraint reporting.

Following research undertaken on preventing patient and visitor violence (PVV) plans are in place to prioritise PVV across the Health Board. This aims to support the effective management and training for staff to empower staff and safeguard patients. PVV and restraint policies will be updated and PVV leads will be identified in all divisions. There are also plans to introduce the NICE approved Brøset Violence Checklist (BVC) tool.

Ockenden 2d: Consultant Nurse in Dementia

A job description is in the process of being banded for an additional Consultant Nurse with a special interest in Dementia post. 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 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 Safeguarding Practice Development Lead and Safeguarding Data Analyst.

A scoping exercise has been completed on training activity to determine key areas of focus and the required support and engagement for revised training packages.

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 ESR.

A review is being undertaken on the restructuring and redesigning mental health hard copy clinical records archiving and retrieval systems to ensure mental health records are managed within the same Health Records Service portfolio as acute patient records. This work requires resources to baseline, plan as well as standardise and manage the ongoing additional service.

Significant work has commenced on the transfer of management of the Mental Health records, which 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); 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.

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'

This specific project will initially aim to deliver in Phase 1 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, by (date).

In order to deliver these actions 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.

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 MHL Division (October 2018). Activities remain ongoing 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 outliers to be identified and targeted for intervention.

The MHLD lead pharmacist for the Health Board will link with the Nurse Consultant in Dementia to ensure that training includes relevant information around psychotropic medication for frontline staff. 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) within care homes / OPMH wards, which will improve the documentation of care, side effects and monitoring, relevant to the use of all psychotropic drug usage. This has been implemented in Swansea with a reduction in falls as a result of the project.

Audit

Information is published annually about the use of antipsychotics in care homes, benchmarked against NICE guidance and Welsh targets for patients with a diagnosis of dementia. This data was collected in primary care in 2017. The WG national audit of antipsychotic use in primary care is under consultation and is likely 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 OPMH.

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

A system is in place for quality impact assessment, progress will be measured from samples of completed QIAs and a record of outcomes and will be included on the internal audit programme 2019/20.

The Board has strengthened its decision making with a greater focus on 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 have been modified to allow more focus on financial matters. The Committee meets 10 times per year and has recently extended the duration of its meetings as a matter of routine to ensure that the Board's attention remains focused going forward.

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 proposals further improve and strengthen the effectiveness of the Board and Committee arrangements, 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 proposals also 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. The Executive Team have considered revised proposals for integrated performance reporting recognising the weaknesses in the current system. Redesigned principles have been agreed and will be tested with the full Board at the Workshop in October. The proposed changes will enable performance monitoring and management throughout the year and escalation by exception and will be proposed for formal adoption by the Board in November 2018. Alongside the revisions to the performance reporting, the Board is developing a revised accountability framework which will be recommended for adoption by the Board in November. This will see accountability strengthened through Directorate and Divisional accountability reviews.

Following the revision of the Policy on Policies and as part of the communication the new Policy on Policies and intranet page was launched during September. This has been cascaded via the Corporate Bulletin (see extract below). Three sessions have been arranged for October to meet with all Governance Leads to discuss the policy in detail and the review and transfer of documents to the new site.

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 policies being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based.

Work has been underway for some months now on reviewing 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. This revised document can be accessed via the following link:-
<http://howis.wales.nhs.uk/sitesplus/861/page/57893>

The policy appends a new template and also includes a table showing the approval route for various types of document. Staff are reminded that all clinical policies should be developed using a person centred approach. Existing Policies should be 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 should be developed with input from experts. Authors of Policies, Procedures and other WCDs are also 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.

Running in parallel to this, work has been undertaken to develop a new intranet page where staff can easily have access to all BCU wide policies, procedures, guidelines, protocols etc. This new site will shortly be located prominently on the home page of the intranet (link to the temporary site:
<http://howis.wales.nhs.uk/sitesplus/861/page/72276>

Governance Leads have been assigned for each Directorate / Area and over the past twelve months have been reviewing their relevant policies etc. which will then to be moved to the new site. In order to avoid any confusion or risk staff, particularly clinical staff not being able to access document quickly (from their former locations) there will be a gradual transition. The Leads will shortly be confirming which documents can move across to the new site and from what date and have been asked to ensure that local communication plans are in place for the main target audience. Access to the documents from the old location will still be active for an initial period but these links will be withdrawn over time.

Staff feedback on the new arrangements has been encouraged.

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 the Compliance Officer to help support this area of work. These improvements will ensure the system logging those reports (other than HIW) is robust and further development of the system will be in place by March 2019.

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>

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) 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 are being developed further into a SOP with a final consulted and agreed draft ready for approval mid-October 2018.

Further work is ongoing to ensure clarity of actions required by all. A training plan is under development by the palliative care team to ensure a full complement of nursing staff are trained. Staff training will commence October 2018.

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

Workforce improvement is a thread that runs through all of the recommendations and as such much of the learning is being incorporated into the new Workforce Strategy.

In the meantime, the priorities for specific action include:

- Supporting the review and redesign of the Older Persons Care Pathway and development of the Older Persons Strategy. Support for the Quality and

- Workforce Group will be provided by the Associate Director of Workforce Performance and Improvement and the Head of Equality and Human Rights;
- Supporting the review of training needs under Recommendation 13 as well as the review of capacity and capability of managing violence and aggression in Health and Safety;
- Development of the engagement tool to be used to underpin the Improvement Programme. The Team Survey element of the Go Engage tool commissioned by the Health Board is being adapted to align with the key priorities above.
- Undertaking a lessons learned review of the management of the HR processes associated with the HASCAS Investigation.

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 underway 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.

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

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.

A review of the Patient Experience real time data feedback is underway and 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.

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.

Work Stream 1 will develop a site by site schedule (Inventory) of any outstanding repairs and actions required from recent and previous external audits and inspections relating to MH&LD OPMH facilities. This base line assessment will determine the level of resources required both in regards to Revenue and Capital to address the programme of work identified.

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 support and availability of revenue funding have been identified as required resources to support the delivery of the three work streams.

Appendix 1

Improvement Group (HASCAS and Ockenden)

Terms of Reference

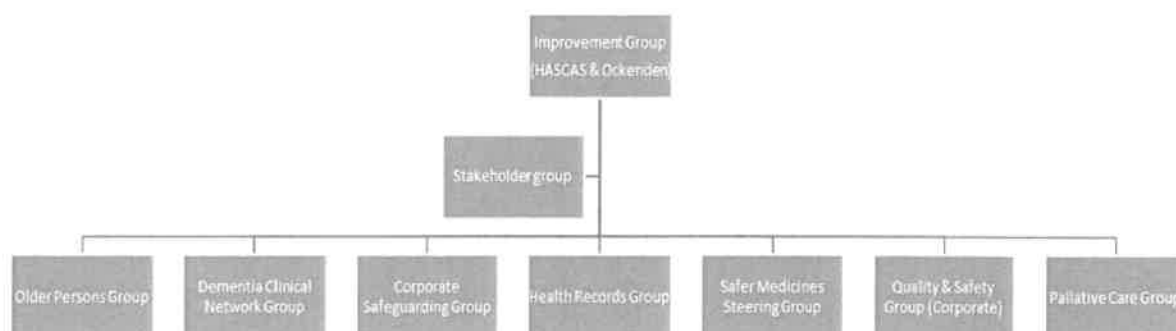
- 1.1 The Health Board will establish under the direction of the Executive Director of Nursing and Midwifery an Improvement Group to oversee the implementation of the recommendations arising from the HASCAS Thematic Report a Lessons for Learning Report and the Ockenden Governance Review to be published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