

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

Executive Summary

This report was commissioned by
Betsi Cadwaladr University Health Board

May 2018

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

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

Executive Summary

This report was commissioned by
Betsi Cadwaladr University Health Board

May 2018

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

Contents

1	Preface	2
2	Acknowledgements	3
	▪ Patients, Families and Friends	3
	▪ Witnesses	3
	▪ Support	4
	▪ Multi-Agency Partners and External Stakeholders	4
3	Investigation Terms of Reference	5
4	Summary of General Findings and Key Lessons for Learning	7
5	Overview of Conclusions and Recommendations	18
	▪ Overview of Conclusions	18
	▪ Recommendations	23

1 Preface

- 1.1** The Independent Investigation into the care and treatment provided on Tawel Fan ward was commissioned formally by Betsi Cadwaladr University Health Board (BCUHB/the Health Board) in August 2015 pursuant to the Welsh Government (Version 3 – November 2013) *Putting Things Right: Guidance on Dealing with Concerns about the NHS from 1 April 2013*. The Investigation was commissioned initially to examine specific concerns raised by some 23 families about the care and treatment received by their loved ones between January 2007 and December 2013. At this time the 23 families were held on the BCUHB open concerns register. In order to identify any other patients whose care and treatment might have fallen below an acceptable standard the Investigation was also asked to examine the archives developed during the following prior processes:
- 1** The Ockenden external investigation (conducted in 2014 and published in May 2015).
 - 2** The North Wales Police investigation (2014-2015).
 - 3** The Betsi Cadwaladr Mortality Review (2015).
- 1.2** Consequently additional patients were added to the Investigation Cohort which rose to 108 in number. Separate confidential reports have been prepared detailing the findings in relation to each case.
- 1.3** The Investigation was also commissioned to provide human resource management reports for any person employed by the Health Board identified with either conduct or competency issues in relation to any established untoward events or substandard practice on Tawel Fan ward.
- 1.4** The care pathways followed, and care and treatment received, by the patients in the Investigation Cohort have been examined closely in order to identify the lessons for learning. It is a matter of public interest to understand exactly what occurred on Tawel Fan ward, how expressed concerns were escalated and managed, and to establish the lessons for learning relevant to both local and national service provision.
- 1.5** Investigations of this kind should aim to increase public confidence in statutory health service providers and to promote organisational competence. It is the duty of any Independent Investigation Panel to conduct its work in an impartial and objective manner. This Investigation has endeavoured to maintain an independent and evidence-based stance throughout the course of its work with the aim of providing as accurate account of events as the available evidence allows.

2 Acknowledgements

Patients, Families and Friends

- 2.1 The Investigation Panel would like to extend its sincere thanks to the patients, families and friends who have contributed to this work. For some individuals the process has been a demanding one whereby challenging and difficult experiences have had to be relived.
- 2.2 The Investigation Panel has heard, and taken into account, a wide variety of views and concerns. There has been no unified set of experiences put forward; family accounts differ greatly. For example: some families stated that in their view Tawel Fan ward was an abusive environment where their loved ones were mistreated, neglected and came to harm. Other families offered the view that the care and treatment their loved ones received was of a very good standard with staff showing kindness and compassion throughout their relative's entire episode of care.
- 2.3 The Investigation Panel acknowledges the lived experience of every person who has come forward and has endeavoured to provide a fair and balanced view based on an independent analysis of events.
- 2.4 It should be recognised that each individual who came forward to the Investigation, either in writing or in person, gave a significant amount of their time to the process. We are grateful to them for this.

Witnesses

- 2.5 Independent Investigations commissioned via NHS frameworks do not have the statutory powers to compel witnesses to take part in proceedings. Whilst individuals who were either employed by the NHS (or who were still active on a professional register) had a requirement to take part in the Investigation, those to whom these conditions did not apply could not be compelled to take part against their wishes. The Investigation would therefore like to thank all of those participating individuals who are currently retired or who no longer work in health related activities for coming forward voluntarily to assist with the inquiry process.
- 2.6 Those current NHS employees who were called to give evidence were asked to provide information about clinical and managerial practice. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Health Board's senior management team who have granted access to facilities and individuals throughout this process.

Support

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

Multi-Agency Partners and External Stakeholders

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

3 Investigation Terms of Reference

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

Terms of Reference

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

Remit

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

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

Purpose

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

(1) Complaints Management

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

(2) Professional Regulation and Employment policies and procedures

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

Escalation

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

Timescales

The Investigation will complete the work program which has been set out in 5 stages.

First Stage: August/September 2015

Second Stage: September/October 2015

Third Stage: October/November 2015

Fourth Stage: December/January 2016

Fifth Stage: January/February 2016

Reporting

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

Team and Resources

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

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

4 Summary of General Findings and Key Lessons for Learning

Investigation Context

- 4.1 There always have been, and probably always will be, occasions when NHS services fail to deliver against the standards that it strives to achieve. The pressures that NHS services face are reported frequently in the media together with the recognition that patient care is sometimes compromised. It is important to recognise that this state of affairs, whilst regrettable, occurs for a number of reasons as part of the ebb and flow of daily service provision within the NHS.
- 4.2 The Investigation Panel does not seek to be an apologist for the NHS in general, or for BCUHB or Tawel Fan ward in particular, however it would be both unrealistic and unreasonable to visit harsher tests than those deemed to be acceptable for any other NHS service currently delivering patient care under the normal day-to-day pressures that are encountered throughout the United Kingdom. It has therefore been essential for the Investigation Panel to work in a manner proportionate to the circumstances and the available evidence base.
- 4.3 The Investigation Panel concludes that the care and treatment provided on Tawel Fan ward was of a good overall general standard even though there were key areas identified where clinical practice and process required development and modernisation.
- 4.4 Nevertheless it was also identified that, on occasions, the experience of some patients and their families was compromised due to a combination of systemic failures exacerbated by significant financial restrictions, poor service design and ineffective governance arrangements. However it should be understood that these issues were not as a result of any failings in relation to Tawel Fan ward *per se* but were encountered by patients and their families across a wide range of services on the care pathway that they travelled.
- 4.5 These issues encompassed problems from the point of first diagnosis through to (and often past) the point of discharge from Tawel Fan ward and/or the eventual death of a patient. These issues also included the lack of dementia friendly Accident and Emergency Department inputs and the difficulties patients and families encountered on medical wards and with other BCUHB services.
- 4.6 Tawel Fan was the common denominator in that of the 108 patients in the Investigation Cohort 105 were admitted onto the ward for a period of time. However it is evident that many of the concerns and complaints raised by families did not relate to the ward and that a significant number of families had nothing but praise for the care and treatment their loved ones received on Tawel Fan and for the kind and compassionate care provided by members of the treating team.

- 4.7 This view was not shared by all of the families in the Investigation Cohort; the Investigation Panel encountered significant dissonance between the accounts provided by family members. It has been a key responsibility of the Investigation Panel to ensure that no single view or family stance took precedence over any other and that all findings and conclusions were made after extensive examination and triangulation of the evidence available. It was also the responsibility of the Investigation Panel to ensure that the focus remained upon lessons for learning rather than calls for punishment and retribution which were entirely disproportionate to the actual findings and conclusions of the multidisciplinary expert Investigation Panel.
- 4.8 Whilst the Investigation Panel found the care and treatment provided on Tawel Fan ward to be of a good overall general standard, there were nine key factors that served on occasions to compromise the quality of the patient and family experience during the period of time under investigation. These factors are set out below and apply to the experience of the older adult (and their families) across the whole care pathway encountered including Accident and Emergency Departments, medical wards, old age psychiatry and community-based care.

Summary of General Findings

Factors Impacting upon Patient Care

- 4.9 **Governance.** During the period of time under investigation governance processes (both corporate and clinical) were weak across the whole of the BCUHB provision; this served to disrupt strategy development and implementation. This also served to prevent a robust approach from being taken in relation to patient safety in that evidenced-based practice and organisational learning were under-developed and could not always be relied upon to provide the levels of protection that were required.
- 4.10 Clinical governance provides the means to ensure patient safety and quality improvement; its effectiveness (or lack of it) has a direct impact on service delivery. In the most basic of terms the care and treatment delivered by BCUHB services was often compromised by:
- poor quality clinical policies and guidelines that did not always provide an appropriate and evidence-based set of standards for practice (particularly in relation to the older adult);
 - limited training and education opportunities for staff;
 - an ineffective approach to patient safety alerts such as those raised by complaints, incidents and safeguarding referrals;
 - inadequate levels of capacity and capability in relation to the workforce in general and medical and nurse staffing in particular;
 - ineffective clinical information systems which compromised access to individual patient information in a timely manner.
- 4.11 **The Care Pathway.** Most of the patients in the Investigation Cohort experienced problems with the care pathway that they encountered. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 4.22 Carer and Family Support.** During the period under investigation the levels of advice, supportive coordination, counselling and education provided to patients and their families were of an inconsistent standard at the point of first diagnosis. For many patients and their families this served to create confusion throughout the dementia journey that they embarked upon.
- 4.23** Consequently patients and their families were not always able to plan for the future in an informed manner and on occasions this compromised the levels of trust and confidence they had in NHS services and also compromised their ability to make decisions and be effective co-partners in care and treatment planning.
- 4.24 The Clinical Record and Professional Communication.** During the period of time under investigation BCUHB operated (and operates still) a hard-copy clinical records system. Recording templates were inconsistent and were not subject to audit. This meant that the quality of the clinical records varied enormously.
- 4.25** Of particular concern was the archiving and retrieval system which meant that clinical records could not always be accessed with ease by members of treating teams. This created problems with continuity and, at times, compromised the efficacy of patient care.

Key Lessons for Learning

Patient and Family Support

- 1 Counselling.** There is a need for a more comprehensive and specialist range of pre and post diagnostic counselling opportunities for patients and their families. Regardless of how well members of the treating team try to communicate diagnostic information they are to some extent boundaried by their primary clinical roles and functions. It is naïve to expect individual clinicians, no matter how caring and compassionate they are, to be able to provide a consultation in a memory clinic, or a ward-based family meeting context, in *lieu* of formal counselling.
- 2 Dementia Coordination and Signposting.** There is a need for the better coordination of patients and their families from the point of first diagnosis; this is in keeping with Welsh Government strategy. Continuity of care and relationship building are essential factors when working with patients and their families over a long period of time, especially as the dementia process is both challenging and progressive.

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

- 3 Clarification at the Point of Admission.** When admissions take place during times of crisis it is difficult for families to understand what is happening and what they are being asked to agree to. It is important to clarify events and revisit the decisions made and the subsequent consequences once the admission is complete and the patient has been made safe. It is not good practice for misunderstandings to arise; however on occasions these will be inevitable. To minimise the likelihood of this it is important that families are provided with a clear account of events as soon as is possible and that plans for the immediate future are discussed with them moving forward.
- 4 Operational Policy Synchronisation.** In order to provide a streamlined service that can meet expectations it is necessary for there to be a consistent set of criteria in place to guide the care pathway. Operational policies should be developed from an ‘integrated’ service perspective so that patients and their families can be signposted correctly and reliably.
- 5 Living Well with Dementia.** Over recent years a more positive and community-based approach to living with Dementia has grown. Clinical services need to ensure that they are in step with this ethos and assessment and care and treatment planning needs to focus on holistic need with the aim of providing meaningful person-centred care which does not focus on disease processes alone.
- 6 Education, Information and Support to Patients and their Families.** People need access to education, information and support throughout their journey with dementia. ‘Frontloaded’ inputs at the point of diagnosis are not enough, and neither are meetings and consultations with members of treating teams once a person has reached a point of crisis. Consideration needs to be given as to how information can be provided and tailored to each stage of the journey, particularly at key points of transition such as admission to acute inpatient wards or eventual placement in care homes. It should also be understood that family support needs will be ongoing and they should be re-assessed and provided for in a dynamic manner.
- 7 Communication Practice across all NHS Services.** Patient and family communication issues were identified in relation to Accident and Emergency, medical and surgical services. There is an obvious need for all NHS services to communicate well; however a key lesson for learning is that all services should (in addition) be dementia aware and appreciate the fact that family members often have to give consent for their loved ones who are no longer able to do this for themselves.
- 8 Placing the Patient at the Centre of Decision Making.** The best interests of the patient should always be at the centre of any decisions made. When there are ongoing disputes between families and treating teams these disputes should be recorded and independent advice sought. It is essential that delays to important decisions are avoided (such as admission or discharge) as these can have a negative impact on the safety and welfare of the patient.

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

Clinical Governance

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

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

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

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

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

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

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

- 14 Policy Development.** Policy guidance should be tailor made to the needs of the older adult. It is poor practice to subsume them into policies produced for adults of working age whereby the evidence-base in relation to older adults is ignored and care and treatment guidance compromised as a result.
- 15 Professional Leadership and Escalation.** When wards are under pressure it is essential that managers and senior clinical practitioners are available to provide advice, leadership and support. During 2013 when Tawel Fan ward was under its most significant period of pressure it was evident that the ward team were able to rely increasingly upon the Modern Matron, the Dementia Nurse Consultant and senior CPG managers. This ensured that (whilst care and treatment and service management issues arose) overarching safety was maintained whenever possible.

Legislative Frameworks

- 16 Mental Capacity, Best Interests and Advocacy.** Legislative frameworks must be deployed for patients deemed to have a loss of capacity when making specific treatment decisions. This is of particular importance for those patients who are not detained under the Mental Health Act (1983). The use of independent advocates should be an integral part of any service provided.
- 17 Patient-Centred Care.** It is important that care giving is flexible and sensitive enough to ensure dignity, health, wellbeing and safety whilst at the same time allowing the patient sufficient autonomy wherever possible. This applies to all patients, but is particularly relevant for those deemed to no longer have the capacity to make decisions on their own behalf. There should be no 'one size fits all approach' and care plans should take into account the needs and preferences of each individual patient which always take preference over those of families and services alike whenever appropriate to do so.
- 18 Family Communications, Engagement and Support.** Legal frameworks are complicated to understand and often associated with preconceptions and stigma. It is important to ensure that each family member is acknowledged in accordance with their particular roles (Lasting Power of Attorney, nearest relative and/or next of kin) and their rights are both explained to them and supported. Strategies need to be agreed and put in place so that communication is effective (and bears in mind the needs of large families) without contravening due process in relation to decision making and confidentiality.
- 19 The Need for Clarity Regarding Legal Frameworks.** NHS organisations must provide clear guidance to services about the use of the Mental Health Act (1983) and the Mental Capacity Act (2005); the guidance should clarify how they must work together and which takes precedence over the other and in what circumstances. These guidelines should be kept under review and audited where necessary on a patient-by-patient basis.

- 20 The Protections that Legal Frameworks Afford to the Patient.** The Mental Health Act (1983) should not be seen as a punitive and restrictive option for the older adult with advanced dementia. Instead it should be seen as the framework under which individuals are protected and their rights upheld.
- 21 The Importance of the Independent Mental Capacity Advocate (IMCA).** Under the Mental Capacity Act (2005) all patients have the right to access an IMCA. This is important when complex and difficult decisions have to be made in the patient's best interests as an independent advocate should always be accessed to ensure they are maintained and protected. When there are disputes between family members and the treating team the input from an IMCA is essential to ensure the patient's needs are paramount and that they are addressed in the best manner possible.
- 22 The use of Legislative Frameworks.** Even if families are engaged in full, when difficult decisions have to be made in relation to care and treatment risk versus benefit analyses, Do Not Attempt Resuscitation (DNAR), end of life care and any planned changes to a clinical placement an Independent Mental Capacity Advocate should be involved where the patient is deemed not to have the capacity to make decisions on their own behalf.
- 23 Accident and Emergency Departments and Medical Wards.** When elderly confused people are admitted to these kinds of NHS facilities the requirements of the MHA (1983) and MCA (2005) cannot be 'suspended'. They apply equally to all care and treatment environments where a patient meets the threshold for assessment and intervention under the Acts. All treatment decisions need to be recorded clearly and any issues in relation to capacity, consent and DoLS should be made explicit and managed in keeping with Acts. The failure to do so could result in illegal detention and the potential for improper care and treatment interventions.

Medication and Treatment

- 24 Psychotropic Medications – Documentation and Standardised Evaluation Processes.** Psychotropic medications carry an inherent degree of risk. It is always good practice to adhere to National Institute for Health and Care Excellence (NICE) guidance and to ensure that documentation is completed in a systematic manner. This will ensure a comprehensive record is made of all decisions taken and will assist with a logical and evidence-based evaluation process. Where there are no pre-set organisational standards or clear levels of expectation clinical practice is determined by individual practitioners and might not always be optimal.
- 25 Risk Assessment.** Risk assessment is a key cornerstone of clinical practice. As such it should be prioritised and conducted as a core multidisciplinary function. All aspects of clinical risk should be recorded and subsequent care plans documented clearly so that explicit rationales for clinical decision taking are set out and patients are protected.

Efficacy of the Care Pathway

- 26 Resourcing.** Patients who are acutely unwell and in crisis require the highest levels of expertise and resource. It is poor practice for financial pressures to remove essential services from wards like Tawel Fan (such as occupational therapy and routine physiotherapy). The quality of the patient experience is reduced, the quality of the care and treatment compromised and the length of stay potentially lengthened. This kind of cost saving is both counter productive and ineffective. Care and treatment approaches should be multidisciplinary in nature. The older adult suffering from dementia often has a range of comorbidities and needs. It is naïve to assume these can be met by a ‘traditional’ doctor and nurse treating team.
- 27 Transitions between Secondary and Primary Care.** The transition point between secondary care and primary care ought to be examined. Arrangements need to be agreed in relation to specialist assessment, monitoring and review once a person has been discharged back to the care of their General Practitioner. This is to ensure that antipsychotic medication is not used as a ‘maintenance medication’ and that all benefits and risk are kept under regular review.
- 28 Access to Medical Assessment.** Psychiatric inpatients should not experience lower levels of medical assessment access than those to be expected in a community setting.
- 29 Management of the Elderly Confused Patient in Acute Secondary Care.** Accident and Emergency Departments and Medical Wards must ensure that the care and treatment provided to elderly confused patients is person-centred, dignified and safe. It is not acceptable for them to be left for hours without food and drink, nursed in corridors, or left unsupervised encountering numerous falls that could be prevented with better assessment and management plans.
- 30 Strategic Planning and Multiple Moves.** Service provision should be as integrated and person-centred as possible so that patients can experience smooth transitions of care which ensure optimal clinical outcomes and inspire trust and confidence. It is not acceptable for patient care to be compromised by rigid boundaries between services. It has long been recognised that multiple inpatient moves have been associated with raised rates of morbidity and mortality. It is never acceptable for multiple moves to be conducted to meet the needs of the service as opposed to the needs of the patient.
- 31 Risk Assessment and Service Modernisation.** Service improvement and modernisation requires financial and service re-modelling. Improvements that require the concurrent running down of one service whilst another is built up carries inherent risks over the period required to enact the change; wards like Tawel Fan can be expected to absorb the pressures. The risks to the system and its ability to manage extant patient services should be understood and compensated for, particularly when specific groups of patients can be readily identified to be placed at additional risk during change management processes.

Safeguarding

- 32 Connectivity between Multi-agency Partners.** Safeguarding frameworks require a consistent and unified approach. Despite the challenges posed by geographies (such as county and statutory agency boundaries) systems and processes have to be robust enough to provide person-centred safety measures. The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (first version 2010 and second version 2013) required small Unitary and Local Authorities to work together to ensure consistency and safety across geographical areas; it also required full cooperation between the NHS and Social Services. It is an essential lesson for learning that safeguarding systems and processes have to be managed across boundaries if they are to achieve their primary goal to safeguard adults at risk.
- 33 Prioritisation and Adequate Resourcing.** Safeguarding adults at risk cannot be compromised by an organisation's perceived inability to adequately resource the systems and processes required. All NHS and Local Authority bodies are required to conduct themselves in accordance with policy guidance and any capacity and/or capability shortfalls should be addressed and managed so that their statutory duties can be fulfilled.

5 Overview of Conclusions and Recommendations

Overview of Conclusions

General Conclusions

- 5.1** The findings and conclusions in relation to BCUHB governance and systems failures have been identified previously by multiple review processes which have already been placed in the public domain. If an organisation operates with inadequate governance arrangements then the likelihood of poor service provision is heightened together with an increased inability to identify and remedy failings and patient safety problems. The findings and conclusions of this particular Investigation concur with those previous findings but also makes a separate and distinct contribution in relation to the following:
- the patient care pathway and service design;
 - patient acuity and restrictions to service provision;
 - evidence-based practice and the care and treatment of the older adult.
- 5.2** Any investigation process that undertakes an examination of care and treatment that took place a number of years ago has to differentiate between findings and conclusions that are ‘historic’ in nature and where practice has moved on and improved, and those where practice remains of a suboptimal nature and where urgent remedial action is required in the here and now.
- 5.3** The three points listed above have been identified by the Investigation Panel as being the basic underlying factors that made a distinct contribution to suboptimal care and treatment provision in the past and which the available evidence suggests are either still unresolved or in a relatively embryonic stage of service improvement and implementation.

The Patient Care Pathway and Service Design

- 5.4** One of the most significant findings of this Investigation is in relation to the fragmented care pathway followed by the majority of the patients in the Investigation Cohort; most of the patients in the Investigation Cohort experienced problems with the care pathway that they were placed on. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as those for medicine and psychiatry, often served to create significant boundaries which had a negative impact upon patients and the timely access to the care and treatment that they required.
- 5.5** Older adults are placed at significant risk when care pathways are not managed well. Disruptions to care pathways are known to increase the likelihood of hospital acquired infections and injuries and, on occasions, death. The poor management of the older person’s care pathway across north Wales is a key finding of this Investigation. The lack of strategic direction and oversight,

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

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

Patient Acuity and Restrictions to Service Provision

- 5.7** The Investigation Panel established that patient acuity rose on Tawel Fan in the years prior to its closure due to:
- the reduction of care home beds;
 - a relatively embryonic community-based Home Treatment Team that could not manage patients in their own homes once they had reached crisis;
 - reductions to the numbers of older adult inpatient beds across the Mental Health and Learning Disability CPG.
- 5.8** This situation was exacerbated by additional pressures placed on mental health services by Emergency Departments, inadequate Out of Hours provision and restricted access to medical and hospice services.
- 5.9** It is recognised widely in Wales that the number of people with dementia is rising steadily and will continue to rise. Pressures on nursing home beds remain and there is evidence to suggest that community-based services remain under-developed and that older people with dementia still experience compromises in relation to the kinds of service they can be offered in community, primary and secondary care settings.
- 5.10** The challenges for BCUHB and its multi-agency partners in 2018 is to provide a range of services that do not discriminate against those individuals with dementia and to ensure that a diagnosis of dementia is not one of exclusion or compromise.

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

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

- 5.12** Of particular concern was the fact that clinical practice was not subject to audit in the manner prescribed within the United Kingdom for the past twenty years. This meant that clinicians were left largely to ‘their own devices’ and that there were no structured clinical governance structures in place to ensure patient safety.
- 5.13** The Investigation Panel heard evidence from many senior clinicians during the course of its work. From the testimonies provided by those witnesses it would appear that the custom and practice around the development and auditing of clinical practice guidance within BCUHB is still in a somewhat embryonic stage. Witnesses described the work as ‘being part of a journey’, or ‘not yet having reached its destination’. This is not acceptable for a modern NHS service and will require urgent and priority actions to take place.
- 5.14** Part of the challenge that BCUHB needs to face is the underlying culture of resistance to clinical policy uniformity and regulation. The Investigation Panel established that a key barrier to progress being made is predominantly one of custom and practice and that there are views still retained by some senior clinicians within the organisation that the clinical decision-making process should not be overseen by formal governance and management structures. This is exacerbated by a lack of organisational confidence and ethos in relation to formal oversight and performance management as a legacy of the highly devolved and medically-led service model that prevailed for many years within BCUHB.

The Issue of Wilful and Institutional Abuse and Neglect

- 5.15** The nature and scale of any failures in relation to patient care on Tawel Fan ward cannot be compared to those of the Stafford Public Inquiry or the Trusted to Care Independent Investigation (conducted in Wales), on either a macro (system) or micro (individual patient) level.
- 5.16** Neither of those robust and universally accepted reports set their findings within the context of institutional abuse or concluded that care and treatment deficits occurred within the context of an abusive system (even though care and treatment fell well below those standards commonly accepted by the general public and statutory services alike). The Investigation Panel concludes that this approach has to be maintained in relation to the circumstances encountered by patients and their families on Tawel Fan ward, especially as the standards of care on the ward have been found to be of a good overall general standard, even though on occasions care and treatment practice across the pathway was compromised.
- 5.17** The Investigation Panel could not replicate the specific findings of abuse from any of the earlier investigations and reviews that did. This does not mean that the Investigation Panel can categorically state that abuse on an individual patient basis *never* took place on Tawel Fan ward; no investigation of this kind could ever make such a bold statement. However the Investigation Panel can, and does, conclude that the evidence relied upon previously was:

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

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

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

Safeguarding

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

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

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

- 5.23** These arrangements made it very difficult for clinical staff in the ward areas to navigate the adult safeguarding system easily. There were delays in the process of safeguarding, which often moved outside of the timescales in the policy, and ward staff who were responsible for the protection of the individual whilst they were in their care, often did not receive feedback in terms of what had been decided within the safeguarding meetings rendering ongoing protection and decisions regarding discharge, difficult.
- 5.24** During the period of time under Investigation there were poor safeguarding record storage and retrieval processes. This resulted in staff being unclear about what protection processes they were supposed to be putting in place and how to best deal with relatives when they were considered to be a risk to the individual in their care. As a result, information to individuals, families and carers was not conveyed clearly which led to confused expectations and understanding of what was happening.
- 5.25** In relation to BCUHB processes, the Investigation Panel found that adult safeguarding had not been well resourced and each CPG had been allowed to develop its own processes and structures. In addition, Board oversight was not strong and the Executive and Independent Members were not advised clearly of the problems relating to adult safeguarding in either the multi-agency partnership or specific clinical areas. Audit systems during this period of time were rudimentary, so opportunities for BCUHB to triangulate data about safeguarding referrals were lost.
- 5.26** At the time of writing this report there was evidence to suggest that good foundation work is taking place in relation to the restructuring and resourcing of the internal BCUHB safeguarding frameworks and processes. However a substantial amount of service development is still required in order to ensure safeguarding works to protect adults at risk across north Wales as many of the issues identified by the Investigation Panel are still a problem within current service provision. The Investigation Panel concludes that this constitutes essential and priority work for the organisation and those responsible for its performance management moving forward.

Summary of General Conclusions Specific to Clinical Care and Treatment

- 5.27** Many of the findings and conclusions made specifically in relation to Tawel Fan are to a large extent redundant as the ward is now closed. However there are key issues that have been identified in relation to clinical practice that need to be highlighted as they are relevant to the care and treatment of the older adult and/or those with dementia regardless of clinical setting.
- 5.28** Many of the findings of the 2014 *Trusted to Care* report dovetail into those of this Investigation. Basically the needs of the older adult and those with dementia require specialist nursing and medical care and treatment. Older adult services should not be seen as ‘Cinderella’ services but should be recognised as priority services that require clinical staff with expert skills and access to specialist

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

- 5.29** During the period under investigation older adult and dementia services were neither planned nor coordinated with the degree of organisational strategic oversight that was required. This not only made an impact upon the quality of the care pathway patients and their families encountered, but also made a direct impact upon the effectiveness of the care and treatment that they received.
- 5.30** It is of significance that during the period of time under investigation there were no older adult or mental health clinical specialists at Board level or within the senior corporate team. Inspections, strategy and assurance processes were overseen by those with limited expertise and a limited understanding of what evidence-based service provision and care and treatment should look like.
- 5.31** At the present time significant work has taken place to make services more aware of the needs of the older adult and those with dementia. However the approach taken remains rather *ad hoc* with separate clinical divisions approaching these issues differently. The work currently being undertaken is primarily being led by the mental health division and BCUHB needs to move away from the stance that dementia is primarily the concern of mental health services and embrace a different ethos where the Health Board accepts the care and treatment challenges of old age and of dementia embrace all health and social care provision in all care and treatment settings. However one very positive step has been the decision to appoint a dedicated dementia specialist into the corporate nursing team to ensure that in future a more integrated approach is taken; in this manner resources are beginning to be aligned to support pace and consistency.
- 5.32** Moving forward BCUHB needs to ensure all aspects of clinical governance come together to ensure the particular needs of the older adult and those with dementia are met. This needs to include workforce capacity and capability, education and training, clinical audit and evidence-based practice guidance, patient safety and safeguarding. Alongside this costed and timed strategic plans need to be developed spanning the entire of breadth of service provision to ensure the needs of the older adult and those with dementia are inbuilt into every service and care and treatment context. The work that needs to be undertaken *must* be built across all executive teams and clinical divisions to ensure full integration and a unified strategic ethos.

Recommendations

Overview

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

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

- 5.34** The Investigation Panel has not been privy to all of the outstanding issues or the levels of progress made by BCUHB to-date. To this end the recommendations fall into two distinct categories – the first requiring a concerted degree of oversight (and possible further development) from Welsh Government in relation to ongoing high-level performance issues, and the second requiring practical, operational service change within BCUHB requiring a less intensive level of oversight from external bodies.
- 5.35** In addition BCUHB will soon be in receipt of the Ockenden Governance Review. This review will provide a significant number of recommendations in relation to governance systems, structures and processes. Consequently this Investigation has limited the setting of its recommendations to strategic and specific clinical practice issues. Following the publication of the Ockenden Governance Review further work will need to be undertaken to provide synergy in relation to action planning and the recommendations from both of the separate investigative and review processes.
- 5.36** On reviewing the progress made by BCUHB in relation to many of the current recommendations it is working to, it is evident that moving forward *all* future recommendations need to be overseen with the support of a structured action plan that sets:
- clear milestones, aims and objectives;
 - clear performance targets and indicators;
 - clear methods of audit and evidence collection, progress review and assurance;
 - clear costings and resource implications;
 - clear indications of where multi-agency inputs are required;
 - clear timeframes and completion dates;
 - clear methods of accountability and oversight.
- 5.37** With this in mind the Investigation Panel has reviewed the progress made by BCUHB in relation to the findings and conclusions of this Investigation. The recommendations have been set with the intention of supporting the work that BCUHB has already embarked upon and to also ensure that future strategic planning incorporates inputs from Welsh Government particularly where multi-agency partners also need to make significant contributions to planning, process and service provision.
- 5.38** The Investigation Panel has identified that during the period of time under investigation, and into the present day, many BCUHB initiatives have either been confounded or rendered ineffective by a lack of integrated, strategic thinking and planning. The recommendations set out below place emphasis on the importance of joined-up thinking and integrated service planning. The expectation is that all recommendations will be completed within 12 months of the publication of this report.

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

The Dementia Care Pathway and Service Design

Progress Made

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

Progress Required

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

Recommendation One: Care Pathway and Service Design

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

Implementation of the National Wales Dementia Strategy

Progress Made

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

- 1 The Health Board has a designated Consultant Nurse in Dementia care who provides input at a strategic and clinical level into services.
- 2 There are currently a wide range of opportunities for patients and families to obtain support through memory services and the third sector (such as the Alzheimer's Society). In addition BCUHB dementia training is now open for

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

- 3 There is a Delirium and Dementia Specialist Nurse available to provide expertise to individuals and services. There has also been a strong focus on the recruitment of Dementia Support Workers who are working across the organisation together with ten Dementia Activity Workers who are further supporting patients when accessing mental health services.
- 4 The Flynn and Eley Review highlighted the importance of support for those affected by or living with dementia at or around the point of diagnosis. They recommended that BCUHB develop a standard offer of post diagnostic support for people living with dementia and their families as part of a wider network of support.

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

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

Progress Required

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

Recommendation Two: Dementia Strategy

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

- The action plan should take into account all of the clinical and practice deficits that have been highlighted by this Investigation and will require independent clinical input and oversight.
- Access to therapy and non-medical interventions and treatments should be an integral part of any costed Dementia Strategy plan which takes into account NICE (and all other) best practice guidance in this regard. The capacity and capability of the workforce should be reviewed to ensure that fit for purpose services can be provided. Implementation should be managed and audited in tandem with Recommendation Ten (see below) as the reduction of the use of antipsychotic medication will to a large extent be predicated upon alternative therapeutic interventions being made available.
- Formal audit and performance management arrangements should be agreed and built into the action plan.

Care Home Provision in North Wales

Progress Made

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

- 1 Practice Development Team.** This team is responsible for ensuring the delivery of quality, evidence-based and personalised care within the homes. They undertake annual quality monitoring audits utilising an electronic tool that scores the delivery of care associated with Healthcare Standards and the Fundamentals of Care. The team facilitates and delivers training in-house and can arrange for specialist nurse support to provide clinical leadership.
- 2 Quality Assurance Framework.** This has been developed to describe and set out quality assurance processes to ensure safe care. This includes holding a monthly clinical management group to proactively discuss each care home with all relevant stakeholders. This helps to gain and collate key intelligence and provides a robust and proactive response in order to support homes as required.
- 3 Contracts and Fees.** The Health Board has employed a contracts team. This team works to explicit performance indicators and can work with the Practice Development Team to raise quality and provide practical support directly into any care home experiencing difficulties.

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

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

Progress Required

- 5.44** The Investigation Panel acknowledges the progress that is being made in this area. Moving forward this progress needs to be audited and any ongoing work programmes need to form part of an integrated process that brings together the BCUHB Mental Health Strategy, the Dementia Strategy and all ongoing service re-design initiatives; particularly those changes and improvements to community support provision.
- 5.45** A fragile care-home market can impact greatly upon NHS community, primary and secondary care services. Care home provision and quality monitoring needs to be unified into wider strategic action planning as part of an integrated approach to providing timely access to appropriate and good quality services.

Recommendation Three: Care Homes and Service Integration

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

Safeguarding

Progress Made

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

Progress Required

- 5.47** At the time of writing this report there were significant areas that still required improvement. However the Investigation Panel acknowledges the fact that BCUHB is aware of the areas that require improvement and is reassured by the levels of increased insight and understanding of its safeguarding responsibilities. BCUHB have identified ongoing issues:
- the current safeguarding training programme is not fit for purpose and requires updating;
 - staff are not attending safeguarding training in the numbers required;

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

Recommendation Four: Safeguarding Training

- BCUHB will revise its safeguarding training programme to ensure it is up-to-date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance.
- BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation.
- BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.

Recommendation Five: Safeguarding Informatics and Documentation

- BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 are implemented – namely:
 - the use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;
 - process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;
 - team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.
- In addition BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided. This to include specific guidance on:
 - the content of protection plans;
 - the recording of strategy meetings and all decisions taken (guidance should require a standardised approach across all BCUHB clinical divisions);
 - formal monitoring and review templates should be developed and audited to ensure safeguarding timescales are met and those with key responsibilities in this regard held to account.

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

Recommendation Six: Safeguarding Policy and Procedure

- The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This Investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are:
 - *“to identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners;*
 - *agree a priority list and activity timeframe to review documents within the parameters of Corporate Safeguarding;*
 - *provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy and legislative safeguarding frameworks;*
 - *agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;*
 - *update and maintain the Safeguarding Policy webpage;*
 - *continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards”.*

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

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

Recommendation Eight: Evaluation of Revised BCUHB Safeguarding Structures

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

Category Two: Recommendations Concerning Localised Operational Service Change

Informatics and Clinical Records

Progress Made

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

Progress Required

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

Recommendation Nine: Clinical Records

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

Medications Management and the Use and Monitoring of Antipsychotic Medications

Progress Made

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

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

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

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

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

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

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

Current Situation

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

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

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

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

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

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

Progress Required

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

Recommendation Ten: The Prescribing and Monitoring of Antipsychotic Medication

- The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.
- BCUHB will continue to work with care homes across north Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of antipsychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit detailed in the bullet point directly above.

Evidence-Based Practice and Clinical Guidelines

Progress Made and Still Required

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

Recommendation Eleven: Evidence-Based Practice

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

Legislative Frameworks: Deprivation of Liberty Safeguards (DoLS)

Progress Made

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

Progress Required

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

Recommendation Twelve: DoLS

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

The Management of Aggression in the Elderly

Progress Made

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

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

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

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

Progress Required

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

Recommendation Thirteen: Restrictive Practice Guidance

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

End of Life Care

Progress Made

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

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

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

Progress Required

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

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

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

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

Recommendation Fifteen: End of Life Care Environments

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

