

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

This report was commissioned by  
Betsi Cadwaladr University Health Board

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

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**Part One**  
**Introduction**

# 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 detailed in this report. 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 Introduction

### Investigation Inception

#### Background to the Tawel Fan Investigation

- 3.1** In the autumn and winter of 2013 a series of events occurred which brought several issues regarding Tawel Fan ward to the attention of senior managers at Betsi Cadwaladr University Health Board. These issues led ultimately to the ward being closed on 20 December 2013; they were multifactorial in nature and are set out below.
- 1** There had been a series of ongoing concerns and issues raised under Protection of Vulnerable Adults (PoVAs) processes by a patient's wife in relation to the care and treatment provided to her husband.
  - 2** There were growing management difficulties in relation to the levels of abuse, aggression and disruption experienced by ward nursing staff from the relatives of some patients. This had led to staff going off sick with stress and depression, with the remainder of the Tawel Fan workforce being described as "*fragile*" in contemporaneous risk assessments.
  - 3** Patient acuity had become increasingly difficult to manage in the light of bed shortages across the Mental Health and Learning Disability Clinical Programme Group in north Wales. A consequence was that Tawel Fan ward had struggled to maintain appropriate staffing levels and subsequent patient safety; these concerns had been escalated appropriately and were under review.
  - 4** On 5 October 2013 a covert recording was made of a nursing handover by a registered nurse member of the Tawel Fan ward team. The recording was given to the relative who had already raised concerns on behalf of her husband. On 12 December 2013 this recording was shared with one of BCUHB's Deputy Directors of Nursing for an assessment of the content which was deemed by her to be unprofessional in nature.
  - 5** On 5 December 2013 a domestic working on the bank alleged that she had witnessed an incident on Tawel Fan ward a week previously. The incident involved four members of staff who apparently restrained a patient (in what she thought) was an inappropriate manner. A PoVA referral was duly raised; an incident form had already been submitted contemporaneously by ward staff in relation to the incident and the subsequent actions that had been required. The PoVA led to the staff involved in the alleged incident being redeployed to non-clinical duties whilst further investigation took place.
  - 6** The combined factors (exacerbated by ongoing staff sickness rates and redeployment issues) meant that the ward could no longer be staffed safely.

- 3.2** Tawel Fan ward was closed on 20 December 2013 following a collective decision taken by the Health Board and senior clinical staff. Patient acuity and low staffing levels had already led to the ward being closed to new admissions a week or so earlier – a decision taken by the Clinical Programme Group Chief of Staff and the Clinical Service Director.
- 3.3** At this stage the ward closure was undertaken as a temporary measure. The patients were sent to other clinical areas and the remaining staff were redeployed.

### Investigation and Inquiry Processes Prior to August 2015

- 3.4** The investigation and review processes conducted prior to August 2015 are set out below. It should be noted that the purpose for doing so is to inform the reader as to the factual sequence of events; at this point in the report no further analysis is given.
- 3.5** **The Ockenden External Investigation.** On 1 January 2014 Donna Ockenden was commissioned by the Betsi Cadwaladr University Health Board to conduct an external investigation into “*concerns raised regarding the care and treatment of patients on Tawel Fan*”.<sup>1</sup> The Terms of Reference required the investigation to conduct a comprehensive examination of all aspects of care and treatment, service provision, policy adherence and workforce management pertaining to the ward.
- 3.6** The investigation report published in May 2015 considered allegations made by eight families regarding their relatives’ care. The investigation found significant failings and determined that the allegations made by families had been “*proven*” and constituted “*institutional abuse*”. The report received a great deal of media interest following publication and the caption “*patients were treated like animals in a zoo*” became a well-recognised headline even though inaccurately quoted from the report.
- 3.7** **The BCUHB Mortality Review.** In response to advice given by Donna Ockenden BCUHB initiated a Mortality Review on 1 June 2014 via an internally commissioned process. In September 2014 a first draft report was sent to the BCUHB Medical Director who advised that the review needed to be widened.
- 3.8** Subsequently on 17 November 2014 work commenced to review some 56 individuals who were understood to have been inpatients on Tawel Fan ward between November 2011 and December 2013. This patient cohort was purported to comprise every person who had died on the ward and also included those who had died following discharge (beyond a 30 day threshold). In September 2015 the Mortality Review analysis was completed and a draft report submitted to the BCUHB Executive Medical Director.
- 3.9** During the course of the review four patients out of the original 56 cases had to be ‘stood down’ as it had not been possible to secure their clinical records. At the completion of the process eight patient cases were identified where there was

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<sup>1</sup> Ockenden D (September 2014) *External Investigation into Concerns Raised Regarding the Care and Treatment of Patients on Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital*

considered to be potential for death to have been avoidable. In addition 36 patient cases (82 percent of the cohort) were found to show evidence of problems in healthcare; however no link to any act or omission was found to have made a contribution to death.

- 3.10** The first-stage Mortality Review was shared with the North Wales Police and the review archive was sent to Donna Ockenden. The first-stage findings were also shared with the Coroner for North Wales (East and Central) covering Denbighshire, Conwy, Wrexham and Flintshire. However the second-stage Mortality Review report was not shared, it is not clear why, but would appear in part to be because the Police and Ockenden lines of inquiry by this stage had been closed. Separate arrangements were agreed in relation to the Coroner at the behest of this Investigation once it was apparent he had not been kept updated.
- 3.11** **The North Wales Police Investigation.** In the autumn of 2014 the North Wales Police (NWP) commenced an investigation which was completed in the spring of 2015. As part of the process NWP commissioned a medical review of 17 patients who had received care and treatment on Tawel Fan ward. The investigation found no evidence of avoidable death, abuse, mistreatment or neglect.
- 3.12** The Crown Prosecution Service subsequently reviewed the evidence and determined that criminal charges should not be brought as the thresholds had not been met.
- 3.13** **Older People’s Mental Health Services Review.** On 23 January 2014 BCUHB commissioned an external review of older people’s mental health services. Dr Margaret Flynn, author of the report into events at Winterbourne View, and Ruth Eley, once the national programme lead for older people and dementia at the Department of Health in London, conducted an external review of mental health services for older people across north Wales to ensure that governance and quality standards were being met. The subsequent report was placed in the public domain in December 2014.
- 3.14** **PoVA Investigations.** Investigations led by Local Authorities and the North Wales Police continued (and in some cases continue still) in relation to the PoVA issues that had been raised in the months and weeks before Tawel Fan ward was closed.
- 3.15** **Human Resource Management Processes.** Alongside all of the investigation and review work listed above BCUHB conducted a series of preliminary investigations and interviews; consequently some BCUHB staff members were suspended from duty or placed in restricted clinical practice roles.

## The Need for Further Investigation and Review

- 3.16** Following the publication of the Ockenden external investigation in May 2015 there were growing calls for further investigation work to be undertaken. These calls came from a diverse range of individuals and institutions and included families, politicians and regulatory bodies. This was for four main reasons.

**3.17 First.** The families who still had concerns open on the BCUHB register felt that whilst an overarching investigation had been conducted by Donna Ockenden their own personal experiences (and the questions arising from them) had not been examined in-depth. Although many of these families had not previously voiced concerns in relation to either abuse or mistreatment of their relatives their anxieties had since been raised by both the information that had been placed in the public domain and the contact made with them as part of the North Wales Police investigation.

**3.18 Second.** Some BCUHB employees had been either suspended or placed on restricted duties as a result of both preliminary internal investigation processes and the findings of the Ockenden external investigation. There was a growing momentum for people to be held to account for what was accepted to be a wide-ranging scandal involving the abuse of both individual patients and public trust.

**3.19 Third.** On 1 June 2015 Welsh Secretary Stephen Crabb said the families concerned wanted to see “*real accountability*” and someone to “*lose their job*” over the scandal.<sup>2</sup> On 2 June 2015 it was reported that Carwyn Jones, First Minister, had said “*the local health board (LHB) will take disciplinary action against those who are responsible*”.<sup>3</sup>

**3.20** At the urgent debate held at the Senedd on 3 June 2015 Darren Millar AM representing Clywd West (and Shadow Minister for Health and Social Services May 2011 – July 2016) said of the Ockenden external investigation:

*“The report painted an awful picture of institutional abuse of vulnerable and sick patients who faced a lack of dignified and compassionate care, inhumane treatment and breaches of basic human rights and fundamentals of care – patients being restrained, patients being nursed on the floor and in urine-soaked mattresses and clothing, patients being treated like animals, according to relatives, and staff behaving like a swarm of seagulls, one described it as, pinning a patient to the floor”.*

He called for those responsible to be sacked:

*“And when I say ‘sacked’, I mean just that – sacked, not removed or put out to other duties; not let go with a sizeable pay-off and a huge settlement package. Their heads should roll. They should be dismissed, never to work in the National Health Service again or, indeed, to be engaged by the National Health Service in any other way... If what transpires from the referrals and the mortality reviews suggests that criminal negligence or activity has taken place, then the North Wales Police and the Crown Prosecution Service must reconsider their positions”.*

Darren Millar also said:

*“... We also need to see an independent panel established to oversee the implementation of the recommendations in the Tawel Fan report. This would add*

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<sup>2</sup> <http://www.bbc.co.uk/news/uk-wales-politics-32966273>

<sup>3</sup> <http://www.bbc.co.uk/news/uk-wales-politics-32966273>

*some rigour and accountability to the process, and, given her insight and expertise, I think it would be wise to include Donna Ockenden in taking this work forward, as well as family members of the victims of Tawel Fan”.*<sup>4</sup>

**3.21 Fourth.** On 8 June 2015 it was confirmed by Mark Drakeford (the then Minister for Health and Social Services) that the Betsi Cadwaladr University Health Board was to be put in special measures.

**3.22** Mark Drakeford had already stated on 3 June 2015 at the debate held at the Senedd:

*“The board’s internal investigation, including disciplinary processes, will now resume. I am clear that these processes must be overseen by independent and expert individuals who are external to the board and independent of it”.*

**3.23** At the 14 July 2015 Betsi Cadwaladr University Health Board meeting it was reported that:

*“The remaining investigation was considerable in its scope with the triangulation of all of the available evidence (including Police statements, previous internal investigations, complaints and the Mortality Review).*

*The Health Board therefore needed to consider how best to manage this process effectively, as well as progressing in a timely manner whilst also ensuring the processes and required Governance practices are adhered to...*

*... The Health Board has recognised that it does not have sufficient capacity or capability within the Health Board to manage such a large and serious exercise and wants to be able to procure an independent and experienced organisation to undertake the remaining part of the work”.*<sup>5</sup>

**3.24** Due to the gravity of the situation confirmation was sought from Welsh Government in relation to appointing HASCAS Consultancy Limited to undertake the outstanding investigative work.

**3.25** Ultimately it was decided that two separate pieces of work were required.

**1** HASCAS Consultancy Limited was commissioned to conduct an expert and evidence-based clinical investigation into the care and treatment provided to patients on Tawel Fan ward. The commission also required an evaluation and assessment of the reasonableness of any acts or omissions by BCUHB employees in order for human resource management decisions to be taken. The full Terms of Reference for the Investigation are set out in chapter 4 of this report.

**2** Donna Ockenden Limited was commissioned to undertake a Governance Review into older people’s mental health services across north Wales. The review was commissioned to examine “*systems, structures and processes*”.

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4 <https://yoursenedd.wales/debates/2015-06-03-3-urgent-debate-the-findings-of-an-investigation-into-patient-care-at-the-tawel-fan-ward-of-bodelwyddan-s-glan-clwyd-hospital>

5 14 July 2015 BCUHB Board paper

## Links to Other Current Investigations/Review Processes

### Ockenden Governance Review

- 3.26** The Ockenden Governance Review was commissioned formally in conjunction with the HASCAS Consultancy Limited Investigation. The two pieces of work have been undertaken independently of each other at the request of BCUHB. However an appropriate level of information sharing has taken place following full scrutiny by the Independent Oversight Panel (the details and function of the Independent Oversight Panel are set out below).

### North Wales Safeguarding Processes

- 3.27** A decision was taken by the Conwy and Denbighshire Local Authorities to conduct their ongoing safeguarding and Protection of Vulnerable Adult (PoVA) reviews in relation to Tawel Fan ward separately from any process commissioned by BCUHB. However, where appropriate and possible cooperation was extended between the Local Authorities and the Health Board.
- 3.28** This Investigation has provided Conwy and Denbighshire Local Authorities access to all relevant key concerns and issues that it has identified as part of an ongoing process throughout the course of its work. This has been done in order to ensure any matters pertinent to maintaining the safety of older adults at risk in north Wales can be acted upon in a timely manner.
- 3.29** Every effort has been made to ensure that BCUHB has been able to fulfil its statutory responsibilities in relation to safeguarding; however in order to preserve the ‘Chinese Wall’ between the Investigation and BCUHB all transfers of information have been managed between the Investigation and the Local Authorities directly within appropriate confidentiality sharing arrangements.

## Investigation Panel Members

### Selection of the Investigation Panel

- 3.30** Dr Androulla Johnstone, Chief Executive of the Health and Social Care Advisory Service (HASCAS) and HASCAS Consultancy Limited (HASCAS/HCL), was appointed as the Chair of the Investigation. The supporting Investigation Panel comprised individuals who worked independently of the Betsi Cadwaladr University Health Board. These individuals were either employed or contracted directly by HCL during the course of the investigation process. Panel members were selected after careful consideration to ensure that they had the required levels of expertise.
- 3.31** The Investigation Panel was supported by a secretariat provided by the Health Board. Organisation and Investigation Panel Member biographies are set out in appendix 1.

### **Independent Investigation Panel Members**

- |                                   |  |
|-----------------------------------|--|
| <b>Dr Androulla Johnstone</b>     | ▪ Chief Executive Health and Social Care Advisory Service and HASCAS Consultancy Limited: Investigation Chair and mental health nursing lead |
| <b>Chris Dent</b>                 | ▪ Director HASCAS Consultancy Limited: corporate governance  |
| <b>Ruth Dixon</b>                 | ▪ Specialist Advisor: social work (safeguarding and legislative frameworks)  |
| <b>Gill Duncan</b>                | ▪ Director HASCAS Consultancy Limited: governance and safeguarding   |
| <b>Jane Duncan</b>                | ▪ Director HASCAS Consultancy Limited: nursing and safeguarding  |
| <b>Dr Tracey Eddy</b>             | ▪ Specialist Advisor: psychiatry   |
| <b>Camilla Flomen</b>             | ▪ Specialist Advisor: pharmacy   |
| <b>Dr Michael Gill</b>            | ▪ Specialist Advisor: medicine   |
| <b>Professor Moira Livingston</b> | ▪ Specialist Advisor: psychiatry, medical workforce and clinical governance  |
| <b>Tim Parry</b>                  | ▪ Specialist Advisor: human resource management and workforce development  |
| <b>Will Smith</b>                 | ▪ Specialist Advisor: mental health nursing  |
| <b>Dr Kevin Stewart</b>           | ▪ Specialist Advisor: medicine and mortality review  |

### **Support to the Investigation**

- |  |  |
|--|--|
| <b>Greg Britton</b>  | ▪ Investigation Manager HASCAS Consultancy Limited: project management |
| <b>Janet Sayers</b><br><b>Daniel Freeman</b><br><b>Georgia Francis</b> | ▪ Kennedys Solicitors: legal advice and assurance                      |
| <b>Bridget Dolan QC</b>  | ▪ Legal advice and assurance   |

## Independent Oversight and Quality Assurance Processes

**3.32** There are inherent difficulties when the commissioner of an Independent Investigation is also the subject of the inquiry process. At the inception of the Investigation HASCAS Consultancy Limited recommended to BCUHB that an oversight panel be established as part of an ongoing governance framework. The purpose of this panel was to provide:

- independent oversight and quality assurance;
- value for money monitoring and scrutiny;
- alignment and coordination between agencies, services and the Investigation;
- a robust audit trail in relation to all of the decisions made and processes undertaken in preparation for any potential future investigations and inquiries (e.g. by the Nursing and Midwifery Council (NMC), General Medical Council (GMC), Coroner, Ombudsman, Police, Employment Tribunals etc.);
- accountability, openness and transparency in the public interest.

### The Original Oversight Panel

**3.33** The Original Oversight Panel met for the first time in September 2015. A key function was to provide a link between the Investigation and the Health Board without compromising the independence of the work. At this stage the commissioner thought that an executive director from the Health Board would be an appropriate lead if supported by other more independent panel members. The Oversight Panel comprised:

- Mr Martin Jones (Chair): Executive Director of Workforce and Organisation Development BCUHB;
- Ms Jenny Williams: Chair of the Regional Safeguarding Board and Director of Adult and Children's Services Conwy Local Authority;
- Mr Trevor Jones: Health Board Committee Advisor (Lay Member).

**3.34** The Oversight Panel Chair linked directly into the BCUHB Silver Command Group. The Silver Command Group had been established in order to provide a swift operational response to the investigation process.

**3.35** It was the role of the Oversight Panel to:

- report to and assure the Health Board on all aspects of process, progress and costings;
- work with the Investigation to ensure that all governance matters were resolved;
- advise on any amendments to the Terms of Reference as required;
- approve and consult with the Investigation regarding recommendations (the Investigation would retain editorial control).

- 3.36 It was not the role of the Oversight Panel to:
- advise on the content of the Investigation findings and conclusions;
  - command or persuade the Investigation to avoid fulfilling the Terms of Reference.

## The Independent Oversight Panel

- 3.37 As the Investigation progressed BCUHB appointed a Director of External Investigations who became the Chair of the Oversight Panel on 1 July 2016.
- 3.38 However by the end of the summer of 2016 it was evident that the scope of the Investigation had grown considerably. The Investigation Chair raised concerns with the Chairman and Chief Executive of the Health Board in relation to strengthening the oversight function. This was to ensure a more robust governance framework was developed moving forward.
- 3.39 On 11 November 2016 a meeting was held between Welsh Government, the Health Board and the Investigation Chair. The need to strengthen the oversight role and function was discussed. Consequently the role and function of independent oversight and quality assurance was reviewed and the decision to establish an entirely independent ‘stand alone’ panel was taken.
- 3.40 On 21 February 2017 the first Independent Oversight Panel meeting was held. The Terms of Reference for the Independent Oversight Panel are set out below.

### ***Purpose***

*Purpose to provide oversight and governance to ensure the process for the completion and publication of the reports resulting from the HASCAS investigation and Ockenden review are concluded in a timely way and protected from any inappropriate influence from those currently and previously employed by the LHB and other stakeholders.*

### ***Key Tasks***

- *To review the scope, methodology and process including completion of the work in a timely manner for the HASCAS Investigation and Ockenden Governance Review.*
- *To ensure the appropriate and timely sharing of information between the HASCAS, Ockenden and separate but related PoVA investigations being taken forward under the local safeguarding arrangements.*
- *Set out and agree the roles and responsibilities of each of the key parties – ie the LHB, regional safeguarding board, HASCAS and Donna Ockenden with all parties to avoid confusion or conflict.*
- *To agree a process and timetable for the conclusion of the work and publication of related reports.*
- *To ensure the LHB has the mechanisms and effective plan in place to communicate with all stakeholders.*
- *To ensure stakeholders are clear on the role and independence of the Panel.*

**Membership**

*Jack Straw (Chair)*

*Helen Bennett*

*Phil Hodgson*

**Meeting Frequency**

*Initial 5 days discussions with key parties to review and assure on scope, methodology and process.*

*2 days of meetings per month to ensure effective governance and oversight until conclusion and publication of the reports.*

*Meetings to be held in North Wales.*

**Governance Arrangements**

*If the Panel cannot secure the necessary co-operation from key partners, such issues should be formally escalated (in writing) to Welsh Government to consider against the agreed terms of reference for the Panel. Welsh Government will then intervene directly where it is appropriate for them to do so.*

*Arrangements will be put in place for the Panel to access the necessary independent legal expertise it requires to enable it to fulfil the key tasks outlined above.*

*To ensure the Oversight Panel can operate independently of Welsh Government and BCUHB, it will be separated from the broader special measures support. However, any barriers to delivering against the terms of reference reported on by the Panel will be acted on via the special measures oversight arrangements.*

*Welsh Government will make the necessary arrangements to ensure that the Panel has the necessary administrative support it requires.*

**Review**

*Any changes to the terms of reference will need to be agreed between the Panel and the Welsh Government”.*

## 4 Investigation Terms of Reference

- 4.1 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”.*

- 4.2** 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 to several reasons which are set out in the Investigation Method chapter below.

## 5 Investigation Method

### Challenges, Scope and Limitations

#### Challenges

**5.1** The Investigation was required to examine the care and treatment provided to 108 patients; the dates those patients were admitted to Tawel Fan ward ranged between January 2007 and December 2013. The size of the patient cohort (combined with the seven-year timespan) presented challenges, especially as the episodes of care required examination several years later (between 2015 and 2017). The challenges to the Investigation included the following:

**1 Witness Engagement.** Due to the passage of time several staff witnesses no longer worked for BCUHB. A small number of them could not be traced and two chose not to take part in this Investigation (as is their right when no longer working in the NHS or on a professional register). This meant their evidence was not made available. However most former employees cooperated in full regardless of their current circumstances.

Many staff witnesses found it impossible to recall the patients whose care and treatment they were asked to make comment on. In order to refresh memories all witnesses (whether they had left the employ of BCUHB or not) were asked to review clinical records. For some witnesses this meant that they had to read in excess of 30,000 pages of clinical information. This was a time-intensive process for both the witnesses and the Investigation alike. However it was essential in order to ensure both accuracy of findings and fairness of process.

**2 General Levels of Witness Cooperation.** The majority of witnesses who were called to give evidence cooperated freely with the Investigation; however a significant number (some 20 percent) did not. Whilst the Investigation acknowledges that individuals who no longer work for the NHS (and who are no longer on a professional register) do not have to cooperate with an inquiry process of this kind, the majority of witnesses who were reluctant to contribute did not fall into these categories.

Consequently there were significant delays in gathering statements of a suitable quality within the timeframe required. Due to the gravity of the matters under examination the Investigation Panel deemed this to be unacceptable. As a result many witnesses had to be called to formal interviews in order to ensure their contribution was made to the standard required and within a bounded period of time.

This caused significant delays to the investigation process as not all of those asked to provide statements had originally been considered likely to require an interview. It is unfortunate that this degree of compulsion was needed but the Investigation Panel was not satisfied with the poor level of response from a number of witnesses and had to ensure full compliance from them.

- 3 Care Pathway.** At an early stage the Investigation Panel found that the concerns raised by families were not always about the care and treatment their loved ones received on Tawel Fan ward. Tawel Fan was the common denominator, but many of the matters families wanted to have examined related to the lack of cohesion with the care pathway followed and were not always specific to any single placement or episode of care. BCUHB decided that all family concerns should be addressed and this widened the scope of the Investigation.
- 4 Assembling the Archive.** At the inception of the Investigation it was thought that the archives of all prior inquiry and review processes were complete, available and ready for analysis; this was not the case. It took 14 months (from August 2015 to October 2016) for the complete North Wales Police archive to be made available to the Investigation. This archive was an essential part of the Investigation scoping and analysis process. Without it neither compilation of concerns nor the accurate identification of patient numbers for inclusion in the Investigation could be completed.

There were also ongoing issues in accessing a complete set of formal concerns, incident and safeguarding documentation from both BCUHB and the Local Authorities. Some of this information was only made available to the Investigation as late as July 2017.

- 5 Documentation.** Families were told by the Health Board at the outset of the Investigation that “*no stone would be left unturned*”. Families were (quite rightly) given the assurance that all of their ongoing concerns about the care and treatment their loved ones received would be the subject of full examination and review. In order to fulfil this expectation the Investigation Panel had to work from a full set of clinical records for each patient. This was of particular importance for those families whose loved ones had been cited in the Mortality Review and where analysis required an assessment of all episodes of care across a wide range of services.

This was an immense task and the Health Board found it difficult to assemble the clinical records required in a timely and systematic manner. In the event the clinical records were released to the Investigation Panel in multiple tranches between September 2015 and July 2017. The Investigation Panel could not in good faith move forward to complete the inquiry process until all of the essential documentation had been made available.

Another complication was the disordered state that the clinical records were in when provided to the Investigation. This meant that on average an additional two days per patient case was required in order to:

- decipher illegible hand writing and poorly photocopied records;
- put the records into a chronological sequence to counter the extreme disarray of the documents and split entries which appear to have been caused by poor scan and collate processes;
- quality review the documents so that commingled patient records could be organised, separated and archived appropriately.

## Scope

- 5.2** As already stated, the Investigation's scope was widened to incorporate care pathway issues. This meant that additional attention had to be given to several other clinical areas such as A&E, medical and surgical wards and community hospitals. As a consequence additional documentary analysis and witness involvement was required as the scope widened from that set out in the original Terms of Reference. These findings are not detailed in this report but form an essential part of many of the patient-specific confidential PTR reports.

## Limitations

- 5.3** An Investigation of this kind is charged with examining events that have occurred and determining whether any lessons can be learned as a result. *The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)* pointed out some of the limitations of any investigation or inquiry process that sits outside a Court of Law. It is essential that all potential stakeholders when considering the findings and conclusions of this Investigation understand the extent and limitations of its powers.

*“The task... is not to determine an allegation or a charge, and its findings are not determinative of civil or criminal liability... it may as a matter of judgement identify criticisms it considers can be made of individuals or organisations arising from those events, but such findings are not binding on those criticised”.*<sup>6</sup>

- 5.4** It is also important to recognise that whilst professional codes of conduct may be used as a point of reference within an investigation or inquiry report such as this, it is not for this Investigation to make determinations as to whether or not those codes have been breached. Such judgements should only be made by the statutory bodies that set the codes after having followed the due process that should precede any such finding. Bodies such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) are the professional regulators that work in the interests of both patients and the general public as legislated by Parliament. Any determinations relating to a breach of a professional code of conduct has to be made by them and them alone in accordance with their stringent rules and procedures.
- 5.5** Whilst the question of whether a professional code may have been infringed might be appropriately raised in a health service investigation such as this, it would be remiss for any investigation or inquiry process to appear to pre-judge the rulings of these statutory bodies that have to adhere to strict process and within legal frameworks.
- 5.6** In the same way that a determination of criminality should not be made in an investigation of this type, any determinations in relation to negligence or breaches of an NHS body's statutory duty of care are matters of civil law which should only be decided by an appropriately constituted Court. Whilst an

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<sup>6</sup> Francis R (February 2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary* P 26

investigation of this kind can identify shortcomings and draw conclusions about the standard and appropriateness of the care and treatment received, findings of ‘negligence’ or any other civil or criminal liability are wholly outside of its remit.

## Document Search, Selection and Management Processes

- 5.7** The Investigation Panel worked ultimately with *circa* 500,000 pages of documentation. Not all of the documentation supplied was of use. Some of the documentation sent to the Investigation was duplicated, and some, following close examination, was found not to be relevant to the work in hand. Of the documentation that was relevant to the Investigation’s scope approximately two thirds was comprised of clinical records or documents pertaining to individual patients. The remaining documentation consisted of BCUHB corporate records in relation to structures, systems and process.
- 5.8** The Investigation also accessed externally generated reports and reviews pertaining to either BCUHB in particular, or to matters relating to the mental health of the older adult across Wales, in general.

### Search

- 5.9** The Investigation Panel expected to source documentation from ‘locked down’ archives when the work commenced. At the inception of any NHS investigation there is a requirement that all pertinent documents are identified, recalled and secured; this is commonly known as the ‘lock down process’. These documents (clinical records being a particular case in point) are usually secured by a senior officer of the organisation who then maintains rigid control over access. It is also usual to expect a quality assurance process of some kind to be undertaken to ensure the documentation is complete, legible and in a general state of good order. Continued security and monitored access is essential to make certain confidential documents are stored safely so that no suggestion of tampering with evidence can be made against either the organisation or an individual, during the course of an investigation, or at any point in the future. The Investigation Panel was surprised to find that (initially) documents had not been formally ‘locked down’ in accordance with commonly accepted NHS good practice.
- 5.10** At the inception of the Investigation it appeared that very few preparatory steps had been taken within BCUHB to identify those documents that the Investigation Panel was likely to need. No policies, prior inspection reports or background information had been identified and collated in advance.
- 5.11** From an early stage in the Investigation BCUHB took the decision to stand senior officers down from the entire process to ensure there was no conflict of interest. The intention of maintaining the independence of the Investigation was understandable; unfortunately this had the effect of the organisation standing back from providing assistance and direction. As a consequence the Investigation Panel had to work through what it needed independently. This was not an ideal situation as the adage “*you don’t know what you don’t know*” applied here.

This placed additional pressure on the Investigation Panel to ensure a comprehensive and relevant investigation archive was assembled.

**5.12** The Investigation Panel had to secure four main categories of documentation in order to get the inquiry process started; they were:

- prior investigation and review archives;
- clinical records;
- corporate documentation;
- externally generated documentation and secondary literature.

**1 Prior Investigation and Review Archives.** The Terms of Reference for the Investigation made clear the requirement to examine the archives of the preceding Ockenden external investigation, the North Wales Police investigation and the BCUHB Mortality Review. This was in order to triangulate findings and conclusions and to ensure any outstanding investigation issues were identified. In order for the Investigation to move forward this foundation had to be established. It became evident within the first four weeks of the work commencing that none of the three archives as presented to the Investigation was complete.

- **Mortality Review:** initially the Investigation was sent eight ‘Preventable Incident, Survival and Mortality’ (PRISM) reports pertaining to eight individual patients. As the Mortality Review draft report had not been made available to the Investigation at this stage the exact numbers of patients involved and completeness of the archive was unknown to the Investigators. When, several months later, the Mortality Review draft report was given to the Investigation it became apparent that another 44 PRISM reports existed that had not been provided previously. This contributed to delays in establishing the total patient numbers of the cohort to be analysed and it also delayed the identification of potential families for inclusion into the investigation process.
- **Ockenden External Investigation:** a file of documents was provided to the Investigation by BCUHB. However on close examination the archive did not appear to be complete. This was resolved by establishing direct contact with Donna Ockenden and no further delays were incurred.
- **North Wales Police Investigation:** the original archive given to the Investigation had been provided directly to BCUHB by the North Wales Police. The assumption was made by the Health Board that this archive contained copies of all statements provided by its staff together with those provided by the families of patients who had been admitted to Tawel Fan ward between January 2011 and December 2013; at this stage BCUHB thought the archive was complete.

On close examination it became evident to the Investigation Panel that this was not the case. Initially the Investigation was given some 120 witness statements arising from the police inquiry process. However by reading through the few corporate documents that had been released to the

Investigation at an early stage it was apparent that many more staff and families had provided statements than were present in the archive held by the Health Board.

During November 2015 discussions were held between the Investigation Chair and the North Wales Police to establish how many statements were missing from the archive given to BCUHB. There ensued a long process which entailed multiple discussions, meetings and written communications. Eventually at the end of May 2016 the North Wales Police allowed members of the Investigation Panel (via a supervised read at the Police Head Quarters) access to a further 70 witness statements. As a result of this supervised read another 20 patients were identified where families had either clearly raised concerns about the care and treatment provided on Tawel Fan ward, or where material within the statements related to matters which the Investigators determined required further investigation despite no explicit or direct complaint about the matter having been made.

Investigation Panel members were permitted to take brief notes at the Police Headquarters and to list the new patient names. It was agreed by the North Wales Police that the Investigation could share these names with BCUHB so that a search could commence for their clinical records. The Police held a full list of family contact details which it was prepared to share with BCUHB directly. At this stage, however, the Police wanted to gain the consent of each individual who had given a statement prior to any further information sharing taking place with the Health Board and prior to the additional 70 statements being added to the archive.

North Wales Police sought legal advice in relation to sharing their documentation outside of the criminal justice arena in order to be clear regarding the legality, the consent of individuals to share the data and security of the data once out of their possession. This delay meant that the Investigation took 16 months to meet its Terms of Reference in this particular regard and to finally establish the exact number of patients in the cohort to be examined.

This delay meant that the Investigation took 16 months to meet its Terms of Reference in this particular regard and to finally establish the exact number of patients in the cohort to be examined.

- 2 Clinical records.** The Investigation Panel acknowledges the difficulties any NHS organisation has when accessing archived clinical records. For this Investigation 108 sets of clinical records had to be recalled. Due to the complexity of the concerns raised by families, the Mortality Review considerations, and the often complex care pathways patients followed, a full set of records was required for each patient; this included their GP records. BCUHB operates a hard copy clinical record system. It is the view of the Investigation Panel that this exacerbated the delays and difficulties in providing the records in a timely manner aggravated by there appearing to be no centralised archiving and tracking system.

It is a simple point of fact that a clinical review of care and treatment cannot be completed without a full set of clinical records to examine. The clinical records were sent to the Investigation Panel in multiple tranches over a 20 month period. The final 78,000 pages of clinical records were sent between March 2017 and the end of July 2017. Apart from the obvious challenges this presented to the completion of a thorough and evidence-based investigation the following also needs to be understood:

- Very few of the individual patient records were sent to the Investigation in complete lots. This meant that most patient records (case by case) were incomplete and additions were sent over a period of several months. This caused delays to the development of timelines, case analyses and witness identification.
- All of the clinical records received by the Investigation were in a disorganised state. Entries were ‘jumbled’ and out of chronological sequence. Multiple forms and entries were ‘split’ meaning that a single document (such as a risk assessment) of some eight pages could be dispersed throughout a file of some 1,000 pages making it very difficult to ‘reassemble’ with accuracy. The scan and collate process used by BCUHB was not fit for purpose. Multiple pages were either difficult to read or illegible. Despite constant feedback to BCUHB from the Investigators it was not possible to either speed up the process or improve the quality of the presentation of the documents supplied.

- 3 Corporate Documentation.** The Investigation Panel required documents pertaining to both the historic management of Tawel Fan ward and the ongoing oversight of consequent governance processes since its closure. It also required clinical governance and audit documentation in relation to the care and treatment of the older adult across north Wales together with relevant policies and procedures.

The Investigation Panel made several requests for this information to be provided. By September 2016 the Health Board released what it purported was everything that it held in relation to Tawel Fan ward with the support of its Information Governance Department.

Unfortunately further requests had to be made by the Investigators as the documentation provided was still not complete. In June 2017 (at the direct request of the Investigation) a full disclosure form was signed by the Executive Medical Director on behalf of the Health Board and given to the Investigation Chair. This was to confirm that (to the knowledge of BCUHB) no further documentation was held by the organisation that had not been disclosed to the Investigation.

- 4 Externally Generated Documentation and Secondary Literature.** These documents were identified by the Investigation Panel throughout the course of its work and sourced directly without the assistance of BCUHB.

## Selection

**5.13** As documents and files were supplied to the Investigation a careful review had to be undertaken. This was a three-stage process:

- **Stage 1.** Each document and file was assessed in order to gauge its completeness, relevance and level of importance.
- **Stage 2.** Once a document or file was designated to be of relevance it was paginated and placed within the investigation information management system.
- **Stage 3.** All relevant documents underwent a detailed read. Clinical documents were recorded on individual patient timelines; corporate documents were recorded on a corporate chronology.

**5.14** The process by which information was entered onto either the corporate chronology or individual patient timelines provided a guide as to where potential gaps in the evidence existed.

## Categories of Documents Reviewed

### Corporate Documentation

**5.15** The Investigation Panel identified this to be:

- 1 BCUHB Board minutes and associated papers relating to Tawel Fan ward.
- 2 BCUHB Annual General Meeting reports (2011-2017).
- 3 Mental Health and Learning Disability Clinical Programme Group records relating to general governance and service operation.
- 4 Clinical policy and procedure guidelines (both corporate and Clinical Programme Group).
- 5 Clinical governance policy and procedure relating in particular to safeguarding, incidents and concerns.
- 6 Corporate disclosures from former BCUHB Executive Directors and those still in post up until 2016 (these comprised emails, correspondence, report and review documents etc.).
- 7 Corporate disclosures from former BCUHB operational service managers and those still in post up until 2016 (these comprised emails, correspondence, report and review documents etc.).
- 8 Relevant Human Resource files and BCUHB preliminary disciplinary proceedings.
- 9 BCUHB job descriptions for Executive Directors, Operational Service Managers and clinical staff.
- 10 BCUHB general workforce data including establishment figures and training records.
- 11 BCUHB review and mental health strategy documentation.
- 12 Correspondence between BCUHB and the Welsh Assembly Government in relation to Tawel Fan ward.

## Archive Documentation from Prior Investigation Processes

**5.16** The Investigation identified this to be:

- 1 The Ockenden external investigation archive.
- 2 The North Wales Police investigation archive.
- 3 The BCUHB Mortality Review archive – phases 1 and 2.
- 4 The BCUHB concerns register and archive.
- 5 BCUHB PoVA and safeguarding information including corporate risk register inputs, patient files and strategy meeting minutes.
- 6 BCUHB human resource management processes and internal preliminary staff interviews.

## Clinical Records

**5.17** The Investigation Panel required complete sets of clinical records for all 108 patients that were included in the cohort under examination. To ensure that the request was proportionate to the work in hand it was determined that mental health records without limit of time should be submitted in relation to all older adult service contacts. However all other records were confined to a five-year interval prior to first admission to Tawel Fan ward. The exception to this was the request for the GP records which were required in their entirety; this is because they provide a ‘cradle to grave’ chronology of all care and treatment provided to each patient.

**5.18** Clinical records that were excluded were those pertaining to other NHS or independent sector organisations that fell outside of the remit of the Investigation Terms of Reference.

## Supporting Documentation

**5.19** Supporting documentation came from a wide variety of external sources and was accessed as required. The report bibliography provides a list of these documents.

## The Health Board’s Statement on Documentation Search, Selection and Management Processes

**5.20** The Health Board provided the Investigation Panel with a statement detailing why the organisation found it so challenging to assemble the clinical documentation that the Investigation required.

**5.21** The statement explained that there are many different kinds of record ‘types’ depending on the specific sort of care and treatment received. The record types that were pertinent to this Investigation are as follows:

- Mental Health;
- Ophthalmology;
- Oncology (Cancer);
- General Acute;
- Community;
- A&E.

- 5.22** Retrieval processes vary across the Health Board provision. There is no single place where the records relating to an individual patient are archived; each record is stored (in general) in the place where the care and treatment occurred. When a request for clinical records is received the ‘type’ is ascertained and a request for retrieval made.
- 5.23** However the response for retrieval is managed differently across the three main BCUHB localities (central, east and west) as the record repositories vary. The responsible departments also differ within each locality. For example: in the central locality (where the bulk of the records required by the Investigation were stored) the Health Records Service retrieve general acute, ophthalmology, oncology (cancer) and A&E records, the Mental Health Service manages the retrieval requests for mental health records, and the Community Service manages the retrieval requests for community records.
- 5.24** On reflection the Health Board is of the view that the single largest issue has been BCUHB officers *“asking the wrong people”* for assistance; it would also appear that there was little corporate knowledge as to how the Patient Administration Systems (PAS) worked. In addition the BCUHB officers involved in supporting the Investigation did not have the operational experience to interpret the information held on patients *“there seemed also to be a lack of knowledge that different casenotes types exist and are managed by different Services within BCUHB, so there was a disparate approach to contacting the right teams for the information”*.
- 5.25** That being said, the Investigation Panel understands that BCUHB was presented with an immense task. It was evident that at all times BCUHB endeavoured to locate the documents as requested by the Investigation Panel in their entirety and maintained a diligent search until the archive was complete.

## Patients, Families and Friends: Involvement and Support

### Patients

- 5.26** The primary action of the Investigation Panel was to identify any patient who was still living. This subgroup represented around 30 percent of the patient cohort at the beginning of the work. It was a matter of priority to ensure that none of the patients still living were subject to any ongoing risks as a result of their time on Tawel Fan ward and that their care and treatment was being delivered in a safe and satisfactory manner. When the Investigation Panel found any evidence to suggest a case review was required, this information was passed to the Health Board with immediate effect.
- 5.27** Only one patient still living had the capacity to decide whether or not to take part in the Investigation and this individual declined to become involved directly.

## Families and Friends: Diversity of Concerns

- 5.28** It is important to understand the breadth and diversity of the views and experiences of the families and friends of patients who received care and treatment on Tawel Fan ward. This had a significant impact on how the ongoing communication and support processes were managed by both BCUHB and the Investigation Panel. Some families wanted:
- to make allegations of abuse and mistreatment;
  - answers to the more general concerns they had raised historically about the care and treatment their loved ones had received;
  - to raise issues about funding, care home placement and matters that had arisen during the general care pathway which were not Tawel Fan specific;
  - reassurance in the wake of the publication of the Ockenden external investigation;
  - reassurance in the wake of the North Wales Police interviews that they had taken part in as prior to being contacted a large number of families had only praise for the ward and the care and treatment received.

## The Tawel Fan Families Group

- 5.29** A ‘Tawel Fan Families Group’ was set up when Donna Ockenden conducted her first investigation. This group was led by family members and was supported by BCHUB in that venues for meetings were provided and the Chair and CEO of the Health Board attended on a monthly basis. This group is still active.
- 5.30** The original membership of this group is understood to have comprised the families of approximately 10 patients who were admitted to Tawel Fan ward (this represented approximately nine percent of the patient cohort under review by this Investigation). It was formed from a small core of families who were involved in the original Ockenden external investigation. Some additional families have since joined this group; it is understood to maintain a stable membership.
- 5.31** During the first 14 months of the inquiry process the Investigation Chair attended the Tawel Fan Families Group when invited. However it became increasingly evident that this attendance could not continue. This was for two reasons.
- 5.32** **First:** the independence of the Investigation process was being compromised due to the demands being made and views voiced in an informally constituted meeting. Whilst the Investigation Panel acknowledged the right of each individual to the free expression of their opinions, potentially defamatory and unsubstantiated allegations were being made about BCUHB staff in an informal meeting context. The Investigators could not continue to be exposed to certain levels of behaviour without an appearance of bias.

- 5.33** **Second:** the Investigation Panel was concerned about the psychological safety of some family members who attended the meetings. Concerns were reinforced by the telephone calls received by the Investigators from several members of the group in the immediate aftermath of the monthly meetings together with the levels of aggression and hostility observed directly by the members of the Investigation Panel who attended.

### General Support to the wider Family Cohort

- 5.34** The Investigation urged BCUHB to set up a more formally constituted families group that could provide consultation, communication and support in a structured manner to all of the friends and family members who were engaged with the Investigation. The Investigation also recommended the use of an experienced independent advocate who could ensure the psychological safety of all concerned together with an objective stance and mediation role should it be required.
- 5.35** In the event BCUHB decided not to follow this approach as it remained uncertain if the pre-existing families group would sanction a newly convened meeting. It remained the responsibility of BCUHB to communicate with all of the families and friends engaged with the investigation process. The BCUHB Chair and CEO continued to meet with the Tawel Fan Families group on a monthly basis and all other families were written to when key stages of the investigation were reached. However the Investigation Panel was made aware that many families who did not belong to the Tawel Fan families group did not find this approach to be either helpful or inclusive.
- 5.36** It remains the view of the Investigation Panel that that this manner of family management was suboptimal and lent itself to a privileging of communication with a vociferous minority and hence an ‘uneven’ recognition of the needs and views of all of the friends and family members engaged with the Investigation. This meant that other support ‘safety nets’ had to work harder and the friends and families who were not part of the Tawel Fan Families group were often excluded from important consultation and communication processes as the Investigation progressed.

### Specialised Support Offered to all Families and Friends

- 5.37** In order to ensure psychological safety the Investigation Panel required BCUHB to provide emergency psychological triage and independent counselling and therapy to any family member who needed it. A process was developed before any of the families were engaged actively with the process. Throughout the course of the Investigation this resource was accessed and used to good effect on a regular basis.
- 5.38** The witness section below details how the Investigation Panel worked with families in relation to briefings, statements, interviews and ongoing communications.

## Witness Search, Selection and Management

- 5.39** Regardless of categorisation all witnesses were afforded the right to engage with the Investigation in a manner where all due courtesy was extended and all due process followed. The Investigation entered into its work with the ethos of natural justice paramount.<sup>7</sup>
- 5.40** In accordance with standard practice, natural justice requires that those who are (or may be) criticised in the course of an investigation such as this are afforded certain procedural protections. These include:
- a right to know what is being alleged against them;
  - a right to be provided with full information and evidence upon which those criticisms are based;
  - a right to respond to those criticisms, known as ‘Salmon’ or ‘Scott’ procedures.
- 5.41** The specific steps taken to ensure compliance with the principles of fairness and natural justice in this Investigation are set out further below.

### Scope and Limitations

#### BCUHB Employees

- 5.42** As has already been stated, an investigation of this kind has no statutory powers to call witnesses to give evidence. All of the Health Board witnesses (former and current) who came forward for interview either did so voluntarily or because their NHS contracts of employment or regulatory body requirements necessitated their full engagement.
- 5.43** The Investigation was faced with an unusual situation whereby multiple BCUHB employees had either already been suspended or placed on restricted duties prior to its work commencing; human resource management processes ran in parallel with this Investigation. Any person who is subject to an open and unresolved internal disciplinary process has the right to complete confidentiality in respect of that process. In keeping with due process this report will not provide any details in relation to those cases although it should be noted that affected individuals took part in this Investigation as witnesses and their evidence has been used.

#### Family Witnesses

- 5.44** The Investigation Panel identified 108 patients whose family members it wished to call as witnesses. It should be understood that whilst 60 families engaged (to a greater or lesser extent) the others were reluctant to take part as they were, in general, happy with the care and treatment their loved ones had received on Tawel Fan ward, or could not be contacted. This created an inbuilt bias which had to be managed carefully.

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<sup>7</sup> <http://www.oxfordreference.com/view/10.1093/oi/authority.20110803100225319>

## Background to the Prior Management of BCUHB Employees

- 5.45** Due to the circumstances already detailed in this report many BCUHB employees had previously been called to interview by the multiple investigation and review processes that took place between January 2014 and May 2015. At the beginning of this Investigation it became clear that many of those who had consequently been subject to pre-disciplinary proceedings (such as suspension) still had little knowledge of what precisely they had been accused of, either the precise nature of the allegations that had been made against them, or the evidential basis for those allegations. Unfortunately it would appear that prior investigatory and human resource processes had not adopted Salmon and Scott compliant procedures in full; this led to a high degree of misunderstanding and distress on the part of those facing allegations. Salmon and Scott procedures, which require witnesses subject to formal investigation and inquiry to be worked with in a fair and transparent manner, are an essential foundation of a fair and unbiased investigation.
- 5.46** In addition formal media interest, combined with informal social media activities, contributed to a situation whereby those witnesses were placed under extreme scrutiny; this compounded the distress caused by a confusing set of investigation processes that ran in parallel with no overarching coordination.
- 5.47** Following the publication of the Ockenden report in May 2015 universal calls went out for ‘punishment’ and ‘retribution’ even though it was still not clear who was responsible for what. The decisions taken by BCUHB to either suspend or place certain employees under restricted practice conditions were, at this stage, neutral actions. This was because the allegations made had still not been established to the standard required (despite what had been released into the public domain) for specific human resource actions to be taken. Despite the neutrality and reasonableness of the actions taken by BCUHB in relation to suspension and restricted practice, this led to some BCUHB staff being targeted by members of their local communities; their health and wellbeing suffered as a result.
- 5.48** Many of those affected lived (and continue to live) in small close-knit communities. They found themselves in a position where their families, friends and neighbours were able to access information about Tawel Fan via media routes before they themselves had been notified formally. This has had a serious impact. For example the Investigation Panel was told: two witnesses have been too afraid to leave their homes; one witness has been turned away from their regular place of worship; several witnesses have been abused in their local supermarkets and shopping centres meaning they felt unable to shop in their home towns; and yet more have been shunned by their friends and neighbours. At the time of writing this report witnesses still found themselves encountering such situations.
- 5.49** The failure of some prior investigations and reviews to adhere to a Salmon and Scott compliant process calls into question the safety and reliability of pre-existing findings and conclusions. Whilst at its outset this Investigation had no reason to doubt the validity of any pre-existing findings and conclusions, it was apparent that a lack of adherence to due process meant that any additional

investigation work could not build on what had been done before and that a complete re-examination of the available evidence was required. This Investigation found that in the main:

- witnesses had not been allowed sufficient time to prepare for interviews;
- witnesses had not been given full knowledge of the allegations made against them (or any other allegations relating to service in general) either verbally or in writing in advance to interviews taking place;
- during the interviews the allegations or issues that were later held up to be the reasons for suspension or restricted practice were not always explicitly addressed by the interviewer and put to the witness;
- witnesses were not made aware of all the evidence being relied upon against them in support of allegations made and so had not had proper opportunity to address them directly or explain factual matters;
- witnesses were not given an opportunity to respond to the direct or indirect criticisms made of them in reports prior to those reports either being placed in the public domain or shared widely with stakeholders external to BCUHB;
- witnesses had no access to a process whereby they could correct, comment on, or reply to any criticisms made even when based on factually inaccurate or incomplete information.

**5.50** It remains unclear exactly how all of the different investigation and review processes worked alongside each other. It is evident that the prior investigations and reviews were run in parallel and that the information that was known to one investigation was not necessarily known to the others. This created a legacy of anxiety and confusion for witnesses in general and for those who faced direct allegations in particular.

**5.51** It also meant that the evidence collected might not have been as robust as had been previously thought as due process had not been followed. It should be understood that not only does due process confer protection in relation to witness rights; it also ensures that investigations move forward with access to robust evidence which can only be gathered if witnesses are enabled to contribute effectively.

## Comment

**The Investigation Panel understands why emotions have run so high and why there have been calls for those considered to be responsible for the Tawel Fan ‘scandal’ to be held to account based upon the information placed in the public domain. However it is never acceptable for a situation to arise whereby witnesses are placed at risk or where they are worked with in a disorganised or unfair manner. It is regrettable that individuals have been so indiscriminately pursued and judged in such an unboundaried fashion. It is also regrettable that the calls for punishment and retribution have been so voracious before all due process has been followed and the evidence-base established.**

**5.52** It is not within the remit of this Investigation to review the conduct of earlier investigations save to the extent to which any earlier processes have impacted

upon our current work. That the methodology of some earlier investigations did not appear to have been fully Salmon and Scott compliant led the present Investigators to conclude that it would be unsafe and unfair to accept the factual findings and conclusions of these earlier investigations, and that all matters required investigation anew.

### Initial Management Processes

#### Work with External Stakeholders

**5.53** The Investigation Panel worked initially with the following departments and organisations to establish a credible witness management process to ensure that all future investigation work adhered to United Kingdom best practice:

- BCUHB Workforce and Organisational Development Directorate;
- The Nursing and Midwifery Council (NMC);
- The Royal College of Nursing;
- The British Medical Association;
- UNISON.

**5.54** Formal links were not made with the General Medical Council (GMC) at this stage as it was uncertain what allegations were being brought forward in relation to medical practice. A witness management protocol was duly developed and adhered to throughout the course of the Investigation. This protocol was shared widely with witnesses and their legal and union representation.

#### Risk Management

**5.55** The Investigation worked with BCUHB to ensure that any potential risks were identified and reported. Potential risks were considered to be:

- 1 To patients or the general public if a practitioner with serious allegations against them continued to work in an environment where they might continue to cause harm or act inappropriately.
- 2 To the Investigation that might require the suspension of an individual from the workplace and/or restriction of that individual to original documents and/or individuals who may be of interest to the Investigation.
- 3 To the emotional wellbeing or mental health of a witness.

**5.56** It was agreed that the Investigation would work with BCUHB to review and update the corporately-held risk register. This in turn would be shared with the NMC, GMC, or where considered necessary, the North Wales Police and the appropriate Local Authorities.

## Selection and Categorisation

**5.57** The identification and classification of witnesses was an important task and one that needed to be conducted in a timely manner. However due to the issues already detailed in this report two major factors had to be taken into consideration:

- the Investigation scope grew necessitating increased witness numbers;
- the delays in receiving documentation meant that witness identification and classification became an iterative process that had to be conducted on an ongoing basis.

**5.58** Nevertheless it was a relatively simple task to identify key witness categories from an early stage. These were:

- 1 Category 1.** Individuals who were already subject to open human resource management processes such as suspension or restricted duties.
- 2 Category 2.** Individuals who had allegations made against them but who were not subject to open human resource management processes.
- 3 Category 3.** Individuals who had no specific allegations made against them but who were (potentially) present when improper actions or failures in care occurred and failed to ameliorate the actions of others. These witnesses included employees who worked on Tawel Fan ward but who had not been named by families directly. Also included were individuals in senior management positions who could reasonably have been expected to ensure the appropriate levels of practice were maintained on the ward (should they be established to have failed).
- 4 Category 4.** Individuals identified as directional witnesses whose evidence was sought to provide context and general information.
- 5 Category 5.** The families and friends of former Tawel Fan patients.

## Identification

### BCUHB Employees (Former and Present)

**5.59 Category 1.** The Investigation was given the names of all BCUHB staff who were subject to open human resource processes at the inception of its work; these individuals formed the initial witness cohort.

**5.60 Category 2.** Individuals in this category were identified by talking to families and from a close examination of the clinical records together with a review of prior investigation archive material.

**5.61 Category 3.** Individuals in this category were identified following a close examination of Tawel Fan ward duty rotas and establishment data; names were also selected from clinical records. Organisational charts and job descriptions were examined in order to determine roles and accountabilities.

**5.62 Category 4.** The same process was used as detailed for category three witnesses.

**5.63 Category 5.** The Investigation was able to identify the first 23 families with ease as their details were on the BCUHB open concerns register – all of the families who had been interviewed by the Ockenden external investigation were included. Other families were either identified by them coming forward to BCUHB as a result of the Helpline that had been set up or through a careful read through of the archives from the North Wales Police Investigation and BCUHB Mortality Review.

**5.64** The Investigation met with 65 family members representing 35 Patients. The Investigation also worked with a further 24 families who were engaged but who did not wish to be interviewed. While 108 patients were identified not all of them had friends or family members who were either still living or who wished to be involved. 48 patients were identified whose families and friends:

- could not be located; or
- did not respond to contact; or
- refused to take part in the Investigation and/or did not wish to be contacted.

### **External Engagement**

**5.65** The Investigation was commissioned to undertake a piece of work with a very specific focus; namely the care and treatment of 108 individual patients. It was not commissioned to examine older adult services across north Wales in general; neither was it commissioned to gauge public opinion or to ascertain any general views held. To this effect whilst the Investigation was happy to hear from any members of the public (or representatives from any relevant public body) it was not the purpose of the Investigation to seek out actively, or report upon, public opinion beyond the confines of the Terms of Reference.

**5.66** The Investigation had to be mindful of bias due to the pre-existing high level of media reporting and also had to separate out opinion and speculation from fact. The Investigation accessed external inspection and regulatory documentation and a wide selection of secondary literature which provided an authoritative and objective commentary on the services under examination.

### **The Decision not to Use Photographic Identification**

**5.67** Throughout the course of the Investigation a small number of individuals from the Tawel Fan Families Group expected staff photographs to be used to aid witness identification. Their view was that BCUHB employees could avoid being identified because family members might not be able to remember their names. The notion was put forward by those family members that any refusal to do this would invalidate any investigation findings and conclusions.

**5.68** The Investigation declined to use staff photographs to identify witnesses. Photographic identification was not used for the following reasons:

- 1 Each member of the Tawel Fan Families Group was written to by BCUHB in private. Privacy was maintained due to the anxieties expressed by some individuals directly to the Investigation as they felt they were being unduly pressured to take part in this exercise. The wider group of engaged families (who had chosen not to be part of the Tawel Fan families group) were not written to as they had not raised any issues regarding staff identification.

When the Investigation subsequently received the responses from families it was apparent that most of the families had not actually witnessed anything that could potentially be constituted as abuse where the name/s of the individual/s involved were not already known to them. The exception to this was where a few individuals could not name an alleged ‘perpetrator’ but said they would refuse to access any photographic information because they acknowledged their memory was uncertain and any identification would be unsafe.

- 2 The Investigation understood that this issue had been raised previously in relation to the Ockenden external investigation. At this time BCUHB took advice which discouraged strongly the use of photographs being used to identify staff. This was due to provisions within the Data Protection Act preventing the use of images for a collateral purpose without the express consent of the subject of the photograph.
- 3 In addition to the points raised above it was determined that:
  - The use of photographic identification in NHS investigations is highly unusual and inherently unsafe. To have any reliability for identification purposes a proper methodology for use of photographic identification evidence would have to be followed. This would require obtaining and exhibiting a large number of photographs of people who were wholly unconnected with BCUHB alongside photographs of Tawel Fan ward staff. Less stringent methods might yield unsafe findings. To adopt this methodology was wholly disproportionate.
  - BCUHB could not provide a complete and contemporaneous set of photographs for the entire Tawel Fan staff cohort; this meant that there would be a significant risk of misidentification based on incomplete information. As such the methodology of using photographs was inherently flawed.
  - The Investigation was informed that photographs of staff had allegedly been posted on social media sites with captions about potential abuse. Whilst the Investigation could not verify this, it was concluded that this might bias any subsequent photographic identification. Furthermore the ongoing safety of staff could be compromised by the use of photographic identification in the growing context of public accusation and recrimination.

**5.69** In summary: the use of photographic identification was considered by the Investigation to be both unnecessary and unsafe.

## Initial Communication Processes: BCUHB Employees

**5.70** To ensure witnesses could engage properly with the Investigation every individual identified as having a potential contribution to make was invited to attend a briefing session with members from the Investigation Panel. Briefing sessions were held in July, September and November 2016. Workshops were held for witnesses in general and one-to-one private sessions were held for all those who had open human resources management processes ongoing and/or allegations made against them.

## Relevant Legal and Policy Requirements: BCUHB Employees

**5.71** From an early stage of the Investigation there was an expectation that its findings and conclusions would culminate in a report for publication. The Investigation adopted all relevant legal frameworks during the course of its work. Salmon and Scott processes were rigidly observed.

**5.72** At the inception of the Investigation work was undertaken to understand which BCUHB policies and procedures would need to be adhered to in relation to employee management. These were identified to be:

- BCUHB (current) Disciplinary Policy and Procedure;
- BCUHB (current) All Wales Capability Policy;
- BCUHB (current) All Wales Grievance Policy and Procedure;
- BCUHB (current) Whistleblowing Policy Procedure for NHS Staff to Raise Concerns.

## Support

**5.73** Witness support is a primary issue when conducting an investigation of this kind. Witnesses can experience high levels of distress which can lead to an intolerable degree of anxiety. In conjunction with good practice principles of natural justice and formal Salmon and Scott procedures it was essential that witnesses were provided with access to confidential, support services. Prior to any work commencing the Investigation required BCUHB to identify a psychological triage system that could fast track individuals to confidential independent counselling, and where necessary, trauma therapy services. This approach was put in place for all witnesses regardless of categorisation. These services were used to good effect during the course of the Investigation.

**5.74** It is a fact that witnesses who whistleblow can be subject to bullying and harassment and that fear of reprisals can prevent individuals from either coming forward, or from telling the truth. When appropriate, witnesses were advised to invoke the BCUHB Whistleblowing Policy (if they had not already done so) with the full support of the BCUHB human resource department and staff representation. This was to ensure a structured support framework was provided. The Investigation also ensured that all witnesses were afforded a high degree of confidentiality so that they could make their disclosures in confidence; a rigid

‘Chinese Wall’ was maintained between the Investigation and BCUHB in relation to statements and the transcripts of interviews.

- 5.75** To support witnesses a viewing room was provided; this was managed by the BCUHB Investigation secretariat. By appointment witnesses could access (via a supervised read) any documents or clinical records they needed in order to write their statements and prepare for interview.

### Written Communication: BCUHB Employees

- 5.76** In accordance with the witness management process that was agreed at the inception of the Investigation all witnesses were written to and provided with the terms of reference for the Investigation together with a witness advice information sheet. Each letter clarified key questions for the witness to consider when preparing a statement. The face-to-face briefing sessions which were offered to all witnesses also provided an opportunity for people to meet with members of the Investigation Panel in advance and to discuss in full what was expected of them.
- 5.77** All witnesses were provided with a detailed breakdown of the themes and key areas that the Investigation wished to examine with them several months in advance of interviews being held.
- 5.78** In addition all witnesses with allegations made against them received a full description of each matter in writing in the form of a ‘Salmon’ letter. Those written allegations were given to the witnesses in categories 1 and 2 by the Investigation Chair in person with legal or union representation present.

### Written Statements and Interviews

- 5.79** The Investigation identified 186 BCUHB employees (both former and present) as witnesses whose evidence was required. Each individual was expected to provide a written statement; in the interests of proportionality a decision was then taken as to whether they needed to progress to the formal interview stage.
- 5.80** A significant number of witnesses (around 20 percent) either ignored the request or produced statements of such poor quality they had to be compelled to attend for interview in order to ensure their contribution was made in an appropriate manner. However it should be noted that the majority of witnesses produced statements of a very high standard which demonstrated an exemplary degree of reflection and professionalism.
- 5.81** A small number of witnesses from the identified cohort of 186 could not be traced. However their lack of contribution was compensated for by the inclusion of other individuals whose roles in connection to (and experience of) Tawel Fan ward in particular, and BCUHB in general, were similar.

**5.82** Of the witnesses who could be traced:

- two former BCUHB employees refused to remain engaged with the Investigation process (neither had allegations made against them) – however their relevant associated work archives were made available;
- one individual who alleged to have witnessed abuse during a ‘restraint’ incident refused to engage with the Investigation;
- 82 were subject to a formal interview process, either because they had a specific and detailed contribution to make, or because they had not cooperated with statement writing;
- the remaining 101 either supplied sufficiently detailed statements or (after careful examination) were stood down as being of no interest.

**5.83** Due to the complexity of the task witnesses received formal briefings (in person and in writing) many months before their interviews. This was in order to provide them an adequate length of time to prepare as many clinical witnesses had to access in excess of 30,000 pages of clinical documentation. This was essential so that they could address the specific matters set before them in a fair, logical and systematic manner.

**Witness Categories 1-4**

**5.84** The majority of interviews were face-to-face meetings but telephone interviews were also conducted on three occasions. Interviews for witness categories 1 – 4 were led by the most relevant members of the Investigation Panel according to who was being interviewed. Where witnesses were extremely distressed panel members were restricted to two. All interviews were recorded and managed by an independent stenography service.

**5.85** Witnesses were invited to bring legal or union representation with them for advice and support. Any other kind of support presence (professional colleagues etc.) was negotiated with the Investigation Chair due to the confidential and sensitive nature of the topics under discussion.

**5.86** BCUHB provided a general support presence at the interview venue to ensure ongoing communication and wellbeing processes were maintained for their employees.

**5.87** All witnesses were offered the opportunity to review their transcripts and to make any amendments as they saw fit. The amended and signed versions were the documents used by the Investigation.

**Families and Friends**

**5.88** The family members and friends of Tawel Fan patients were invited to take part in the Investigation as formal witnesses. Consequently they were worked with in accordance with investigative due process. Pre-investigation briefing sessions were offered and briefing packs given. Families were invited to supply a statement if they wished to do so in order to set down their thoughts and concerns prior to formal meetings with members of Investigation Panel.

- 5.89** All those who wished to be interviewed attended a formal process which was recorded and transcribed. All witnesses were offered the opportunity to review their transcripts and to make any amendments as they saw fit. The amended and signed versions were then used as the basis for developing the individual family terms of reference which set the direction for future inquiry.
- 5.90** Families who did not wish to participate in a face-to-face process were kept involved via written communication. Their terms of reference were negotiated and agreed with them. The option to meet with the Investigators was kept open.
- 5.91** As has already been mentioned, all family members who engaged actively with the Investigation were offered counselling and support.

### Scott, Factual Accuracy Processes and Anonymity

- 5.92** Each witness who has been subject to criticism (either directly or indirectly) in this report was contacted in writing prior to publication with any points of criticism made about them. In keeping with usual NHS good practice for lessons for learning reports the decision was taken (in general) to assign anonymity to all witnesses; therefore names are not routinely provided in this report.
- 5.93** The only exception to the naming of individuals is where they are identified in the interests of clarity. For example: where direct quotes have been taken from documents already in the public domain (such as Annual Reports and Senedd debates) and where the post holder's identity is already part of the public record. Individuals have been named in this report because they have been:
- part of the Investigation Panel or Oversight Panel processes;
  - senior officers of the Health Board designated by name in order to clarify their roles within the organisation;
  - identified as having made public statements about, or authored reports in relation to, Tawel Fan ward.

## Investigation Methodology

### Root Cause Analyses

- 5.94** The examination of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying factors that on detailed analysis are considered to have contributed to either a critical incident or poor practice occurring. This methodology is the process advocated by the All Wales *Putting Things Right: Guidance on Dealing with Concerns about the NHS from 1 April 2013* when investigating critical incidents within the National Health Service.
- 5.95** The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration

of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents happening (or situations occurring) in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility. RCA is a four-stage process. This process is as follows:

- 1 Data collection.** This is an essential stage as without data events cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
- 2 Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established. From this causal factors or critical issues can be identified.
- 3 Root Cause Identification.** The RCA process advocates the use of a variety of tools in order to understand the underlying reasons behind any causal or contributory factors identified. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'.
- 4 Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

**5.96** When conducting RCA processes investigation panels should avoid generalisations and use findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes or contributory factors, and it has to be acknowledged that this, as with all processes, has its limitations.

## Investigation Process and Panel Working

**5.97** The Investigation Panel organised its work in a structured manner; this was to ensure both probity of process and the development of a robust audit trail. Due to the difficulties in accessing archives and records the process was (at times) an iterative one; however the following stages occurred in the general order set out below.

- 1** An archive was developed for the systematic referencing, retrieval and storage of investigation material.
- 2** All documentation supplied to the Investigation was listed, read and ordered into the archive. Throughout the course of the work a 'corporate chronology' was developed which charted key organisational events and milestones.
- 3** The Investigation analysed all available documentation in order to identify any patients whose care and treatment might have fallen below an acceptable standard. This was a key part of the Investigation terms of reference.

- 4 Spreadsheets were developed in relation to family, patient and BCUHB employee management.
- 5 The families and friends of former Tawel Fan patients were invited to engage with the Investigation in order to develop their individual investigation terms of reference in relation to any specific concerns they wanted to have addressed.
- 6 All clinical records were read and entered onto individual patient timelines; this represented the 'first reading process'. The concerns of the families together with any preliminary issues raised by the Investigation Panel were recorded. Due to the delays in accessing clinical records (and the 'piecemeal' manner in which they were sent to the Investigation) this process had to be repeated and revisited for 100 of the patients in the cohort throughout the course of the investigation.
- 7 A quality assurance process was undertaken for each individual timeline to ensure all clinical records had been read and interpreted correctly. This process also ensured that all information contained in the disparate prior investigation archives was brought together for each patient and that all of the issues were identified and recorded in one place. Due to the difficulties in accessing clinical records this process had to be repeated in full for 36 of the patients in the cohort.
- 8 Once completed and quality assured the clinical timelines underwent the 'second reading process'. This ensured that each case was reviewed by the most appropriate expert members of the Investigation Panel for a detailed examination.
- 9 Themes for examination were identified (in conjunction with family allegations and concerns). These were put in writing to the witnesses identified by the Investigation. This ensured all witness statements and interviews addressed specifically the matters under review.
- 10 Once all of the information gathering processes were complete the Investigation undertook a Root Cause Analyses of the evidence collected. This was supported by the use of corporate documentation and secondary literature pertaining to professional and service best practice standards.
- 11 Lessons for learning were identified and recommendations developed.
- 12 Legal assurance processes were undertaken for each patient case.
- 13 Salmon and Scott factual accuracy processes were followed.
- 14 The *Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report* was written.
- 15 108 individual patient reports were prepared for BCUHB.
- 16 Human Resource management actions were identified.

## **Liaison with the Betsi Cadwaladr University Health Board**

- 5.98** Despite the necessary ‘Chinese Walls’ that were kept in place during the course of the work, the Investigation had to maintain a working relationship with BCUHB as a) the organisation under investigation and b) as the commissioner of the process.
- 5.99** The Investigation conducted its work in private and communicated headline findings to BCUHB only towards the end of the investigation process. During the course of the Investigation corporate members of the Trust Board were called as witnesses. The Independent Oversight Panel ensured quality monitoring processes were deployed and held at arm’s length from the Health Board. This guaranteed that the work was completed in a satisfactory manner whilst maintaining the total integrity of the Investigation’s independence. The Betsi Cadwaladr University Health Board received the report after all due process was completed and was not permitted to exert any influence over the Investigation or the report findings and conclusions.

## **Part Two**

# **Background and Context Information**

## 6 Betsi Cadwaladr University Health Board

### Background Information

- 6.1** Chapter 6 of this report sets out concise descriptions of the services under investigation. It provides a history of the Health Board and the difficulties the organisation encountered both prior to (and after) those specific to Tawel Fan ward entered the public domain.
- 6.2** It also provides the context for the clinical findings and conclusions set out in Part 3 of this report so that the reader can understand the background to the challenges clinical services encountered and the weakness of the system in which they were expected to deliver.

### Inception of the Organisation

- 6.3** Betsi Cadwaladr University Health Board was founded in shadow form in August 2009. Mrs Mary Burrows was appointed as the Chief Executive Officer designate and Mr Thomas Michael Williams was confirmed as the Chair of the Health Board.
- 6.4** On 1 October 2009 the Health Board was established formally as a statutory health organisation following implementation of the Welsh Assembly's One Wales National Reform Programme. The Health Board took over the responsibilities of the six Local Health Boards of Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham, together with the North Wales and North West Wales NHS Trusts (the North Wales NHS Trust had been the result of an earlier merger between the North East Wales NHS Trust and the Conwy and Denbighshire NHS Trust).
- 6.5** At its inception the population served was 676,000 across north Wales and also included some parts of Powys, Cheshire and Shropshire. The Health Board employed some 17,000 staff and held a budget of 1.2 billion. It was responsible for the operation of three district general hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd near Rhyl, and Wrexham Maelor Hospital) as well as 22 other acute and community hospitals and a network of over 90 health centres, clinics, community health team bases and mental health units. The Health Board coordinated the work of 121 GP practices and NHS services provided by dentists, opticians and community pharmacists.
- 6.6** The Health Board's first Annual Report (2009/2010) described the Welsh Assembly reforms as innovative *"to create a system of integrated health care by abolishing the internal market. We have therefore been able to bring public health, primary, community, mental health and acute hospital services together for the first time and in partnership with local government and the voluntary*

sector”.<sup>8</sup> The intention was to realise in full the opportunities presented by service integration.

- 6.7** The Annual Report also stated the view that strong clinical leadership would be required in order to raise standards across north Wales. To this effect 11 Clinical Programme Groups were formed each headed by a Chief of Staff.

*“Clinical Programme Groups (CPGs) are the way in which we have organised the range and complexity of clinical services across North Wales. Each of the eleven CPGs are led by a Chief of Staff who is a clinically qualified practising professional, who takes responsibility for services and is supported by a team of clinicians and managers”.*

- 6.8** The newly formed Health Board understood that the health of the population it served compared poorly with other areas in the United Kingdom. It was recognised that the determinants of health included lifestyle factors (such as smoking and alcohol consumption) and environmental factors (such as unemployment, low incomes, poor housing and access to healthcare); all of which needed to be addressed for the future alongside multiagency partners.

### Mental Health and Learning Disability Clinical Programme Group (CPG)

- 6.9** The Mental Health and Learning Disability CPG provided clinical services and was also responsible for multiple commissioning and operational functions across north Wales. The early thinking of the Chief Executive designate was as follows:

*“CPGs ... act as clinical units with service line reporting and management and are held to account for sound resource management and performance. They are part of the discussion and decision-making to deliver cost improvement. Being accountable for clinical efficiency, safety and quality reinvesting in services through good management is a key requirement of their management responsibility”.*<sup>9</sup>

- 6.10** *A Strategy Direction 2009 – 2012: Bringing People and Services Together for North Wales* (October 2009) set out the Health Board’s vision for a devolved management model:

*“The organisation is one of light touch and minimal bureaucracy that operates within a system of earned autonomy able to exercise effective authority and control when required. As clinicians and professionals at the forefront of planning and delivering a safe, effective, efficient and high quality service, its governance arrangements are simple yet robust; devolved yet highly accountable”.*

<sup>8</sup> Betsi Cadwaladr University Health Board (2009/2010) *Annual Report: Bringing Services and People Together*

<sup>9</sup> Mary Burrows (January 2009) Clinical Programme Groups – a briefing

- 6.11** The Mental Health and Learning Disability CPG managed a comprehensive range of services:

*“The Mental Health and Learning Disability CPG covered adult and older person’s inpatient and community services, adult Learning Disability services, Substance Misuse services and Forensic services across the six counties of North Wales and North Powys. The CPG had responsibility for the commissioning of nursing homes, home care and independent hospital placements. The workforce of the CPG consisted of nursing, medical, clinical psychology and administrative staff; it did not include occupational therapy other therapists and pharmacy. Clinical programme management structures were established, with clinical leads and clinical programme managers managing each of the seven specialities, Older Persons Mental Health (OPMH) being one of them, across North Wales”.*<sup>10</sup>

- 6.12** The Health Board envisaged a matrix way of working with the CPGs coming together, in conjunction with primary care and multiagency partners, to ensure robust care pathways for patients. The ethos was one of ‘earned autonomy’ whereby each CPG would be led by clinicians and work with an ever-increasing range of delegated powers from the corporate Health Board.

### Memory Clinics in BCUHB (2010 – 2014)

- 6.13** In 2006 Welsh Assembly Government published a National Service Framework for older people in Wales.<sup>11</sup> The framework stated that memory clinics should be made available for the specialist diagnosis and management of dementia. This was reinforced by *The National Dementia Action Plan for Wales* in 2010 where early assessment and diagnostic processes were advocated strongly.

- 6.14** Most of the patients in the Investigation Cohort lived (and some live still) in central north Wales. Between 2010 and 2014 there were four memory clinics covering this geographical area based at each Community Mental Health Team site.

- South Denbighshire – Ruthin Community Hospital;
- North Denbighshire – Glan Traeth Day Hospital, Rhyl;
- West Conwy – Bodnant Unit, Llandudno; and
- East Conwy – Bryn Hesketh Unit, Colwyn Bay.

- 6.15** The operational policy in place between 2010 and 2014 stated that:

*“Memory clinics in Conwy and Denbighshire provide specialised outpatients services offering assessment of memory problems, early diagnosis, prescribing anti dementia medication and advice and can promote improvement in psychosocial health related quality of life for patients and their families”.*<sup>12</sup>

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<sup>10</sup> Witness statement excerpt

<sup>11</sup> Welsh Assembly Government (2006) National Service Framework for Older People in Wales

<sup>12</sup> BCUHB (2010) Mental Health and Learning Disability CPG Memory Clinic Operational Policy 2010 and reviewed in 2014

**6.16** The philosophy of care was:

- 1 Be effective and efficient and support people through the early stages of dementia and promote the move towards crisis prevention.
- 2 Be responsive to the needs of patients and carers, and help maximise independent living, enhance functioning, minimise the need for support and reduce carer burden.
- 3 Provide treatments based on best practice (NICE-SCIE, 2006).
- 4 Be integrated with other services for people requiring memory services (CMHT).
- 5 Work to agreed criteria for referral, treatments, transfer and discharge.
- 6 Be patient-centred and provide equitable access ensuring patients are treated with dignity and respect and are informed fully about their assessment, diagnosis and care in partnership with their health care professional.

**6.17** The key functions of the clinics were:

- referral and access;
- assessment and diagnosis (screening);
- ongoing support and follow up (review);
- post diagnostic, evidence-based psychosocial interventions.

**6.18** Referral to the memory clinic service was GP led with initial assessments being nurse led. Memory clinic services were comprised of multidisciplinary teams who could be called upon to assess and diagnose. These team members comprised:

- a medical lead – Consultant Old Age Psychiatrist with an interest in Dementia;
- a clinical nurse specialist;
- mental health nurses;
- a health care support worker;
- a clinical psychologist;
- an occupational therapist; and
- administrative support.

**6.19** Referrals could also be made as required to:

- Speech and Language Therapy;
- Dietetic services;
- Physiotherapy;
- Social Work;
- Geriatrician services;
- Neurology; and
- Specialist Dementia Nursing.

## BCUHB Community Mental Health Teams (CMHTs) During the Period under Review

**6.20** CMHTs primarily provide mental health services in community settings; referrals in north Wales were, in the main, via General Practice. The Royal College of Psychiatrists describes CMHTs as being:

*“... made up of a group of mental health professionals who work together to help people with a wide range of mental health problems. The different professions all have different knowledge and skills which can be used to tackle problems together... The team will have a base, like a clinic. They may see you there, but can also see you in an out-patient clinic, GP surgery, day-centre, or your home”.*<sup>13</sup>

**6.21** The BCUHB operational policy stated *“The service offers appropriate community and recovery focused mental health and social care to adults with mental health needs. Principally within primary care, with additional, secondary and specialist care provision to meet severe and/or complex needs when required”.*<sup>14</sup>

**6.22** The CMHTs across north Wales operated mainly a Monday to Friday 9.00 – 5.00 service. Emergency services were available out of hours; however the operational policy did not detail how these could be accessed practically.

**6.23** The guidance applied generically across all adult services; in relation to older adult services the policy had this to say:

*“In general the principles iterated above apply across all adult services. It is accepted that there are generally discrete Older Persons Mental Health Teams which cover both functional illnesses such as depression and organic conditions such as Dementia. Individuals should be cared for by the team that can most effectively meet the person’s needs, rather than having arbitrary age boundaries”.*

**6.24** Whilst the operational policy stated that the principles detailed within it applied across all age ranges, the guidance was not specific enough in relation to services for the older adult. A fundamental flaw was that it did not equate well to the actual CMHT and Crisis and Home Treatment service configurations in place at the time for those patients over 65 years of age. In effect the practical guidance offered for older adult services was not interchangeable with that for adults of working age services and was therefore rendered ineffective.

**6.25** Consequently it is not possible to detail with any degree of accuracy the operational policy expectations of CMHT services for the older adult during the period under Investigation. Neither is it possible to understand how the

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<sup>13</sup> <http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/mentalhealthinthecommunity/mentalhealthteamkeyfact.aspx>

<sup>14</sup> BCUHB (2013 – 2015) The Role of County wide mental health teams in Community Mental Health Services Operational Protocol (V1.3)

interactions and co-working between the Memory Clinics and the CMHTs (whilst referred to) were actually expected to operate in reality.

## BCUHB Acute Care Pathway for the Older Adult during the Period under Review

- 6.26** The Investigation Panel found it difficult to understand the nature of operational process in relation to acute and inpatient mental health service provision for the older adult across north Wales for the period under investigation. This is due to two main reasons:
- 1** Several of the policy documents sent to the Investigation are not dated and have no version control information within them. As the documents provide no specific indication as to time, place or service it is difficult to understand how they fitted into a general care pathway approach for the older adult.
  - 2** Guidance in relation to services for the older adult was subsumed within policies for adults of working age. This was problematic as service provision for the two distinct age groups was not the same. The service configuration described for adults of working age did not equate with that in place at the time for the older adult. This was striking in relation to gatekeeping and assessment functions, emergency out of hours arrangements, and community and acute inpatient liaison and co-working.
- 6.27** The BCUHB Mental Health and Learning Disabilities CPG Acute Care Operating Framework (2013 – 2015) set out the standards for the “*delivery of safe and sustainable*” care and treatment across all adult services in north Wales. The policy set out an evidence-based approach to service delivery – however it is difficult to understand how this could be implemented in an organised and systematic manner for older adult services for the reasons set out above.

## The Ablett Unit

- 6.28** The Ablett Unit is a mental health provision based on the Glan Clywd Hospital site near Rhyl. Prior to December 2013 it was comprised of the following wards and services:
- **Dinas Male Ward:** a ten-bedded acute psychiatric admission ward for male adults of working age (up to 65 years);
  - **Dinas Female Ward:** a ten-bedded acute psychiatric admission ward for female adults of working age (up to 65 years);
  - **Tawel Fan Ward:** a 17-bedded acute psychiatric admission ward for male and female older adults with organic-based mental health problems (in general for patients over 65 years but condition specific taking into account the needs of younger people with organic brain disease);
  - **Tegid Ward:** a ten-bedded acute psychiatric admission ward for male and female older adults with functional mental health problems (over 65 years);
  - **Cynnydd Ward:** an eight-bedded rehabilitation ward for male and female adults of working age;

- **Section 136 Assessment Room;**
- **North Wales ECT Service;**
- **Conwy and Denbighshire Home Treatment Team:** Adult Mental Health;
- **Glan Clwyd Hospital Psychiatric Liaison Team:** Adult and Older People's Mental Health.

**6.29** The Health Board was not able to provide an Operational Policy for this unit detailing how it worked and how it related (and continues to relate) to the main Glan Clwyd hospital site.

## Tawel Fan Ward

**6.30** Tawel Fan ward was opened in 1995 as a 17-bedded acute assessment facility on the closure of Denbigh Hospital. The ward formed part of the psychiatric provision at the Ablett Unit.

**6.31** It has been difficult to establish the exact role of the ward at its inception; the Investigation Panel could not access a contemporaneous operational policy for the ward (or for any similar mental health provision within BCUHB).

**6.32** However a 2004 strategy document states that it was (at this stage) a ward for the assessment and treatment of both functional mental illness and organic brain disease for men and women over 65 years of age. As time progressed the ward became an acute assessment and treatment ward for organic brain disease only. In the years immediately prior to the ward being closed it was described as “*an acute organic ward for patients with challenging behaviour*”.<sup>15</sup>

**6.33** Tawel Fan ward was closed on a temporary basis on 20 December 2013. At the time of writing this report the ward remained closed

## Summary of the Literature in the Public Domain in Relation to BCUHB Governance

**6.34** A concise summary of the literature already in the public domain relating to governance within the Health Board is set out below. Over the past four years the Health Board has been the subject of four governance reviews; the fourth of which was still being conducted by Donna Ockenden at the time of writing this report.

**6.35** **First Governance Review.** In June 2013 the Welsh Audit Office and the Healthcare Inspectorate Wales published *An Overview of Governance Arrangements: Betsi Cadwaladr University Health Board*. The report was commissioned amidst growing concerns that “*the leadership arrangements at the Health Board are not driving organisational integration at a sufficient pace*”. These concerns had been ongoing for at least 18 months and had led to two prior independent reviews in 2012 each as a result of concerns over organisational

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<sup>15</sup> SBAR for temporary closure of beds on Tawel Fan ward for patient safety 14 December 2012

structure and financial management. The findings were grouped under the following themes:

- 1 Effectiveness of the Board and its subcommittees.
- 2 Management and clinical leadership structures.
- 3 Quality and safety arrangements.
- 4 Financial management and sustainability.
- 5 Strategic vision and service reconfiguration.
- 6 The way forward.

**6.36** The conclusions stated that:

*“Most significantly we have concerns that the Health Board’s governance arrangements and organisational structure are compromising its ability to adequately identify problems that may arise with the quality and safety of patient care. The current governance arrangements and procedures do not adequately address ‘the gap between the ward and the Board’, and may even be contributing to it...*

*... The Health Board’s organisational structure, based around Clinical Programme Groups (CPGs) is designed to support the aim of being a clinically led organisation. However, problems have been evident for some time as a result of the imbalance in size of different CPGs and the shortcomings in connectivity between CPGs, geographical hospital sites and the Executive team. These have been exacerbated by weaknesses in the arrangements to hold CPGs to account on key aspects of financial and clinical governance”.*

**6.37** These conclusions were based upon findings that identified:

- relationship breakdowns at Board level;
- a lack of cohesion and consensus amongst Executive Directors;
- concerns about the quality of information that was supplied to the Board;
- an inadequate management infrastructure to support the CPG Chiefs of Staff;
- poor quality patient-safety arrangements;
- a lack of financial stability;
- inconsistent strategic direction.

**6.38** **Second Governance Review (internally commissioned by BCUHB).**

In September 2014 the Health Board received a report from the Good Governance Institute; this review had been commissioned directly by them. The review stated that *“It was clear from the outset that BCU Health Board was an organisation with a number of problems, and faced a major task to create and sustain a financially and clinically viable organisation. The need to establish new management and clinical leadership as well as the need to rebuild the Board around sound governance principles was recognised”*.<sup>16</sup>

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<sup>16</sup> Good Governance Institute (September 2014) A Review of the Governance Systems at Betsi Cadwaladr University Health Board (BCUHB)

**6.39** The review concluded that there had been a lack of strategic direction.

- 1** Risk management and governance structures ‘floated’ within BCUHB, were not grounded and did not work together to achieve common goals.
- 2** Competing issues could not be prioritised in respect of their impact on the organisation.
- 3** The Board did not appear to add value to the organisation.
- 4** The CPG matrix model of working was confused and ineffective exacerbated by weak scrutiny arrangements with the corporate Board.

**6.40** **Third Governance Review.** This review was conducted between December 2014 and January 2015 by Ann Lloyd at the behest of Welsh Government.<sup>17</sup> The report was commissioned in the context of the Health Board having been placed in “*targeted Interventions*” under the NHS Wales Escalation and Intervention Protocol.<sup>18</sup> The reasons why this action was taken were:

- 1** Significant changes in the financial plan for 2014/2015 and concerns about the ability of the organisation to deliver a revised plan.
- 2** Significant concerns about the delivery, safety and quality of mental health services.
- 3** The management and control of capital schemes, capital planning and capital cash control.

**6.41** The report stated “*at this stage there were concerns about the Health Board’s ability to meet Welsh Government performance targets together with the capacity and capability of the organisation to deliver its key responsibilities*”.

**6.42** The report set out the first stage of targeted intervention; the diagnostic review. The review covered the following areas:

- the failure to implement Board plans and financial recovery;
- the management of capital schemes;
- governance and financial controls;
- actions needed to address quality concerns in mental health services;
- the three-year operational and strategic plan;
- Board functioning in relation to capacity and decision making;
- leadership capacity and capability.

**6.43** The report noted that a continued deterioration in performance had resulted in patient safety concerns. The report summary stated “*it will take a mammoth effort on behalf of the whole executive team to enable the organisation to improve this performance*”.

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<sup>17</sup> Lloyd A (2015) Betsi Cadwaladr University Health Board Targeted Intervention: January/February 2015

<sup>18</sup> Welsh Government (March 2014) *NHS Wales Escalation and Intervention Arrangements*

- 6.44** Specific mentions of mental health services referred to the findings of the Healthcare Inspectorate Wales (in conjunction with the Royal College of Psychiatry) which had identified several areas for improvement; namely:
- record keeping;
  - basic quality of care;
  - environmental issues;
  - staff training and development;
  - medicines management;
  - range of patient mix;
  - clinical relationships.

## Special Measures and the Current Situation

### Betsi Cadwaladr University Health Board Targeted Intervention and Special Measures

- 6.45** On the 8 June 2015 the Health Board was placed under “*special measures*” an escalation of the NHS Wales Escalation and Intervention Protocol. Mark Drakeford (the then Minister for Health and Social Services) said the decision to put the Health Board in special measures was made because “*It reflects serious and outstanding concerns about the leadership, governance and progress in the health board over some time*”.<sup>19</sup>
- 6.46** At the time of writing this report the Health Board remains in special measures.

### Betsi Cadwaladr University Health Board Current Position

- 6.47** Very little has changed since the time the Health Board was established. BCUHB still remains the largest Health Board in Wales. Its budgets, population and workforce figures have all remained relatively stable over the past nine years.
- 6.48** The Health Board’s publically accessible website states the following:

*“The Health Board has refreshed its purpose, commitments and values and these are reflected within annual and three year planning. Work is ongoing to embed these elements within the core communication, engagement and development of the Board. They are as follows:*

#### ***Our Purpose***

- *To improve health and deliver excellent care.*

#### ***Our Vision***

- *We will improve the health of the population, with a particular focus upon the most vulnerable in our society.*

<sup>19</sup> <https://www.theguardian.com/uk-news/2015/jun/08/wales-health-board-special-measures>

- *We will do this by developing an integrated health service which provides excellent care delivered in partnership with the public and other statutory and third sector organisations.*
- *We will develop our workforce so that it has the right skills and operates in a research-rich learning culture.*

### ***Our Corporate Goals***

- *Improve health and wellbeing for all and reduce health inequalities.*
- *Work in partnership to design and deliver more care closer to home.*
- *Improve the safety and outcomes of care to match the NHS's best.*
- *Respect individuals and maintain dignity in care.*
- *Listen to and learn from the experiences of individuals.*
- *Support, train and develop our staff to excel.*
- *Use resources wisely, transforming services through innovation and research”.*

## 7 Dementia Strategy in Wales

### The Picture in North Wales between 2011 and 2016

7.1 The following information is provided to inform the reader about the national picture in Wales relating to dementia care and mental health. This is so that the strategic thinking across Wales can be understood and the challenges faced by patients, families and services set in a wider context.

#### 1000 Lives Campaign (Initiated in 2008)

7.2 The 1000 Lives Campaign initially took place between 2008 and 2010 across Wales. The intention was to save 1000 lives and to prevent a further 50,000 episodes of harm in healthcare. Due to the success of the campaign it was extended into the 1000 Lives Plus initiative which continued for a further five years.

7.3 It was recognised that improving dementia care should be a key part of the programme. To this end 1000 Lives Plus worked with Health Boards in Wales to improve the quality of life and care for people with dementia and their families and carers. Key targets were:

- to reduce uncertainty for people with suspected dementia by early diagnosis and intervention;
- to enable people with dementia to access increased opportunities for decision making for the future including financial, housing and care and treatment planning;
- the introduction of ‘care bundles’ to include pre-diagnostic assessment, neuropsychological assessment, a brain scan and a physical health screen;
- referrals to the third sector (such as the Alzheimer’s Society);
- improvements to care in general hospital wards and inpatient units by identifying those with dementia on admission and ensuring the correct care pathways were followed;
- the inclusion of families in care planning and to ensure that their mental health and general needs were supported;
- the reduction of antipsychotic medications (particularly for those in community settings) and for alternative interventions to be used whenever possible;
- maintaining the quality of life of those with dementia and their carers.

#### The Mental Health (Wales) Measure 2010

7.4 The Mental Health (Wales) Measure (2010) was a new law made by Welsh Government with a similar legal status to an Act of Parliament. The Measure introduced a number of important changes relating to the assessment and treatment of people with mental health problems.

**7.5** The Measure was intended to ensure that where mental health services were delivered, they focused more appropriately on people's individual needs. It had four main parts; they are as follows.

- *“Part 1 seeks to ensure more mental health services are available within primary care.*
- *Part 2 gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.*
- *Part 3 gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services.*
- *Part 4 offers every in-patient access to the help of an independent mental health advocate”.*<sup>20</sup>

**7.6** Primary principles were:

- a) *“Patients and their carers should be involved in the planning, development and delivery of care and treatment to the fullest possible extent – so that professionals seek to involve a person as fully as possible in their care and treatment in a sensitive way, and one which promotes their confidence and recovery.*
- b) *Equality, dignity and diversity – so that professionals have due regard to a person's needs arising from their race, gender, religion, sexuality, age or disability when delivering a service.*
- c) *Clear communication in terms of language and culture essential to ensure patients and their carers are truly involved, and receive the best possible care and treatment – so that there is always an understanding that poor communication too often leads to inappropriate care and treatment, and that good communication is likely to lead to better outcomes. This principle also states that all possible steps should be taken to ensure that bilingual (Welsh and English) services are available.*
- d) *Care and treatment should be comprehensive, holistic and person-focussed – so that professionals are sensitive to the full range of a person's needs and that they plan care, treatment and support across whatever will help a person's recovery.*
- e) *Care and treatment planning should be proportionate to need and risk – so there is a recognition that, whilst on the one hand, some people with complex needs may need detailed care plans, on the other some people may need un-complicated help that will still significantly improve their situations.*
- f) *Care and treatment should be integrated and coordinated – so that when offering care and treatment, professionals recognise the range of services that may benefit a person, whether in the statutory or voluntary sectors, or whether specialist mental health services or more general services, and actively work together with other services to coordinate service delivery”.*

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<sup>20</sup> <http://www.mentalhealthwales.net/mental-health-measure/>

## National Dementia Vision 2011

**7.7** In association with the Alzheimer’s Society, Welsh Assembly Government published the *National Dementia Vision for Wales: Dementia Supportive Communities* in 2011. It was recognised that the numbers of people with dementia were rising in Wales and set to rise further in the immediate future.

**7.8** It was acknowledged that if people were given an early diagnosis together with the appropriate levels of “*information, support and care*” it was possible to live well with dementia. The priority was to develop Dementia Supportive Communities. The vision required:

*“1. Improved service provision through better joint working across health, social care, the third sector and other agencies.*

*2. Improved early diagnosis and timely interventions.*

*3. Improved access to better information and support for people with the illness and their carers, including a greater awareness of the need for advocacy.*

*4. Improved training for those delivering care, including research”.*<sup>21</sup>

**7.9** It was recognised that there were several gaps in current service that needed to be addressed across Wales. These included:

- employing dementia clinical coordinators to support those diagnosed with dementia;
- creating a new young onset dementia service for Wales;
- developing education and information for those diagnosed with dementia;
- developing dementia training for health and social care professionals and Local Authorities;
- creating education and information opportunities to support carers.

## National Mental Health Strategy 2012 – 2016

**7.10** In 2012 Welsh Government published *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales 2012 – 2016*; this was the first part of a ten-year plan. The intention was to provide an integrated strategy that addressed the mental health and wellbeing needs for all people of all ages. Previous national strategies had been age specific, but it was thought that this approach had led to service breakdown at key points of transition. The strategy aimed to ensure that transitions and transfers between services were *based on need and not on artificial boundaries*”.<sup>22</sup> In order to succeed the strategy depended upon partnership working across the NHS, Social Services and the Third Sector.

**7.11** The vision was for a holistic approach throughout the care pathway. This would require partner agencies to work together to ensure that a fully integrated

<sup>21</sup> Welsh Government, The Alzheimer’s Society (2011) *National Vision for Wales: Dementia Supportive Communities* PP 4-5

<sup>22</sup> Welsh Government (2012) *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales 2012 – 2016* P5

approach was provided that could deliver an effective and person-centred service model.

**7.12** In relation to older people it was noted that “1 in 16 people over 65, and 1 in 6 over the age of 80, will be affected by dementia. Current estimates are that approximately 43,000 people in Wales are experiencing dementia and this is predicted to increase by over 30% in the next 10 years”.<sup>23</sup>

**7.13** The strategy proposed:

- older people should have timely access to an equitable range of services;
- older people should receive assessment from individuals in primary care mental health services who are trained to identify and recognise the early signs of dementia and depression;
- services should prepare for the anticipated rise in the number of people with dementia;
- improving care and support for dementia sufferers and their families through the implementation of the *National Dementia Strategy* the 1000 Lives + and the *Intelligence Targets for Dementia*;
- developing the role of assistive technologies for those people with dementia living in rural or isolated settings.

## The Current National Picture in Wales

### National Mental Health Strategy 2016 – 2019

**7.14** The second part of the ten-year strategic plan was published in the form of a delivery plan in October 2016; at this stage the focus was on sustainability and future delivery. There are 11 priority goals for the future:

- **Goal 1:** People in Wales are more resilient and better able to tackle poor mental wellbeing when it occurs.
- **Goal 2:** The quality of life for people is improved, particularly through addressing loneliness and unwanted isolation.
- **Goal 3:** Services meet the needs of the diverse population of Wales.
- **Goal 4:** People with mental health problems, their families and carers are treated with dignity and respect.
- **Goal 5:** All children have the best possible start in life which is enabled by giving parents/care givers the support needed.
- **Goal 6:** All children and young people are more resilient and better able to tackle poor mental wellbeing when it occurs.
- **Goal 7:** Children and young people experiencing mental health problems get better soon.
- **Goal 8:** People with a mental health problem have access to appropriate and timely services.
- **Goal 9:** People of all ages experience sustained improvement to their mental health and wellbeing through access to positive life changes.

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<sup>23</sup> Op Cit (2012) P 12

- **Goal 10:** Wales is a ‘Dementia Friendly Nation’.
- **Goal 11:** The implementation of the strategy continues to be supported.<sup>24</sup>

**7.15** Specific actions in relation to Goal 10 included:

- the improvement to the quality of life and care for people with dementia (or at risk of dementia) and their carers;
- Health Boards, Local Authorities and the Third Sector to increase the number of people who can “spot the signs of” dementia;
- Health Boards to provide primary care support workers who will deliver face-to-face support, information and advice;
- Health Boards to ensure effective liaison services are in place to meet the needs of people with cognitive impairment in acute hospital settings;
- Welsh Government to roll out Good Work: a training and development framework for dementia care across Wales.<sup>25</sup>

### Together for a Dementia Friendly Wales 2017 – 2022

**7.16** The *Together for a Dementia Friendly Wales* strategy will be the dementia strategy in Wales. The priority areas are:

- 1 Diagnosis rates:** this is regarded as vitally important in order to unlock support and treatment at an early stage. The assessments will be made available in the Welsh language.
- 2 Working in partnership with the Third Sector:** increased partnership working is to be encouraged in care delivery and service planning.
- 3 Access to Dementia Support Workers:** the intention is to provide this level of service to all people newly diagnosed with dementia.
- 4 Increased, care homes, primary care and hospital settings that are dementia friendly:** this will require education and training initiatives but also a refocusing of service where appropriate levels of age appropriate psychiatric liaison services are available.
- 5 Training of Health and Social Care Professionals:** by 2019 the intention is for 75 percent of NHS employed staff who come into contact with the public to be trained to an appropriate level of dementia awareness and care.
- 6 Increased assessment and support for carers:** this should include information, respite care, support and an opportunity for therapeutic alliances.
- 7 Young Onset Dementia Services:** services to be provided that deal specifically with the needs and challenges of younger people with dementia and their families.

<sup>24</sup> Welsh Government (October 2016) *Together for Mental Health: Delivery Plan 2016-19* PP4-34

<sup>25</sup> Op Cit (2016) P 30

- 8 Life Course approach:** services to be developed in a structured manner that provide consistent support from the point of first diagnosis to end of life care.
- 9 Limiting the use of antipsychotic medication:** in collaboration with the Older People's Commissioner in Wales, the Royal College of Psychiatry and the Royal Pharmaceutical Society an approach will be promoted where antipsychotic medication is not routinely used in the care and treatment for people with dementia.
- 10 End of life care:** skilled inputs will be required to ensure the levels of expert support and guidance are given. Health Boards will need to identify professionals for training in initiating serious illness conversations, and work with bereavement services to recognise the differing needs of families and carers of those with dementia.

### Strategy and Vision in the Context of this Investigation

- 7.17** This Investigation has found national concerns, challenges and thinking to be reflected directly by the findings and conclusions set out within this report; there is a high degree of synergy.
- 7.18** BCUHB in general, and Tawel Fan ward in particular, appear to have experienced many of the same challenges and difficulties as other Health Boards in Wales (principally between 2011 and 2013) in relation to the provision of mental health services to the older adult and those with dementia.
- 7.19** The lessons for learning from this report should underpin and support future strategy development and implementation.

## 8 Accounts and Experiences from Families and Friends

- 8.1** 35 families came forward to engage with the Investigation directly choosing to be interviewed as formal witnesses. This group included those whose concerns were still held on the open BCUHB register; they raised specific issues about care and clinical practice and 18 of them made allegations about potential abuse, mistreatment and neglect.
- 8.2** One family raised matters in relation to their mother and father, both of whom died on the same medical ward within days of each other. Another family raised matters concerning a brother and sister who were both treated on Tawel Fan ward at the same time. In total 37 patients were represented.
- 8.3** A further 25 families were engaged with the Investigation but chose not to raise concerns via face-to-face meetings. Those families had been identified by the statements they had given to the North Wales Police or because their loved ones had been included in the BCUHB Mortality Review. Written communication took place between them and the Investigation Panel; this ensured any matters those families wished to have investigated were both identified and included.
- 8.4** The remainder of the patients in the cohort had no family members come forward to the Investigation to raise concerns on their behalf. Where this was the case the Investigation Panel examined all extant archives together with clinical records to identify any areas where clinical practice fell below an acceptable standard and investigated accordingly.

### Accounts from Families and Friends

- 8.5** The Investigation Panel worked with people who were often anxious and confused. Several of the family members and friends who engaged with the investigation process were elderly and needed a great deal of reassurance; they also required several attempts to provide coherent accounts about the care pathways their loved ones had been placed upon.
- 8.6** Many individuals came forward because they were angry, confused or shocked in the wake of the publication of the Ockenden external investigation and their subsequent contact with the North Wales Police. They often recast prior events on the ward (that had not worried them previously) in the light of the reported abuse and felt worried that they might have ‘missed something’ and failed their loved ones in some way.

### Understanding the Diversity of Experience

- 8.7** The experiences that some families shared with the Investigation directly (or had already shared with the North Wales Police) had many areas of commonality; however other accounts did not and varied greatly one from another.

**8.8** In common families raised concerns in relation to care and treatment, such as diagnosis, medication and crisis management. They wanted to understand better whether or not their loved ones had received an acceptable level of service. In the main they sought explanations about specific matters as well as general reassurance.

**8.9** However 18 families made direct allegations of abuse, mistreatment and neglect. Those allegations included:

- unexplained bruising and injuries;
- rough handling;
- shouting and disrespectful behaviours on the part of nursing staff (to both patients and their families);
- patients being dirty or unkempt;
- patients being ignored and neglected;
- disproportionate and undignified restraint.

**8.10** In stark contrast 31 families made it quite clear that neither they nor their loved ones had ever experienced anything of this kind on Tawel Fan ward. Those families made statements to the effect that:

- staff were always kind, compassionate and thoughtful;
- their loved ones were always treated in a person-centred manner;
- their loved ones were clean and well kempt;
- patients were treated gently and respectfully at all times, but especially when they became aggressive and violent;
- staff were always ready to support families and provide clear explanations about care and treatment;
- the ward was, in general, clean and tidy.

**8.11** This level of inconsistency is difficult to understand especially as these families are distributed equally across the three-year period under investigation.

## Concerns and General Themes

### Themes from Families' Concerns

**8.12** Those families and friends who raised concerns did so across the continuum of care.

- 1 Diagnosis:** 29 families described diagnostic ambiguity and communication failures in both community and inpatient settings. Those failures applied to episodes of care in mental health, medical and surgical environments. Families were not always certain exactly what key diagnoses had been made and raised concerns that care and treatment plans might not have been optimal as a result. Some families said that the full impact of a dementia diagnosis had not been explained to them properly. This meant that they were often unprepared for how the disease progressed and that they did not always know how best to manage it or work with health and social care professionals.

- 2 Medication, Therapy and Treatment:** 29 families raised concerns about psychotropic medication regimens being potentially unsafe leading to the deterioration of cognition and mental functioning. Concerns were raised in general in relation to the lack of treatment inputs from occupational therapy, physiotherapy, psychology and speech and language therapy.

There were also anxieties expressed that essential medications for physical conditions were either omitted or administered inappropriately. In addition families could not be certain that physical conditions were identified appropriately and that the correct interventions and referrals had been made in a timely manner.

- 3 Care Pathways:** around 70 percent of the families who were engaged with the Investigation described care pathways where admission, transfer and discharge processes were chaotic leading to extreme distress. Crisis management in the community at the beginning of the acute care pathway, and delayed transfers of care at the end of it, were described as being of particular concern.

Also of concern was the difficulty in accessing emergency interventions when loved ones fractured bones or became physically unwell on Tawel Fan ward.

- 4 Clinical Management and Nursing Care:** 46 families raised specific concerns about the quality of the clinical assessment and management of their loved ones; particularly in relation to physical comorbidities. 20 percent of families engaged with the Investigation also expressed the view that their loved ones received poor levels of nursing care in that patients were sometimes left dirty and in urine soaked clothing; however around half of those families cited a single occasion when this was noted to have occurred and did not describe a continual state of affairs. 18 families in this sample raised concerns in relation to weight loss and poor nutritional management.

- 5 The Mental Health Act (1983 & 2007):** families were not always certain whether or not their loved ones had been detained under a Section of the Mental Health Act (1983); consequently 19 families were of the view that an illegal detention might have taken place. Confusion was also expressed about the roles of the Nearest Relative and the rights of patients and families.

- 6 Management of the Behavioural and Psychological Symptoms of Dementia (BPSD):** a small but significant sample of families suggested that both medication and restraint were used to manage aggression and disinhibition. Four families raised particular concerns in relation to improper physical restraint. Five families suggested their loved ones might have been locked in their bedrooms, three others thought that they had been confined in (or by) chairs, and six more stated their loved ones had been ‘manhandled’ in a rough and undignified manner.

- 7 Safeguarding and Incident Management:** 35 families raised concerns in relation to safeguarding practice. Most of those families were uncertain as to what safeguarding practice was, however they understood enough to know

that a formal system should have been in place to investigate and manage significant falls where injuries had occurred and patient-on-patient assault. Concerns were not only raised in relation to specific incidents but into the way in which they were managed and the time it took for families to get resolution.

15 of the families in this sample were of the view that accidents and incidents on the ward were neither reported to them nor investigated. Several were of the view that this constituted a 'cover up' of poor practice.

- 8 Family Communication and Involvement:** 35 families said that there had been issues with communication on occasions; some related to single events. Around 50 percent of those families were of the view that ward staff did not communicate with them appropriately about their loved one's care and treatment and that to this day many families were uncertain as to how important decisions were taken. 10 families from this sample also found ward staff to be rude and unhelpful which made them difficult to approach and as a consequence those families felt an increasing sense of frustration and loss of confidence.
- 9 Ward Environment and Equipment:** 10 families described Tawel Fan ward as being dirty, untidy and smelling strongly of urine; two families also described occasions when there was no hot water for patients to be washed or bathed in. Of particular concern was the lack of access to fresh air in that the garden was often closed and out of use; this meant that patients were confined to the ward. Another 15 families expressed concerns about the overall poor levels of maintenance on the ward with shabby fittings and fixtures being cited.
- 10 End of Life Care:** four families were confused about 'Do not Attempt Resuscitation' orders and five were concerned about end of life care pathways; concerns were expressed that their loved ones might have had treatment withheld inappropriately and their deaths hastened unnecessarily. Nine families raised concerns that their loved ones might have died avoidable deaths that could have been prevented had care and treatment been managed better.
- 11 The BCUHB Mortality Review:** those families whose loved ones had been included in the BCUHB Mortality Review wanted to understand if their deaths had been avoidable. They wanted clear explanations about the care and treatment provided and, if unacceptable levels of care were identified, for both clinicians and BCUHB to be held to account.

**8.13** The themes listed above became the initial framework for the Investigation Panel's work. In addition several families raised concerns that were particular to them and their loved ones. Those concerns have been addressed under the Wales *Putting Things Right* process in confidential, individual patient reports and are not included in this 'lessons for learning' report as the numbers are too small to be generalised across the patient cohort.

**Part Three**  
**Findings, Analyses and Conclusions**

## 9 Care and Treatment: System

### Overview to Chapter

- 9.1** Details of the inception of BCUHB and the purpose and roles of the Mental Health and Learning Disability CPG are given in chapter 6 of this report. Also in chapter 6 is a summary of previous governance and service reviews. The purpose of chapter 9 is to provide a concise narrative overview of BCUHB's historic governance arrangements and the managerial structures that were in place to support the delivery of clinical services. It is not intended to replicate or replace the work that Donna Ockenden has conducted as part of the independent Governance Review into BCUHB's structures, systems and processes.
- 9.2** Chapter 10 addresses the specific care and treatment themes raised by families and identified by the Investigation Panel. In order for the resulting findings and conclusions to be understood in context chapter 9 also provides essential background information in relation to clinical leadership, professional standardisation, resource management and workforce.

### The Clinical Programme Group (CPG) Approach

#### Foundation and Emerging Concerns

##### Background

- 9.3** Executive Directors and Non-Officer Members of the Health Board provided evidence to the Investigation; they were comprised of both past and present post holders. In addition evidence was provided by Senior Managers who either led, or worked within, the Mental Health and Learning Disability CPG. Those witnesses described the creation of BCUHB in 2009 as a difficult and confusing process. Eight NHS organisations had been brought together (one in itself the result of a previous merger nine months earlier) all of which had worked traditionally to different lines of accountability, leadership and governance.
- 9.4** Mary Burrows who was the then Chief Executive Officer was aware at the outset that the creation of such a large and complex Health Board was not going to be a simple task. In her statement given to the Public Accounts Committee in August 2013 she explained that organisational development on this scale would normally take between five and seven years to accomplish. The challenge not only included the complex merger but the implementation of national strategy and the need for comprehensive service redesign. A venture of this kind would ordinarily require a significant development budget, however BCUHB commenced its work against the backdrop of financial restriction and cost saving; this created a tension at the outset which was never resolved.

## The Clinical Programme Group Model

- 9.5** The intention behind the CPG model was to cut across pre-existing cultural, geographical and service boundaries in order to deliver a unified approach to strategy and operational service. It was envisioned that the proposed structure would spearhead the clinical leadership of NHS services within an ethos of earned autonomy. However in the event CPGs ran with a high degree of autonomy with delegated powers from the point of their inception.
- 9.6** The Public Accounts Committee questioned Mary Burrows specifically about the decision to implement the CPG model. The Committee expressed concerns in relation to the pedigree of the model and the potential for it to obstruct the line of sight between ‘Board and Ward’. In the evidence submitted to the Committee Mary Burrows stated that the CPG model and structure had a proven track record and that any perceived disconnect between ‘Board and Ward’ could not be attributed to the model alone; she said:

*“This structure was developed using evidence from London and Birmingham NHS organisations and considered in depth... The clinical model is similar to other Health Boards and NHS organisations that manage complex care... A Board would not generally be expected to be sighted on all operational matters... The point is to ensure appropriate escalation of issues requiring the involvement of the Board... The desirability of avoiding a ‘Board to Ward gap’ is universal in all large organisations and is about ensuring an open, integrated culture and good informal and formal communication flows”.*<sup>26</sup>

- 9.7** It was also noted that the model had been piloted and developed by the Chief Executive in the former North Wales NHS Trust which was one of the predecessor organisations to BCUHB. Whilst the pilot was still in its infancy when BCUHB was established this was put forward by Mary Burrows as an example of reasonableness and to demonstrate that a period of pre-planning and initial evaluation had been undertaken.
- 9.8** The views put forward by Mary Burrows were well made, but not necessarily shared by all of her Health Board colleagues. Whilst the CPG model in itself might have been tried and tested, many members of the Health Board had reservations about the manner in which it was interpreted, implemented and overseen at BCUHB.

## Assurance Framework

- 9.9** Highly devolved operational service models are not uncommon within the NHS and other healthcare providers across the world. However this kind of model is required to rest upon a firm foundation of pre-agreed assurance and oversight process together with the formal delegation of powers. It would appear from an early stage there was a mis-match of expectation as to how this would be achieved. Three former Non-Officer Members of the Health Board told the Investigation Panel:

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<sup>26</sup> Public Accounts Committee (August 2013) Inquiry into Governance Arrangements at Betsi Cadwaladr University Health Board: Responses to Questions raised in earlier Evidence from Mary Burrows, CEO BCUHB-12 September 2013

*“This was a novel, devolved structure, with a single clinician Chief of Staff leading each CPG Board to deliver an all-North Wales health programme. This model emphasised clinical leadership in a structure with devolved clinical, financial and management authority... In the early years, the Health Board was heavily involved in clinical reconfiguration and modernising processes, with some centralisation of specialist services and some controversial services closures.*

*The Health Board was also working to challenging financial targets. These years were a time of developing and reinforcing an all-North Wales identity, but at times it felt like we were driving against strongly held allegiances, particularly by senior clinical staff, for the old DGH [District General Hospital] model.*

*However, concerns developed and intensified at Board level about the effectiveness of the CPG structure model fairly soon after its establishment. Whilst the model inherently devolved a great deal of authority and decision-making to CPG boards, there was a non-officer-group expectation of a far greater level of transparency and accountability to the Board than ever happened. We believe it to be accurate and fair to state that, despite these mounting concerns, the CEO was totally committed to the CPG model and the group of clinical leaders (Chiefs of Staff), and to the autonomy of that group”.*<sup>27</sup>

**9.10** In order to be safe and effective clinical services depend upon strong, corporately owned governance frameworks that are both embedded and mature enough to fulfil their purpose in relation to assurance and oversight. It is a basic tenet of good governance: the more autonomous and devolved the clinical service model the stronger the concept of ‘corporate franchise’ has to be; this is to ensure the standardisation of quality and safety across complex organisations, together with strategic synergy. Autonomy and devolution have to operate within a pre-determined corporate ‘brand’ and set of expectations which in healthcare will include:

- values and strategic direction;
- policy and procedure ratification;
- performance management targets and monitoring processes;
- patient safety systems and structures.

**9.11** In the case of BCUHB the new clinical service model was developed simultaneously to that of the corporately owned governance frameworks. At this stage corporate identity and strategic vision were in the process of development and governance frameworks were immature and untested. Against this backdrop CPGs were allowed to develop their own systems and structures independently from specified corporate expectations and guidance. The concept of ‘earned autonomy’ appeared to be a misnomer as a high degree of CPG self direction was evident from the outset. The formal statement provided to the Investigation on behalf of the current Health Board stated:

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<sup>27</sup> Witnesses statement excerpt

*“Each Chief of Staff was accountable to a named Executive Director. However in practice this was supplemented by a close working relationship between the Chief of Staff and the then Chief Executive... CPGs were not mandated to develop consistent governance arrangements. They were given the flexibility to put in structures and organisational arrangements that would best support them to deliver their objectives”.*<sup>28</sup>

**9.12** By 2010 there were increasing levels of disquiet at the Health Board. However a ‘pull me push you’ dynamic had been set in motion whereby autonomy once given was difficult to take back and complex structures and systems had been allowed to develop independently of each other which did not always work well together to attain the goals they were intended to achieve.

**9.13** It was evident that this level of disquiet persisted for several years after the inception of the CPGs. Within the Mental Health and Learning Disability CPG matters were exacerbated by senior managers often being uncertain about job roles, responsibilities and lines of reporting. This applied to the lines of reporting which connected the CPG to the Health Board, but also to those that connected CPG Senior Managers to the complex organisational structures that comprised the services they were directly responsible for.

**9.14** A former executive of the Health Board had this to say about the Mental Health and Learning Disability CPG:

*“It was a disorganised, dysfunctional element of the service... It wasn’t prioritised, it wasn’t overseen particularly well, and certainly there was a significant lack of experience and expertise at the senior level within the organisation around how mental health services should be run, delivered and reported upon... one of the issues that [ran] across the whole organisation, but mental health was perhaps where it was most obviously visible... [services] were effectively run by clinicians with very little oversight or control from senior management within the organisation”.*<sup>29</sup>

**9.15** The same witness also reflected that strategic commissioning and service planning was under developed in the newly established Health Board. This was because post holders had little prior experience of working across large health and social care economies and could not have been expected to steer and support the kind of complex mental health service re-design that was required across north Wales:

*“They had little in the way of understanding or capability around design, service planning, performance management or what the expectations would be of an organisation the size of Betsi for the future... [the decision to use] existing personnel and not bring in expertise from outside of the area to help develop what the solutions could look like, was a fundamental error”.*

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<sup>28</sup> Betsi Cadwaladr Health Board Statement P 5

<sup>29</sup> Witness transcript excerpt

- 9.16** By 2012 the Health Board understood that formal intervention was required across the organisation as a whole. The statement provided to the Investigation on behalf of the current Health Board stated:

*“The inadequacy of the operational management arrangements established in 2009 increasingly became a source of tension and frustration at Board level. In November 2012 the Board established a working group chaired by the then Vice Chair to develop proposals for a revised operational management structure to address the perceived weaknesses... This work progressed but final proposals were not placed before the Board as they were overtaken by the issues and events giving rise to wider governance concerns in May 2013. These governance concerns were reported publically in June 2013 as the part of the Joint Governance review undertaken by [Welsh Audit Office and Health Inspectorate Wales]”.*

## Lines of Accountability

- 9.17** During the period under investigation the Health Board was comprised of 20 members. This included the Chair and Vice Chair (both appointed by the Cabinet Secretary and Minister responsible for health), the Chief Executive (appointed by the Board with the involvement of NHS Wales), eight Executive Directors and nine Independent Members.
- 9.18** The Health Board was permitted to establish the committee structure best suited to its own particular configurations and needs within the provisions set out by regulatory and Welsh Government requirements. In 2009 the Health Board established a committee structure which provided assurance and oversight of the following aspects of the Board’s core business:
- Quality and Safety;
  - Finance and Performance;
  - Audit;
  - Information Governance;
  - Charitable Funds;
  - Remuneration and Terms of Service;
  - Mental Health Act requirements.
- 9.19** However between 2009 and 2013 it was not always apparent how the Health Board’s core business and committee structures dovetailed into those of each CPG. The Investigation Panel took into consideration the evidence from some 40 BCUHB Executive, Independent Member and Senior Management staff (both past and present) as to how this was managed on a practical basis. A key finding was that no consistent view was put forward and to this day many of the witnesses remain uncertain as to how the system actually worked or how effective it really was. This is an important finding in itself.

- 9.20** A former clinical executive of the Health Board who had also been a CPG Chief of Staff reflected that:

*“What was quite light was governance. Good news was encouraged, but the governance structures were light... [the CPG model] was a very brave decision, but I think that the architecture of governance was probably not thought through as closely so the lines of accountability were quite blurred. We had Clinical Executives, the Nurse Director and Medical Director, but it felt very often like my key relationship, as the Chief of Staff, was almost directly to Mary [the CEO] and there was an Executive Team that went round the sides...*

*... I remember... going to see Mary, though, because we were very concerned about what we were hearing from wards and staff in the hospitals that they were a bit lost with that question of actually who was running the hospital”.*

- 9.21** This witness also reflected upon the levels of accountability that were required:

*“Clinical leadership was going to be this all-purpose antibiotic that was going to sort out all the governance and risk issues and champion improvement... The governance at the time actually felt more like ‘tell me’ rather than ‘show me’, and I think it felt like we had a climate where there wasn’t sufficient connection between what was going on at ward, and what was going on at Board level...*

*... People would be keeping an eye on statistical control charts and seeing trends and variation, and it wasn’t safety in the rear-view mirror; it was safety occasionally having a glance in the rear-view mirror, or something really just shunting you from behind”.*<sup>30</sup>

- 9.22** The Investigation Panel reviewed the job descriptions of the Executive Directors and the senior managers of the Mental Health and Learning Disability CPG. There were two things that were immediately obvious:

- job descriptions often ran into an excess of 15 pages and were excessively detailed and demanding – lines of accountability were complex and could require a single post holder to report to 10 different people;
- Job descriptions across different post holders often held the same accountabilities, functions and roles leading to confusion as to ‘who’ was directly accountable for ‘what’.

- 9.23** It was evident that in the early years there were attempts to streamline roles and responsibilities and to strengthen accountabilities. The statement provided to the Investigation on behalf of the current Health Board stated:

*“The three clinical executives had lead responsibility for the oversight and assurance of quality and safety within the organisation. The three clinical executives were the Executive Medical Director, the Executive Nurse Director and the Executive Director of Therapies... in 2010 it became apparent that clinical executives needed greater ownership and sight of quality and safety*

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30 Witness transcript excerpt

*issues and informal arrangements matured by 2011 into a Quality and Safety Lead Officers Group chaired by the Director of Nursing. In addition a Concerns Scrutiny Group was established chaired by an Independent Board Member”.*

- 9.24** Despite this change it remains unclear to the Investigation Panel how the new structures actually worked. They had been developed after those of the CPG and no one could explain how the CPGs reported up in to these structures and how interconnectivity was achieved.

### **Operational Management**

- 9.25** The then Chief Executive chaired a Board of Directors meeting which was the key operational decision-making forum within the Health Board. The membership comprised Chiefs of Staff and Executive Directors. Each CPG Chief of Staff was accountable to a named Executive Director.

- 9.26** The Investigation Panel interviewed the Executive Director who was responsible for the oversight of the Mental Health and Learning Disability CPG:

*“One of my reflections is if I compare that to other organisations that I have worked in at an Executive level, the degree of delegation and authority vested in those clinical leadership roles was significantly more than I have seen in other roles, and that was by design... The management structure within the Clinical Programme Group was designed by the Chief of Staff and colleagues... I had an element of input in that, as the Executive responsible, principally around ensuring that that structure was affordable within the financial envelope given. I did question, debate and discuss with the Chief of Staff the design of that structure, but ultimately it was a delegated function that the Chief of Staff had the authority to design the structure as they wished to do. That wasn't just in Mental Health that was in all of the Clinical Programme Groups”.*<sup>31</sup>

- 9.27** In relation to direct operational accountability the same witness told the Investigation Panel:

*“There was a place for challenge, but it was in the construct of the Executive role not being to undermine what the CPG wanted to do and the direction they were moving in. It was constructive challenge and to help. As I say, I referred earlier to conversations I had with the Chief of Staff where I would discuss issues with him. I would give him my perspective, as an Executive Director, about how I might approach those things, but, ultimately, the authority and responsibility sat with the Chief of Staff”.*

- 9.28** There were issues in relation to clear lines of reporting, both formal and informal:

*“... In reality, the Chiefs of Staff had a very close working relationship with the Chief Executive. They had regular meetings individually and collectively with the Chief Executive, and there were instances, for example, when the Director General would visit from Welsh Government. There would be a meeting with the*

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<sup>31</sup> Witness transcript excerpt

*Chief Executive and the Chiefs of Staff. Rarely would Executive Directors be involved in the same discussion, so there was a relationship and a leadership and the position of the Chiefs of Staff was clearly positioned as these are the leaders in the organisation who are driving the change”.*

**9.29** In any large and complex organisation perspectives will differ depending on where a person sits within it. When giving evidence Executive and Independent Members of the Board (past and present) were of the view that autonomy was conferred to CPGs and that the first four years of BCUHB’s existence was spent wrestling it back. However the experience of those managing the Mental Health and Learning Disability CPG was somewhat different. They describe a confusing and ill-defined period where the ‘push me pull you’ dynamic hampered both progress and the day-to-day management of clinical services.

**9.30** The Investigation Panel was told that the notion of autonomy and devolution was not always as clear-cut as everyone thought it to be. The main problem was finance; whilst the budget had been devolved to the CPG this appeared to be ‘on paper’ only. The former CPG Chief of Staff reflected on his role and the devolution that never really happened in his view:

*“The complex matrix management system of the Health Board meant that the authority and accountability of the role was never clear and changed over time, an issue raised in the 2013 WAO/HIW joint review. Authority was delegated by the lead Executive for Mental Health, the CPGs were supposed to develop earned autonomy by meeting budgets, however this was never achieved and for 11/12 all appointments were by Executive agreement. The financial context for mental health was one of real budget reductions and year end removal of external funding in the setting of a low benchmarked spend on mental health including OPMH in North Wales.*

*The accountability, including personal Performance and Development Review... of the Associate Chiefs of Staff... changed in 11/12 as the ACoS Nursing started to report directly to the Nurse Director and the Assistant Nurse Directors. Nursing staff appointments required approval by corporate nursing, and they provided the framework and managed the reporting of workforce and professional governance (fundamentals of care, supervision, training, infection control etc.) for nursing. Reporting and escalation of specific safety issues was to the site Assistant Nurse Director. The ACoS Operations worked with the Director for Primary, Community and Mental Health and from 13/14 reported to the interim Operating Officer”.*<sup>32</sup>

**9.31** The Associate Chief of Staff Operations was also of the view that autonomy and devolution were aspiration rather than reality. He reflected that his role had no real authority or power. He held no budget and had restricted operational responsibilities. He said *“It was a very medically-led model, so it had the Chief of Staff and then there were Medical Leads, more or less, in each speciality and their job descriptions would be that they were in a way the Operational*

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32 Witness statement excerpt

*Managers of the service, so they had financial control*".<sup>33</sup> The locus of control would appear to have sat in reality in the more traditional hospitals and units that to an extent predated the formation of either BCUHB or the CPG. In the case of the Mental Health and Learning Disability CPG the 'new model' in effect presided over a disparate group of services that continued much as they had always done.

- 9.32** It was the view of this witness that BCUHB had in reality a highly centralised model of working and that autonomy never truly occurred because key financial decisions all had to be taken by the Executive Director Team. For example: every vacancy had to be signed off by the Executive Director of Nursing meaning this important aspect of operational service management never sat within the CPG function.
- 9.33** Ultimately the Investigation Panel found the actual lines of accountability and levels of autonomy impossible to track with accuracy. None of the witnesses provided the same narrative as to how key functions worked within BCUHB, either at corporate level or within the CPG. In the absence of clearly documented committee structures, and accompanying terms of reference, the finding has to be that an 'organic' and mismatched system was in place.

## Culture and Managerial Capacity and Capability

### Underlying Culture

- 9.34** The Investigation Panel defines organisational culture as the systems of shared assumptions, beliefs, and values which govern how people behave in the workplace.
- 9.35** Mergers between NHS organisations are notorious for the difficulties presented by the marrying together of different cultures. The failure to address this issue can undermine organisational development and service improvement for years after the initial merger has taken place. The Investigation Panel has not heard of any other NHS organisation that has had to merge, in effect, nine separate Trusts together; therefore it was no surprise to hear about the interplay of different cultures and tribalistic behaviours that persisted within BCUHB following its inception and the challenges that this presented over the years.
- 9.36** Witnesses described six key factors pertaining to culture that impacted upon BCUHB's ability to both move forward and quality assure the services that it provided.
- 1** Each of the three original NHS provider Trusts across north Wales had very different cultures. These were resistant to change and this was exacerbated by the geographical distance between them. Each of these three Trusts had developed a distinct approach to policy guidance and professional standardisation. In the case of mental health services these differences persisted for many years and (to an extent) persist still.

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<sup>33</sup> Witness transcript excerpt

- 2 The creation of CPGs and the emphasis on autonomy and devolution prevented the Health Board from developing a strong corporate ‘brand’. The organisation did not give itself sufficient time to establish its identity before handing over key responsibilities to the CPGs. This served to lessen the Health Board’s control over organisational development and belief and value systems.
  - 3 The establishment of BCUHB brought together a range of services that had not traditionally been provided by a single organisation before. The inherent differences in culture, custom and practice between services as diverse as (for example) Forensic Psychiatry and District Nursing were not acknowledged. Those services as provided by each individual CPG retained a ‘looking out for themselves culture’ particularly in view of the ever-present financial challenges and restrictions; this created barriers to developing integrated care pathways and inter-service cooperation.
  - 4 Witnesses described the north Wales workforce as being very stable. People would train in north Wales and work in north Wales for all (or most) of their professional lives. Consequently the exposure to fresh thinking, innovation and challenge was limited and the culture somewhat inward looking. One witness described the consequence of this as there being *“a danger of services becoming something like the Galapagos Islands developing their own systems, processes and methodologies”*.<sup>34</sup>
  - 5 Witnesses also described a somewhat dogged resistance to change and a culture of passive resistance which ultimately triumphed over initiatives for change.
  - 6 There was a distinct view from those individuals working in Mental Health Services that the prevailing culture at the Health Board was one of acute secondary care medical and surgical provision. This was reflected by the experience and backgrounds of the Board members as a whole and this served to reduce the status and visibility of mental health services, particularly those relating to older people.
- 9.37** Set alongside these particular cultural issues were other underlying factors; those of professional affiliations, behaviours and expectations. Dominant professional cultures were very evident, particularly amongst medical staff, whereas nursing as a profession appeared to have a lower profile and level of prominence across BCUHB; in particular within the Mental Health and Learning Disability CPG.
- 9.38** This is illustrated by the fact that nine out of the 11 CPG Chiefs of Staff were doctors, and that six out of the seven heads of programme/clinical directors in the Mental Health and Learning Disability CPG were psychiatrists.
- 9.39** The last and perhaps most important aspect of BCUHB’s underlying culture was that attributed to Mary Burrows in particular, and the Health Board, in general. We heard from several witnesses the phrase *“bring me good news”*. From an

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34 Witness transcript excerpt

early stage the corporate ‘message’ appeared to be upbeat and positive. Witnesses from the Mental Health and Learning Disability CPG described a culture which made discussing challenging and difficult aspects of healthcare provision uncomfortable. This led to a culture of muddling through and only escalating concerns to the Health Board *in extremis*. A senior clinician told the Investigation Panel:

*“BCUHB developed a culture in which any criticism of management was seen as disloyal. Mental Health reflected the culture in the organisation as a whole in this respect. The initial Chief Executive... had a mantra “Bring me Good News”. This was interpreted by almost everyone else as “Don’t Bring Me Bad News”. This led to a massaging of information so that positive things were highlighted and negative things minimised or falsified. It also led the organisation to persecute those who viewed things in a different light”.*<sup>35</sup>

- 9.40** Several witnesses reflected that this ethos led to perceived bullying and harassment on the part of management in an effort to prevent the escalation of clinical concerns.

### **Capacity and Capability**

- 9.41** At the inception of the Mental Health and Learning Disability CPG a Chief of Staff was appointed. The role was principally one of clinical leadership where the post holder remained in a clinical position. The job description sent to the Investigation indicated that the post holder was required to work between “2 – 5 sessions per week” across north Wales (a session equates to four hours). The job summary detailed:

*“The Chief of Staff will lead and be accountable for the performance of the Clinical Programme Group, making sure that s/he is able to secure first class improvements in health and well-being. The Chief of Staff will provide leadership for safe, high quality care and promote the services s/he provides, leading teams and staff within the Clinical Programme Group. S/he will work closely with members of the Health Board, Professional Forum, Stakeholder Reference Group, Partnership Forum and other Chiefs of Staff and their teams.*

*S/he leads the development and management of the Clinical Programme Group (CPG) to support the Health Board’s strategic vision. S/he will introduce learning and innovation to the CPG, creating an environment and system of safety, quality, learning and improvement based on needs and outcomes. A key requirement of the role will be to demonstrate improved outcomes and experience for those using services and provide valuable clinical information to improve clinical practice.*

*With Directors, s/he will contribute and participate in working with health, local government and other partners to improve health and promote, develop and deliver safe, effective and high quality services for North Wales”.*

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35 Witness statement excerpt

- 9.42** However in reality the Chief of Staff's role was comparable to that of a traditional NHS Chief Executive with delegated financial, operational service and strategic responsibilities. The population covered was in excess of 650,000 with an annual budget of *circa* £90 million and a workforce of 2,000 people.
- 9.43** Once established the management structure of the Mental Health and Learning Disability CPG appears to have been subject to unceasing evolution; however one constant was the triumvirate model whereby the Chief of Staff was supported by an Associate Chief of Staff for Nursing and an Associate Chief of Staff for Operations.
- 9.44** The Executive Director who was responsible for the oversight of the Mental Health and Learning Disability CPG reflected that:
- “I think for all the Chiefs of Staff it was an incredibly big ask to step into those roles and to be given that breadth of responsibility... I don't believe that there was a structured programme [for] operational management and development. There was a development programme. There was individual coaching for some individuals... However, would that have comprehensively prepared somebody for an operational management role, running a £70-odd/£80 million organisation? My honest answer to that is you would expect more operational experience”.*
- 9.45** When referring to the Associate Chiefs of Staff for both operations and nursing the same witness had this to say:
- “What people had was essentially an Operational Manager and a nurse, both at Band 8D, so relatively senior in terms of operational management, but, again, I would have to say that – and this is not just in Mental Health – to take on the span of responsibility for the whole of North Wales... was a big step for those individuals”.*
- 9.46** The capacity and capability of the new CPGs was further compromised by the financial pressures that the newly founded Health Board started with. At the point of inception there was a target to take out 20 percent of the management costs. The final reflection of the Executive Director who had oversight of the Mental Health and Learning Disability CPG was *“that led to people trying to manage on a very limited resource base, so not the most healthy combination”*.
- 9.47** A senior manager who worked within the Mental Health and Learning Disability CPG told the Investigation Panel:
- “There were huge pressures to save money, I do understand that, and I was signed up to some of those cost-saving plans, but it really didn't work. We had lost the local knowledge in some of those changes, and also, we cut back too far on the management structure”.*<sup>36</sup>
- 9.48** The management infrastructure was cut back at the very time when it was needed the most. Managers found themselves working across a vast geographical area

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36 Witness transcript excerpt

having to take over services that were unfamiliar to them. In effect the CPG was a somewhat illusory phenomenon with a floating senior team supported by a small cadre of relatively inexperienced support staff.

- 9.49** The real locus of activity and control appears to have sat within the programme groups and day-to-day operational services. Those services appear to have continued much as they ever had but against the backdrop of severe financial constraint and ever increasingly confused lines of accountability.

## Conclusions

- 9.50** The Investigation Panel understands that a great deal has already been placed in the public domain in relation to BCUHB's first four years of existence. It is evident that the situation was complex and that despite years of disquiet very little happened to impact positively upon the situation until intervention from Welsh Government took place in 2013.
- 9.51** However it is important to set the issues out in the words of the people that lived through the experience. What came through from the discussions that the Investigation Panel had with witnesses was the breadth and scale of the problem which affected every tier of the organisation. No matter where individuals sat within BCUHB they all described feelings of great misgiving about the structures they worked in and their inability to intervene and bring about positive change. It was evident that each witness described authority as always resting 'somewhere else' no matter how senior they were in the organisation. This level of helplessness is already a matter of public record and is a damning indictment on the leadership and culture of BCUHB in its early years.
- 9.52** From all accounts it is now widely accepted that the CPG model was a failed experiment financially, operationally and strategically. The circumstances that faced BCUHB would have confounded most new organisations; however these were exacerbated by a fundamental lack of accountability, leadership, strategy and structure. The joint Welsh Audit Office and Healthcare Inspectorate Wales report "*An Overview of Governance Arrangements Betsi Cadwaladr University Health Board Joint Review undertaken by Healthcare Inspectorate Wales and the Wales Audit Office* (June 2013) stated that:

*"Most significantly we have concerns that the Health Board's governance arrangements and organisational structure are compromising its ability to adequately identify problems that may arise with the quality and safety of patient care. The current governance arrangements and procedures do not adequately address 'the gap between the ward and the Board', and may even be contributing to it..."*

*... The Health Board's organisational structure, based around Clinical Programme Groups is designed to support the aim of being a clinically led organisation. However, problems have been evident for some time... These have been exacerbated by weaknesses in the arrangements to hold CPGs to account on key aspects of financial and clinical governance".*

- 9.53** This Investigation was charged specifically to conduct an investigation into the care and treatment provided to patients on Tawel Fan ward. Clinical services are not provided in a vacuum therefore they cannot be investigated without an examination of the wider system in which they are provided. It is important to understand the context in which day-to-day services were managed and that whilst all of the disquiet and organisational disruption was going on around them wards like Tawel Fan continued to deliver care and treatment to vulnerable older adults across north Wales.

## Clinical Governance

### Context

- 9.54** Clinical Governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care; this is achieved by creating an environment in which clinical excellence will flourish.<sup>37</sup> In January 2013 Welsh Government published *Safe Care, Compassionate Care National Governance Framework to Enable High Quality Care in NHS Wales*. It said:

*“The Board of each NHS Organisation is accountable for ensuring the quality and safety of all services it provides and commissions. This includes promoting an open and supportive organisational culture where patients, staff and stakeholders can have their voice heard. All NHS organisations are required to have a Quality and Safety Committee to ensure sufficient focus and attention is given to such matters. This must be served by its independent members and report directly to the Board”.*

- 9.55** It is important to understand that regardless of whether an NHS organisation decides to operate a devolved model of service delivery or not, some functions of an NHS Board cannot be delegated or devolved either in whole or in part without robust frameworks and schedules being first put in place; even then an NHS Board retains the ultimate accountability for the success or failure of any approach taken. The Welsh Government paper also said:

*“However experience has shown us that it’s not just systems, but also the culture, values and behaviours that organisations and staff exhibit which are equally important. It is this which has the greatest impact in ensuring all patients and service users get the very best standards of care. It is the responsibility of the Board to ensure an appropriate culture exists and is cultivated within the organisation, reflecting the core values of NHS Wales...”*

*... In discharging their assurance role, Boards and individual Board members need to ensure that they have the required skills to fulfil their responsibilities. Effective Board Development should therefore be considered an essential ingredient within the organisation’s assurance framework and journey to being a truly quality-driven organisation”.*

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<sup>37</sup> Welsh Office, Quality Care and Clinical Excellence, 1999

**9.56** There are seven traditional pillars of clinical governance; they are:

- service user, carer and public involvement;
- risk management;
- clinical audit;
- staffing and staff management;
- education and training;
- clinical effectiveness;
- clinical information.

**9.57** The Investigation Panel read thousands of pages of clinical governance related committee meeting minutes and reports in an effort to understand how the clinical governance systems, structures and processes led by the Health Board and the Mental Health and Learning Disability CPG practically ensured the quality and safety of the patient experience. However there is no need to detail this evidence here; this is for two reasons. First: there is a substantial body of review work already in the public domain that provides the necessary information. Second: the Ockenden Governance Review will address this in significant detail requiring no repetition here.

**9.58** Nevertheless, what does needs to be discussed is the fracture between those systems, structures and processes and the actual reality on the ground for clinical services. The Investigation Panel found an organisation that was high on aspiration but somewhat low on practical implementation; this left patient services vulnerable as they operated for much of the time outside of good governance frameworks.

## Findings

**9.59** The Investigation Panel met with senior officers from BCUHB, both past and present, all of whom had a role in the implementation and oversight of clinical governance. It is a fact that none of them could consistently articulate the actual processes followed either from a Health Board or CPG perspective. It would appear that actual practice differed entirely from what the formal structures and procedures would suggest with a complex interplay of ‘wheels within wheels’, role confusion and ignorance as to what good clinical governance should look like.

**9.60** There are eight key areas that the Investigation Panel found to be of concern; these areas equate broadly to the traditional seven pillars of clinical governance. The exception is that of service user and carer involvement which is addressed extensively throughout Chapter 10 and is not examined here. The eight areas are as follows:

- quality improvement initiatives;
- professional standardisation – policy and procedure;
- clinical audit;
- education and training;
- clinical leadership and supervision;

- patient safety – escalation and management;
- workforce – safety and wellbeing;
- clinical information.

- 9.61** The Investigation Panel was told repeatedly by witnesses that BCUHB did not operate clinical governance as ‘we would recognise it’. We were told by a senior member of the executive nursing team that *“The cycle and the pillars [of clinical governance]... were completely lost in the merger and clinical governance, the pillars that I was familiar with working with started to disappear, so we didn’t talk about quality, we didn’t talk about audit and we didn’t talk about effectiveness”*.<sup>38</sup>
- 9.62** This fundamental lack of prioritisation and understanding was a confounding factor. The other confounding factor was the sheer size of the organisation and the CPG service model which often worked in isolation from, rather than in tandem with, corporate priorities.
- 9.63** To illustrate the challenges BCUHB faced in relation to clinical governance the narrative accounts of those witnesses involved in implementation and oversight are set out below to provide specific examples of where the challenges sat and how they ultimately impacted upon clinical service delivery on wards like Tawel Fan.

### Quality Improvement Initiatives

- 9.64** The Investigation Panel found very few corporate or CPG-led quality improvement initiatives for the period under investigation. This ties in with the view offered by many witnesses that quality improvement was not something deemed to be a priority during those years.
- 9.65** However there was one wide-ranging corporately-led example. The Assistant Director of Nursing Community and Primary Care who was based at the Glan Clywd site during the period under investigation described a corporate initiative on the part of the Executive Director of Nursing; the Transforming Care Project. The project was intended to empower ward managers and modern matrons by focusing on the effectiveness and efficiency of ward management. In 2011 two wards were selected on the Glan Clywd site and quality improvements were noted. The Health Board was pleased with the work but demanded that this was rolled out with immediate effect to the other 72 wards within the organisation deemed to require this approach. In order to achieve this, the programme had to be diluted and as a consequence lost effectiveness.
- 9.66** The corporate team resource comprised three people to achieve a project that ran across the whole organisation. The Assistant Director of Nursing Community and Primary Care explained that the ability of the corporate nursing team to embed this kind of quality improvement was compromised:

*“We did escalate our confusion in terms of our job description, our role, but the most important thing that we raised at the time, and I remember it distinctly and*

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38 Witness transcript excerpt

*I would raise again now, is about our legitimate authority to act, and this was discussed amongst the Executive. We raised it to our Director of Nursing because whilst we were being fielded at the front door... there was a lot of noise and conversations coming from the Assistant Chiefs of Staff for Nursing who actually actively stated 'You don't have any legitimate authority or power over my service'".<sup>39</sup>*

- 9.67** Due to prevailing attitudes a corporate quality improvement initiative was implemented unevenly across the organisation with the process requiring constant negotiation in order to take things forward. This initiative illustrates the fact that the Health Board was prepared to compromise on quality in a bid to get even coverage; there was no concept of prioritisation led by patient safety metrics, or an appreciation of the resource input required to achieve such an ambitious project. It also illustrates the fact that CPGs could thwart a Health Board quality improvement initiative and limit levels of cooperation.
- 9.68** Nevertheless an important finding to note is that prior to its closure the Tawel Fan Ward Manager had taken part in the Transforming Care Programme which was found to be a positive opportunity and had been supported by the Mental Health and Learning Disability CPG. This was good practice.

## **Professional Standardisation – Policy and Procedure**

### ***Policy Development and Ratification***

- 9.69** Most senior witnesses told the Investigation Panel that clinical policy development and ratification procedures were seriously flawed during the period under investigation. The Assistant Director of Nursing Community and Primary Care had this to say about policies and procedures:

*“When the merger took place there were numerous policies, some duplicates, some still with gaps... The Executive Team were very aware at the time of the confusion of the policies. This was raised on more than one occasion at the Quality and Safety Committee because most probably, although it wasn't an unusual event where you merged so many organisations, you're bound to get so many different policies. The concern was raised to the Executive in terms of the resource, the appetite and the energy to go into a period of time which would be a significant amount of work to actually pull together the policies and decide on which policies were going to be used.*

*Post-merger there was a period of time whereby websites were left available where staff could hook into older policies which belonged to the former organisations. We were obviously in a period of transition, but to my knowledge there wasn't sufficient resource provided to the organisation or within the organisation to take forward that enormous piece of work, coupled with the fact that some of the authors of the policies have either left the organisation or some of the policies were outdated and most certainly due for review. The enormity of*

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<sup>39</sup> Witness transcript excerpt

*that wasn't unknown to the Quality and Safety Committee. Whether we've reached the end of that journey yet I still don't know".<sup>40</sup>*

- 9.70** When the Investigation Panel commenced its work one of the first things required was the collection of clinical guidelines, policies and procedures. We were puzzled to hear people ask us "*which ones do you need? The corporate policies or the local ones*".
- 9.71** Over the course of the Investigation it became evident that whatever processes the Health Board thought it had in place to ratify policies during the period under investigation they were entirely ineffective and to a large extent ignored by services on the ground. The documents presented to the Investigation were often written on the headed paper from the previous NHS Trusts even though they bore development and review dates several years post merger.
- 9.72** Of particular concern was the view offered by many BCUHB senior witnesses who described this issue as still being unresolved when they were interviewed by Investigation Panel in the summer of 2017.
- 9.73** The majority of the clinical policies that were reviewed by the Investigation Panel appear to have been developed within the Mental Health and Learning Disability CPG – they do not always appear to be evidence-based and it is difficult to determine how best practice guidelines were determined. This potentially placed clinical services, patients, and the clinical staff who were expected to follow those policies, at risk.

#### ***Access to Clinical Policies and Guidelines***

- 9.74** During the period under investigation clinical witnesses explained that most policies were kept as hard copy versions in folders on wards and clinical areas. They were uncertain as to the ratification process and were equally uncertain as to how ward teams would learn about any changes to policy and procedure. Some witnesses said that amended policies would be discussed at handovers and others said that staff would be notified in some other way (not specified) of any changes and asked to update themselves; the Investigation Panel could not establish what formal alert processes were actually in operation. There also appeared to be no prescribed sign off system that recorded whether clinical staff had actually read the amended information or not as would be usual practice in most other NHS organisations.
- 9.75** Managerial witnesses were (in general) of the view that policies were not printed off as hard copies and were accessed formally via the BCUHB intranet. There was a degree of uncertainty as to how all clinical staff were notified of any new policies but witnesses suggested this was achieved via email alerts or briefing meetings. The Investigation Panel identified an inherent problem with this approach due to the lack of access clinical staff had to computers. On a ward like Tawel Fan upwards of 35 staff would have access to two machines only; this would limit the effectiveness of accessing clinical policies and guidelines.

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40 Witness transcript excerpt

- 9.76** The two accounts listed above, in essence, describe the two different processes in relation to corporate and local policy development. It would appear that the paper copies held on wards were primarily those policies developed locally with those on the intranet being developed via corporate processes.
- 9.77** Unfortunately to this day, not all of the policies on the intranet are in-date or bear formal ratification identifiers. Specialist clinical witnesses also told the Investigation Panel (in the summer of 2017) that many policies are missing from the intranet and that the process of both policy access and quality control was still a work in progress.

### **Clinical Audit**

- 9.78** The National Institute for Health and Care Excellence (NICE), published *The Principles for Best Practice in Clinical Audit* in 2002, which defined clinical audit as:

*“A quality improvement process that seeks to improve patient care and outcomes through a systematic review against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement to healthcare delivery”.*

- 9.79** One of the ways that learning organisations determine their clinical audit agendas is through the examination of complaints, incidents and safeguarding alerts. This becomes part of the continuous quality improvement cycle which is the foundation of clinical governance. Basically clinical audit looks at current practice and modifies it where necessary to improve patient care; this should be a dynamic process.
- 9.80** The Investigation Panel could find little evidence to suggest that clinical audit was a viable function (beyond the most basic of levels) within either BCUHB as a whole, or the Mental Health and Learning Disability CPG in particular, during the period under Investigation. The Assistant Director of Nursing Community and Primary Care told the Investigation Panel:

*“The Audit Team was actually based just across the way from the car park from Tawel Fan actually from the Ablett Unit, and when I’ve made enquiries in terms of the numbers of nursing audits that were in the system at the time, it was negligible. So the audit programme was a medically-driven audit programme... it was reliant on medical staff out there generating their own concepts of what audit they would like to take forward. That was most probably very pertinent and very important and very credible, but in terms of hooking into the strategic aims of the organisation, that wasn’t there to my knowledge”.*<sup>41</sup>

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41 Witness transcript excerpt

- 9.81** The former Executive Medical Director (January 2014-February 2016) had this to say:

*“So there wasn’t a QI [quality improvement] culture... It was very variable. It was very unreliable. There wasn’t a culture of Quality Improvement or a methodology where we say, ‘this is the methodology we use’. There were bits and bobs going off here, there and everywhere, a bit of Kaizer, a bit of Six Sigma, a bit of this, a bit of that. It is much improved now, but during the restructure it was, listen, we have to do it with this envelope, and, actually, there isn’t money in the pot”.*<sup>42</sup>

- 9.82** When interviewed senior witnesses explained that clinical audit was regarded primarily as a medical function and that topics were selected in relation to a doctor’s own personal research interests. There was a weak corporately-owned agenda and there was no link into any key mechanisms such as complaints, incidents and safeguarding alerts. This fundamental lack of clinical audit process undermined patient safety systems and rendered BCUHB’s clinical governance framework ineffective.
- 9.83** Complaint, incident and safeguarding reporting has an essential role to play in determining where clinical practice needs to be modified in order to ensure patient safety and clinical effectiveness. They are not an ‘end in themselves’ and no process can be said to be performing well if it does not feed into an overarching patient safety and quality improvement system; at best they become largely meaningless, at worst the activity (no matter the lack of join up) can provide a false sense of assurance.

## **Patient safety – Escalation and Management**

### ***Complaints***

- 9.84** The all Wales *Putting Things Right* (PTR) process is the integrated processes for the raising, investigation of, and learning from complaints. The PTR process came into being at around the same time BCUHB was established. The Head of Investigations and redress told the Investigation Panel that *“we were struggling with a new structure, a new organisation and PTR coming into force”*.<sup>43</sup>
- 9.85** The purpose of the PTR regulations is to ensure that:
- complaints are investigated thoroughly in a timely manner;
  - a full explanation is provided as to why things might have failed;
  - a determination is made as to whether there has been any breach in the duty of care and to provide redress through a number of potential channels.
- 9.86** These were all elements contained within the Health Board’s policy. The expectations within the regulations are that complaints are acknowledged within two working days of receipt and that a full response should be provided within 30 working days of receipt following appropriate investigation. Where a

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<sup>42</sup> Witness transcript excerpt

<sup>43</sup> Witness transcript excerpt

complaint is particularly complex, there is scope for this to be extended to six calendar months.

**9.87** The local BCUHB policy during the period under investigation described the process for managing concerns and was explicit about roles and responsibilities. The corporate concerns team was responsible for logging all complaints received and passing them to the CPG for investigation and the drafting of responses. Once a response was prepared, the corporate team would quality assure the reply before submitting it to the relevant Director for final approval, signature and despatch. This process remains largely unchanged today although the processes have been streamlined with additional support provided through the Corporate Team.

**9.88** The former Director of Corporate Services was brought into the organisation on the back of the Healthcare Inspectorate Wales/Wales Audit Office report in 2013. He had this to say about complaints management:

*“I was aware there was a significant backlog of complaints when I joined the Health Board which had accumulated over some time largely as a result of capacity within both the CPGs and corporate teams. The Health Board was consistently not meeting the 30 day response requirements of the PTR regulations and many complaints had not been responded to within the six month exceptionality period”.*

*“From my perspective, it didn’t feel as though concerns were treated seriously by the service, they are a window onto what’s happening, and it didn’t feel to me that they were taken seriously – it’s somebody having a whinge – when actually it could be telling us something really important, or hinting at something really important. We go back to the cultural thing, ‘I’m too busy to deal with something that actually could be telling me we are harming patients’.*

*That was the first observation. The second was, they were put at the bottom of an in-tray because ‘I can’t be bothered with that just now, I have far more important things to do’. The third was, often it felt as if investigations were cursory in many cases, and it was a quick skim through notes and come to a conclusion... Often there could be conflicting evidence in there that we’re then sending to a family, there was nobody holding the ring on the whole complaint, and working out what really did happen or what should have happened”.*<sup>44</sup>

**9.89** The former Director of Corporate Services told the Investigation Panel that there were capacity issues in the corporate team and capacity and capability issues within the Mental Health and Learning Disability CPG. Of particular concern was the maintenance of good relationships with the North Wales Coroners as delays to investigations would often lead to Inquests having to be delayed.

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44 Witness transcript excerpt

- 9.90** The Assistant Director of Corporate Affairs who held the PTR portfolio during some of the period under investigation had the following insights to offer:

*“At the time of my taking over (April 2012) there was a backlog of complaints, second responses and arranging meetings with complainants. A [improvement] plan was put in place to reduce the back log and streamline the incoming complaints to better manage them within the 30 day target. This had mixed success, reducing the backlog and focussing on the longest waiting complaints but timely investigation by the CPGs remained challenging. The performance against the 30 day target was at that time 20-30%”.<sup>45</sup>*

- 9.91** The improvement plan was put into place in 2012. The main aims sought to change the culture within the CPGs and to change the working practices to support PTR. Alongside this was a comprehensive RAG rated register that set out clear process redesign and training needs. The hope was to reduce the backlog of complaints that had accrued and to improve BCUHB’s relationship with the Ombudsman. However resourcing the plan remained problematic. There had been no corporate steer provided in relation to CPG structures and the Investigation Panel was told *“there wasn’t even an agreed list of what their responsibilities were”*. The Assistant Director of Corporate Affairs reflected that significant delays were often incurred:

*“A lot of the CPGs, because budgets were so tight... , took a view that if there was a corporate bit to do it, they wouldn’t put anything in and Concerns fell into that role so there were no dedicated complaints officers created in most of the CPGs because the view was ‘Corporate will do that so I am going to employ the people that I need to do all these other things, I am going to have infection control and all of that in place’, so Concerns became an add-on to everybody’s job. It was nobody’s actual responsibility; it just suddenly went into everybody’s job description”*.

- 9.92** The Investigation Panel was also told about the strong medical model which sometimes served to prevent complaints from being investigated in a timely manner. In relation to the investigation of complaints concerning doctors there was a strong culture whereby doctors would be reluctant to provide an opinion about another doctor’s practice. This was made more difficult by virtue of the new organisation and the resulting change to working relationships.

- 9.93** Of particular concern, and one that relates to the Tawel Fan situation, is that of the complainants who ‘bypassed’ the system. The Investigation Panel was told that on occasions complainants who were unhappy with the formal response they received would bypass the system going directly to either the Chair of the Health Board or to the CEO. This created a difficult situation especially if the complaint had already been closed after all due process had been followed. Patients and families would often request a re-examination of their case and by circumventing the system everything would commence all over again but without any coordination or proper oversight. In these cases patients and families decided not to make a referral to the Ombudsman choosing instead to try to get a different

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45 Witness statement excerpt

result by ‘escalating’ their complaints to senior officers at the Board. Unfortunately those officers would sometimes ‘take on the case’ which caused a high degree of confusion, and on occasions, contradiction. Following careful examination, the Investigation Panel noted that several of the so called ‘open cases’ in relation to Tawel Fan on the BCUHB register had in fact already been closed prior to this Investigation commencing. However families were able to pressure BCUHB into re-opening their cases (sometimes following direct political intervention) when in actual fact the Ombudsman should have been the next point of contact. This was poor practice.

- 9.94** The final point to make is that because the CPGs managed the complaint investigation process most of the data (and potential lessons for learning) that were collected stayed within the CPG and never reached the Health Board. There was no routine method to report trends and the Investigation Panel was told that CPGs were only required to report on an annual basis and then it was in the most basic manner. The Investigation Panel could find no evidence to suggest that the learning from complaints management informed any lessons for learning processes, clinical audit schedules, policy revision or education and training programmes.

### ***Incident Reporting***

- 9.95** Prior to 2011 incident reporting was done via the old IR1 process. This was a method of hard copy reporting which required the completion of a triplicate form. From 2011 BCUHB adopted the Datix electronic incident reporting system. The advantage of this system was the ability to capture information, generate trend analysis and ensure the timely investigation of incidents.
- 9.96** Another benefit of the Datix system is that it contains many fields that can also monitor and record other kinds of patient safety issues; for example complaints management. From 2011, in theory, the whole organisation would have been able to analyse this data.
- 9.97** The Investigation Panel was told that since the advent of Datix senior managers review every incident within 24 hours and ensure that an appropriate level of investigation takes place. However during the period under investigation there appeared to be no process by which the governance loop was closed and feedback provided to the clinical areas raising the alerts. This prevented the learning of lessons from both a service and individual practitioner point of view.
- 9.98** Due to the lack of a clinical audit programme that was tied in formally to a clinical governance system there is no evidence to suggest any learning from incidents ever triggered a review of clinical policy and procedure or education and training programmes. A senior member of the corporate team explained:

*“The Concerns Managers were trying very hard to manage both incidents and complaints. As a result, because I think it’s safe to say all of the Concerns Managers were appointed from the old Complaints Teams, they ran with complaints because they knew them and incidents very much got left to the CPGs to sort out, so the Corporate Team initially, because we were struggling to try*

*and implement it all, focussed on what we understood more which was the complaints process”.*

- 9.99** The Investigation Panel could see that performance data were collected by the Mental Health and Learning Disability CPG and shared on a regular basis via its internal governance committees and groups. What could not be tracked was any kind of service improvement that was initiated as a result of these processes during the period under investigation.
- 9.100** It is important to note that the Investigation Panel found incident reporting to be of a good general standard on Tawel Fan ward. However at interview the qualified staff could not remember a single case whereby they ever received any kind of feedback. The staff described a process which was (for them) largely an ‘act of faith’ that was time consuming, and lacking in transparency.
- 9.101** The Investigation Panel asked for examples of completed investigation reports however these were not forthcoming (save for a single example) and the centralised storage system within the CPG could not yield this information. It would appear that incident reporting (and any subsequent investigation findings) did not feature as part of regular ward and clinical department briefings and few patient safety alerts were triggered as a result.
- 9.102** During the period under investigation the Mental Health and Learning Disability CPG appeared to compartmentalise complaints, incidents and safeguarding alerts. Because each process was managed by a different corporate department and/or CPG lead there was no automatic oversight process that provided the necessary degree of scrutiny and coordination. This was a missed opportunity as there was no automatic process that ensured the appropriate alerts were raised from the data being ‘sent upwards’ from clinical services on the ground.

### ***Safeguarding***

- 9.103** Safeguarding systems and practice are examined extensively in Chapter 10 and so do not need to be set out in detail here. However it should be understood that there were poor levels of corporate ownership, exacerbated by a weak corporate understanding, of the importance of protecting adults at risk and the role of the Health Board in achieving this.
- 9.104** Throughout the period under investigation the BCUHB matrix system was found to equate poorly with the six Local Authority areas. By allowing the 11 CPGs to set up their own individual systems in relation to safeguarding the Health Board both complicated the NHS response and also diluted the resource available to manage the required processes; this dilution also meant that the levels of expertise that were required were not addressed and safeguarding became a ‘process’ rather than a patient safety alert and management system.
- 9.105** During the period under investigation it was evident that there was little synergy between the six Local Authorities and that the guidance provided by them varied greatly and often did not conform to extant pan Wales Safeguarding Policy expectations. This meant that the Health Board did not always receive the level

of support and advice that was needed from the lead statutory agencies and that safeguarding alerts sometimes either went unheeded or were managed ineffectively.

### *In Summary*

**9.106** Patient safety and quality improvement requires every NHS commissioning and provider body to be a learning organisation. The power of the triadic system of patient safety alerts comprising complaints, incidents and safeguarding must not be underestimated. The Investigation Panel found that these systems did not work effectively either on their own or together. The activity levels that these systems generated appear to have provided a degree of assurance both at CPG and Health Board level; however the intelligence that these systems produced was not incorporated into any overarching clinical governance process rendering the whole ‘industry’ an end in itself to a large extent, and one that did not promote patient safety and provide the necessary alerts that were required to the Health Board. This is a key example of where weak BCUHB governance systems (already identified by many other service reviews) caused a complete rift between board and ward.

## **Professional Leadership and Supervision**

### *Professional Leadership*

**9.107** The Investigation Panel found it difficult to understand how professional leadership was understood and managed within the Health Board. The creation of the CPGs, which fractured links with the corporate team, together with the somewhat muddled development of job descriptions and key roles and responsibilities, meant that lines of reporting were difficult to establish with lines for escalation and general professional leadership also being blurred.

**9.108** In reality people tended to develop their own methods of escalation and support, however these were not always recognised formally leaving both individuals and services, in general, unsure as to who was actually in charge in relation to clinical and professional matters, as opposed to those relating to operational management.

**9.109** Most of the CPG-based senior clinical service management roles were undertaken by doctors. The Investigation Panel estimates that this ran at around 85 percent of all post holders. Those post holders also retained responsibilities for medical appraisal, medical work plans and medical supervision; this meant that the lines of clinical leadership and professional accountability for doctors were relatively clear and robust.

**9.110** Within the Mental Health and Learning Disability CPG the clinical leadership processes for the nursing profession were less clearly defined. The structures in place meant that until the November 2012 appointment of modern matrons there were no formally designated nurse managers or leaders between the Band 7 Ward Managers and the Associate Chief of Staff Nursing who was supported by a single Head of Nursing and Regulation (neither of whom were older adult mental health specialists). Instead reliance appears to have been placed upon mid-tier

service managers, but holding a nurse registration was not necessarily part of the job description, and so the level of input they were expected to provide in relation to clinical and professional leadership was not clear.

- 9.111** In addition, mid-tier service managers did not usually have backgrounds in the provision of older adult mental health or dementia care services. This meant they often took over the management of those services with a limited range of understanding pertaining to clinical, operational and strategic matters. This did not support adequately escalation processes, professional leadership or supervision in this demanding and specialist field.
- 9.112** The Investigation Panel noted that there were no nurse leaders within the corporate nursing team who held mental health nursing qualifications. This meant that there was a relative void for the nursing profession in relation to professional development and leadership within mental health services in general, and the ward managers responsible for dementia care inpatient facilities, in particular.
- 9.113** Things began to improve within the Mental Health and Learning Disability CPG towards the end of 2012 with the appointment of a Deputy Associate Chief of Staff for Nursing, Modern Matrons and a Dementia Nurse Consultant; this was good practice. However the creation of those new roles created tensions within pre-existing structures. Programme Managers argued that these new appointments cut across existing responsibilities and management functions as lines of accountability went through the CPG senior management structure bypassing those of operational service. This conflict was not resolved and was to limit the effectiveness of the Modern Matrons in effecting change and escalating concerns as their authority and power-base did not sit within the operational services that they were appointed to influence and support.
- 9.114** A senior witness told the Investigation Panel that nurse-led quality improvement initiatives were often ‘sabotaged’ by doctors and managers who were not part of the nursing structure:

*“In 2013 I was heavily involved in the Health Improvement Programme... chairing two meetings each week (acute care and patient experience). This process was set up in response to a range of issues identified by ACOS Operations and Nursing as requiring intervention... From my perspective, the above work represented a comprehensive service improvement approach that had the support of Matrons, Patients, Carers and Families. This work was located within a wider Health Improvement Programme that was chaired by ACOS Nursing. Unfortunately, there was significant resistance to this process making it extremely difficult to implement proposed actions. After working closely with patients and carers over a 6-month period it was very disappointing that such efforts didn't make the impact that they could have.*

*Later in 2013, when the Star Wards initiative was being implemented across in-patient services, the national lead for Star Wards met with staff... [and] as part of this process met one of the Consultants for the unit. During this encounter, the Star Wards leader... became very upset and distressed about the*

*way she was spoken to by the Consultant and consequently made a complaint in writing about her experience of visiting the unit”.*<sup>46</sup>

**9.115** The reason the above quote has been included is to provide an example of how nurse-led initiatives were regarded and to demonstrate how easy it was to derail both corporate and CPG led quality improvement programmes. The quote also serves to illustrate that not only was nurse leadership weak but that nursing as a profession appears to have been undervalued and, on occasions, undermined in a totally unacceptable manner. If senior nurse leaders within the organisation could be both disrespected and ignored then it is relatively easy to understand how powerless the staff on wards like Tawel Fan felt when trying to effect change and service improvement – even for things as simple as getting a worn and urine soaked carpet condemned and new one purchased – which in the event was to take them the best part of three years.

### ***Nursing Strategy and Supervision***

**9.116** The Investigation Panel was not sent a copy of any corporate nursing strategy for the period under investigation; this does not mean that one did not exist. Nonetheless a nursing strategy dated May 2011 was provided by the Mental Health and Learning Disability CPG which had been developed by the Associate Chief of Staff – Nursing; it should be noted that this document did not refer to any overarching corporately owned framework implying that one perhaps did not exist at this stage. This document was supported by a CPG Nursing Education and Training Strategy that was developed in June 2011.

**9.117** The CPG nursing strategy was concise in nature and focused upon national strategic drivers and the need for nursing as a profession to develop competency-based roles. It recognised that care pathway development would be required to meet national targets and to meet the challenges presented by an ageing population and the expectation that 50,000 people would be diagnosed with dementia in Wales by 2020. The strategy set out key value statements and the aspiration that there would be more nurse prescribers and registered approved clinicians (in relation to the Mental Health Act). The strategy also suggested that health care support workers would be trained more effectively and that an ‘assistant practitioner’ role could be established at Band 4 and trained to foundation degree level.

**9.118** In January 2012 a CPG quarterly nursing and quality report was circulated. It stated that in order to implement the nursing strategy nine sets of metrics had been developed under three ‘crosscutting’ themes. Also in 2012 an integrated workforce plan was developed for the CPG. This set out a practical, costed plan in relation to future service development and the workforce that would be required to deliver it.

**9.119** The Investigation Panel found that the Mental Health and Learning Disability CPG undertook a comprehensive and structured approach to the development of a nursing strategy that was set within the context of robust integrated workforce planning; this was good practice and the momentum from these early years

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<sup>46</sup> Witness statement excerpt

began to promote quantifiable organisational change during 2013 and subsequent improvements in patient care delivery. How this impacted positively on wards like Tawel Fan is set out in the remaining part of this chapter subsection.

### ***Clinical and Management Supervision***

**9.120** The Investigation Panel asked for copies of the corporate clinical and managerial supervision policies that were in place during the period under investigation; the Health Board could not support this request.

**9.121** However the Investigation Panel was sent the December 2012 Mental Health and Learning Disability CPG Management Supervision Guidance. This guidance stated that supervision processes linked into the CPG regulatory and clinical governance frameworks. It said *“This document sets out a framework of core principles and minimum standards for supervision for nurses and support workers working in the CPG. It does not replace or limit Clinical and/or Professional Supervision practice, which may take place at a greater frequency and at a greater depth than this minimum standard outlines”*.

**9.122** The guidance set out the difference between managerial and clinical supervision. Managerial supervision was something all staff members were expected to receive; clinical supervision was something that all staff members involved in direct clinical practice were expected to receive. It said this specifically about managerial supervision:

*“Managerial Supervision is focussed on an individual’s overall wellbeing, workload, functioning within the team and maintaining clarity about role, responsibilities and accountability. Alongside performance management there is a strong staff care element within this role. Managerial Supervision is a collaborative process and takes place with the line manager. Managerial Supervision involves:*

- *management of workload of supervisee including annual leave, sickness absence and discipline;*
- *regular monitoring and review of a staff member’s performance towards achievement of Health Board, local and agreed personal objectives;*
- *giving constructive feedback on practice and performance – both acknowledging the positive and areas for development;*
- *planning of new tasks, setting objectives and standards and reviewing tasks;*
- *identification of individual training and development and resource needs relating to tasks;*
- *completion of performance objectives and progress”*.

**9.123** The guidance said this about clinical supervision:

*“Clinical/Professional Supervision is focussed on the working relationship between the clinician/professional and individual service users and their carers/family. It is an opportunity to systematically reflect on and understand the needs of the service user and carer and consider the practitioner’s interventions and responses in the work. Often professional bodies have guidelines and their own*

*standards in relation to clinical/professional supervision which can be found in the relevant literature.*

*Managerial and clinical/professional supervision may be carried out where appropriate by separate individuals, but often the same individual is responsible for both types of supervision. Where dual supervision is the case additional formal arrangements might need to be introduced”.*

- 9.124** The Investigation Panel built the topic of clinical supervision into every set of questions given to each witness. It was evident that despite the service replacement costs, the Mental Health and Learning Disability CPG pushed ahead to provide ‘managerial’ supervision to all of its nursing staff, both registered and non-registered; this was good practice. The witness who appeared to understand the supervision implementation process best was the Modern Matron who covered the Ablett Unit (including Tawel Fan ward) during the period under investigation. She had this to say:

*“Throughout 2013/14 there was a concerted effort to be fully compliant with mandatory training, managerial supervision and personal development reviews. The band 5s were finding it difficult to complete the band 3s Supervision and PDR’s due to staffing levels. Therefore, I assisted with some of the band 5s, freeing up [the ward Manager on Tawel Fan ward] to supervise the band 3s. The [guidance states] that ‘All supervisors are responsible for ensuring that they have received relevant training and are competent to provide the form of supervision they are facilitating’.*

*Some Band 5 staff did ask for training but there was none available for Managerial Supervision, and I did raise it in the Managers meeting. By the end of 2013, most staff apart from those off sick had been completed... We had worked on introducing a tiered system of completion i.e. Band 5s to supervise band 2s and 3s, and band 6/7 to supervise band 5s. There were a number of issues for example there was no training for supervision”.*<sup>47</sup>

- 9.125** The CPG supervision guidance that was sent to the Investigation Panel appears to have been reasonable in nature conforming to national good practice guidance. However the real issue was the cost of managing such a process which was considerable in relation to service replacement. This was to be a major factor in implementing the guidance as there were not always the staff resources available. Nevertheless the CPG made good progress and nearly all of the clinical nurse witnesses that provided evidence stated they had received supervision on a regular basis. This was good practice.

## **Workforce, Safety and Wellbeing**

### ***Workforce***

- 9.126** The Health Board Executive Director of Workforce and Organisational Development (in post during the period under investigation) told the Investigation Panel:

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<sup>47</sup> Witness statement excerpt

*“Staffing budgets amount to 50% of the total Health Board’s resource and approximately 80% of delegated budgets... Unsurprisingly, cost improvement programmes will include expectations on reduced workforce costs. CPGs and subsequent structures were, and are, required to bring forward proposals which would be incorporated within the Health Board’s financial and operational plan...”*

*... The Health Board’s operational plan for 2012/2013 included a targeted cash releasing saving circa 8%, of which £30 million related to pay...*

*... Mental health services have been, and continue to be, challenged around the attraction of medical staff at both Consultant and training grade level. The age profile of the workforce in general... is heavily weighted to the older age cohorts”<sup>48</sup>*

- 9.127** Senior witnesses told the Investigation Panel that the recruitment and retention of staff had become a problem in the years leading up to the closure of Tawel Fan ward. This was a particular concern in relation to medical out of hours cover and a general concern in relation to mental health nursing staff with an ageing workforce with many employees due to reach the age of retirement. This coupled with vacancy restrictions and tight corporate control over recruitment (in a bid to meet financial targets) meant that the established staff cohort was weakened and that agency, bank and locum staff were relied upon to deliver services on inpatient wards.

### ***Medical Staffing***

- 9.128** North Wales has always experienced difficulties in recruiting doctors; this has been associated with its relative geographical isolation and limited clinical networks. Medical training has historically been based at Cardiff University; and this has meant that graduates have often chosen to start their careers in larger conurbations in the south of Wales where ongoing training and job opportunities are perceived to be more advantageous.
- 9.129** Consequently the Health Board has always relied upon a relatively high number of agency and locum medical staff. It should be noted that the Health Board is not alone in facing this particular kind of problem but its particular circumstances exacerbate what is an issue across the United Kingdom.
- 9.130** There are particular challenges in the recruitment of psychiatrists to substantive posts in north Wales; the aspiration to appoint Welsh speaking psychiatrists makes the recruitment of this scarce resource even more of a challenge.
- 9.131** During the period under investigation the primary problem in relation to medical staffing was the availability of doctors on call. This was a particular problem for inpatient services at the Ablett Unit and has been verified by numerous contemporaneous internal and external reviews (detailed in the Service Development, Inspection and Review subsection below).

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48 Witness statement excerpt

- 9.132** In April 2012 an On Call Report was written by the Head of the Acute Care Programme that detailed the situation faced by mental health services. A new on call system had been in place since 2011; prior to this time some mental health services had been run with no, or partial, medical input out of hours. The new service depended upon inputs from four tiers of staff.
- 1 Tier 1:** this comprised Band 6 nursing staff who were appointed and trained to be on the “*front line during out of hours*”. The system was thought to be safe and was kept under careful review.
  - 2 Tier 2:** this initially comprised junior and senior medical trainees, but the use of junior trainees had been questioned during a General Medical Council visit as there was a lack of appropriate supervision from senior doctors. During weekdays and Bank Holidays there was a designated junior doctor attached to each of the three main hospital sites across north Wales. However at weekends and at night, whilst there was an on call doctor based in the east and west part of the provision, there was no doctor based at the Ablett Unit.
  - 3 Tier 3:** 13 Consultants covered north Wales; they formed a “*front line for advice, assessment and delivering treatment plans out of hours*”. This system was noted to be working well.
  - 4 Tier 4:** this tier comprised all of the remaining Consultants who were available for telephone conversations and advice should the need arise.
- 9.133** Whilst the new system was a significant improvement on the one that had gone before the issue of medical out of hours cover at the Ablett Unit was a consistent problem for the wards on the site. The Investigation Panel can chart distinct difficulties in accessing on call medical cover from the examination of the case notes for the patients in the Investigation cohort. 16 were found to have issues in relation to the lack of out of hours medical cover and where the quality of care and treatment was potentially compromised.

### ***Nursing Workforce***

- 9.134** During the course of this Investigation thousands of pages of e-rostering, workforce reports, emails, and Situation, Background, Assessment and Recommendation (SBAR) reports were taken into consideration. Workforce planning is a complex and multifactorial matter. This report cannot detail all of the issues here; however the salient points are set out below.
- 9.135** In 2013 the Deputy Associate Chief of Staff – Nursing for the Mental Health and Learning Disability CPG conducted a workforce review in relation to inpatient services using the Hurst Model benchmarking tool. At this time 24 wards provided inpatient care on four sites across north Wales requiring a total of 595.31 whole time equivalent staff as opposed to the 543.72 staff that were actually in post. It was estimated that the spend on bank and agency nursing (*circa* £998,000) would equate to 27 whole time equivalent qualified nursing staff and 38 whole time equivalent health care support workers; a key recommendation from the workforce review was to recruit to some of the vacant

posts and improve the ratio of qualified to unqualified nursing staff which at this stage stood at 50:50 instead of the preferred 60:40.

**9.136** On the 22 November 2013 an SBAR that identified the staffing gap in the CPG inpatient services was circulated. It stated that the CPG was struggling to manage the gap between the required staffing levels (as determined by the Hurst Model) and the existing staffing levels. It had been assessed that the usage of increased overtime, and bank and agency nursing were neither sustainable nor desirable into the future. The risks identified were:

- decreased staff morale;
- staff were required to work too many hours which was exhausting them and impacting on performance and (increasingly) sickness levels;
- staffing could not be maintained which was impacting negatively on the patient experience.

**9.137** One of the immediate and positive effects of the workforce review was to make ward managers and their deputies supernumerary towards the end of 2013.

#### ***Workforce Issues on Tawel Fan Ward in the Autumn of 2013***

**9.138** Many of the families in the Investigation Cohort raised specific concerns about staffing levels and the effectiveness and quality of patient supervision on Tawel Fan ward. The concerns varied in nature: some families stated simply that the ward staff appeared to be stressed and over worked; however other families made clear allegations that their loved one's care was compromised directly as a consequence of staff shortages. Those allegations and concerns are addressed in depth in Chapter 10 but are mentioned here to illustrate that growing levels of concern about ward staffing levels were not just held by ward staff and managers of the service.

**9.139** The Investigation Panel charted every shift on Tawel Fan ward over the two-year period prior to its closure; this included patient acuity, staffing levels and skill mix. It was noted that the ward was rarely occupied at full capacity; however patient acuity levels had started to rise sharply at the end of 2012 as admission rates for patients with behaviours that challenged increased due to the closure of inpatient facilities at Wrexham and the loss of care home beds in the community (this is examined in depth below in the patient care pathway and pressures on inpatient services subsection of this chapter).

**9.140** The bed occupancy on Tawel Fan ward appears to have averaged out at around a steady 80-85 percent which equates to an average of 12-13 beds being filled at any one time. Following the workforce review in 2013 the staffing establishment on Tawel Fan was identified to require five nurses in the morning, four in the afternoon and three at night (the Investigation Panel could not determine the exact skill mix); in addition the Ward Manager and the Deputy were designated as supernumerary. This did not substantially vary from pre-existing staffing levels (which records show for day shifts) were usually based upon three to four qualified staff with three to four health care support workers, depending on patient acuity.

**9.141** During the last year the ward was open the maintenance of safe staffing levels became an ever-increasing challenge. The Modern Matron was required to work with the Tawel Fan Ward Manager in authorising and monitoring staff duty rotas on both a daily and weekly basis. The Modern Matron told the Investigation Panel:

*“From my experience the staff changed their shifts to ensure the ward was adequately staffed, and not due to personal reasons, and I trusted them to do this... Staffing the ward relied heavily on bank/agency use due to the above reasons. Many of the shifts were taken by existing staff or by staff who limited most of their bank work to Tawel Fan. As a result of this most of the staff were familiar to the patients and improved consistency in care. Although Mental Health wards had access to the Health Board Bank, they very rarely allocated anyone, and we found that it would get to mid afternoon with no communication, that turned out to mean that the shift had not been covered. Therefore, Mental*

*Health decided to try and create its own bank... When I was redeployed in July 2014, I don't remember the bank being fully operational...*

*... The process of having bank hours authorised was very time consuming. An approval system for bank/agency staff was introduced. Ward Managers had to establish if there were any gaps in the rota. They would then contact all the other wards (locally and further afield) to ascertain whether any staff could be spared. All the wards were in a similar position and only rarely could they help out. The Managers would then contact their Matron, who would then seek approval... to get extra staff. If the search for Bank Staff proved unsuccessful, and on most occasions it was ward staff doing extra hours, [the Service Manager] would then escalate the issue to [ACOS Nursing] who would discuss it with the Deputy Director of Nursing. By this time it was usually late in the day and at times it was difficult to secure Agency Staff”.<sup>49</sup>*

**9.142** The Investigation Panel accessed numerous contemporaneous email exchanges pertaining to the staffing challenges on Tawel Fan ward; representative examples are provided below:

*“[September 2013] Just to confirm that as the agency were unable to find us staff for today we have managed to staff the ward by utilizing staff from Tegid and as and when required from Dinas and Cynydd. This was not an ideal situation for any of the wards but was sufficient to maintain safety”.*

*“[September 2013] Just to inform you all that we are running the ward with two Level three observations with four staff this morning and three staff after 17:30. Any ideas how we can keep our twelve patients safe, as well as our staff? Haven't filled out a DATIX I think the system is still down. Can you please pass this onto the relevant people”.*

*“[September 2013] We have a potential staffing problem on Tawelfan due to short term sickness. We have 2 x 1-1 and are 2 staff down tomorrow and 1 on*

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49 Witness statement excerpt

*Friday. We have exhausted all our bank and O/T options. Just checking Dinas and the General Bank but just warning that we may need agency”.*

- 9.143** The issues in relation to Tawel Fan ward staffing were principally two-fold. The first issue was about the maintenance of safe-staffing numbers to ensure the care that was provided did not compromise patient safety and wellbeing. The second issue was about staff skill mix and patient acuity. During the period under investigation the ward was open to admissions for a diverse range of patients; some were strong, physically fit and aggressive men in their 50s and early 60s; some were frail older women who were in need of end of life care in their 80s and 90s (patient acuity issues are discussed in depth below in the Patient Care Pathway and Pressures on Inpatient Services subsection below and also in chapter 10).
- 9.144** It is evident that robust work was undertaken throughout 2013 to ensure workforce issues were addressed; however there was a legacy of vacancies and inadequate levels of recruitment that still had to be resolved together with service development for the future.

### ***Safety and Wellbeing***

- 9.145** The Investigation Panel found that several of the staff on Tawel Fan ward had ongoing health problems that made working in such an environment both physically and mentally challenging. The ward required high levels of physical stamina and strength due to the nature of many of the required nursing interventions.
- 9.146** Whilst capacity issues, such as workforce numbers were examined and reported upon on a regular basis, capability issues, such as age, health, skill sets and expertise etc. were not addressed in the same way. The primary focus during the last two years of Tawel Fan’s existence was the ability to run the ward with the required levels of staff available and to this end agency and bank staff were used to cover patient acuity issues, vacancies, and long-term sickness. This was not an ideal situation as some of those staff had no mental health training and there were limitations as to how well they could input once on the ward; this placed an additional burden on the ‘regular’ staff which on occasions they found to be exhausting.
- 9.147** It is of particular note that the behaviours of some family members who visited Tawel Fan ward over the years was of a totally unacceptable nature necessitating, on occasions, the police to be called for assistance. This kind of behaviour included:
- the repeated use of foul, and extraordinarily offensive, racist language;
  - physical violence whereby, for example, walls were punched and kicked;
  - death threats and other threats of general physical violence being made to staff;
  - intimidatory behaviours, such as screaming and shouting (this was considered to be so serious that contemporaneous documentation shows that during the autumn of 2013 a security presence was under consideration to manage a particular family member);

- inebriated family members coming onto the ward in an aggressive and incapacitated state;
- raucous and disrespectful behaviour on the ward, for example, wheelchair races in the corridors, which family members were reluctant to cease.

**9.148** It is without doubt that the ward staff tried to manage these behaviours in a professional manner and it is a key finding of the Investigation Panel that staff took a compassionate and considerate approach to this kind of behaviour as they understood the extreme distress and pressure that some family members experienced. However on occasions the ward staff needed to escalate their concerns about the safety, of not just themselves, but their patients. On those occasions different approaches were taken by management with no standardised line being observed.

**9.149** When interviewed senior managers could not articulate what the policy guidance stated about the management of abusive and aggressive family members. They understood that there was a zero tolerance stance that should be taken but could not say what would happen to support staff on the ground to manage such matters. The only contemporaneous policy documents in place in the months prior to Tawel Fan ward being closed were those developed by predecessor NHS Trusts and no one appeared to be certain as to their status during the period under investigation.

**9.150** Matters reached unacceptable levels in the autumn of 2013. The Investigation Panel tracked through the email correspondence relating to this situation and it was evident that a policy was eventually identified but it was also evident that locating this policy took time and that senior managers had not been able to ‘lay their hands’ on one easily.

**9.151** It is a fact that in the months and weeks leading up to the Tawel Fan ward closure the levels of abuse and aggression on the part of family members had risen to the point where formal escalation and risk assessment had to take place. Once the matter was escalated senior managers sought to support the ward team and legal advice was taken. However it took several months for matters to be resolved and in the meantime ward staff were left in a vulnerable position with little being done to support them in a timely manner with their health and wellbeing suffering as a result.

## **Education and Training**

### ***Mandatory and Statutory Training***

**9.152** The Investigation Panel was sent a comprehensive range of documentation in relation to the training and education programmes available to clinical staff in BCUHB. For the period under investigation there appears to have been appropriate mandatory and statutory training opportunities. This kind of training comprised:

- fire safety;
- manual handling;
- infection control;

- protection of vulnerable adults (PoVA) – levels 2 and 3;
- child protection – levels 2 and 3;
- MAPPA (multi-agency public protection) processes;
- domestic violence and MARAC (Multi Agency Risk Assessment Conference) processes;
- Mental Capacity Act (2005);
- Mental Health Act (1983);
- personal safety and de-escalation techniques;
- breakaway skills;
- restrictive physical interventions;
- safe holding;
- basic and immediate life support.

**9.153** However within the Mental Health and Learning Disability CPG there were distinct service replacement difficulties exacerbated by recruitment controls; this meant that it was sometimes impossible for staff to be released from the work place to attend anything other than the most essential of training events.

**9.154** Compliance with mandatory and statutory training was monitored closely. Table 1 sets out the levels of training compliance for Tawel Fan ward nursing staff during the last year of its operation; it should be taken into account that some of the training listed above was deemed not to be applicable for this particular service area.

**Table 1**

<b>Training Type</b>	<b>Percentage of Staff who Attended</b>
Fire safety	<b>75%</b>
Manual handling	<b>96%</b>
Infection control	<b>96%</b>
PoVA level 3	<b>100%</b>
Child protection	<b>76%</b>
MAPPA awareness	<b>38%</b>
Domestic violence and MARAC awareness	<b>38%</b>
Basic and immediate life support	<b>100%</b>
Mental Capacity Act (2005) awareness	<b>0%</b>
Mental Health Act (1983) compliance	<b>58%</b>
Personal safety and de-escalation skills	<b>100%</b>
Breakaway skills	<b>100%</b>
Restrictive Physical Intervention	<b>58%</b>
Safe holding	<b>100%</b>

- 9.155** Tawel Fan ward compared remarkably well against the training records of the other 19 inpatient wards in the CPG; both for adults of working age and those for the older person. The areas where lower rates of training were noted were due to a combination of service replacement issues and long-term staff sickness. Mental Capacity Act (MCA) training had a 0% attendance – however only six of the inpatient wards in the CPG managed to get training levels up to between 96-100% with 12 wards falling between 0% and 42%.
- 9.156** The Investigation Panel found this lack of training in relation to the Mental Capacity Act (2005) to be of great concern as it was evident that Tawel Fan ward staff (and also those on Tegid, Glan Traeth and Bryn Hesketh wards) did not always understand the requirements of the Act. This is to some extent understandable as implementation of the Act between 2005 and 2014 was highly complex and problematic across the United Kingdom; however this level of complexity required the receipt of ongoing expert advice, support and training.
- 9.157** It was not possible to track the levels of training that psychiatrists received in relation to either the Mental Capacity Act (2005) or the Mental Health Act (1983); a close examination of the clinical records would suggest, that on occasions, there was confusion in relation as to which part of the legislature should be used and for what purpose.
- 9.158** The Investigation Panel found that nursing staff at interview were also confused as to the difference between the powers conferred by the Mental Capacity Act (2005) and those of the Mental Health Act (1983). It should be taken into account that many of the staff interviewed had stopped working in clinical practice due to ongoing human resource management processes and that they were not aware of the 2014 “*Golden Cage*” ruling. However it was evident that some of the nurse witnesses who were in current practice had substantial gaps in their knowledge with two recently qualified nurses never having heard of the Mental Health Act Code of Practice. The Investigation Panel found this to be unacceptable.

### ***Education***

- 9.159** Three of the senior nurses on Tawel Fan ward explained that they had been engaged in educational activities, two had been on a palliative care course and the third, the Ward Manager, had been part of the Transforming Care project; this was good practice.
- 9.160** However a key finding has been the limited nature of ongoing educational activities for the registered nurses both on Tawel Fan ward and elsewhere within the Mental Health and Learning Disability CPG during the period under investigation. Many senior managers when interviewed were of the view that mental health nurses did not need additional education in relation to dementia care and nursing practice as this should have been covered during the pre-registration nurse training process. The Investigation Panel found this attitude to be uninformed and of concern.

- 9.161** Chapter 7 of this report details the requirement for all clinical staff working with older adults to receive specialist training in dementia care and management; this has been a Welsh Government directive since 2011. The Investigation Panel notes that an SBAR (dated 12 May 2011) addressed the issue of the lack of specialist dementia care training across north Wales. At this time basic training was supplied by Local Authorities to care homes, but there was an absence of education and training for secondary care NHS services. At this stage Glyndwr University offered a 12 week module designed for newly registered nurses; but Bangor University did not offer anything of this kind. The SBAR stated that Bangor University had been granted funding but that the modules had not yet been formally commissioned or taken through accreditation processes.
- 9.162** Witnesses told the Investigation Panel that by 2013 Bangor University was providing dementia training; however it would appear that no staff from Tawel Fan ward were able to attend due to service replacement issues. Internal and external inspections and reviews were to all find that there was a virtual absence of dementia training available to staff at the Ablett Unit and this was being addressed prior to Tawel Fan being closed.

## **Clinical Information**

### ***Patient Safety Data***

- 9.163** The above narrative describes clinical governance arrangements that were not always connected and which often operated as separate ‘stand alone’ processes. This was exacerbated by patient safety data systems that did not work together at either a corporate or CPG level to identify trends and raise alerts. The Investigation Panel was told by senior witnesses that in the early years clinical governance reports to the Health Board were sporadic and unsatisfactory in nature; indeed this was a point of contention for many years. As has been described above, clinical governance processes were neither planned nor coordinated within a corporately agreed framework; this also applied to data collection and dissemination systems. The reality of the situation was that the Health Board and its corporate services could not access either accurate or timely patient safety data and the clinical governance system it presided over was severely compromised as a result.
- 9.164** Moving forward in time the DATIX system was introduced into BCUHB in 2011, this had the facility to collect information and produce patient safety reports; it also had the facility to allow managers across the organisation to integrate data and conduct trend analyses. However the Investigation Panel was told that it took several years for the full benefits to be realised and during the period under investigation the use of DATIX was limited and appears not to have been used to full effect. Consequently whilst patient safety reports were prepared they were not always the result of an appropriately acquired set of metrics and the Health Board’s line of sight to clinical services in relation to patient safety continued to be compromised.

### ***Clinical Documentation and Professional Communication***

**9.165** During the period under investigation the Investigation Panel found the clinical records system within the Mental Health and Learning Disability CPG to be problematic on five main counts:

- 1** Across the Health Board case notes were hard copy records; this meant that all entries had to be made by hand (and for mental health patients) contained in numerous and voluminous files the contents of which were often difficult to access, locate and interrogate. Case notes did not always follow the patient and disparate treating teams could not always identify when and where previous episodes of care had taken place and what the implications for any current admission would be. Case notes were stored in the place where each episode of care occurred – in the absence of an electronic database it was not always possible to track a patient’s care pathway and access any information that could be pertinent to a current admission. This was exacerbated by the complex care pathways many patients embarked upon due to service disruptions and bed shortages across north Wales.
- 2** The Investigation Panel was told that access to medical secretaries and ward administrators was limited and unpredictable; this meant that letters, case histories and discharge summaries to GPs could be delayed by several weeks, and in many cases, months. Many wards had only two computers which had to be accessed by both medical and nursing staff alike; this led to further delays in the writing of letters and referrals which were often, as a consequence, completed by hand.
- 3** There was very little professional standardisation of the clinical record. Most medical entries were made on blank sheets of paper and the quality of entries varied substantially as a result. In the absence of corporately agreed formats and templates medical staff tended to write ‘shorthand’ notes which did not always provide clear rationales for the care and treatment provided. The Investigation Panel found the headed paper used on Tawel Fan, Bryn Hesketh and Glan Traeth wards to belong to the Conwy and Denbighshire NHS Trust that had ceased to exist some four years prior to the clinical entries being made. Patient identifiers were often omitted from documentation together with details of the unit and placement; this was poor practice. The templates used for nursing assessment and care plans do not appear to have followed any standardised paperwork as the documentation used on Tawel Fan, Tegid, Glan Traeth and Bryn Hesketh wards all varied enormously. The audit of clinical records appears to have been of the most rudimentary nature commenting on a lack of signatures or incomplete forms rather than assessing the content, quality and appropriateness of entries.
- 4** Professional communication had to work hard to compensate for the limitations of hard copy case notes. In the absence of an easily accessible electronic patient record faxes, hand-written briefings and telephone calls had to be relied upon which was time consuming, placing an additional burden on an already highly pressured workforce.

- 5 Integrated case notes were achieved in part whereby medical and nursing records were stored in the same patient files. However visiting health care professionals to ward areas like Tawel Fan would not always write in the ward-based case files preferring instead to maintain a separate record which was not kept on the ward. This practice meant that it was difficult to understand palliative care, speech and language and occupational therapy assessment outcomes; it would appear that advice and instructions were issued verbally and not always recorded in the central patient record; this was poor practice.
- 9.166 Despite the problems listed above the Investigation Panel found that the 108 sets of case notes that were reviewed were, on the whole, maintained reasonably well although there was considerable variation between the inputs of individual clinicians. It was difficult to assess the quality of the patient records as they were received in a commingled and jumbled state. However the difficulties that BCUHB had in assembling comprehensive sets of records (even for those patients still living) demonstrates the difficulties clinical staff experienced in real time when tracking patients' histories and assembling adequate clinical information. Of particular concern was the fact that incident, safeguarding, Mental Health Act and other independent professional assessments were not held in the central patient record. All of this information was absent in the case notes and the Investigation Panel had to make numerous requests for this information to be sent.
- 9.167 The Investigation Panel found that there were ineffective systems in place to support the effective and safe use of a hard copy patient record. This is a significant finding.

## Conclusions

- 9.168 During the period under investigation the Health Board did not develop, or oversee, a truly effective clinical governance system; this is already acknowledged and has been the subject of several prior published review and investigation reports.
- 9.169 Nevertheless the Mental Health and Learning Disability CPG developed its own clinical governance structures and patient safety processes (albeit those activities went largely unregulated and unscrutinised by the Health Board) a particular example being that of policy and clinical guideline development, monitoring and review. In the absence of a corporately owned and led quality improvement ethos five things appeared to have occurred:
- 1 CPGs had a relatively weak grasp of what they were required to deliver. This meant that gaps in clinical governance systems, structures and processes often occurred together with a lack of connectivity to the corporate Board.
  - 2 The lack of direction, resource and managerial capacity meant that clinical governance processes took years to progress. This meant many significant policy and strategy developments were only forthcoming two to three years after the establishment of the CPGs; as basically they had been required to

start 'from scratch'. This had the outcome of destabilising clinical governance, in effect, pushing progress backwards rather than forwards in the early years.

- 3 Clinical staff and managers were overburdened by the bureaucracy of patient safety systems and yet did not receive the positive benefits from the consequent learning that should have resulted.
  - 4 Clinical governance activity (which was considerable) operated within a 'closed loop' whereby processes became an end in themselves rather than the drivers behind quality improvement.
  - 5 Patient safety systems did not always provide the intelligence required to alert both services and the Health Board to areas in the system that required development and improvement.
- 9.170 The Investigation Panel concludes that the Mental Health and Learning Disability CPG worked hard to put in place robust clinical governance systems, structures and processes. However implementation and effectiveness was hampered by the interplay of workforce restrictions, financial constraints, cultural and professional *mores*, and the absence of corporate strategic direction.
- 9.171 The implementation of clinical governance appears to have been dependent upon the energy and expertise of a relatively small number of individuals who were not always mandated to carry out their duties; this sometimes necessitated a high degree of negotiation within the CPG for standards to be maintained and progress moved forward.
- 9.172 In order to be truly effective the traditional seven pillars of clinical governance have to be regarded as part of the same interconnected and interdependent system. The Investigation Panel found that the seven pillars were not overseen in this manner and were managed as separate functions by disparate teams, both at Health Board and CPG level. In the absence of a corporately owned strategy and implementation plan there were few linkages made and a general lack of coordination was evident.
- 9.173 It is without doubt that there was substantial clinical governance activity; however activity on its own does not equate to meaningful engagement or outcomes. The levels of activity quite possibly gave rise to a false sense of security because reports were written and findings disseminated. However without a clear understanding of how clinical governance should work, and the outcomes that it should deliver, it was reduced to a series of processes that operated on the most basic of levels.

### **The Effects on Clinical Areas such as Tawel Fan Ward**

- 9.174 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 wards like Tawel Fan was compromised by:

- poor quality clinical policies and guidelines that did not always provide an appropriate and evidence-based set of standards for practice;
- 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 in relation to trend analysis and patient safety alerts, and the access to individual patient information.

**9.175** The factors listed above all combined together to create the potential for ineffective and unsafe service delivery. Tawel Fan ward had many other pressures placed upon it (these are detailed in the chapter subsection below) and the fact that care and treatment delivery took place without good governance ‘safety nets’ in place heightened the risks that both patients and staff were exposed to.

## Service Development, Inspection and Review

### Findings

**9.176** Alongside the background of emerging conflict, financial pressure and organisational development, the Health Board was required to provide clinical services; this was its main *raison d’etre*. BCUHB was also required to deliver those services against national strategic and operational performance targets.

**9.177** A selection of the internal and external performance and quality reviews that were conducted in relation to the direct provision of patient care (during 2012 and 2013) are set out below. The reviews that have been selected are those that pertain specifically to the quality and safety of the inpatient experience at the Ablett Unit in general and Tawel Fan ward particular. This is so the reader can understand the degree of quality monitoring that was in place during the 18 months prior to the Tawel Fan ward closure and can also understand how the service was performing in keeping with national strategic and operational expectation.

### Internal Review

#### *1000 Plus Review (June 2012)*

**9.178** In June 2012 one of the corporate Associate Directors of Nursing led a 1000 Plus Patient Safety Campaign Review which entailed a walk-around visit to the Ablett Unit. A short report was compiled; it said:

*“The visit was very successful, it demonstrated to us that staff across the CPG are not just aware of patient safety issues but are actively taking steps to improve the quality of patient care and reduce potential harm to patients... There were three main areas which staff consistently raised to us across the visit:*

- a) *Personal safety for staff was highlighted to us. We noted the high rates of compliance for training in restraint and that staff felt confident in using these techniques... However staff consistently raised with us the lack of personal safety alarms that could work effectively across the unit.*
- b) *The physical estate of the Ablett Unit was raised by nearly all of the areas we visited... They noted patient washing facilities, toilets and bathrooms were poor... This included the fabric of the units but also design... We also noted some patient areas washing areas which had mould and rust.*
- c) *The issue of medical cover was raised by the unit. This issue included the lack of medical advice from a Senior House Officer out of hours. Staff told us that the timeliness of response was important in ensuring patient safety and that periodically this did not always happen”.*

**9.179** The plan was to follow up progress three months after the review – the Investigation Panel did not receive the progress report and so cannot comment further on how these issues were addressed. However from the other evidence that was received it would appear that improvements to ward environments and duty doctors on call arrangements were not taken forward at this stage and continued to be a source of concern to clinical staff and families alike during the months that followed.

#### ***Implementation of Dignified Care Review Recommendations (September 2012)***

**9.180** In March 2011 Ruth Marks the Older People’s Commissioner for Wales published a report which detailed the “*shamefully inadequate*” care and treatment that some older people experienced in hospitals in Wales.<sup>50</sup> The report, entitled “*Dignified Care?*” detailed a series of recommendations, including the need to change the culture of caring for older people in Welsh hospitals by:

- *“empowering ward managers to run their wards in a way that enhances dignity and respect;*
- *equipping staff to support people with dementia;*
- *prioritising continence care;*
- *ensuring consultations between patients and clinical staff are held in private”.*

Other recommendations included creating the sort of hospital environment which could promote greater dignity and respect by reviewing the capacity and capability of those staff caring for older people in Wales. Ruth Marks said: “*Fundamental change is needed to prevent what is sometimes shamefully inadequate care and treatment*”.

**9.181** In September 2012 an internal audit was conducted to look at the extent to which BCUHB had implemented the recommendations from the Commissioner’s *Dignified Care?* review. The plan was for the audit to be reported to the Health Board Executive Director of Nursing; this built on an earlier audit BCUHB had conducted the previous year.

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<sup>50</sup> [http://www.olderpeoplewales.com/en/news/news/11-03-14/Dignified\\_Care.aspx#.Wj9sF3nLjMA](http://www.olderpeoplewales.com/en/news/news/11-03-14/Dignified_Care.aspx#.Wj9sF3nLjMA)

- 9.182** The Investigation Panel found the evidence trail and format of the audit difficult to follow. The main document was a ‘RAG rated’ register which set out compliance against the national recommendations in red, amber or green depending on the level of attainment reached.
- 9.183** The exact methodology used was not apparent – however it appears that all 27 inpatient wards in the Mental Health and Learning Disability CPG took part.
- 9.184** From the documents received it would appear that the audit depended largely upon self assessment as each ward completed the audit form which was then collated by the Head of Regulations and Professional Development.
- 9.185** The audit reviewed the following:
- 1 Recommendation 1 – Stronger ward leadership is needed to foster a culture of dignity and respect.** This was rated green.
  - 2 Recommendation 2 – Better recognition of the needs of older people with dementia is needed, together with improved communication, training and support and standards of care.** This was rated amber.
  - 3 Recommendation 3 – Lack of timely response to continence needs was widely reported and is unacceptable.** This was rated amber.
  - 4 Recommendation 4 – The sharing of patients’ information in the hearing of others should cease wherever possible.** This was rated green.
  - 5 Recommendation 5 – Too many older people are still not being discharged in an effective and timely manner and this needs urgent attention.** This was rated amber.
  - 6 Recommendation 6 – The appropriate use of volunteers in hospitals needs further development and learning from successful initiatives.** This was rated green.
  - 7 Recommendation 7 – Staffing levels to reflect the needs of older people both now and in the future.** This was rated green.
  - 8 Recommendation 8 – Simple and responsive changes to the ward environment can make a big difference.** This was rated green.
  - 9 Recommendation 9 – Effective communication can raise patient expectation and involvement and can improve their hospital experience.** This was rated green.
  - 10 Recommendation 10 – The experience of older patients, their families and carers should be captured more effectively and used to drive improvements in care.** This was rated green.

**11 Recommendation 11 – Good practice should be better identified, evaluated and learnt from to bring about improvements in care.**

This was rated green

**12 Recommendation 12 – All those working with older people in hospitals should have appropriate levels of knowledge and skill.**

This was rated amber.

- 9.186** The Investigation Panel found that the somewhat upbeat message provided by the audit did not necessarily match the evidence supplied to underpin it; this gave a misleading level of assurance to both the CPG and the Health Board. In reality most of the actions listed in the audit were aspirational and had not been properly embedded at this stage; some of the ‘evidence’ was both incomplete and unreliable meaning that either an amber or red rating would have been more truthful. The Investigation Panel found issue with the quality of most of the evidence that was put forward to support the audit, together with how it was interpreted; recommendations 8 and 10 provide two examples.
- 9.187** Recommendation 8 related to the environment and was rated as green across the entire Mental Health and Learning Disability CPG. This is against the background of universal criticism (from staff, patients, families and external reviewers alike) of the condition that the Ablett Unit (for example) was in at this time. Opportunities were not taken up to replace worn carpets that smelt of urine, or to upgrade bathing and toilet facilities. The *“simple and responsive changes to the ward environment”* that were needed and were causing concern were neither mentioned nor addressed in the audit.
- 9.188** Recommendation 10 related to the experience of both patients and their families and the measures that needed to be taken to elicit their feedback; this was rated as green. This recommendation ‘sign off’ depended upon the monitoring of complaint reviews. However the Director currently responsible for managing the *Putting Things Right* and the complaints management process within BCUHB told the Investigation Panel that at this particular stage in the organisation’s life the compliance rate in relation to patient and family complaints was poor *“the response rate of 30 days was down to about 10%. It was dire”*.<sup>51</sup> This would have limited a systematic lessons for learning approach from being taken using this important data. The audit also stated that carers and patients were being surveyed. However at the time of conducting the audit the Investigation Panel could see that the survey response rate was very low. For example the Tawel Fan ward sample was comprised of two people suggesting that work in this regard was embryonic at best.
- 9.189** Whilst the impetus behind the audit was commendable it was poor practice to provide such a high-level of assurance which could both mislead and prevent important service development from taking place.

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51 Witness transcript excerpt

***Internal Spot Checks (September 2012)***

**9.190** Also in September 2012 a series of ‘spot checks’ were conducted; they built upon a similar exercise that had taken place the year before. The spot checks were commissioned as a response to the Care Quality Commission report into Dignity and Nutrition which had been published in October 2011.<sup>52</sup> The report detailed the work of Dame Jo Williams who had led 100 unannounced visits to hospitals in England between March and June 2011. In summary her report found:

- patients’ privacy and dignity were not respected – for example curtains were not closed properly when personal care was given;
- call bells were out of patients’ reach, or calls for help were not responded to in a timely manner;
- staff spoke to patients in a condescending or dismissive way;
- there was not always enough staff with the right training on duty;
- patients were not given help to eat and drink;
- the needs of patients were not always assessed properly which meant they did not get the care they needed (for example specialist diets);
- records of food and drink were not maintained properly;
- many patients were unable to clean their hands before eating meals.

**9.191** The BCUHB spot check audit tool was developed by one of the corporate Associate Directors of Nursing on behalf of the Executive Director of Nursing, Midwifery and Patient Services. All 26 inpatient wards within the Mental Health and Learning Disability CPG that were open at this time were audited.

**9.192** The Investigation Panel found there to be a high degree of cut and paste from the audit that had been conducted the year before. The audit took place over a three-day period – however it is not clear who conducted the observational ward work; the findings were as follows:

- both spot checks (2011 and 2012) found a 100 percent compliance rate in relation to privacy and the use of curtains; these findings were apparently supported by a previous Fundamentals of Care audit;
- call bells were found to be a problem in most ward areas, mainly in bathrooms, and assistive technologies were to be explored;
- there were no examples of patients being spoken to in a disrespectful manner;
- a caring attitude and manner was observed in all areas;
- clean finger nails was highlighted as an area of good practice – 100 percent of patients had personal hygiene care plans and all patients during the spot check were observed to be clean and well kempt;
- staffing was raised as a concern by ward nurses in relation to vacancy freezes – however this was being managed by the use of bank and agency cover;
- specialist training in relation to dementia was found to be variable – however the audit stated that “*all patients are treated with respect and communicated with in a way that maintains dignity*” – 100 percent of the nurses interviewed said they could access specialist input if required (such as continence nurses);
- there was variation in relation to how food charts were filled in – at this stage all older people’s wards were introducing ‘intentional rounding charts’;

<sup>52</sup> Care Quality Commission (October 2011) Dignity and Nutrition: National Overview

- access to hand hygiene facilities were not noted to be a problem;
- it was recorded that 100 percent of patients had nutritional requirements identified in care plans;
- mealtimes were protected.

**9.193** The Investigation Panel once again found it difficult to ‘marry up’ the findings of the spot-check with some of the actual evidence that was relied upon. It would appear that there was an active identification and pursuit of good practice with a lesser focus upon areas that were not working so well. Scores of 100 percent are to be commended but it is difficult to have confidence in those scores across 26 wards and over 300 patients, especially with something as difficult to ensure as clean nails, always a challenge on mental health wards for patients of all ages.

**9.194** An example where the Investigation Panel found the tone of the audit to be out of step with the issues under examination was the use of curtains to maintain dignity. Whilst the curtains separating beds might have been used appropriately by nursing staff the audit did not seem to appreciate that the use of curtains on mental health units is an anathema and speaks to an outdated service provision where single bedrooms cannot be provided. Whilst nursing practice might have been good in this regard, the underlying issue was that patients should not be nursed in such environments in the first place; the audit leads did not appear to understand this – hence the 100 percent score when a zero score was perhaps indicated.

### ***Review of Tawel Fan Ward***

**9.195** A review of Tawel Fan ward was conducted in October 2013 as a response to a series of complaints raised by the wife of one of the patients. The review team comprised the following:

- the Dementia Nurse Consultant;
- the CPG Safeguarding Lead;
- the Leadership Development Facilitator;
- a member from the Transforming Care Team;
- the Older Person’s Mental Health Programme Manager;
- the BCUHB Mental Health Act Administrator;
- the Modern Matron;
- the Interim Deputy Associate Chief of Staff.

**9.196** The review visit took place on 17 October 2013; on this day 12 of the 17 beds were occupied. There were three registered nurses on duty supported by four healthcare support workers, two of whom were from the bank.

**9.197** The ward environment was described to be both attractive and suitable for the patient group *“There are displays of artwork produced by patients, pictures and houseplants in communal areas... the furnishings are bright and in good repair... The garden area is attractive and in good order with the new garden furniture”*.

**9.198** The ward staff said that they found the patient acuity difficult to manage and that group activity sessions could not always be maintained. It was noted by the

reviewers that these sessions were *“an essential and fundamental part of assessment and treatment, and not a luxury”* and that staffing needed to be reviewed. It was noted however that the patients on the ward were due to take part in a 16 week music project to be facilitated by a music therapist.

- 9.199** The reviewers identified that the use of bank and agency staff was common and that it was difficult for those staff to always be as effective as regular members of the ward team as they did not have the same level of therapeutic relationship with the patients on the ward.
- 9.200** It was witnessed consistently *“that staff are compassionate and sensitive to the holistic needs of their patients, in what can be a very demanding role both physically and emotionally”*.
- 9.201** The patients were all observed to be clean, well cared for and dressed appropriately in their own clothes. All personal hygiene was carried out behind closed doors in bathroom and bedroom areas. It was also noted that patients were supported and reminded discreetly to use the toilet when necessary.
- 9.202** Staff were observed to support patients in taking adequate food and fluids in an *“unhurried, sensitive, gentle and patient manner”*. The dining area was noted to be bright, clean and well organised with a convivial atmosphere at mealtimes.
- 9.203** The reviewers noted that plans for the future would include a dementia mapping exercise and an opportunity for all registered nurses to attend training in medicines administration to update their practice which would be mandatory.
- 9.204** The Investigation Panel found this review to have been conducted by suitably experienced and qualified individuals who reviewed against robust standards of care and who spent sufficient time on the ward to produce reliable findings.

#### ***Dementia Care Mapping August 2013 – January 2014***

- 9.205** A major improvement to Older People’s Mental Health Services took the form of the appointment of a Dementia Nurse Consultant in November 2012. This individual led a dementia mapping exercise across inpatient services. Dementia Care Mapping had been identified in the CPG Dementia Plan (2013-2015) as the mechanism that would replace the ‘intelligent targets’ care bundle. The plan was for each inpatient dementia unit to be subject to mapping twice a year as part of a quality improvement programme.
- 9.206** On 30 October 2013 a mapping exercise was conducted on Tawel Fan ward. On this day there were ten patients on the ward cared for by three qualified nurses, three health care support workers (two of whom were agency staff) and one ward manager. The mapping exercise was conducted by three individuals who were independent of the ward.
- 9.207** On the day of the mapping two ward rounds were in progress, one patient was receiving palliative care and another patient was receiving 1:1 observations. As a consequence the ‘regular’ staff were engaged in clinical activities that required

knowledge of the patient. The agency staff were allocated to the patient requiring 1:1 observations. Also on this day it was noted that the ward was undergoing refurbishment.

**9.208** The mapping exercise summarised that:

*“Overall the CPG can be satisfied that, based on the observations made, Tawelfan ward is meeting the basic essential physical care needs and care is safe. The mapping shows that when regular staff (rather than agency) are engaging in a therapeutic intervention, whether it be physical or emotional, then well being is seen to be at a higher level. However, the mapping team noted that opportunities for regular staff to engage are currently limited due to their diminished numbers and reliance on agency staff”.*

**9.209** The main recommendations were:

- 1** That regular staff were made aware of the positive impact their interactions with the patients had on their wellbeing.
- 2** Following the ward’s refurbishment attention should be given to ‘Environmental Orientation’.
- 3** Routine daily blood pressure monitoring should be reviewed as it was unlikely all patients required this level of observation and that the time could be used in a more therapeutic manner.
- 4** All case notes should include a completed copy of ‘This is Me’.
- 5** Person-centred therapy approaches should be taken to support patients to improve wellbeing and to lessen any behaviour that challenged.

**9.210** The plan was to conduct the mapping exercise again in six months time. No serious concerns were raised and no poor practice was observed.

**9.211** This mapping process was conducted by highly experienced individuals who worked within a robust methodology and spent sufficient time on the ward to make reliable findings.

## **External Review**

### ***Healthcare Inspectorate Wales Monitoring Visit to Tawel Fan Ward***

**9.212** The Healthcare Inspectorate Wales conducted an unannounced monitoring visit to Tawel Fan ward on 17 July 2013. As part of the visit the Inspectorate met with patients and their families and reviewed clinical records. The visit focused upon:

- the environment of care;
- the administration of the Mental Health Act (1983);
- general patient care.

- 9.213** It was noted that the curtain partitions in shared bedrooms provided only the most basic of privacy and dignity. The ward was noted to be clean and bright but that a smell of urine pervaded. At this stage the garden was noted to be full of weeds and in need of maintenance.
- 9.214** The Inspectorate noted that on the day of the visit there were five registered nurses on duty supported by three health care support workers. Staff were committed to providing good care for the patients and there was good interaction between staff and patients as they carried out their assessments and care needs. Staff reported morale to be reasonable but that they had to spend long periods of time completing documentation; this cut down the time available to spend with patients. It was also noted that there was no evidence of activities being provided.
- 9.215** During the visit two patients were noted to be left alone in their bedrooms. One was reported to be sat in a “*bucket*” chair (the ‘Stroke Chair’) doubly incontinent. It was noted that as the nursing station was a long way from these bedrooms it was important staff checked on patients on a regular basis. On this occasion it was determined patient safety and dignity had been compromised. The action required was that the Health Board needed to review staffing levels to ensure they met the needs of patients.
- 9.216** There was a requirement to submit an action plan by the 1 November 2013 to demonstrate the required improvements were undertaken. The Investigation Panel was not given a copy of this action plan – however it is apparent that work commenced on the garden and the ward environment with immediate effect and that music therapy was commenced and staffing levels were reviewed.

### ***Delivery Unit NHS Wales Review of Inpatient Mental Health Services***

- 9.217** The Delivery Unit from NHS Wales conducted a review of inpatient mental health services at the Ablett Unit which was reported to BCUHB on 1 October 2013. A key message was in relation to the poor quality of the accommodation, in particular the toilet facilities on the older adult wards “*that detract the nursing staff from being able to provide the level of privacy and dignity that patients require*”.<sup>53</sup> It was also noted that the layout of Tawel Fan ward meant some patients had to share bedrooms and that this caused them “*anxiety and discomfort*”. The lack of gender specific toilets, unsafe garden areas and a lack of reliable hot water supply and heating were also flagged.
- 9.218** Another key message was in relation to the limited out of hours medical cover and the proposal to rota only one qualified nurse at night for the older adult wards. It was noted that there were no junior doctors available out of hours and all assessments were conducted by a band 6 nurse. Concerns were raised over the quality and supervision of such assessments.
- 9.219** An audit of the clinical records demonstrated that patients had a holistic assessment, risk assessment and risk management plan and a care and treatment plan that was Mental Health Measure compliant. It was also noted that older

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53 NHS Wales Delivery Unit Briefing for Betsi Cadwaladr University Local Health Board on the Review of Inpatient Mental Health Services, Ablett Unit, Bryn Hesketh and Cefni Hospital

adult services accessed Independent Mental Health Advocates (IMHAs) and Independent Mental Capacity Advocates (IMCAs) on a regular basis. However the basic assessment forms on the older adult wards were found to be overly bureaucratic and needed to be reviewed.

- 9.220** The complexity of the patient profile on the older adults wards was noted together with the growing difficulties nursing and residential homes in the area had in coping with such patients leading to increased admission rates, it was identified that band 6 nurses would need support in preventing unnecessary admissions out of hours.
- 9.221** Issues in relation to the lack of therapeutic activities were identified together with the lack of dedicated therapy staff and psychological therapy input. It was found that this failed to meet Royal College of Psychiatrists' standards.

## Conclusions

**9.222** The Investigation Panel selected a total of seven relevant inspections and reviews (five internal and two external) during the 18 months prior to the closure of Tawel Fan ward. Whilst the quality of the reviews varied (together with the reliability of the evidence used and subsequent findings made) on the whole a consistent picture was built up. Areas of good practice were routinely identified to be:

- kind and caring staff with good interpersonal skills;
- good general standards of nursing care;
- the cleanliness and wellbeing of patients.

**9.223** Areas that required improvement were routinely identified to be:

- environmental issues such as worn fittings and fixtures, mixed sex facilities (such as toilets and bathrooms), unkempt garden areas and poor access to a reliable hot water supply;
- skill mix and staffing levels on older adult wards (such as Tawel Fan);
- the lack of therapy inputs and activities on wards;
- the lack of out of hours medical cover in the Ablett Unit;
- overly bureaucratic nursing assessment forms and processes which took nurses away from direct patient care.

**9.224** When assessing the care and treatment provided on Tawel Fan ward it is important to understand the context in which ward staff were working. Many senior witnesses were of the view that Tawel Fan was an isolated ward and that abuse might have occurred unnoticed due to a lack of routine management 'foot fall'. However the Investigation Panel does not share this view. Tawel Fan ward was part of a busy mental health unit that had been approved for student nurse training, had unrestricted family visiting hours (apart from protected meal times) and was subject to review and inspection on a regular basis.

- 9.225** It would appear from the substantial amount of evidence available that general nursing care was deemed to have been of a good standard and that most of the ongoing issues that required attention were those that belonged to the ‘system’ and not to individual practitioners or treating teams. It is frustrating to read the reviews that found the same findings over again with little action appearing to have been taken to remedy matters. It begs the question ‘why bother to audit or review?’ if no practical action plan is going to be implemented in order to bring about the changes required and to manage the identified deficits.
- 9.226** However in the weeks and months prior to the closure of Tawel Fan ward it is evident that substantial refurbishments were undertaken which addressed most of the environmental issues that had been identified. It was also evident that skill mix and staffing levels were being addressed together with training inputs for staff and therapy inputs for patients; this was good practice which formed part of a re-energised programme of dementia planning and strategy work within the Mental Health and Learning Disability CPG in the autumn of 2013.
- 9.227** At this point in time, based upon contemporaneous strategic planning documents (such as the CPG Dementia Plan), it is evident that the CPG had begun to look outwards towards external accreditation and validation. For example:
- 1** Tawel Fan ward was, at this stage, involved in both an art project and 12 week music therapy project.
  - 2** There was to be a review of the use of antipsychotic medication across BCUHB which would involve a full audit and a review of prescribing guidelines.
  - 3** Psychological support to carers was to be strengthened.
  - 4** The recovery model was to be promoted in keeping with the “*living well with dementia*” ethos.
  - 5** Mental health liaison services were to be strengthened and the quality of inpatient dementia care services was to be improved.
- 9.228** At this point in time the CPG provided five inpatient dementia units with a total of 78 beds across north Wales. It was recognised that the current dementia Welsh Assembly Government (WAG) ‘care bundles’ did not allow for the appropriate level of quality review. Approval had been sought from WAG to replace the current targets with a twice-yearly round of dementia mapping; this was so that the patient experience was placed at the centre of the quality improvement programme and that quality was raised on a patient-by-patient basis.
- 9.229** Another benefit was that any subsequent learning provided direct feedback to staff which promoted their levels of professional awareness; training programmes could also be designed around any identified deficits of care. In effect the proposal around future quality assurance was being tied into a proper clinical audit process which in turn influenced training, education and

service development; this was both good practice and represented a significant step change in both approach and culture.

**9.230** In addition a key step forward was the plan to use the Royal College of Psychiatrists' accreditation process for dementia inpatient services. The Accreditation for Inpatient Mental Health Services (AIMS) is an evidence-based standards tool by which the quality and safety of service delivery can be assessed together with areas that require improvement. This was good practice.

**9.231** There is an inherent paradox that Tawel Fan ward was closed at a time when it had been assessed to be delivering good standards of care (by both internal and external reviewers), had been refurbished, was subject to a workforce review, had a three-month range of therapies set to be provided, and when the CPG had a robust plan for the way forward for inpatient dementia care services.

## The Patient Care Pathway and Pressures on Inpatient Services

### Context

**9.232** Inpatient NHS services form part of a wider health and social care system. This system is made up of a diverse range of services; when put together they comprise a care pathway. In relation to dementia care this pathway will include GP and memory clinic services (at the first stage of the dementia journey), community mental health and social care services (that provide ongoing care and treatment), secondary care inpatient services (if required for acute assessment and crisis intervention) and care home placement (for those individuals who can no longer be looked after in their own homes). It should also be taken into account that any kind of dementia is a life limiting condition. This means that palliative care will need to be part of any pathway consideration at the end of the dementia journey. Any pressure on one part of the system will inevitably have a direct impact upon the others.

### Findings

#### External factors

##### *Care Home Beds*

**9.233** Between 2011 and early 2013 several care homes for the elderly mentally ill (EMI) were closed across north Wales. These closures were for a variety of reasons but common denominators were concerns relating to quality of care and safeguarding. It has been difficult to estimate how many beds were lost to the health and social care system but it is understood to have been around 80, 32 of which were in the central north Wales where Tawel Fan ward was located.

**9.234** Many of the people who lived in those homes had been placed under Continuing Healthcare arrangements; this meant that the NHS retained full responsibility for their ongoing care and placement. At the point of the care home closures several of the individuals affected had to be placed within older people's inpatient care provision whilst the process of finding them alternative accommodation was instigated. Senior witnesses told the Investigation Panel that the closure of care home beds was also problematic for the following reasons:

- a) There was no appetite, custom or practice for out of area placements – this meant that the north Wales health and social care system had to absorb the bed shortages. The Investigation Panel was told that cost factors had historically been one reason for this.
- b) There was a period of time (between 2011 and 2013) where those care homes identified as being in difficulty had decreased capacity to manage patients who presented with either physical illness or behaviours that challenged; there was a reluctance on their part to manage individuals who were perceived to present with high risks. This led to increased crisis admissions (often via Accident and Emergency departments) onto either medical wards or acute psychiatric assessment wards like Tawel Fan. This was found to apply to 33 patients in the Investigation Cohort.
- c) The diminished number of care home beds had an impact upon delayed transfers of care. This meant that once stabilised on either medical or mental health wards there was a restricted number of places for people to be discharged to. 18 patients in the Investigation Cohort were identified to have been delayed transfers of care.

### ***End of Life Care***

**9.235** Another external pressure on acute inpatient mental health facilities was the lack of hospice beds or specialist community-based provision for those who required end of life care. The main hospice for the central north Wales locality was St Kentigern's; this resource was under pressure and could not be relied upon to take those patients with end of life care needs associated with dementia.

**9.236** Patients with dementia and physical care needs were increasingly being 'funnelled' onto psychiatric wards, either due to care homes being unable to cope, or medical wards being reluctant to manage patients with behaviours that challenged. Many of these patients were frail and required end of life care. This meant that psychiatric wards often had to provide this service for patients as there was nowhere else for them to go; this applied to nine patients in the Investigation Cohort.

### **Factors Internal to BCUHB**

**9.237** Between 2011 and 2013 there were six main pressures and care pathway issues that impacted directly on older people's psychiatric inpatient services. The Investigation Panel established its findings from an examination of the clinical records for the 108 patients in the Investigation Cohort and by talking

to families and senior clinical and managerial witnesses. The Investigation Panel found the following:

- 1 Community mental health services for the older adult were still under development during the period under investigation. This meant that there was limited access to Crisis and Home Treatment interventions. The consequence was that patients who were acutely unwell were often admitted to secondary care inpatient wards because there was no alternative means to provide assessment and treatment in the community. This was exacerbated by the absence of robust out of hours arrangements within older people's community services which necessitated people in crisis being admitted onto acute inpatient wards via Accident and Emergency departments as there was no other alternative for patients and their families to seek help and support.
- 2 The earlier closure of Accident and Emergency assessment beds meant that patients in crisis were often admitted onto medical wards; admissions which might have been avoided by an extended period of initial assessment. Medical wards on the Glan Clwyd Hospital site had significant pressures on beds and ongoing staffing issues. It is a fact that medical wards (on occasions) nursed dementia patients in corridors close to the nurses' station in order to keep them away from other patients and to provide the levels of observation required; this was totally unacceptable as patients' dignity and safety were compromised. There is also evidence to suggest that (on occasions) those patients were also overly sedated in order to manage aggressive and disruptive behaviours.

Consequently older people whose behaviour could challenge (and were thought to have a dementia) were often referred to old age psychiatry inpatient services even if still physically unwell. This created a challenge and impacted negatively on the quality of care and treatment provided for four main reasons:

- patients who were still physically compromised and weakened by infections, fractures and strokes were admitted to inpatient psychiatric environments that did not always have the environment, equipment, or levels of specialist nursing and therapy to manage them;
- there were no formal 'shared care' arrangements in place which meant that once transferred to a ward like Tawel Fan patients had no immediate access to continued medical follow up or review;
- physiotherapy, palliative care and other such services did not automatically 'follow the patient' on transfer and so referrals often had to be remade leading to delays in care and treatment inputs;
- patients who were physically frail and compromised were nursed on wards with fellow patients whose behaviour was often challenging and extremely violent; the competing needs that resulted were difficult to manage and created situations where patients could be placed at risk.

- 3 Older adult mental health inpatient services underwent a period of redesign; wards were closed so that money could be reinvested in community services. However at the same time financial pressures had (in effect) led to a freeze on staff vacancies; this was exacerbated by pre-existing recruitment and retention difficulties. These factors led to increased pressures on those wards that remained.

This made a direct impact on the ability to operate some inpatient wards safely and throughout 2012 and early 2013 Wrexham inpatient services experienced periods of extreme challenge. The management of this challenge led to ward mergers and temporary closures in an effort to ensure staffing was maintained at safe levels. However this had a further impact on the remaining old age psychiatry inpatient services across the system which had to absorb the pressures by accepting an increased level of patient admissions. Tawel Fan became the ward that was required to admit most of the patients across north Wales with complex and challenging presentations; this gradually changed the nature of the ward and increased patient acuity levels.

Another consequence of bed pressures in older people's psychiatric inpatient services was that patients with functional illnesses (such as depression) were often placed on wards for those with organic brain disease (such as dementia).

- 4 Moving people to inpatient services long distances away from where they lived fractured continuity of care; this was exacerbated by individuals often being discharged to care home placements in yet other geographical locations due to lack of available beds in their place of origin. This meant that individuals could encounter situations whereby they passed through multiple Consultants, Community Psychiatric Nurses and Social Workers, all of whom often had difficulties accessing the patient's hard copy case notes that often remained in the locations in which they were developed.
- 5 *Circa* 2009/2010 it had been agreed that inpatients from the Ablett Unit would access specialist medical assessment via Accident and Emergency services at Glan Clywd hospital should this be required. This was seen as a means of managing duty and out of hours medical care together with the linkages between mental health and acute medical services. In the event this meant that patients with extreme confusional states and behaviour that challenged, and who required specialist medical assessment, would be sent to Accident and Emergency departments where they could wait for many hours.

This required the booking of an ambulance and a nurse escort from the Ablett Unit which could deplete wards already pressured by low staffing levels. The quality of experience for the patient was often very poor as they could be required to wait for assessment in a strange environment, often requiring a change to incontinence pads, no access to insulin (if diabetic) and having difficulties in accessing food and drink throughout the wait to be assessed. It should also be noted that Accident and Emergency departments are absolutely not the right place for inpatients on psychiatric wards with dementia to be assessed for physical conditions.

6 Bed pressures on adults of working age psychiatric wards meant that on occasions patients under the age of 65 (some as young as 18 years) were admitted to old age psychiatry wards. In the case of Tawel Fan there were at least three examples where this was the case. One 18 year old was admitted (if only for a period of five hours), and two young male patients (one with a forensic history) were ‘slept out’ on the ward at night on a regular basis over a period of several weeks. The Investigation Panel found nowhere in the clinical records that a risk assessment was undertaken prior to such actions being taken; this was unacceptable practice and both diminished the quality of the patient experience and potentially impacted upon patient safety.

9.238 These factors and pressures should be set within the context of growing patient acuity and complexity and the increasing difficulty in maintaining staffing establishments both in relation to capacity and capability. During this period patients could be subject to multiple ward moves which were service need rather than care need driven. 44 Patients in the Investigation cohort experienced:

- transfers to wards ‘out of area’ to ease bed pressures with a resulting loss of continuity of care;
- multiple ward moves as the patient was passed from one service to another with little or no coordination (one patient experienced six moves over a five-week period);
- moves to Accident and Emergency departments when acutely ill necessitating delays of between 24-48 hours to access a medical bed.

9.239 The level of chaos and disruption cannot be underestimated. The Investigation Panel found from the examination of the case notes of the 108 patients in the Investigation Cohort that this resulted in difficulties for staff who were constantly firefighting, and disruption and outright misery for patients and their families. During this period of time the patient was not at the centre of the care pathway; instead they were often treated like parcels who were sent from one ward to another in an effort to keep services running.

### **The Experience of Families and Patients**

9.240 The care pathway issue was a major factor for the families who engaged with this Investigation; most of them had experienced a problem with at least one part of the care and treatment journey that was followed by their loved ones. Families described the following issues in relation to inpatient care:

- chaotic admission processes (especially for those out of hours) which often required being routed via Accident and Emergency departments where patients could wait for hours agitated, distressed, hungry and incontinent;
- multiple ward moves whereby the rationale provided to families was bed shortages;
- admissions increasingly taking place ‘out of area’ meaning that elderly relatives often had to travel long distances across north Wales to visit their loved ones; this was problematic when accessing public transport and also when having to carry dirty and urine soaked clothing home in order to launder it;

- anxieties about the difficulties their loved ones had in accessing appropriate and timely medical, surgical and end of life care;
- discharge placements to care homes that were often found long distances away from where families lived; this caused a great deal of distress with relatives resisting discharge until placements could be found ‘closer to home’ (consequently this often created a delayed transfer of care situation increasing pressures on the system yet further).

**9.241** Families described ‘being up against the system’. Once their loved ones were admitted to Tawel Fan ward families (understandably) thought the clinical staff on the ward were accountable for all aspects of the care and treatment deficits that had been encountered. However the situation was far more complex with no one individual or service being able to make the changes required on either a patient-by-patient or system-wide basis to what was, in effect, a system in increasing turmoil.

### **Continuity of Care and Multiple Moves**

**9.242** It has long been recognised that multiple moves and transfers between services is to be avoided whenever possible for the older adult. The consequence of multiple transfers both into and out of hospital placements has been the subject of numerous research studies over the years. The research indicates that the greater the number of transitions between services the greater the risk; risk is exacerbated by poor levels of professional communication and the loss of continuity of care when transitions are not coordinated or overseen by people who know the patient well. In general poor ‘hands off’ processes during any kind of transition have been linked to:

- adverse incidents;
- low satisfaction rates (for families and patients);
- breakdowns in health requiring rehospitalisation and increased medical intervention;
- increases in mortality.

**9.243** Research conducted by the Kings Fund (2009/2010) estimated that around 48 percent of inpatient hospital beds were occupied by people over 65 years of age; this estimate excluded obstetrics, midwifery, learning disability, adult mental illness, child and adolescent psychiatry, forensic psychiatry, psychotherapy, old-age psychiatry and well babies. The research identified that older people would be more likely to experience prolonged stays in hospital and that the longer the stay the greater the exposure to the risk of physical and mental deterioration due to iatrogenic illness (the result of diagnostic and therapeutic procedures undertaken on a patient), hospital acquired infections (such as *C. difficile*) and injury (resulting from falls).<sup>54</sup>

**9.244** In March 2012 the Kings Fund published *Continuity of Care for Older Hospital Patients: a Call for Action*; the paper looked specifically at multiple moves and transfers within hospital contexts. This paper stated “*Continuity is fundamental to high-quality care. Without it, care is unlikely to be clinically effective, safe,*

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54 Kings Fund (March 2012) *Continuity of Care for Older Hospital Patients: a Call for Action*

*personalised, efficient or cost-effective. Breakdowns in continuity of care put patients at risk, cause duplication and add avoidable costs to both health and social care*". The Kings Fund paper looked at the experiences of older people over 70 years of age when in hospital inpatient settings in England. It identified that:

- patients who were moved around frequently from ward to ward experienced a decreased quality in the care and treatment provided; this was exacerbated when handovers between professionals and teams were conducted poorly resulting in care that lacked coordination and planning;
- patients found multiple moves dehumanising; a female patient described her experience as *"I feel like I'm being moved around like a parcel... I feel like a parcel and not a person anymore"*;
- multiple moves decreased the confidence patients and their families had in a service;
- older patients were likely to be moved from ward to ward (many transfers taking place out of hours) with no explanations given;
- on transfer patients also changed treating teams which led to continuity of care issues;
- patients were communicated with poorly with no overarching coordination process in place or person identified that was responsible for care.

**9.245** The Kings Fund research was conducted at the same time as the period under investigation. What it underlines is that patients can come to harm, both physically and psychologically as a result of multiple transfers and the loss of continuity of care; it also demonstrates that these issues were prevalent across the whole of the United Kingdom at this time. However the situation in north Wales was exacerbated by the sheer size of the geographical area over which patients were moved and the fact that all parts of the care pathway were affected negatively by access and resourcing issues making multiple transitions and transfers more likely. It is without doubt that many of the patients in the Investigation cohort experienced poor quality care as a result and some came to direct harm.

## Conclusions

**9.246** The poor management of the older person's care pathway across north Wales is a key finding of this Investigation; this factor alone is responsible for much of the suboptimal care and treatment that is identified in chapter 10 below. The problems were multifactorial and combine all of the issues that have been examined in this chapter so far. The Investigation Panel concludes:

- 1** There were factors external to BCUHB, such as a lack of care home and hospice beds. The Health Board had a joint responsibility alongside its multiagency partners to commission this resource but during the period under investigation it was scarce, placing additional pressures on NHS community and inpatient provision.
- 2** Service developments within the Mental Health and Learning Disability CPG were limited by financial restrictions. This meant that the scaling down of inpatient services was required to take place first in order to develop those of

community services; unfortunately this created pressures in the system exacerbated by workforce difficulties.

- 3 Each CPG developed its own set of priorities within discrete strategic planning initiatives. It would appear that this was not always directed by the Health Board in keeping with the original ethos of the Welsh Assembly's One Wales National Reform Programme. In reality matrix working was limited and could be described as 'silo-based' within each individual CPG. Integrated care pathways did not automatically extend across BCUHB and patients would often encounter 'internal' boundaries and difficulties when transitioning from one part of the service to another.

9.247 As a result most of the patients in the Investigation Cohort experienced problems with the care pathway that they were on. As a result patients experienced:

- distress and loss of dignity;
- compromised care and treatment that was sometimes provided in clinical environments that were suboptimal;
- hospital acquired infections and injuries;
- compromised levels of health, safety and wellbeing.

## Specific Pressures on Tawel Fan Ward

9.248 The preceding chapter subsections provide a narrative about the challenges to, and pressures on, the system. This subsection examines the impact upon Tawel Fan ward and focuses on those remaining issues that have not already been examined above.

### Patient Acuity

9.249 The growing pressures on acute admission beds across north Wales meant that Tawel Fan ward became the admission ward for dementia patients with complex presentations and behaviours that challenged. The general issues that impacted upon the ward have already been discussed above; however there were also more specific issues that applied to Tawel Fan ward specifically.

### Palliative Care

9.250 As has already been mentioned patients who required end of life care were sometimes managed on Tawel Fan ward; this was not an ideal arrangement as it had become a ward specifically designated for the management of extreme challenging behaviour; this meant there was on occasions:

- an inherent conflict of care needs;
- a lack of access to out of hours pain management and specialist medical input;
- a lack of access to specialist nursing care;
- a lack of access to appropriate equipment;
- an inappropriate environment that could not always afford the necessary levels of dignity, peace and safety required for the dying patient.

- 9.251** The Tawel Fan ward treating team was often placed in an unenviable position. Whilst it would have been a relatively straightforward matter to send a dying patient over to the Glan Clywd Hospital site this would not have been to a pre-arranged medical bed. In order to access a medical bed the patient would have been sent via ambulance to the Accident and Emergency Department from whence they would be sent to the Acute Medical Assessment Unit and then (eventually) onto a medical ward bed (if one was available). Witnesses told us that in extreme cases this could take up to 48 hours.
- 9.252** In the event, and with the express consent from families, the decision would sometimes be taken for patients to stay on Tawel Fan ward. This applied to nine of the patients in the Investigation cohort. On those occasions referrals would be made to the Palliative Care Team so that an end of life plan could be developed and the necessary levels of support provided to the patient. Notwithstanding the best efforts of all involved, the patient and family experience would on occasions be suboptimal.
- 9.253** Two of the qualified staff on the ward had received palliative care training; it is also evident that during the day time the ward was appropriately staffed to take into account the needs of the dying patient. However an acute psychiatric admission ward can never be regarded as an ideal place for end of life care, and staffing levels at night were often not adequately resourced to support the levels of care and treatment needed.

### **Levels of Violence and Aggression**

- 9.254** During the 18 months prior to Tawel Fan being closed the ward began to be classified as the one for the management of challenging behaviours. As a consequence there was a cohort of relatively young male patients admitted in their 50s and 60s; all with a tendency towards extreme aggression and physical violence. This altered the dynamic of the ward to a large extent and saw the need to intervene with restrictive physical interventions on increasing occasions in order to maintain patient safety.
- 9.255** The levels of violence and aggression on the ward escalated during this period requiring additional 1:1 observation levels to be instigated together with the assistance from the Restrictive Physical Intervention Team and advice that had to be sought from the Clinical Nurse Specialist for Violence and Aggression.
- 9.256** Whilst, on the whole, this cohort of patients appear to have been managed appropriately and safely it should be remembered that the ward also provided care and treatment to a diverse range of elderly patients whose care needs were often impacted upon as a result. The therapeutic environment was often disrupted for weeks and months at a time minimising the time that could be spent engaging in therapeutic activities and individualised care plans.

## Therapies and Ward Activities

### Therapy Inputs

- 9.257** Chapter 10 details the lack of psychological therapy inputs on the ward; it also examines the withdrawal of routine occupational therapy and physiotherapy services; this chapter subsection also provides an analysis.
- 9.258** The Investigation Panel was told that clinical psychology services for the period under investigation were focused on the community and that referrals could not be made from inpatient units. In the light of the increasing levels of patient acuity and the challenges presented by intransigent aggressive behaviour (that was often resistant to psychotropic medication) inputs from clinical psychology services were indicated but not available. This minimised the quality of the care and treatment approach provided to patients and also meant that the ward nursing staff did not have access to the levels of specialist clinical advice that they needed.
- 9.259** Senior witnesses explained that during 2011 the Therapies CPG withdrew the occupational therapist and physiotherapist posts from Tawel Fan ward; this occurred once the post holders had resigned from their employment – presumably as a consequence of the recruitment controls in place.
- 9.260** Prior to this time occupational therapy and physiotherapy had been offered on the ward as part of an ongoing therapeutic programme in keeping with the National Institute for Health and Care Excellence (NICE) best practice guidance. Visits were made on a regular basis by the occupational therapist to ensure cognitive assessments were conducted, meaningful person-centred leisure activities took place and the environment was assessed in relation to patient needs. The physiotherapist visited on a daily basis and provided proactive treatment activities such as exercise groups, limb strengthening exercises (to prevent falls) and person-centred assessments in relation to mobility.
- 9.261** Once this level of input had been removed it was not replaced; therapy inputs became more reactive in nature being linked to specific problems and discharge assessments. This placed increased pressure on the ward nursing staff who tried to fill the gap as best they could.

### Activities

- 9.262** One of the issues that families raised with the Investigation Panel was the apparent lack of activities that took place on the ward. From an examination of the clinical records it can be determined that the following took place on a regular basis:
- music therapy and singing;
  - crafts and painting;
  - pat dog therapy;
  - beauty therapy and nail care;
  - crafts and painting;
  - reminiscence therapy.

**9.263** However in 2013 as patient acuity levels rose (and in conjunction with difficulties staffing the ward) the activities that were offered reduced. It should also be noted that the ‘pat dog’ became too nervous to enter the ward as the patients were disruptive and noisy. This deficit was identified by both the internal and external reviews that took place in 2013; BCUHB was reminded that activities should not be regarded as ‘optional extras’ but were instead essential parts of care and treatment programmes. Consequently a workforce review was undertaken and art and music therapy projects were instigated; these projects were at the point of coming to fruition when the ward was closed.

## Tawel Fan Ward Environment

### Mixed Sex Wards and Heightened Levels of Risk

- 9.264** The widely accepted definition of a mixed-sex ward is one where sleeping accommodation, bathrooms and toilets are not segregated; in mental health inpatient wards this also extends to day rooms and lounges.
- 9.265** If men and women are to be accommodated on the same ward then the following must apply:
- sleeping accommodation is in single rooms, with toilet and washing facilities en-suite or very close by; these facilities are clearly designated either male or female; or
  - with single or shared bedrooms giving out onto one corridor, single bedrooms, toilet and bathing facilities are grouped to achieve as much gender separation as possible (for example, women towards one end of the corridor, men towards the other); and
  - a day lounge for use by women only as well as spaces where men and women can socialise and take part in therapeutic activities together; and
  - every effort is made to ensure the availability of staff who are the same sex as the users they are caring for, especially for intimate care.
- 9.266** To all intents and purposes Tawel Fan ward was a mixed sex ward; in the view of the Investigation Panel it failed to provide the necessary levels of segregation.
- 9.267** There were no designated separate-sex toilet and bathing facilities or day room areas for female patients only. The sleeping accommodation comprised 11 single bedrooms with one double bedroom and a four-bedded bay. Due to the design of the ward patients could move around freely and if bedroom doors were not kept locked during the day patients of either sex could enter any of the bedrooms unrestricted as there was no means of partitioning sleeping areas into male and female zones.
- 9.268** Due to the patient acuity on Tawel Fan ward this presented a significant risk to vulnerable individuals in relation to patient-on patient assault; both male and female alike. Due to the high levels of disinhibition shown by many of the patients on the ward there were also significant dignity and privacy issues.

## **The Ward Environment as a Therapeutic Space**

### ***Bedrooms***

- 9.269** The ward environment restricted the numbers of patients who could be admitted. Six beds were in shared-bedroom accommodation; one four-bedded bay and one two bedded-room. This meant that if all of the single rooms had been allocated the only space available would be in a shared bed space. If a person was extremely challenging then they would not be considered appropriate for room-sharing and this would automatically reduce the ward's ability to admit even if a bed was technically open.
- 9.270** The Delivery Unit NHS Wales Review of Inpatient Mental Health Services on 1 October 2013 identified that the sharing of bedrooms on Tawel Fan ward made patients anxious and that the curtain partitions between the beds spaces were totally inadequate when maintaining dignity and privacy.

### ***Observation and Ward Layout***

- 9.271** The Investigation Panel visited Tawel Fan ward on many occasions after its closure in order to assess its suitability as a therapeutic space for older adults with dementia. The layout was complex in nature with poor lines of observation and a nursing office that was positioned away from the main locations of ward activity. Most of the useable space was comprised of corridors which were not wide enough to accommodate sofas or chairs to provide additional space for seating. The Investigation Panel had never seen a ward layout of this kind used for older people's mental health inpatient services; it should be noted that the Investigation Chair has a research interest in mental health hospital design and spatial syntax theory. Appendix 2 provides a plan of Tawel Fan ward.
- 9.272** The layout of the ward was problematic for the following reasons:
- there was no potential for the segregation of male and female patients in relation to bedrooms, toilets, bathing facilities and sitting areas;
  - there was no private or quiet space for patients to sit in;
  - the ward was too large and the layout too complex in relation to the numbers of patients (routinely admitted) for the nursing cohort to be able to keep all areas under supervision;
  - the lack of visual access throughout the ward meant that bedrooms had to be kept locked during the day in order to keep the patients under observation; this prevented them from accessing their own rooms and lessened their autonomy and freedom of movement;
  - there was no designated low stimulation or de-escalation space for patients to be nursed in;
  - there were no noise reduction strategies in place which meant that sounds (such as screams and shouts) travelled throughout the ward making a peaceful and quiet environment difficult to achieve.
- 9.273** It has long been recognised that ward layouts have implications for the maintenance of patient observation and safety; it has also been recognised that ward layouts will have implications in relation to the numbers of ward staff that

are required (both nursing and domestic) to manage them effectively. Whilst the Tawel Fan ward layout might serve a different patient population well it was not best-suited to the needs of older adults with organic brain disease.

### ***Management of the Estate***

**9.274** It is a fact that during the period under investigation the Ablett Unit had distinct problems in relation to the maintenance of the fabric and fixtures of the building it was housed within; these shortcomings were identified by both internal and external reviews, complaints from patients and families and complaints from clinical staff and service managers. Perennial problems were those relating to:

- ant infestations;
- a routine lack of hot water as the central boiler kept breaking down;
- mould, mildew and rust;
- peeling plasterwork in patients' bedrooms;
- unkempt and poorly maintained gardens and grounds;
- worn, urine soaked carpets;
- broken and shabby furniture.

**9.275** Restrictions to budgets appear to have been the main reasons why the repeated requests for improvements were not actioned. The Investigation Panel was able to chart numerous emails from clinical staff and managers together with complaints from families over a three-year period which were not effective in bringing about the improvements that were required. It would appear that the two external reviews that were conducted in 2013 (from the Healthcare Inspectorate Wales and the Delivery Unit NHS Wales) finally brought about the required changes.

### **Equipment**

**9.276** The Investigation Panel was told by clinical witnesses that the access to, and maintenance of, equipment was an ongoing problem; this is supported by the information found in clinical case notes and the statements provided by family members. There were issues in relation to delayed access to equipment and also an inability to get broken equipment replaced in a timely manner; this problem was so insurmountable that ward staff were advised to use patient amenity funds to replace basic items – the fund was not designed to do this. There were consistent problems:

- access to 'Hi Lo' beds was often delayed, this meant that patients had to be nursed on mattresses on the floor, this was far from ideal for the patient's mobility and ability to get up off the floor unaided, it was also poor practice in relation to the safety of ward staff as it presented an inherent moving and handling issue;
- broken equipment such as weighing scales and ECG machines were slow to be either mended or replaced;
- there were no designated patient lockers for the safe storage of their possessions;
- staff personal alarms were often lacking or did not work.

## In Summary

**9.277** It would give the wrong impression to say that Tawel Fan ward was an inherently unpleasant environment; it was not. The building was relatively new (having been built in 1995) and was light and airy providing a feeling of space. However the ward environment was not optimal for the type of patient that was nursed there and it was not maintained well over the years. This not only caused levels of distress to families and patients alike, it also placed an additional burden on the ward staff who had to work with suboptimal equipment and in an environment that did not lend itself to the work in hand.

## Conclusions

**9.278** Throughout 2013 the Investigation Panel could track significant developments in relation to strategy implementation, service development and ward-based improvements. As has been said previously, had the ward been kept open it would be reasonable to assume a series of improvements in the quality of care and treatment would have taken place as scheduled. The ward had been refurbished extensively in the early autumn of 2013, the workforce had been reviewed and a therapy and activities programme had been set in train.

**9.279** However during the period under investigation mental health services had been under significant pressure with supporting systems and infrastructures being underdeveloped and largely ineffective.

**9.280** Most NHS services experience pressures at some time or another; but the pressures that were prevalent on Tawel Fan ward between January 2011 and December 2013 were unusual and all pervading.

**9.281** When considering any care and treatment deficits that might have occurred on Tawel Ward it is important to take into account all of the competing factors that provided the backdrop against which services were delivered. Most of the factors appear to have been outside of the direct control of the ward staff and those who managed them directly. The issues were multifactorial and of longstanding.

# 10 Care and Treatment: Clinical Practice and Process

## Overview to Chapter

### Evidence Base

- 10.1** The Investigation Panel adopted an evidence-based approach which did not depend solely upon the experiences and reflections of witnesses whether they were family members or BCUHB employees. The evidence comprised the following:
- 1** An examination of prior concerns and investigation archives (owned by BCUHB, the North Wales Police and various north Wales Local Authorities).
  - 2** A detailed examination of patient clinical records.
  - 3** Witness statements and interview transcripts from both families and BCUHB employees.
  - 4** Reports from independent inspectors and regulators.
  - 5** Secondary literature including all relevant England and Wales strategy and clinical best practice guidance.

### The Ownership of the Evidence-Base

- 10.2** The Investigation worked with archive material from the North Wales Police and various Local Authorities. Whilst these archives formed an important part of the evidence base they were not owned by the Investigation commissioner (BCUHB). This meant that although there were no restrictions placed on access, there were restrictions placed on usage, particularly the manner in which they could be reported. The Investigation has therefore not taken any direct quotes from these archives and none appear in this report.

### Patient and Family Confidentiality

- 10.3** It is unusual for an investigation of this kind to rely upon patient records (so extensively) as part of its evidence base. Approximately 25 percent of the patient cohort was still living at the time of writing this report and confidentiality considerations must apply. The same confidentiality considerations must also apply to the records of deceased patients as these often contain confidential information about friends and family members. The Investigation Panel is mindful that this part of the evidence base has to be restricted in relation to reporting in a public facing document and extreme care has been taken.

- 10.4** The purpose of this report is to identify thematic lessons for learning so that services can be improved. Its purpose is not to detail specific findings in relation to individual patient care and treatment; for this reason patient case studies are not used. Patient specific findings are the subject of confidential reports prepared for Betsi Cadwaladr University Health Board as part of the *Putting Things Right* process; it should be noted that these individual reports are private and will not be public facing.

### **BCUHB Employee Statements and Interview Transcripts**

- 10.5** In keeping with the ‘lessons for learning’ ethos, and coupled with the fact that many of the witnesses interviewed were subject to open human resource management processes, specific criticisms of individuals in relation to specific patient cases will not be detailed in this report.

### **Chapter Ordering**

- 10.6** The chapter is ordered in a sequential manner with each of the topics addressed flowing naturally one from the other. This provides the reader with the necessary knowledge base to understand all of the issues as they arise. The reader is asked to use the findings and conclusions in chapter 9 as context.

## **Dementia Diagnostic Process**

### **Context**

- 10.7** The following narrative relates to what was recognised guidance and accepted good practice at the time relevant to the period under Investigation.
- 10.8** For a detailed explanation of dementia and the various brain diseases that cause it the reader is advised to follow the link to the Alzheimer’s Society <https://www.alzheimers.org.uk/> where a series of excellent advice and information leaflets are available.

### **What is Diagnosis?**

- 10.9** In medicine, diagnosis is the process of identifying a medical condition or disease by its signs and symptoms and from the results of various diagnostic procedures.
- 10.10** Within psychiatry diagnosis is usually reached after considering information from a number of sources: the referral from a General Practitioner (GP); a thorough history taken from the service user; collateral information from carers (family or involved others) and Mental State Examination and observation. Diagnosis relating to potential organic brain disease (the underlying cause of Dementia) will also require a series of detailed clinical assessments and physical tests.

**10.11** The process of reaching a diagnosis can be assisted by *The International Statistical Classification of Diseases and Related Health Problems* (most commonly known by the abbreviation ICD). In the United Kingdom psychiatry uses the ICD 10 (10th revision – published in 1992) *Classification of Mental and Behavioural Disorders* which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

**10.12** Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can provide an understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis can provide a platform on which to address care, treatment, and risk management issues. The importance of receiving a diagnosis is explained by the Alzheimer’s Society:

*“People with dementia have a right to a diagnosis. A diagnosis empowers people to make decisions about their lives and future care. In some cases it enables access to medication that can slow down cognitive decline, and it helps individuals and their families to understand the changes that they are experiencing. A diagnosis of dementia should also open doors to appropriate Services”*.<sup>55</sup>

**10.13** A substantial number of service users may well meet the diagnostic criteria for more than one diagnosis at any given time, for example, a person may have a dementia caused by Vascular Disease, a Depressive Disorder and a substance misuse problem. For those service users with a number of concurrent diagnoses, or who have very complex presentations, a case formulation can be an invaluable aid to understanding the service user and providing guidance for treating teams in terms of prioritising care and treatment goals.

### **Differential Diagnosis and Diagnostic Formulation**

**10.14** When making a diagnosis it is sometimes difficult to understand exactly what is occurring. A differential diagnosis takes into account the process of weighing up the likelihood of one disease versus that of another being responsible for a person’s illness. It is good practice for clinicians to keep an open mind and to record any considerations in the patient record when signs and symptoms do not fit neatly into one precise diagnostic category.

**10.15** A diagnostic formulation (or a clinical formulation) is the process by which clinicians reflect upon a case and weigh up in a holistic manner what is known about an individual patient. The patient’s risks, social situation and the impact of their illness on both themselves and others are used to construct a deeper understanding of how a care and treatment plan should be developed.

### **Assessment**

**10.16** Whilst it is not a legal requirement to adopt the guidance provided by The National Institute for Health and Clinical Excellence (NICE) it is considered to

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<sup>55</sup> Alzheimer’s Society (October 2015) *Diagnose or Disempower? Receiving a Diagnosis of Dementia in Wales*

be good practice. Some of the following narrative has been taken from the NICE-SCIE *Guideline on Supporting People with Dementia and Their Carers in Health and Social Care* (2007): it is important to note that contemporaneous guidance has been used. The text has been paraphrased and shortened in places to ease understanding. Where this has been done the exact referencing has been given to aid the reader should they wish to read the original version.

### ***Initial Presentation with Memory Problems***

**10.17** Making a diagnosis is a complex task; especially in the early stages of the condition. It can take as long as 12 months from the appearance of first symptoms until a diagnosis is made.

**10.18** It is important to understand that receiving a diagnosis of dementia is a challenging process for both the person affected and their loved ones. Pre-diagnosis counselling should always be considered and great care taken by healthcare professionals when undertaking assessment. The British Psychological Society has this to say:

*“Receiving a diagnosis of dementia is a life-changing event. For the person affected by dementia, becoming aware of significant changes in memory or everyday ability creates a psychological dilemma about whether or not to seek help. Making the decision to acknowledge one’s difficulties and to seek help can be a frightening experience, exacerbated by the stigma surrounding dementia in the wider community. While opting to carry on as if nothing has changed may enable the person to avoid some of the emotional distress, it can also lead to increased conflict with family members and increased levels of stress. It is vital that health professionals are sensitive to the psychological impact of what people are experiencing, whilst providing an accurate and timely assessment”.*<sup>56</sup>

**10.19** People usually present to their GP when they first have concerns about their memory; this means routine investigations are usually carried out in a primary care setting. The focus for these investigations is often to exclude any conditions that could be causing the memory problems or making the situation worse.

**10.20** The GP should carry out a basic memory test to check out the severity of the problem. The GP should also carry out a physical examination and a basic dementia blood screen that would normally include:

- routine haematology (blood tests);
- biochemistry tests (including electrolytes, calcium, glucose, renal and liver function);
- thyroid function tests;
- serum vitamin B12 and folate levels; and
- syphilis and HIV tests (only if clinically indicated).<sup>57</sup>

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<sup>56</sup> The British Psychological Society (2016) *Psychological Dimensions of Dementia: Putting the Person at the Centre of Care* P6

<sup>57</sup> National Institute for Health and Clinical Excellence (2006) *Dementia: The NICE – SCIE Guidelines on Supporting People with Dementia and their Carers in Health and Social Care* PP160-161

**10.21** At the point of initial assessment it is important to rule out any treatable illness such as an infection that may be causing or aggravating the situation. For this reason further examinations (such as an electrocardiogram, cholesterol and urine testing) can all be useful.

**10.22** When treatable causes have been ruled out and there remain concerns about memory then the person should be referred to a memory clinic so that a more specialised assessment can take place.

### ***Memory Clinics***

**10.23** The NICE-SCIE guidance states that a memory clinic should provide a single point of referral to aid the early identification and diagnosis of dementia. The service should:

*“...include a full range of assessment, diagnostic, therapeutic, and rehabilitation services to accommodate the needs of people with different types and all severities of dementia and the needs of their carers and family. Memory assessment services should ensure an integrated approach to the care of people with dementia and the support of their carers in partnership with local health, social care, and voluntary organisations”.*<sup>58</sup>

**10.24** At the memory clinic a holistic assessment can be expected and should include:

- the taking of a detailed history of memory issues together with any other mental health problems;
- a thorough look at past medical history and family history;
- consideration of current medication, other treatments and psychosocial factors that may contribute to (or affect) treatment options;
- a psychosocial history that covers what the individual enjoys doing, their daily routine, religious or belief systems, together with a sexual history;
- a history taken from someone close to the person being assessed;
- cognitive and mental state examination.<sup>59</sup>

**10.25** It is of particular importance to document any sensory impairment that might impact on both initial testing and any assessment that might be conducted in the future. Where possible assessment should be carried out using the person’s first/preferred language.

**10.26** A full physical examination, including a neurological examination, should be conducted together with a baseline assessment of cognition. This should include as a minimum:

- memory: short, medium and long term;
- attention and concentration;
- praxis (performance of certain actions);
- executive function (planning, organising and conducting tasks).<sup>60</sup>

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58 Op Cit P23

59 Ibid P160

60 Ibid P160

**10.27** Further psychological testing may be beneficial when the diagnosis is uncertain. In such circumstances clinicians should not rely on cognitive assessment alone especially when there are:

- sensory impairments;
- communication difficulties;
- no assessment tools available in the person's first language.

### ***Diagnostic Imaging***

**10.28** It is usual (unless the dementia is moderate to severe and the diagnosis is clear) to confirm the diagnosis and its subtype with neuro-imaging. The following has been summarised from the NICE-SCIE guidance.<sup>61</sup>

**10.29** Neuroimaging is an important part of the diagnosis and subtyping of dementia; this matters due to the guidance around the use of acetylcholinesterase inhibitors and Memantine (types of medication).

**10.30** The best neuroimaging test is widely considered to be Magnetic Resonance Imaging (MRI), if available, as this will identify subcortical vascular changes. If this is not available then a Computerised Tomography Scan (often referred to as CT or CAT) may be helpful.

**10.31** In addition where vascular dementia is considered and the diagnosis is unclear scans such as Single-Photon Emission Computed Tomography (SPECT or PET) can also help differentiate Alzheimer's disease, vascular dementia and frontotemporal dementia if the diagnosis is in doubt.

### **Making the Diagnosis**

**10.32** A diagnosis of dementia should be made by healthcare professionals with expertise in differential diagnosis using international standardised criteria. Many cases of dementia may have a mixed picture (for example: Alzheimer's disease and Dementia with Lewy Bodies): such cases should be managed according to the condition that is thought to be the predominant cause of the dementia.<sup>62</sup>

**10.33** At all stages it is important to keep good documentation of findings and the rationales for investigations and decisions. Good documentation also supports coordinated care if the patient requires other health or social care services in the future. When everything is documented clearly at the outset it becomes easier as the disease progresses to understand:

- what was discussed and agreed;
- the wishes of the patient and their families;
- their understanding of the diagnosis and prognosis and what has been agreed in terms of treatment or intervention;
- the expectation of, and outcome from, any interventions that are agreed.

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<sup>61</sup> Ibid PP23, 1554

<sup>62</sup> Ibid P24

## Communicating the Diagnosis

**10.34** The diagnosis should be discussed with the patient. Carers should also be involved in full where the patient wishes this to be the case. Consent and advanced decision making should be part of this discussion early on so that as the person deteriorates their wishes as stated when capacitous can be observed. This includes an understanding of their psychosocial and religious needs.

**10.35** Communicating the diagnosis is a challenging experience for both the person with dementia and their family members. Healthcare professionals should set aside ample time to discuss the diagnosis and its implications. Of the utmost importance is the recognition that people with dementia and their families might need ongoing support to cope with the difficulties presented by the diagnosis. Healthcare professionals should not view these early conversations as being single events. Communications in relation to diagnosis require follow up and repeated opportunities for discussion and information exchange.

**10.36** The Alzheimer's Society understands well the importance of post diagnostic counselling and support.

*“Many people with dementia are left without support following a diagnosis. However, appropriate support and advice is essential for people with dementia to gain the maximum value from their diagnosis. With the right care and support, people with dementia can still enjoy a good quality of life. Post-diagnosis support consists of information, advice and support for people with dementia and their carers within the first 12 months of their receiving a diagnosis of dementia. Many of the services described may continue to be helpful to a person with dementia for several years. However, services received in the first year of diagnosis have a particular role to play in setting someone on the right track for the years to come”.*<sup>63</sup>

**10.37** It is usually the responsibility of the Memory Clinic and/or GP or Community Mental Health Team to provide both verbal and written information covering:

- diagnosis;
- signs and symptoms of dementia;
- treatment options;
- impact and risks of treatment;
- prognosis.

**10.38** Early communications should also include signposting to local care and support services, financial and legal advice, advocacy, medico-legal issues (such as driving) and guidance on what to do if things deteriorate or if there is an emergency. This should all be recorded in the case notes.<sup>64</sup>

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63 Op Cit

64 Ibid P164

**10.39** The Alzheimer’s Society stresses that:

*“If dementia is diagnosed early enough that the individual has the capacity to participate in medical, legal and financial decisions, this makes it easier to involve the person with dementia in the planning of medical and psychosocial interventions, suited to their needs both in the present and through plans for future care. There is currently a very positive emphasis on the co-production of care in Wales. Alzheimer’s Society welcomes the increasing opportunity for people to shape the services they receive. However, a co-production approach to delivery of care for people with dementia is simply impossible if people with dementia do not receive a diagnosis”.*<sup>65</sup>

**Assessment Diagnosis and Treatment of Non Cognitive Symptoms Associated with Dementia**

**10.40** Non cognitive symptoms associated with dementia can include:

- depression;
- delusions;
- mood disturbances (such as anxiety and irritability);
- personality changes;
- aggression;
- changes to sleep patterns.

**10.41** People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviours that challenge should be offered an assessment at an early opportunity. This should establish any likely factors that may generate, aggravate or improve such behaviour. The assessment should be comprehensive and include a full physical health assessment which should:

- exclude delirium;
- consider the co-existence of another mental illness such as depression or psychosis;
- should identify undetected pain or discomfort; and
- consider side effects of medication.<sup>66</sup>

**Co-Morbidities and Dementia**

**10.42** It is important to understand that the older adult will probably have a wide range of co-existing illnesses and conditions. Some of which might actually be the underlying cause of a dementia.

**10.43** Comorbidity is where a condition or disease co-exists with another. Most diseases can co-exist alongside many others. It is important to understand that a person with dementia might also have many other physical and emotional conditions at the same time – all of which will impact upon one another.

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<sup>65</sup> Ibid P33

<sup>66</sup> Ibid P27

**10.44** The physical comorbidities of Dementia include:

- falls;
- delirium;
- dental and gum disease;
- epilepsy;
- frailty;
- incontinence;
- malnutrition;
- sleep disturbance;
- visual impairment.

## Findings: The Family Experience

**10.45** In total 29 families raised concerns about the diagnostic process and the subsequent communication and support they received. They gave evidence on behalf of themselves and their loved ones who were patients on Tawel Fan ward. However these concerns were not confined to Tawel Fan ward and encompassed experiences across all services from the point of first contact.

**10.46** Families also described diagnostic ambiguity and communication failures that applied to episodes of care in surgical and medical environments. Families were not always certain exactly what key diagnoses had been made or how they interacted with each other; consequently they raised concerns that care and treatment plans might not have been optimal as a result.

**10.47** Table 2 below provides a synopsis of the concerns raised; it should be noted that many families raised more than one.

**Table 2**

Type of Concern Raised	Numbers
General lack of support at the point of diagnosis	<b>29</b>
Confusion over the diagnosis which was communicated poorly and/or insensitively	<b>19</b>
Misleading information given	<b>1</b>
Diagnosis changed without a full explanation given	<b>1</b>
Incorrect diagnosis given in error	<b>2</b>
Anxiety about care and treatment decisions provided in the light of the diagnosis given	<b>6</b>
Disagreement with the diagnosis given and concerns over the process followed	<b>4</b>
Delays to a diagnosis being made	<b>5</b>

## Receiving the Dementia Diagnosis

**10.48** The 29 families who raised concerns were of the view that they had not been engaged with in an appropriate manner and that the diagnosis, treatment options and prognosis had not been discussed in a way that held meaning for them.

**10.49** The families were able to reflect on their experiences with the benefit of hindsight. This hindsight enabled individuals to state with certainty the kinds of opportunities they felt were missed. Three main areas were identified:

**1 First – the Initial Reaction.** The shock of receiving the diagnosis permeated for months, if not years, after it was first communicated. This meant that both patients and their family members found it difficult to absorb information whether given verbally or in writing. Initial reactions ranged from a sense of complete denial to a fierce optimism that a cure could be found.

Families described a general dissatisfaction with how they were initially informed and ‘held’ by services. Many felt they were left to signpost themselves and that their own individual needs in relation to distress and shock were not addressed. Basically they expected more.

**2 Second – Care and Support Post Diagnosis.** Families described a range of experiences in relation to what happened next.

At one end of the spectrum patients and their families were followed up by memory clinics at six or 12 monthly intervals and were referred back to their GP for ongoing care. Patients and their families found this ‘watch and wait’ scenario difficult to live with. For them an enormously challenging diagnosis had been given in a seeming vacuum. For these patients and their families confusion grew together with a growing sense of helplessness.

At the other end of the spectrum patients and their families were assigned to a CMHT where they had regular contact with a Community Psychiatric Nurse (CPN), a Social Worker and Support Worker. For these individuals support, education, service provision (day hospitals, activity groups etc.) and carer assessment were provided. Consequently their experience improved.

**3 Third – Proactive Care and Treatment Planning.** Regardless of how people were followed up families reflected that very little activity took place in developing (and discussing) short, medium and long-term plans and options for the future. Confusion remained in relation to prognosis and the nature of the potential challenges ahead. Also absent was the opportunity for advance directives to be written and discussions about person-centred care looking forward to the future when capacity issues might become an issue.

**10.50** It was evident to the Investigation Panel that this sample of 29 families was not worked with in a standardised manner. This presents a confusing picture as geographical and patient acuity issues did not always appear to be factors when determining how the level of service inputs were decided.

### **Confusion about the Diagnosis**

- 10.51** 19 families raised concerns about diagnostic uncertainty with an additional four believing that the wrong diagnosis had been given. There were three main areas of concern raised.
- 10.52** **First.** Several of these families experienced what the Investigation Panel identified as ‘snapshot’ syndrome. The majority of the concerns brought to the attention of this Investigation came from the sons and daughters of patients – not the husbands, wives and partners who lived with them on a daily basis and who were usually the designated next of kin.
- 10.53** Patients and their spouses often ‘held back’ vital information from their sons and daughters, determined to cope on their own for as long as possible. This sometimes led to a mismatch regarding the initial information parents gave their children about diagnosis and the reality of situation over time as the dementia progressed. This added to the confusion and uncertainty felt by the sons and daughters (and sometimes siblings) of the patient.
- 10.54** **Second.** Families expressed concerns about the accuracy and quality of the diagnostic process as it was not in general explained to them. This led to a lack of confidence in the resulting findings and confusion about how a diagnosis had been reached. Families often felt unable to challenge and seek clarification as they did not wish to offend and/or did not always have sufficient knowledge to ask the right questions.
- 10.55** **Third.** Four families refused to accept the diagnosis given to their loved ones. It is evident that they found the diagnosis stigmatising and sought different explanations. Despite meetings with the treating team, repeat tests, specialist referrals (and on occasions second opinions) these families remain of the view their loved ones were misdiagnosed and ‘let down’. Whilst it is difficult to see what else could have been done in relation to the clinical diagnostic process, there is a clear issue here about stigma and how this was managed by mental health services.

### **Diagnosis and Informed Consent**

- 10.56** It is only possible to give informed consent if a diagnosis is provided together with a clear understanding about the care and treatment options available and any associated risks. Families raised the following issues.
- 1** Across the entire spectrum of care (including GP practice, medical and surgical services) patients and their families felt they did not have consistent access to clear diagnostic information that was explained to them in simple terms. This had a significant impact on how effectively informed consent could be given by the patient (or family members when the patient was no longer able to do so).

- 2 Families described confusion when their loved ones were taken to medical and surgical settings. They were often asked to give consent to care and treatment approaches that they did not understand and felt rushed into agreeing with.
- 3 Mental health services, both community and inpatient, consulted with patients and families about care and treatment options (such as the prescribing of Risperidone); this was good practice. However with hindsight families felt that they did not know enough about the diagnosis to be able to contribute to the treatment decisions and now feel anxious that they might have caused their loved ones harm.
- 4 Many families have been left with the anxiety that different services along the care pathway did not always know about (or appreciate) all of the different diagnoses and conditions their loved ones suffered from. To this day many families worry that they might have let their loved ones down by not being fully conversant with their medical history so that they could have both directed services and made better decisions about care and treatment.

**Having Confidence in the Dementia Diagnosis and Subsequent Care and Treatment Plan: Tawel Fan ward**

- 10.57** As many families did not know at the point of diagnosis what the future held (or what their needs were likely to be moving forward) it is only with hindsight that they could offer feedback to the Investigation Panel as to how limited in effectiveness their initial engagement with mental health services was. For those patients and their families who had only received ongoing support from their GP (with intermittent inputs from the memory clinic) the dementia process often progressed to the point of crisis with no education or support having been given.
- 10.58** The subsequent lack of knowledge often made the admission to an acute psychiatric setting (such as Tawel Fan ward) even more difficult to deal with as it was outside of the experience of most patients and their family members and was something they were not prepared for.
- 10.59** On admission to Tawel Fan patients had usually progressed to a moderate or advanced stage of their dementia. A complete assessment and re-examination was always undertaken immediately following admission. However this sometimes either changed the original diagnosis or added layers of complexity to it; something families often found difficult to understand as they did not have a firm foundation to build new information upon.
- 10.60** Even at this stage families still did not always appreciate the progressive nature of their loved one's dementia. This is when a family's knowledge and understanding was tested to the limit; this is also when any prior communication issues were compounded.

## Findings: Identified by the Investigation Panel

### Issues in Relation to Bias

- 10.61** It is important to understand that the 29 families in this particular sample raised concerns because they were unhappy. The majority of families in the Investigation Cohort raised no concerns in relation to the diagnostic process they experienced and appeared to be satisfied with the service they received. It should be noted that the Investigation Panel could find no correlation between the levels of support provided to families and the resulting satisfaction, or lack of it, with the service.
- 10.62** The Investigation Panel examined the case notes of 108 patients of which 105 were relevant to the subject of diagnosis. These case notes included those of the patients whose families had raised concerns.

### Memory Clinic Operational Practice

- 10.63** During the period under investigation BCUHB had in place an appropriately resourced and accessible memory clinic service across north Wales; this was good practice.
- 10.64** However, between 2011 and 2013 (across the whole of Wales) it was not routine for an intensive ‘wrap around’ level of service to be provided at the point of first diagnosis. This was still largely aspirational (and to some extent still is). Public Health Wales stated in its August 2014 audit:

*“Appropriate follow up and support after dementia diagnosis is essential, or timely diagnosis serves little purpose. A key contact who is “multi-skilled and multi-rolled” and who stays with the patient and family throughout the course of the illness is desirable. Consideration needs to be given to whether memory assessment services take on this responsibility or whether they act as a source of expert advice and signposting to appropriate services”.*<sup>67</sup>

- 10.65** At this time only one Health Board in Wales had appointed dementia coordinators who acted as the key contact with the patient and/or family throughout the course of the illness. BCUHB did not provide this level of service and this is one reason why patients and their families were not always supported in a consistent and streamlined manner.
- 10.66** During the period under investigation Public Health Wales noted that 85.7 percent of the 24 memory clinics across Wales had been integrated with Community Mental Health Teams (CMHT); this assisted with signposting and follow up. It was noted that ‘older’ long-established services still provided ‘stand alone’ inputs; BCUHB was amongst the 14.3 percent of providers which fell into this category.<sup>68</sup> This served to ‘detach’ memory clinics from other community-based services even though in BCUHB they were co-located in the same buildings.

<sup>67</sup> Public Health Wales (August 2014) 1000 Lives: Wales National Audit Memory Clinic and Memory Assessment Services P3

<sup>68</sup> Op Cit P10

**10.67** This ‘detachment’ was exacerbated by the disconnection between the policies and procedures for memory services and those of community mental health teams. There were no clear referral criteria or guidelines as to how services should work together. This level of ambiguity is another reason why patient and family experience was inconsistent and serves to explain why it varied so much.

**10.68** However it should be noted that BCUHB compared well with its other Wales counterparts in relation to:

- assessments in Welsh language;
- home-based assessment;
- access to specialist diagnostic counselling;
- access to cognitive stimulation services;
- access to support for carers;
- access to life-story work.<sup>69</sup>

### **Dementia Diagnostic Assessment: Areas where Practice was not Optimal**

**10.69** High-level findings were identified as follows:

- 1 There was an inconsistent quality of holistic baseline assessment undertaken in memory clinics.
- 2 Case note reviews and psychiatric histories were often documented poorly.
- 3 Early assumptions were sometimes made that the diagnosis was Alzheimer’s disease without all of the diagnostic tests being completed.
- 4 Neural imaging was primarily limited to CT scans (across memory clinic and inpatient secondary care services alike).
- 5 Unusual presentations were not always diagnosed using a full set of tests (for example perfusion scans).
- 6 Differential diagnoses and diagnostic formulations were largely absent.

### ***Baseline Assessment***

**10.70** There was an inconsistent level of holistic baseline assessment undertaken in memory clinics in central north Wales. The Investigation Panel found that some case notes detailed a high standard of holistic baseline assessment; but many others did not.

**10.71** The 2006 NICE guidance sets out a clear rationale as to why this kind of assessment was (and is) essential. When assessing a patient for the first time it is important to ascertain a full history; this should include as a minimum a review of:

- all past and present medical conditions;

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<sup>69</sup> Ibid

- all past and present psychiatric conditions;
- social circumstances;
- lifestyle choices (for example smoking, alcohol consumption etc.);
- spirituality and sexuality.

**10.72** When this is not done there is always the risk that a diagnosis can be made out of context and without all of the information required. It is evident that memory clinics conducted comprehensive physical testing (such as CT scans, ECGs and blood screens etc.) and completed an evidence-based range of cognitive and psychological assessments; however this was not always set within a wider holistic context. This was problematic for the following reasons:

- there was often insufficient information to support a differential diagnosis when there was a level of ambiguity and uncertainty;
- diagnostic formulation could not take place in a meaningful manner;
- social circumstances were not properly understood or evaluated (for example; domestic abuse, neglect and levels of carer stress);
- the opportunity was missed for a person-centred approach;
- a poor baseline was provided for future psychiatric and social service assessments and interventions.

**10.73** Had better assessment been undertaken at an earlier stage treating teams could have developed a more robust understanding when predicting carer stress, future risk, and the potential for familial breakdown in the home environment. It could also have honed the diagnosis.

**10.74** NICE guidance explains that providing a dementia diagnosis can be difficult in the early stages and that it can take a full 12 months for the full diagnostic picture to emerge. This is why it is so important to ensure that everything that can be known (and should be known) is ascertained at the earliest stage possible and taken into account as part of the emerging picture.

**10.75** The Investigation Panel had the advantage of having access to each patient's full medical and psychiatric history. This meant that a complete understanding could be gained retrospectively. Even so it took a meticulous amount of examination before a concise history for each patient could be understood; rarely was a full summary provided in any clinical record that could be accessed easily and was in one place. This reinforced the concerns the Investigation Panel had about how well the knowledge about patients had been ascertained by the memory clinics. It was evident diagnoses were often made without all of the available information (in particular social and medical histories) about the patient having been taken into consideration.

**10.76** This lack of clearly documented and holistic baseline assessments meant that the initial diagnostic process was not always optimal, no matter how well psychiatric and physical examinations were otherwise undertaken, or how well the diagnostic picture went on to be built up over the ensuing years.

### ***Differential Diagnoses and Formulation***

- 10.77** The Investigation Panel did not find explicit written evidence to suggest that differential diagnoses were considered as part of either initial or ongoing assessment processes. This was considered to be highly unusual considering how difficult the diagnosis of dementia subtypes can be in the early stages.
- 10.78** The clinical records show that during initial assessment (usually at a memory clinic) complex presentations and a wide range of symptoms were often recorded. What could not be evidenced was the manner in which dementia subtypes, or co-existing subtypes, were differentiated one from the other; this is where a more systematic process could have been helpful. The clinical records indicate that a diagnosis of Mixed-Type Dementia was often given – whilst this was probably correct the clinical records do not detail the process by which this diagnosis was reached and how each subtype of dementia was identified and confirmed.
- 10.79** The Investigation Panel found that diagnostic formulations were virtually non-existent within the clinical records; this was poor practice for such a vulnerable and complex group of patients. The Investigation Panel viewed this as a significant omission.
- 10.80** Patients with dementia will experience a combination of mental health and physical co-morbidities; they will also have a range of social and emotional needs. The lack of formulation can preclude the early involvement of other health and social care professionals and can also preclude the development of holistic care, treatment, and risk management plans.

### ***Limited use of Neuroimaging***

- 10.81** Clinicians in north Wales made good use of CT imaging and it was standard practice for all patients to have a routine scan at the first point of contact with the memory service. This was usually repeated on admission to Tawel Fan ward if the patient was new to the treating team or if there were any outstanding concerns or diagnostic uncertainty. This was good practice.
- 10.82** However the Investigation Panel could not detect the use of MRI or SPECT scanning except for a very small number of patients. On occasions where patients presented with an unusual presentation or challenging behaviours a wider use of neuroimaging was perhaps indicated – especially in the early stages of the diagnostic process at memory clinics.
- 10.83** The Investigation Panel was told that there were limited neuroimaging facilities on the Bangor and Glan Clwyd Hospital sites and that those patients who required SPECT scans had to travel to Wrexham.
- 10.84** The Investigation Panel wanted to understand if resource issues were responsible for the limited use of SPECT and MRI scans or if there were other issues to consider. One of the lead Consultants at the Ablett Unit, who has an active and respected research profile in neurological imaging, was able to give a robust explanation as to why SPECT and MRI scans were not routinely used by inpatient services.

- 10.85** The Investigation Panel was told that all patients who required SPECT or MRI scans would receive these tests after a “*Judicious*” decision was taken. The Investigation Panel was also told that once admitted to Tawel Fan ward most patients would be in the advanced stages of their dementia and the logistics of travel to Wrexham combined with extreme agitation could often rule out the feasibility of further neuroimaging. Due to the demanding and unpleasant nature of the scanning process a risk/benefit analysis had to be undertaken.
- 10.86** Despite reassurances the Investigation Panel found that this still did not explain the virtual absence of SPECT and MRI imaging across such a large cohort of patients. From a close examination of the clinical records 10 percent of the patient cohort was identified where (regardless of the challenges) additional scanning would have been good practice.
- 10.87** On reflection the Investigation Panel identified that its concerns and doubts were reinforced by the absence of clearly written rationales in the clinical records in relation to neuroimaging and the choices that were made. It would appear that CT scanning was chosen because it was the most readily accessible test available rather than it always being the most appropriate. Whilst this might not have been of such significance for those patients admitted to Tawel Fan ward in the later stages of their dementia, the full spectrum of neuroimaging should have been utilised more effectively by the memory clinics in the earlier stages of the diagnostic process.

### ***Documentation and Continuity of Care***

- 10.88** In keeping with the rest of Wales BCUHB operated (and operates still) a hard copy clinical record system. This report has already detailed the difficulties the Investigation Panel encountered when trying to access clinical records. During the period under investigation this was also an issue encountered by treating teams when trying to access clinical information about the patients in their care. In relation to diagnostic process this was problematic because:
- 1** During the first and/or early stages of contact with a patient the lack of access to an electronic database meant that other kinds of professional communication (such as telephone calls, fax messages and letter writing) had to work harder when assembling baseline information. This was labour intensive and meant that information transfers could be slow.
  - 2** Delays were often incurred whilst clinical records detailing prior contacts were gathered; in the absence of a database that could be easily interrogated it was not always possible to know where to look and how many previous episodes of care had taken place. This was a particular problem if the patient was not known to the service.
  - 3** The recording of around 95 percent of clinical information was done by hand. This was time consuming and often lent itself to a ‘short hand’ method of recording taking place – this often worked against the detailed transcribing of medical histories, diagnostic formulation and assessment rationales (including decisions made in relation to neuroimaging).

In addition hand-written records can run into multiple volumes relatively quickly. Because there was no 'cut and paste' facility information often did not get transferred into new folders once the old ones were full. This meant that on occasions information relevant to the diagnostic process could be absent.

- 10.89** Continuity of care and professional communication also played a part in the somewhat confusing diagnostic picture families described. When examining the pathways many patients followed it is apparent that they would receive GP, Community Mental Health and Social Work services in their north Wales county of origin, they could then be transferred for inpatient care to a different part of north Wales, and then be discharged to a care home placement to yet another.
- 10.90** During these multiple moves many patients would 'pass through' several care and treatment teams. It should be noted that hard copy records did not always follow them as they were usually retained in their place of origin. This meant that handover processes and discharge summaries were essential in order to ensure a smooth transition of information. The Investigation Panel found that these processes were often delayed and incomplete; this was when diagnostic information could be 'lost' inside the system. This was where errors and omissions in recording sometimes took place leading to a mismatch of information that could confuse both families and treating teams alike.

### **Dementia Diagnostic Assessment: Areas of Good Practice**

- 10.91** Whilst the narrative above sets out some of the limitations found with the diagnostic process a great deal of good practice was identified.
- 10.92** High-level findings were identified as follows.

#### ***Memory Clinics***

- 1** There were good levels of multidisciplinary assessment including inputs from: nursing; psychiatry; psychology; occupational therapy and social work.
- 2** There was a wide range of evidence-based examinations and tests combined with cognitive and psychological assessment in keeping with NICE guidance.

#### ***Tawel Fan ward***

- 3** On admission all patients were assessed and re-examined in full accordance with NICE guidance.
- 4** Physical examinations and mental health assessments continued on a regular basis throughout admission coupled with good diagnostic processes for physical conditions.
- 5** There was a high standard of referral to neurology, medicine, surgery and palliative care services when a specialist view or diagnosis was required.
- 6** There was a good use of family meetings.

### ***Community Services***

- 10.93** As has already been stated it can be difficult to arrive at an accurate diagnosis in the early stages of a dementia process. The Investigation Panel found robust and evidence-based practice in the following areas:
- a) Psychology services were accessed for those patients with early onset dementias or complex presentations when a more detailed analysis was required in relation to cognitive testing.
  - b) Occupational therapy assessments were conducted in the home (usually at a more advanced stage of the dementia process) which also provided a good opportunity to assess carer stress and the family dynamic.
  - c) Nursing and psychiatric assessments were undertaken in a coordinated manner with a high level of consultation and information exchange.
  - d) Regardless of the issues already identified in relation to neuroimaging, it should be understood that CT scans were used as part of the regular baseline assessment. Despite United Kingdom guidance recommending the use of neuroimaging it is unusual to see such high levels of CT scanning being used for patients in such a consistent manner.
  - e) From a close examination of the 105 patients under examination NICE guidance appears to have been met in full in relation to physical examinations and cognitive and psychological assessment. This was conducted for all patients in a detailed and systematic manner.

### ***Assessment and Re-examination on Tawel Fan Ward***

- 10.94** Patients were usually admitted to Tawel Fan ward because they had either reached a state of crisis in the community or because they had been transferred due to extreme agitation and confusion from other secondary care environments (such as medical or surgical wards). The primary purpose of admission would be for specialist assessment and review.
- 10.95** On admission most patients had progressed to a moderate or advanced stage of their dementia. For those patients already known to service their diagnosis was well established; for those being referred from acute secondary care services this was not always the case.
- 10.96** There is ample evidence to demonstrate that on admission to Tawel Fan ward a comprehensive assessment and examination was undertaken for each patient. On occasions when a patient was admitted out of hours there were delays to the clerking in process and sometimes physical examinations had to be delayed until the following day. However these delays did not appear to cause harm and were remedied rapidly.
- 10.97** An appropriate range of assessment tools and examination processes were used in keeping with NICE guidance. Where specialist advice was indicated (from neurology, medical or surgical, or palliative services) timely referrals were made.

- 10.98** For those patients who were already known to service it was unusual for the dementia diagnosis to be changed on the ward. However for a small number this was the case. One of the advantages of an acute admission is that a patient can be observed throughout a 24 hour period. This provides the opportunity to conduct a more thorough assessment which can lead to a better understanding of the person. It was evident that the treating team kept an open mind and that the repeat testing (including CT scanning) at a more advanced stage of the dementia process on occasions served to refine the diagnosis and on rare occasions alter it. This was good practice.
- 10.99** For those patients who were not known to the service the records detail that NICE guidance was followed in relation to examination and assessment with the added advantage of 24 hour observation. The clinical records detail daily reviews on the part of nursing staff and regular reviews from medical staff. These reviews and updates were recorded in sufficient detail to ascertain sustained good practice.
- 10.100** Of particular note is the meticulous level of detail to be found in the clinical record whereby nursing staff record daily observations and record any changes to both mental state and physical presentation. This ranged from identifying in-growing toenails to a lowering of blood pressure for physical conditions, to behavioural charting and cognitive assessment for psychiatric conditions. It was evident that the nursing staff were vigilant, recorded their observations and concerns well and reported them on to the medical team promptly.
- 10.101** In turn the medical team responded to the issues raised by nursing staff in a timely manner. Thorough physical examinations and mental health examinations were undertaken and rapid referrals were made if a specialist diagnosis or second opinion was required.
- 10.102** An examination of the clinical records shows that families were invited to meetings on a regular basis. Where possible these were separate from the ward round in order to ensure a family-friendly non-threatening environment; this was good practice. On these occasions diagnosis, care and treatment plans, and future placements were discussed and the views of the family sought. It can be determined from the clinical records that family choice and preference was always taken into account with a high level of ongoing communication, consultation and involvement. On occasions there were differences of opinion between families and the treating team however these were usually managed in a sensitive manner.

## **Pre and Post Diagnostic Counselling and Support**

### ***Support***

- 10.103** Clinical witnesses to the Investigation were deeply concerned when they heard how families felt they had been unsupported and that poor levels of information had been provided. Clinical witnesses thought they had worked well with families and had given a great deal of time and thought to the communication process.

- 10.104** Clinical witnesses described the practice whereby they would meet with patients and families when the initial diagnosis was given; on these occasions time would be taken to explain the diagnosis and what would happen next. Further meetings were also offered so that more detailed information exchange could take place over time.
- 10.105** However whilst clinicians could explain their practice in relation to patient and family communication and the giving of information, what was described was a focused explanation of the dementia and the initial treatment plan. For patients and their families being given information was one thing, learning to live with the ramifications was another.
- 10.106** In view of the concerns raised by the 29 families information exchange (on its own) was not enough. It is easy to see how expectations and perspectives diverged; families felt they were being ignored, clinicians thought they were being helpful and supportive.
- 10.107** This situation illustrates well the need for sustained support which can not always be given by treating teams as part of their ordinary day-to-day work. This underlines the importance of both past and present Welsh Government strategies relating to the care of the elderly mentally ill and their families. Designated dementia coordinators could have provided the ongoing and consistent levels of communication and support that families told the Investigation Panel that they needed and which were not provided by BCUHB mainstream services in their 2011-2013 configurations. This was of particular note for the patients and their families who were not assigned to a community mental health team.
- 10.108** It should be noted that the Memory Clinics usually suggested that patients and their families contacted the Alzheimer's Society for ongoing support; this was good practice. However this was often in *lieu* of other more formal and ongoing arrangements that could be managed as part of a comprehensive care package.

### ***Pre and Post Diagnostic Counselling***

- 10.109** Whilst post diagnostic counselling is something that is now being put into place for all patients and their families it was not readily available between 2011 and 2013. However BCUHB provided both pre and post diagnostic counselling for those with early onset dementia. Counselling was also made available to their families with particular care being given to the patient's children. This was good practice.

## **Conclusions**

- 10.110** It is not the function of an Investigation Panel to attempt the re-diagnosis of patients; this would be both improper and unprofessional. None of the Investigation Panel met the patients and conclusions have to be framed with this in mind. The task in hand is to ascertain whether or not due diagnostic process was followed in keeping with national best-practice guidance. It is not possible to undertake more than a retrospective review using the test of reasonableness.

Examining the patient records and talking to families and clinical staff after so many years since the events took place had its limitations.

- 10.111** The diagnostic process was pertinent to all the clinical services that the patients in the patients in the Investigation Cohort encountered. Therefore whilst this Investigation was commissioned primarily to examine patient care and treatment on Tawel Fan ward, it is important to understand that the issue of diagnostic practice and process is not something that can be applied to Tawel Fan ward in isolation.

### **Patient and Family Experience**

- 10.112** The Investigation Panel concludes that the 29 families who raised concerns provided valuable insights into how services should be provided in future in relation to communication, information exchange and support.
- 10.113** Their accounts make for challenging and difficult reading. It is evident that many individuals are still deeply affected by their experiences. To this day some family members suffer from guilt because they feel they should have been able to do more to support their loved ones. Others remain angry about what they perceive to have been an uncaring service which did not support them appropriately at the outset of their journey with dementia.
- 10.114** The Investigation Panel concludes that services, and the BCUHB employees who worked in them, sought to provide both information and support to patients and families alike in a professional and caring manner. Indeed there are examples of very good practice to be found.
- 10.115** However there was a gap between patient and family need and the ability of service to deliver it. This gap in service is still apparent across most of Wales and is one of Welsh Government's key targets to address in its 2017-2021 dementia strategy.

### **Clinical Practice**

- 10.116** Based on the evidence from 105 sets of clinical records the Investigation Panel concludes that just over 10 percent of the patient cohort was subject to a very high standard of diagnostic process. For example, there was evidence of good multidisciplinary working with neurology services, movement disorder clinics, psychology, and tertiary services to determine a full diagnostic picture.
- 10.117** Regardless of any omissions in relation to clinical formulation 78 percent of the patient cohort received a good general level of diagnostic input in keeping with NICE guidance.
- 10.118** As has already been stated; diagnosing a dementia and its subtype can be a difficult process especially in the early stages. Clinical witnesses gave robust explanations in relation to their practice; however the Investigation Panel concluded that on balance there still remained *circa* 12 percent of the 105 patients in the cohort under examination who were not managed in an optimal manner. This related to:

- significant delays in reaching a diagnosis (primarily in memory clinics): and/or
- diagnoses given which later had to be changed): and/or
- cases where further more intensive testing was indicated; (memory clinics and Tawel Fan ward).

**10.119** The Investigation Panel concluded that the patient cases where there were delays in diagnostic process and/or incorrect diagnoses given were largely avoidable had all due process been followed at the time. The Investigation Panel also concluded that the cases where more intensive testing was indicated (for example where there was complexity of presentation and/or extreme disinhibition or aggression) should automatically have triggered more detailed neurological examinations.

**10.120** It has been difficult to determine the extent to which the clinical outcomes of the 12 percent of patients might have been affected based on diagnostic process alone. However the Investigation Panel could not ascertain any significant omissions in the care and treatment provided that a more optimal diagnostic process might have prevented. Neither could it be ascertained that any patient was placed at risk by any active care and treatment decisions based on an incorrect diagnosis. This is examined in more detail in the Medication and Treatment chapter subsection of the report.

**10.121** A 12 percent figure could be perceived to be high but should be considered in context. It is important to understand that the Investigation patient cohort was selected because potential problems with care and treatment had already been identified through one route or another – hence the need for this investigation. Patient cases where care and treatment raised no cause for concern were (by default) not examined.

**10.122** To set any figures in perspective it should be understood that central north Wales memory clinics assessed *circa* 1,200 new patients between January 2011 and December 2013 (which is the main period of time under investigation). The Investigation worked with a particular sample where specific issues had been identified and which might not be representative of the wider 1,200 strong patient cohort. It would therefore be incorrect to assume that this specific 12 percent figure can be generalised across either central north Wales in particular or BCUHB in general.

### **Underlying Factors: Root Cause Analyses**

**10.123** Areas that were not optimal combined systemic, local service, and individual practitioner factors. It is important to understand which factors were in play so that recommendations and actions for service improvement can be targeted appropriately. Appendix 3 provides information about root cause analyses factors.

### ***Family Communication and Support***

**10.124** There are a diverse range of factors to consider when understanding why the patient and family experience was suboptimal for so many people. There were the obvious gaps in service provision which meant that there was a lack of sustained follow up and support. However a dementia diagnosis is challenging to

communicate, especially when it is given to a person whose memory is beginning to fail and levels of cognition are declining. In addition families are often in a state of shock and have to take on a great deal of information in order to start reframing their lives. It should also be understood that health and social care practitioners need to be skilled and competent in ‘breaking bad news’ and they need to be able to sustain relationships in a professional manner when emotions run high and extreme levels of distress are present. The identified factors are:

- organisational (in relation to service provision);
- communication;
- education and training;
- patient and family.

### ***Documentation and Clinical Recording***

**10.125** The factors in relation to documentation access and clinical recording are entwined together. The lack of an electronic record meant that assembling clinical information relating to both medical and psychiatric history was often challenging. In addition clinical staff had to write *circa* 95 percent of the clinical record entries by hand; this was time consuming and often lent itself to a ‘shorthand’ style of clinical entry. When taken together sufficient diagnostic information was often either unavailable or not recorded in enough detail.

**10.126** The difficulties identified in relation to clinical record access and development rest largely with the system. This was a key causal factor when understanding why there were often gaps in the clinical record pertaining to history and baseline assessment. Another systemic factor was the lack of standardised documentation used by services. From the records examined (by and large) there was a ‘blank sheet’ upon which to write. This meant that there was great variation in both the content and quality of the clinical record entries made. The Investigation Panel observed that some clinicians (doctors, nurses and occupational therapy in particular) wrote better clinical entries than others; they also conducted better holistic baseline assessments. The lack of standardised documentation and overarching assessment process is a systems issue especially as there appeared to be no overarching audit or supervisory process. The identified factors are:

- organisational (in relation to records systems);
- communication (professional communication challenges);
- education and training;
- task (procedures and protocols);
- individual practitioner;
- working conditions.

### ***Holistic Baseline Assessment – Culture and Ethos***

**10.127** The overall underdevelopment of a holistic baseline assessment which set the patient into their particular social context, speaks to local service and individual practitioner factors as over time alternative opportunities arose to gather this information but often seemed to take a somewhat ‘second place’ to more

specialised clinical examinations and tests. It would appear that to a large extent this was a genuine ‘blind spot’ during the diagnostic process.

**10.128** In 2018 services are focusing on “*living well with Dementia*” in keeping with Welsh Government and the Alzheimer Society’s vision for the future. During the period of time under Investigation this ethos was not so well developed and potentially not so well understood. The identified factors are:

- organisational (in relation to strategy and leadership);
- task (procedures and protocols);
- education and training.

### ***Differential Diagnosis and Clinical Formulation***

**10.129** As has already been mentioned, there was a virtual absence of differential diagnosis consideration or formulation in the clinical records under review. The factors in play appear to have been local service and individual practitioner based as the Investigation Panel noted that new clinicians coming in from other organisations external to BCUHB would consider differential diagnosis and would also write formulations when undertaking assessments. The identified factors are:

- task factors;
- team factors;
- individual factors.

### ***Geographical Issues and Continuity of Care***

**10.130** The population across north Wales is scattered over a large geographical area. Patients might live in one of the six north Wales counties, be admitted for inpatient care to another and eventually discharged to a care home placement in yet another. This movement of patients challenges continuity of care as there can be multiple changes to care and treatment teams, it also places pressure upon access to readily available clinical information. This is a systemic and multiagency issue across north Wales and is an important underlying factor when considering both the ongoing support of patients and families and information exchange. The identified factors are:

- organisational (and wider system);
- communication (professional liaison processes);
- task.

### **Key Lessons for learning**

**10.131** The main lessons for learning are:

- 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 families 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 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.
- 4 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.

- 5 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.
- 6 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.

## Medication, Therapy and Treatment: Mental Health

### Context

**10.132** This chapter subsection builds upon the information provided in the diagnosis section above. The importance of following robust diagnostic process together with comprehensive physical and psychological assessment is essential prior to medication and treatment being given.

#### Best Practice Guidance: Alzheimer’s Society

**10.133** The Alzheimer’s Society produced its *Optimising Treatment and Care for People with Behavioural and Psychological Symptoms of Dementia: a Best Practice Guide for Health and Social Care Professionals* in 2011. This guidance was in place for most of the period of time under investigation. It brought together in one place a systematic, person-centred care and treatment framework.

**10.134** The guidance stressed the need for a multi-faceted approach to the care and treatment of people with dementia and focused upon the potentially serious, adverse effects of antipsychotics.

*“More than 90 per cent of people with dementia will experience BPSD as part of their illness ... pharmacological interventions, and in particular antipsychotic medication, are often used as a first line treatment. While atypical antipsychotics do confer modest benefits in treating aggression and psychosis over 6-12 weeks, they are associated with a number of adverse outcomes and side effects”.*<sup>70</sup>

**10.135** The guidance went on to say that (in 2011) 180,000 people with dementia were receiving antipsychotic medication across the United Kingdom and that it was estimated this had led to 1,800 associated strokes and 1,600 associated deaths each year.

**10.136** The method advocated was a stepped model where a preventative and a careful “*watch and wait*” approach was taken. This approach advocated person-centred assessment, symptom identification and psychosocial interventions. Pharmacological treatment was to be considered only when all other interventions had been shown to be ineffective.

**10.137** Once the need for antipsychotic medication was indicated the guidance advocated a careful documentation of target symptoms prior to prescribing, with a close monitoring of efficacy and side effects after prescribing. This was to be managed by specialist clinicians who would review benefits and risks on a daily basis.

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<sup>70</sup> Alzheimer’s Society (2011) *Optimising Treatment and Care for People with Behavioural and Psychological Symptoms of Dementia: A Best Practice Guide for Health and Social Care Professionals* P4

## United Kingdom Best Practice Guidance: Medication and Treatment

### *United Kingdom*

**10.138** Whilst it is not a legal requirement for prescribers to adopt the guidance provided by NICE it is considered to be good practice. The main guidance relating to the management of persons with dementia is NICE Guidance CG42, *Dementia: Supporting People with Dementia and their Carers in Health and Social Care* (2006). The guidance makes clear the importance of a person-centred approach when providing care and treatment:

*“There is broad consensus that the principles of person-centred care underpin good practice in the field of dementia care and they are reflected in many of the recommendations made in the guideline. The principles assert:*

- *the human value of people with dementia, regardless of age or cognitive impairment, and those who care for them*
- *the individuality of people with dementia, with their unique personality and life experiences among the influences on their response to the dementia*
- *the importance of the perspective of the person with dementia*
- *the importance of relationships and interactions with others to the person with dementia, and their potential for promoting well-being”.*<sup>71</sup>

**10.139** The sections of CG42 of particular relevance to medication and treatment are as follows:

**a) Interventions for cognitive symptoms and maintenance of function for people with dementia (Section 1.6).**

This section provides guidance on attendance at group cognitive stimulation programmes and discusses the appropriate use of acetylcholinesterase (AChE) inhibitors such as Donepezil, Rivastigmine and Galantamine and also Memantine.

**b) Interventions for non cognitive symptoms and behaviour that challenges in people with dementia (Section 1.7).**

This section discusses both non pharmacological and pharmacological interventions that can be used for people exhibiting Behavioural and Psychological Symptoms of Dementia (BPSD). It encourages carers and clinicians to view the person holistically before resorting to drug therapy. It advocates the use of treatments such as aromatherapy, massage and multisensory stimulation in the first instance.

If psychotropic medication is used then the guidelines state that target symptoms should be identified and documented. There should be regular monitoring of any changes to the target symptoms which should be recorded and reviewed on a regular basis.

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<sup>71</sup> National Institute for Health and Clinical Excellence (2006) *Dementia: The NICE – SCIE Guidelines on Supporting People with Dementia and their Carers in Health and Social Care*

**c) Behaviour that challenges requiring urgent treatment (Section 1.7.3)**

This section describes methods of avoiding escalation into aggression and recommends de-escalation and means of safe restraint. Should these interventions fail and the use of drug therapy or rapid tranquillisation (RT) become necessary it recommends that staff are trained in the use of the appropriate drugs and are knowledgeable about the potential risks associated with them.

**10.140** Professional and regulatory bodies also provide guidance to health professionals. These bodies include the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). For psychiatrists there is also the guidance provided by the Royal College of Psychiatrists.

**Responsibilities of Prescribers (mainly doctors for the cohort under investigation)**

**10.141** The GMC provides extensive guidance to support doctors in maintaining good standards of prescribing. A concise summary from the *Good Medical Practice* (August 2013) and *Good Practice in Prescribing and Managing Medicines and Devices* (February 2013) is as follows:

- prescribers should keep up-to-date and only prescribe where competent to do so;
- before prescribing the prescriber should have a good knowledge of the patient (diagnosis, comorbid conditions and other prescribed and over the counter medications);
- the prescriber should be aware of drug reactions and any associated risks (seeking advice when necessary);
- prescribers should keep contemporaneous records;
- all medicines (but especially those prescribed for frail elderly people with multiple conditions) should be reviewed frequently to assess benefits, side effects and need to continue;
- at the point of discharge or transfer all measures should be taken to ensure safe continuity of care.

**Responsibilities of Nurses Administering Medication**

**10.142** Guidance for nurses is currently provided by the Nursing and Midwifery Council. Individual healthcare organisations will also have their own standards which their staff are obliged to comply with. Below is a concise summary of the NMC *Standards for Medicines Management* (2010). Standard 8 states that nurses should:

- know the therapeutic uses of the drug to be administered, its normal dosage, side effects, precautions and contraindications;
- check that the prescription is clear and unambiguous;
- administer or withhold in the context of the patient's condition (where a drug is withheld the reasons must be recorded);
- contact the prescriber without delay where contraindications to the medicine are discovered, the patient has a reaction to the medicine, or assessment suggests the medicine is no longer suitable;
- make a clear, accurate and immediate record of administered medicines, withheld medicines and those refused by the patient.

## **Responsibilities of Pharmacists**

- 10.143** The professional and practice responsibilities of pharmacists working in hospital environments were first set out formally in 2012 by the Royal Pharmaceutical Society of Great Britain.<sup>72</sup> Pharmacist input should aim to maintain patient safety in terms of medicines use and to optimise treatment. In most inpatient settings these objectives are met by ward visits, attendance at multidisciplinary meetings, and contact with prescribers and other relevant staff. Oversight of prescribing also takes place in the dispensing pharmacy where prescriptions will be checked prior to dispensing and supplying drugs.
- 10.144** Pharmacy departments will usually be responsible for developing policies relating to the use of drugs in line with legislative frameworks and best practice guidance and will also contribute (where appropriate) to the development of treatment algorithms in collaboration with colleagues from other disciplines.

### ***BCUHB Policy Guidance***

- 10.145** The policies viewed by the Investigation Panel were in use principally between 2009 and 2013; it was not possible to assemble a full set of policies for the period under investigation.
- 10.146** Of those that were available it was noted that they applied in general to the relevant national guidance in place at the time; however there were some limitations. National guidance provides a basic minimum set of recommendations; it does not usually provide the level of detail required to support hospital staff when conducting their clinical duties.
- 10.147** The BCUHB policies that were viewed did not always provide specific information and were non-directive in places being advisory rather than definitive. This meant that they could have been difficult to interpret leading to a potential variation in practice standards. Another issue identified was that several policies had not been updated or reviewed within the timeframes required.

## **Medications and their Uses**

### ***Risks***

- 10.148** The use of drugs in any area of medicine and for any population is never without risk. All drugs have the potential to cause side effects which will pose varying levels of risk and harm. These effects are generally more likely and extreme in older people because of decline in physical resilience across all systems.
- 10.149** The prescribing of drugs should always be a balance between risks and benefits; sometimes the risk of giving a person medication can be considered necessary. For example: when a person with dementia is significantly violent or aggressive (and also poses a risk to their own safety and wellbeing) any risk of side effects might be considered more acceptable than the risk of harm due to behaviour. In this kind of situation it is the responsibility of the treating team in

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72 Royal Pharmaceutical Society of Great Britain (2012) *Professional Standards for Hospital Pharmacy Services*

collaboration with other properly concerned parties (such as family members) to reach a conclusion on where the balance lies.

**10.150** Drug treatments for people with dementia is complex for a number of reasons:

- older people frequently have multiple physical conditions being treated alongside their dementia; this increases the risk of drug interactions;
- the psychotropic drugs used may also adversely affect the stability of any physical conditions;
- psychotropic drugs have many side effects that are not helpful to older people with less physical resilience;
- many of the drugs utilised are not specifically licensed for the treatment of symptoms that arise in dementia.

### ***Off Licence Usage***

**10.151** Many drugs are used ‘off licence’ or ‘off-label’ when treating people for the effects of dementia. The use of drugs ‘off-license’ or ‘off-label’ occurs when a drug is prescribed and administered outside the terms of its Marketing Authority. For example: Risperidone is the only antipsychotic licensed for the treatment of dementia but others (such as Olanzapine and Quetiapine) are also used because their particular side effect profile can be more favourable. The lack of licensing generally means that no robust trials have been done by the company producing the drug. In the United Kingdom it is considered reasonable to utilise off licence drugs provided that:

- the prescriber is aware of this and accepts the additional responsibilities;
- the employing organisation is aware of the practice and sanctions it; and
- there is a good enough body of peer evidence and opinion to support it.

### ***Drug Treatments for Dementia***

**10.152** There are few drugs currently available for the treatment of the actual process of dementia. Those that are available are only effective for certain conditions.

**10.153 Alzheimer’s Disease:** is considered to be caused by two main processes; structural change to key pathways in the brain, and a reduction in the production of the neurotransmitter or chemical messenger *acetylcholine*. Together these two processes cause a reduction in the ability of the person to process and remember information.

**10.154** The reduction of acetylcholine seen in Alzheimer’s disease can be compensated by the use of drugs such as Donepezil (Aricept®), Galantamine (Reminyl®) and Rivastigmine (Exelon®). As a group they are called cholinesterase inhibitors because they have the common action of preventing the breakdown of any available acetylcholine thus prolonging and enhancing it’s activity. These drugs will only have benefit whilst there is enough acetylcholine being produced. The nature of dementia is that there is a fault in the production of acetylcholine. Consequently as this process naturally progresses, there will not be adequate amounts for the brain to function regardless of the conserving powers of the

drugs. This is why these drugs can only slow down cognitive decline and do not stop the underlying degenerative process.

- 10.155** Because many dementias are considered to be mixed, it is not unusual for the cholinesterase inhibitors to be offered to those with other dementias, in the hope that the Alzheimer's component will benefit. The cholinesterase inhibitors are not without side effects and these include slowing of heart rate, cardiac arrhythmias, stomach ulcers, abdominal pain and appetite changes amongst others. The side effects can be too troublesome for many people and this gives rise to a high rate of withdrawal from treatment.
- 10.156** Memantine is another drug used in the treatment of dementia. It has a different action to that of cholinesterase inhibitors in that it helps to prevent the death of nerve cells, thus conserving function. Memantine is licensed for the treatment of moderate to severe Alzheimer's, or earlier in those unable to tolerate cholinesterase inhibitors.
- 10.157 Dementia with Lewy Bodies (DLB):** resembles Parkinson's disease in that it affects parts of the brain associated with movement. People with DLB often have problems with movement control that are seen quite early in the illness. There is no particular treatment for those with DLB at this time. People with DLB often have profound side effects to antipsychotics because they are very sensitive to the extrapyramidal effects caused by these drugs.
- 10.158 Vascular Dementia:** is caused by changes to the blood vessels in the brain which usually arise because of cardiovascular disease which affects the body as a whole. People with vascular disease are likely to be treated with drugs to lower cholesterol, control blood pressure and prevent blood clots from forming. It is generally the formation of blood clots in the brain which gives rise to areas of cell death due to blockages in blood flow. In terms of treatment of the dementia itself, there is no specific treatment currently available.

#### ***Non Cognitive or BPSD Symptoms***

- 10.159** Alongside the memory and other cognitive problems seen in dementia can be those of agitation, depression, disinhibition and violence. There can also be delusions, hallucinations and sleep disturbance. It is these symptoms of dementia which cause many difficulties for the carers and sufferers of dementia in terms of management and the maintenance of safety. The management of these symptoms are usually treated using psychological and pharmacological (drug treatment) methods.
- 10.160** The drugs used are generally those for the treatment of psychiatric illness. They include antipsychotics, antidepressants, mood stabilisers, benzodiazepines and other hypnotics. It is also common to attempt to manage these symptoms with the aforementioned cholinesterase inhibitors and Memantine. The evidence base in terms of the efficacy and safety of these drug classes (commonly used to manage BPSD) is generally poor. The use of the psychotropics is therefore controversial and most of the drugs utilised are not specifically licensed for use in dementia.

**10.161 Antipsychotics:** the use of antipsychotic medication remains controversial. The Alzheimer's Society has this to say:

*“Drug trials have shown that risperidone has a small but significant beneficial effect on aggression and, to a lesser extent, psychosis for people with Alzheimer's disease. These effects are seen when the drug is taken for a period of 6–12 weeks.*

*Antipsychotic drugs may be prescribed for people with Alzheimer's disease, vascular dementia or mixed dementia (when it is usually a combination of these two). If a person with Lewy body dementia (dementia with Lewy bodies or Parkinson's disease dementia) is prescribed an antipsychotic drug, it should be done with the utmost care, under constant supervision and with regular review. This is because people with Lewy body dementia, who often have visual hallucinations, are at particular risk of severe adverse (negative) reactions to antipsychotics”.*<sup>73</sup>

**10.162** The Alzheimer's Society also states that:

*“The risks and benefits of taking an antipsychotic should always be discussed with the person with dementia, where possible, and any carer. The first prescription of an antipsychotic should only be done by a specialist doctor. This may be an old-age psychiatrist, geriatrician or GP with a special interest in dementia. The doctor should explain the alternatives, the symptoms that are being targeted, and plans to review, reduce and stop the antipsychotic”.*<sup>74</sup>

**10.163** The main indication and licensing for the use of antipsychotics is the treatment of psychotic disorders. The common mode of action across all this class is the ability to block or modify the activity of the neurotransmitter *dopamine*. It is postulated that the symptoms of psychosis such as hallucinations, delusions and thought disorder arise as a result of too much dopamine activity in the limbic area of the brain. Therefore reducing dopamine in this pathway should, and indeed in many cases does, improve these symptoms. Reduction of dopamine occurs in other pathways where the effect is not wanted and this causes well known side effects of antipsychotics.

**10.164** Side effects of antipsychotics include anticholinergic effects such as dry mouth, blurred vision, constipation, urinary retention, fast heart rate and cognitive impairment. There are also effects on blood pressure control, usually causing a drop in blood pressure and levels of sedation. Extrapyrimal symptoms (EPSEs) generally fall into the domains of Parkinsonian effects (tremor, stiffness, slowing of movements, mask like face), dystonic reactions (muscle spasms that can affect any muscle group and may increase the risk of choking), akathisia (a feeling of inner restlessness, often seen as increased agitation and aggression) and tardive dyskinesia (facial grimacing, tongue protrusion and rocking). A further significant effect of the antipsychotics is that they can affect heart rhythm, causing arrhythmias which have been associated with cardiac arrest and sudden death.

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<sup>73</sup> [https://www.alzheimers.org.uk/info/20162/drugs/106/drugs\\_used\\_to\\_relieve\\_behavioral\\_and\\_psychological\\_symptoms/5](https://www.alzheimers.org.uk/info/20162/drugs/106/drugs_used_to_relieve_behavioral_and_psychological_symptoms/5)

<sup>74</sup> [https://www.alzheimers.org.uk/info/20162/drugs/106/drugs\\_used\\_to\\_relieve\\_behavioral\\_and\\_psychological\\_symptoms/5](https://www.alzheimers.org.uk/info/20162/drugs/106/drugs_used_to_relieve_behavioral_and_psychological_symptoms/5)

- 10.165** As time progresses it is becoming evident that antipsychotics as a class are associated with increased incidence of blood clots, pneumonia (caused by aspiration and possibly choking) in addition to their well known effects of weight gain, diabetes, cholesterol increase, and cardiovascular disease. People with DLB are particularly prone to Extrapyramidal symptoms and in extreme cases they can be life threatening.
- 10.166** However there is a role for antipsychotic medication for people with dementia especially in acute psychiatric hospital environments when behaviour can be extremely aggressive and challenging. In such circumstances the *British National Formulary* states that Risperidone should be considered for “*Short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer’s dementia unresponsive to non-pharmacological interventions and when there is a risk of harm to self or others*”. There is a requirement to keep the prescription under review.
- 10.167** The NICE 2006 guidance states that if antipsychotic medication is to be used then the following conditions need to be met:
- *“There should be a full discussion with the person with dementia and/or carers about the possible benefits and risks of treatment. In particular, cerebrovascular risk factors should be assessed and the possible increased risk of stroke/transient ischaemic attack and possible adverse effects on cognition discussed.*
  - *Changes in cognition should be assessed and recorded at regular intervals. Alternative medication should be considered if necessary.*
  - *Target symptoms should be identified, quantified and documented.*
  - *Changes in target symptoms should be assessed and recorded at regular intervals.*
  - *The effect of comorbid conditions, such as depression, should be considered.*
  - *The choice of antipsychotic should be made after an individual risk–benefit analysis.*
  - *The dose should be low initially and then titrated upwards.*
  - *Treatment should be time limited and regularly reviewed (every 3 months or according to clinical need)”.*<sup>75</sup>

## **Benzodiazepines**

- 10.168** These drugs are used for the treatment of agitation, aggression and sleep disturbance. The group includes Diazepam, Lorazepam and Temazepam amongst others. Although they are commonly used in dementia, there is a lack of formal evidence for their efficacy. It is recommended by the Maudsley Guidelines that they are avoided when possible.
- 10.169** Benzodiazepines are sedative and can contribute to falls and hip fractures and have been associated with cognitive decline. They can also cause an effect known as ‘paradoxical disinhibition’ which means that instead of the drug having the desired and intended result of calming the person and reducing aggression,

<sup>75</sup> National Institute for Health and Clinical Excellence (2007) *Dementia: The NICE – SCIE Guidelines on Supporting People with Dementia and their Carers in Health and Social Care*

they become more aggressive and agitated. This is more likely to occur in people with brain injury or brain changes, such as those with dementia.

**10.170** However, under some circumstances (such as when an individual is highly distressed) it can be reasonable and appropriate to trial a benzodiazepine. Provided this is done with close attention to the effects in terms of benefits and risks and the drug use is kept to a minimum in terms of dose, frequency and duration, it can be beneficial.

### **Antidepressants**

**10.171** Depression is commonly seen in association with dementia and may worsen the cognitive decline caused by dementia. Treatment of depression may therefore improve cognitive functioning. Specific Serotonin Reuptake Inhibitors (SSRIs) such as Sertraline and Citalopram are generally used and may also improve symptoms of agitation.

### **Other Interventions and Treatments**

**10.172** The NICE 2006 guidance recommended a wide range of interventions and treatment for people with dementia. These include:

- access to respite and short break services;
- day care (for example: day hospitals) and night sitting;
- meaningful therapy activity provided in an environment that meets the individual's needs;
- structured group cognitive stimulation programmes;
- aromatherapy;
- multisensory stimulation;
- therapeutic use of music and dancing;
- animal assisted therapy;
- massage;
- reminiscence therapy;
- counselling;
- psychological therapies (for example: cognitive behaviour therapy).

## **Findings: The Family Experience**

**10.173** 29 families raised concerns in relation to psychotropic medication. These concerns focused upon practice specifically related to Tawel Fan ward. The concerns can be set in context when considered in conjunction with the issues examined above in the diagnosis section of the report.

**10.174** Table 3 below provides a synopsis of the concerns raised; it should be noted that several families raised more than one.

**Table 3**

<b>Type of Concern Raised</b>	<b>Numbers</b>
Lack of timely prescribing (in particular for physical conditions – antibiotics and statins)	<b>3</b>
Poor medication cessation and changes to medication regimens	<b>1</b>
Inappropriate prescribing and suitability of medication in relation to diagnosis (for example: the use of off license prescribing)	<b>7</b>
Poor management of compliance and use of the covert medication policy	<b>1</b>
Administration: omission and method	<b>4</b>
Side effects and over sedation	<b>11</b>
Medication leading to an increased incidence of falls	<b>2</b>
Medication which might have led to a general decline and/or death	<b>8</b>
Medication given without family consent and/or full explanations being given	<b>Most of the sample</b>
Medication errors	<b>1</b>
The lack of psychological therapy	<b>1</b>

### **Initial Family Communication and Treatment plans**

**10.175** Family concerns were often associated with the circumstances regarding their loved ones admission to Tawel Fan ward. Two main scenarios were evident:

- crisis admission from the community (either from the patient’s own home or from a care home setting);
- transfer from community hospitals, medical or surgical wards.

**10.176** At the point of admission to Tawel Fan ward families were trying to support their loved ones who were often agitated, aggressive, confused and disinhibited. For most patients their presentation had become so challenging that admission to an acute psychiatric assessment ward was considered to be the only viable option in order to maintain the safety and wellbeing of all concerned. Admission was usually required for a general psychiatric assessment and medication review.

**10.177** Families described situations whereby the crisis (and ensuing decision to admit) had happened ‘very quickly’. They were often confused about why their loved ones had deteriorated and how long the admission to Tawel Fan ward would be for. Many families told the Investigation Panel that they had assumed admission would only need to be for a week or so. They also assumed that any medication changes would have a relatively immediate and positive effect which would automatically lead to a discharge back home.

- 10.178** In the event this was seldom the case. Patients were usually in the moderate to advanced stages of their dementia accompanied by complex comorbidities. Following admission families did not always understand:
- 1** The need for psychotropic medication to manage the acute presentations of their loved ones (agitation, disinhibition and violence).
  - 2** The progressive nature of their loved one's dementia and the limited efficacy (and purpose of) of any ongoing medication regimen.
- 10.179** It is evident meetings with families were held on a regular basis on Tawel Fan ward and that general medication issues were discussed. It is also evident that the use of antipsychotic medication (such as Risperidone) and the subsequent risks were also discussed with families and (where appropriate) consent sought. However the clinical records did not detail the level and extent of the information exchange.
- 10.180** With the benefit of hindsight families reflected that these family meetings (and the way they were managed) had not always been sufficient to ensure that they understood all of the issues in enough depth; hence their continued concerns and levels of anxiety. Families could not (and to an extent still cannot) understand why their loved ones presented in the manner that they did, why certain interventions were needed and why (despite a hospital admission) they still either continued to decline or died.

## **Concerns about Medication Choices and Sedation**

### ***Medication Choices***

- 10.181** A key issue raised with the Investigation Panel was that of medication choices. It should be understood that whilst some families raised these issues with members of the Tawel Fan treating team at the time their loved ones were on the ward, others did not. Many families had been satisfied with the choices that had been made – however in the light of the high media interest in Tawel Fan ward (and the reported issues about mortality) they had begun to question them retrospectively.
- 10.182** Subsequently several of the families browsed the internet in a quest for information. In the main families found their research (which yielded lists of side effects and potential risks) very upsetting and difficult to understand. In addition some families were alarmed to read that several medications had been prescribed 'off license' assuming that this was, in the words of one family, "*reckless practice*".
- 10.183** Most of the families in this sample wanted the Investigation Panel to explain to them whether or not their loved ones had been harmed as a result of the medication choices made and also wanted to know if prescribing practice had followed nationally accepted good practice guidance.

### *Sedation*

- 10.184** 11 families raised specific concerns in relation to over sedation querying whether the correct choice and dosage of medication had been prescribed. Very few families suggested that medication had been used as a ‘chemical cosh’, however three families described excessive salivation and, what was in their view, an ‘altered state of consciousness’ whereby their loved ones were extremely confused, drowsy or acting out of character. In addition two families also queried whether medication might have led to an increased rate of falls.
- 10.185** From a close examination of the clinical records it can be determined that when families had raised their concerns with ward staff directly those conversations had been recorded contemporaneously and discussed by the wider treating team. As a result medications were often reviewed and adjusted. This was good practice.
- 10.186** However the family experience as described to the Investigation Panel would indicate that (in their view) this was not always the case. Concerns about sedation were not always managed or resolved in a manner that left families feeling confident in the medication choices that were made.

### **Concerns about General Decline and Potential Contribution to Death**

#### *General Decline*

- 10.187** Patients were usually admitted to Tawel Fan ward because they were in crisis; admission would be against a backdrop of general decline in both physical and mental states. Due to a combination of factors patients would often appear to experience a period of further decline once on Tawel Fan ward. This was often due to:
- the natural ongoing progression of the dementia;
  - an acute event (such as a small stroke) which led to a significant change in presentation;
  - an infection or other co-existing physical illness such as cancer or coronary heart disease etc.
- 10.188** As has already been discussed, families did not always understand the psychiatric diagnosis or any other comorbid conditions that affected their loved ones. Consequently many of the families in this sample suggested that medication (rather than any other reason) was the main cause for decline.
- 10.189** When this was explored with families it became evident that medication was the one factor they could usually identify as being ‘new’. At this stage families were still hopeful that hospital admission would somehow ‘turn things around’ and that the distressing symptoms their loved ones were exhibiting could be reversed and actively treated. This is a key point: expectation did not match the reality of the situation; medication was used primarily to manage and lessen the symptoms, not cure the underlying causes.

- 10.190** The notion of ‘decline’ was varied. Some families described decline in relation to an increase in aggressive behaviour which peaked on Tawel Fan ward and then appeared to decrease following discharge. The concern raised was that the medication might have caused the agitation which then disappeared on discharge once the treatment plan had been reviewed. Families did not always understand that patients were discharged because their aggression and challenging behaviour had abated and that consequently medication could be reviewed and decreased accordingly. It was evident that families had not had this explicit cause and effect relationship of behaviour, medication and review explained to them in a way that they had understood.
- 10.191** Other families described decline in relation to increasing physical frailty, loss of cognition and mobility. These families expressed their concerns about medication potentially having ‘speeded up’ the progression of the dementia causing an earlier loss of both function, and in some cases, life expectancy.
- 10.192** Families told the Investigation Panel that they wanted the potential impact medication might have made to any decline examined and explained to them.

### ***Potential Contribution to Death***

- 10.193** Of most concern were the issues raised in relation to medication and potential cause of death. Six families made direct allegations in this regard. Some of these families had pre-existing concerns and others had theirs raised by the findings of the BCUHB Mortality Review which had been shared with them.
- 10.194** Families asked the Investigation Panel to provide a detailed explanation as to what had occurred and why. These explanations are provided in full in the confidential patient reports prepared as part of the Wales *Putting Things Right* process. This report does not discuss individual patient cases but addresses the specific themes and lessons for learning that have been identified from the examination of them.

### **Compliance, Consent and Lasting Power of Attorney**

- 10.195** It is quite common for patients to refuse medication on occasions; especially when they are confused and uncertain about what they are being offered. Families (with one exception) did not raise specific concerns about the use of the covert medication policy; however several were uncertain as to why it had not always been used to greater effect.
- 10.196** This uncertainty went side-by-side with expectations about how medication should be prescribed and administered in general. It was evident that some families were confused about consent and capacity issues and what both they and their loved ones could either agree to, or refuse.
- 10.197** A small number of family members had a Lasting Power of Attorney. This sometimes raised additional uncertainty as it was not always clear what this was in relation to (financial matters or welfare) and how it could impact upon the clinical treatment decisions taken by the Tawel Fan treating team.

**10.198** In short: families were of the view that they had significant rights in relation to the decisions made about their loved one's care and treatment and that these had not always been recognised sufficiently; consequently they believe that their views and concerns had not always been taken into account in an appropriate manner.

### **Summary of Concerns**

**10.199** The families who raised concerns about medication and treatment had the following in common:

- genuine concerns that their loved ones might have come to harm as a result of medication choices;
- a sense of frustration that their preferences and views had not been taken into full account by the Tawel Fan ward staff;
- a lack of understanding about diagnosis and prognosis which might have hindered them when giving informed consent;
- feelings of anger, anxiety and guilt;
- general feelings of dissatisfaction with, and a lack of confidence in, the services managed by BCUHB.

## **Findings: Identified by the Investigation Panel**

### **Issues Relating to Bias**

**10.200** The Investigation Panel was tasked to assess the quality and reasonableness of medication, therapy and treatment practice in relation to the 105 patients in the Investigation Cohort found to be relevant to this subject. The concerns raised (and allegations made) by families were directly in relation to practice on Tawel Fan ward. The Investigation Panel focused its primary attention on Tawel Fan ward for this reason and also because this was the place where most psychotropic medications were prescribed.

**10.201** The Investigation Panel also assessed prescribing practice in Memory Clinics and Community Mental Health Teams for the patient cohort prior to admission to Tawel Fan ward. This was all found to be unremarkable and in accordance with national guidance. Due to the paucity of content in the clinical records it was not possible to determine what kind of psychosocial and psychological therapy inputs were provided in the community. This is unfortunate as it would appear (from the limited information available) that psychological therapy and psychosocial interventions were routinely available for many patients. In the interests of balance it would have been useful to have been able to understand this in more detail; however there was not enough information to make a meaningful examination possible.

**10.202** The Investigation Panel also found the quality of the clinical record post discharge from Tawel Fan ward to be limited in content. However every attempt has been made to chart the continued medication history for each patient in order to assess both prescribing practice and the impact that it continued to have.

## Background and Context

- 10.203** It has not been possible to place findings into straightforward ‘optimal’ and ‘suboptimal’ divisions in relation to clinical practice. The picture that emerged was multifactorial and at times inconsistent.
- 10.204** It is important to state at the outset that the Investigation Panel found, in general, the use and choice of psychotropic medication on Tawel Fan ward fell within United Kingdom good practice parameters for the client group. Prescribing was found to be both appropriate and reasonable for the majority of patients. There were five principal Psychiatrists who were prescribers for the patients on Tawel Fan ward; no specific issues were identified in relation to individual practitioner practice.
- 10.205** That being said there were instances where both prescribing and administration practice could have been more robust. There was also a virtual absence of non-pharmacological therapy and treatment provided to patients once on Tawel Fan ward; this was a significant omission in view of the particular needs and challenges they presented with. This lack of a holistic therapy and treatment approach served to place undue emphasis on traditional medically-led pharmacological interventions.
- 10.206** It should be taken into account that the patient profile on Tawel Fan ward was extremely varied ranging from cohorts of relatively young male patients in their 50s and early 60s, to cohorts of the frail elderly (both men and women) in their 80s and 90s. Physical strength, general health and levels of Behavioural and Psychological Symptoms of Dementia (BPSD) varied enormously. Some of the patients were extremely challenging and difficult to manage due to their disinhibition and extreme aggression; these patients were often within the age range for those usually found on adults of working age wards. Other patients were extremely frail and vulnerable, whilst at the same time exhibiting behaviours that often challenged and provoked the younger more physically active and violent patients on the ward.
- 10.207** In short it is important to acknowledge that there can be no overarching ‘one size fits all’ interpretation of national and United Kingdom guidance and research when examining the care and treatment of such a diverse group of patients. The only common denominator is organic brain disease which in itself is an umbrella term embracing a wide variety of conditions and treatment options.

## High-Level Findings

- 10.208** High-level findings were identified as follows:

### *Medication*

- 1** Policies and procedures relating to medication, whilst adhering to national and United Kingdom guidance, did not always provide an adequate set of detailed directions to clinical staff. There were significant omissions in relation to guidance for the older person and poor clinical governance procedures in relation to audit, monitoring and review.

- 2 During the period under investigation specialist mental health pharmacists were often in short supply which meant their advice and day-to-day supervision was limited on wards like Tawel Fan.
- 3 Medication errors did not appear to have been investigated in keeping with BCUHB policy guidance.
- 4 Medication reconciliation processes appear to have been of a variable standard on admission to Tawel Fan ward. This led to medication errors and omissions for two patients.
- 5 Baseline clinical assessments did not always detail the target symptoms to be treated in a systematic manner. This meant that on occasions clinicians did not state what range of problems medication was supposed to effect and what specific symptoms each drug was hoped to modify.
- 6 In general all psychotropic medication appears to have been kept under regular review; this was good practice. However the clinical records do not always provide enough detail to explain the rationales as to why particular psychotropic medications were prescribed in the first place and how the risk/benefit assessment was conducted.
- 7 Medications were (on occasions) stopped and new ones started without any seeming understanding of the half life of the drugs involved and the potential consequences of this.
- 8 For a small number of patients side effects were not always recognised and managed in a timely enough manner.

### ***Therapy and Treatment (Inpatient)***

- 9 There is a virtual absence of reference to any other kind of therapy or treatment (either psychological or psychosocial) in the clinical records. Non-pharmacological interventions would appear to have been largely absent. There appears to have been restricted access to occupational therapy and physiotherapy services which prevented a holistic care and treatment approach from being taken.
- 10 Nursing care plans did not evidence how therapeutic and psychosocial approaches were taken in relation to:
  - the de-escalation of aggression;
  - person-centred care plans that detailed behavioural symptoms and the specific approaches that were needed;
  - person-centred care plans that detailed structured therapeutic interventions (such as cognitive stimulation, meaningful activities, life story work etc.).

### ***Family Communication and Patient Consent***

- 11 Communication and information exchange with patients and their families appears to have been conducted on a regular basis; however many families are of the view (on reflection) that this could have been managed better and that their views, concerns and wishes were not always taken into account.
- 12 Capacity, consent and Best Interests decisions were sometimes managed poorly in relation to medication choices.

### **Medication Policy Guidance**

#### ***Policy Guidance***

- 10.209** The Investigation Panel found it difficult to assemble a full range of policies relating to medicines management for the period of time under investigation. This was due in part to BCUHB being unable to find historic policies and also being unable to confirm that those supplied had all been through a corporate ratification process.
- 10.210** Not all of the policies provided were pertinent to, or within the precise timeframe for, the matters under investigation. The following policies were considered to be relevant and were reviewed by the Investigation Panel:
- MM02 Hospital Medicines Code (2011-2014);
  - BCUHB Antibiotic Compliance Measurement Tool (2011- no review date given on document);
  - MM12 Procedure for Medicines Errors (2015-2017);
  - MD03 Covert Administration of Medicines Clinical Protocol (2011-2014);
  - Form for Adults Unable to Consent to Investigation or Treatment (no date on document);
  - Delirium Guidelines (no date on document);
  - Protocol for Rapid Tranquilisation for adults 18-65 years (2009-2010);
  - Protocol for the Administration of Depot Medication (no date on document).

#### ***MM02 Hospitals Medicines Code (generically known as Medicines Policy)***

- 10.211** The purpose of an overarching Medicines policy is to describe the various governance functions and responsibilities that are required for the safe management of medicines within a healthcare organisation. The document should, as a minimum, provide direction on all the generic functions concerning the management of medicines and the professional responsibilities associated therein. These functions will include:
- the method of procurement of medicines by wards or departments;
  - their safe and appropriate storage;
  - prescribing standards requirements and procedures;
  - administration to patients standards and procedures; and
  - safe disposal of unwanted or date expired medicines.

**10.212** To achieve these objectives, the policy should be written with attention given to the Medicines Act (1968), Misuse of Drugs Act (1971) and all subsequent legislation. There will also be documents and directives produced by bodies such as the National Institute for Health and Care Excellence (NICE) and professional regulators that need to be taken into account.

**10.213** As a corporate governance tool the Investigation Panel found the Hospitals Medicines Code to be acceptable with broad guidance provided for the management of medicines. However several omissions weakened its ability to provide clear and definitive direction to clinical staff.

**10.214** Some areas of the policy suggest inadequate levels of responsibility and support on the part of the organisation. Other areas of the policy were not specific enough in keeping with what would usually be expected in a document of this kind. Limited guidance was provided in relation to:

- drug alerts;
- the process for reporting fraud;
- the use of unlicensed medicines;
- the secure storage of prescription pads;
- standards for prescription writing and cancellations;
- clarity on verbal prescriptions;
- standardisation of medicines storage;
- cold chain processes.

### ***Other Policies***

**10.215** The Covert Administration of Medicines Clinical Protocol (2011-2014) was well written and evidence-based. The document was concise and able to provide good levels of guidance and support to clinicians. It made suitable reference to the relevant legislation (the Mental Health Act (1983), the Human Rights Act (1998) and the Mental Capacity Act (2006)), and detailed the exact circumstances when covert medication could and should be used.

**10.216** Of particular concern was the Protocol for Rapid Tranquilisation (2009 – 2010) as this only made reference to adults of working age. The Investigation Panel remains unclear what policy guidance (if any) was in place for the older adult.

**10.217** The other policies reviewed ranged in quality. It was evident that the formation of BCUHB in 2009 had not led to a robust review of policy documentation across the provision. The Investigation Panel found that the policies appeared to have been drawn together without them necessarily being updated or written on appropriately headed paper; subsequently it was not always possible to determine who ‘owned’ the policies and how the corporate body ratified and monitored them. This situation appears to have continued for many years and was still an issue up until the time Tawel Fan ward closed.

**10.218** The Investigation Panel was told by senior BCUHB employees that current governance systems pertaining to medication policies remain underdeveloped. Problems are still ongoing and were identified as follows:

- 1** Accessing policies is difficult as they can only be found via the intranet; no hard copies are disseminated. This means that staff must be able to access a computer (which is sometimes difficult) and have access to an NHS Wales email account (which they sometimes do not have). Matters are not helped by the fact that the list of policies on the intranet is not complete.
- 2** After nearly eight years from the inception of BCUHB legacy issues still remain. Some policies are still developed in localities without formal corporate ratification.
- 3** Audit, monitoring and review processes remain inconsistent casting doubt on the acceptability of some of the policies currently in circulation.

### **Pharmacy Services**

**10.219** During the period of time under review witnesses told the Investigation Panel that there were fluctuating levels of specialist pharmacy input into mental health services.

**10.220** Historically there were two specialist mental health pharmacists working in BCUHB (a third post was commissioned relatively recently). They had to cover a large geographical area across north Wales which meant they could not spend a great deal of time in any one place. Over the years many business cases were presented to the Health Board but not supported.

**10.221** The main reason for the limited resource was the funding and service configuration model which meant that ring-fenced monies for mental health services did not include enough specialist pharmacy input.

**10.222** When Tawel Fan ward was open there was one specialist mental health pharmacist who covered the Ablett Unit together with all primary and community services in the central region. Services were provided to Tawel Fan ward but they were limited in nature due to resource issues; it was not possible for a pharmacist to attend ward rounds and inputs tended to be more reactive rather than proactive.

**10.223** That being said there is evidence to show that drug administration charts were reviewed on a regular basis and appropriate advice written on them in relation to potential medication interactions and drug dosages. There is also evidence to show that 20 of the patients in the Investigation Cohort had interventions made from a specialist pharmacist in relation to advice, quality assurance and potential patient safety issues; this was good practice. Despite the resource restrictions pharmacy services appear to have provided a consistent and diligent level of assurance to the drug treatments of patients on Tawel Fan ward. A close examination of the 105 patient case notes suggests that pharmacist inputs were appropriate and that in the main few significant areas of concern were missed.

Those that were missed were due to the medicines reconciliation process and are examined in paragraphs 10.248 – 10.52 below.

### **Therapy and Psychology Resource**

**10.224** Witnesses told the Investigation Panel that access to therapy and psychology services was restricted for patients on Tawel Fan ward. During the three years prior to the ward closure financial pressures within BCUHB led to a gradual reduction of service. It is important to take this into account as treatment interventions should not focus on pharmacological solutions alone. In order to understand the context of medication usage and prescribing practice it is important to take into consideration the availability of other therapy and treatment options open to clinicians and treating teams for the period of time under investigation.

### ***Occupational Therapy and Physiotherapy***

**10.225** Occupational Therapists and Physiotherapists were not employed by the Mental Health and Learning Disability CPG. These individuals were instead employed by a separate CPG responsible for therapy services.

**10.226** As an organisation BCUHB encountered constant financial pressures. This had the effect of either removing certain clinical posts (or not filling vacancies as they arose) over the years. Witnesses explained that the Mental Health and Learning Disability CPG had no control over the financial and service decisions made by other CPGs even if it impacted directly upon its ability to deliver patient care. Individual CPG autonomy and a lack of service integration meant that financial decisions did not always take patients' needs and care pathways into account. In practical terms this meant that key posts were in effect removed from Tawel Fan ward.

**10.227** Prior to 2011 the Investigation Panel was told that the ward had regular access to occupational therapy services. This provided a specialist and professional level of input to patients from a proactive therapeutic perspective. Therapy programmes designed to support people with dementia were provided directly on the ward. However in the fullness of time the post holder allocated to the ward left the organisation and was not replaced. From this time on access to occupational therapy was restricted to more 'reactive' inputs, such as functional assessment, usually as part of the discharge process.

**10.228** Also prior to 2011 there was daily attendance on the ward from a physiotherapist. Once again the inputs were of a proactive therapeutic nature. There was an emphasis on physical exercise, movement groups and limb strengthening (to prevent falls). Regular visits enabled the physiotherapist to build up a relationship with the patients on the ward and to be an active member of the multidisciplinary team. This level of service was also withdrawn and once again only 'reactive' service inputs could be accessed to address specific physical interventions or equipment issues.

**10.229** Prior to 2011 the level of therapy input and intervention provided directly onto Tawel Fan was good practice and in keeping with the contemporaneous guidance from both the Alzheimer's Society and NICE. Once this was no longer available dependence grew upon the ward nursing staff to 'fill the gap'. This was not always possible on two counts: skills and expertise; and resource. Therapy inputs could reasonably have been expected to lessen or prevent the need for psychotropic medication as well as improve the quality of the patient experience; the withdrawal of these services was regrettable.

### ***Psychology Resource***

**10.230** Witnesses told the Investigation Panel that psychology services for older people were (and are still) resource limited. Historically psychology services have not had a role with older people's inpatient units in BCUHB; instead the focus has been confined to community settings. It was not possible to understand exactly why this was.

**10.231** It is evident that there was an under-resourced level of service for this extremely complex and vulnerable group of patients. People with dementia often become agitated and distressed; they are also prone to anxiety and depression. This is often exacerbated by feelings of fear, boredom and loneliness. Psychology services had (and have still) a role to play in ensuring therapeutic programmes of care were developed to promote both health and wellbeing. This approach could also have served to lessen or prevent the use of pharmacological interventions.

### **Prescriber Practice: Psychotropic Medication**

**10.232** Most of the patients admitted to Tawel Fan ward exhibited symptoms of BPSD. These symptoms had not been manageable in a community setting necessitating the need for an acute psychiatric inpatient admission. At this stage most of the patients met the criteria for psychotropic medication by virtue of their distress and challenging presentation. Medication (antidepressants, antipsychotics and benzodiazepines) were prescribed primarily to alleviate anxiety, depression, distress and extreme levels of aggression during the period of assessment.

**10.233** Prior to admission most patients had been prescribed either acetylcholinesterase inhibitors or Memantine. Some had also been prescribed small doses of benzodiazepines (usually by their GP) and antidepressants if assessed to have been low in mood. Those patients who had been admitted from care homes were often at a more advanced and challenging stage of their condition and consequently psychotropic medication had (on occasions) already been considered prior to admission in an attempt to avert crisis.

**10.234** Once on the ward medication regimens were commenced in the context of physical examination and psychiatric assessment. This ensured symptoms were identified and any risks in relation to medication regimens were determined. Thereafter physical observations were conducted on a regular basis (daily checks were undertaken for the frail elderly and those identified to be at significant risk). 24 hour general observations were undertaken by nursing staff and any potential side effects or deterioration in either mental or physical health were reported to

medical staff; this was good practice. An examination of the clinical records shows that on admission the following was always conducted as a minimum:

- mental state examination and cognitive testing;
- physical examination and body mapping;
- blood tests and urine analysis;
- repeat CT scans (if indicated);
- ECG monitoring prior to antipsychotic medication being prescribed;
- medicines reconciliation.

**10.235** However there were two areas of practice (across the cohort as a whole) where the prescribing of psychotropics could have been managed better.

- target symptoms were not always identified in sufficient detail in relation to each the specific drugs prescribed – this would have made the reliable monitoring of medication efficacy difficult;
- simultaneous drug changes (additions and withdrawals) took place.

**10.236 Target Symptoms.** From an examination of the clinical records it was evident that whilst symptoms were recorded it was never made clear which drug was being prescribed precisely ‘for what’. Clinical records did not always contain explicit guidance and no systematic steps were put in place to help measure and monitor quantifiable change. It is important that this kind of process is in place as the prescribing of any psychotropic medication carries a risk which needs to be balanced against any anticipated benefits in a methodical manner.

**10.237 Simultaneous Drug Changes.** 10 percent of the cases examined gave the general impression that drug changes were somewhat reactive in nature with abrupt alterations made to medication regimens. It was uncertain whether the prescribers had taken into full account the half life of the medications that had been withdrawn and any possible interactions with those new medications started simultaneously.

**10.238** Good practice should recognise that rapid changes to prescribed medications do not allow time for evaluation. This is complicated further when alterations are made to more than one medication at the same time. The sum of these actions means that it is never certain which drug is responsible for either positive or negative effects.

**10.239** As has been stated; most of the patients admitted to Tawel Fan ward were in a state of crisis. However many of them had been on either low dosages of medication in the community, or none at all (apart from cholinesterase inhibitors). This kind of patient is called medication naïve. In such circumstances it is usually good practice to keep new medication regimens as simple as possible with careful titration. This is so evaluation can be undertaken in relation to reaction and response.

**10.240** Included in the 10 percent of patients where prescribing practice could have been improved are examples where a range of drugs were prescribed relatively swiftly after admission. In some cases this could include an antipsychotic,

an antidepressant and a benzodiazepine. Whilst on occasions this was reasonable practice on others it served to complicate the patient's presentation and made it difficult to understand:

- the patient's baseline level of functioning and how much their agitation was a result of being admitted to a strange environment;
- which drug was having the best effect;
- which drug might be responsible for causing side effects (such as falls and increased levels of agitation).

## **Prescriber Practice: Comorbidities, Physical Health and Risk Management**

### ***Medicines Reconciliation and Drug Errors***

- 10.241** It is to be expected that psychiatrists working with elderly people will have a robust knowledge of the care and treatment of physical comorbidities and any drug interactions and side effects that could impact upon them. In the main this appears to have been managed well on Tawel Fan ward with good physical examinations taking place on a regular basis and good liaison being maintained with neurologists, physicians and other specialist clinical teams. This is also a key area where specialist pharmacist input provided a good level of support.
- 10.242** However there were two exceptions where a lack of knowledge combined with poor medicines reconciliation processes potentially placed patients at risk.
- 10.243** Medicines reconciliation is the process by which a list of pre-existing medications and their dosages are determined at key points of transition; in this case admission to Tawel Fan ward. It is evident that on two occasions drug errors were made. On these occasions it was evident that neither the clerking in doctors nor the nurses on the ward understood that the medication doses for pre-existing physical conditions had been transcribed incorrectly and were extremely high.
- 10.244** It was evident that the ward staff were not acquainted with the medications in question; however it was incumbent upon them to research any medications prior to either prescribing or administration if they were unfamiliar with them, or to seek pharmaceutical advice.
- 10.245** In the event no patient came to harm but this begs another question; that of medication errors. There is no evidence to suggest these errors and omissions were reported and investigated. This was remiss.

### ***Specific Health Risks and the Prescribing of Antipsychotics***

- 10.246** There are significant comorbidities to consider when treating the older adult with dementia. This is of particular significance in relation to the associated risks of both stroke and aspiration pneumonia when prescribing antipsychotics.
- 10.247** A particular risk associated with the atypical (newer) antipsychotic group of drugs is that of stroke. The first reports of increased cerebrovascular accidents with Risperidone emerged in 2002, followed by similar concerns around Olanzapine in 2004. Increased incidence of cerebrovascular accident (CVA) is

now considered to be a class risk of atypical antipsychotics (across all age groups), due to their mechanism of action.

**10.248** Because of these now well known and established risks, the use of antipsychotics in people with dementia should only be considered when it is thought that the potential benefits outweigh the risks. There is also a recommendation that antipsychotics should only be used for a short time (between six to 12 weeks) where there is persistent aggression and where there has been no response to non-pharmacological interventions.

**10.249** It is also understood that the use of antipsychotics is associated with an increased risk of aspiration pneumonia. The risk of pneumonia is not restricted to elderly people taking antipsychotics for BPSD. It is also noted in younger patients taking antipsychotics for schizophrenia.<sup>76</sup> This study noted that the risk of pneumonia was higher for antipsychotics such as Clozapine and Olanzapine that had high receptor affinity for antimuscarinic and anti-histaminergic receptors. It is proposed that these receptor interactions contribute to aspiration pneumonia by causing dry mouth, oesophageal dilatation and hypomotility (slowed passage of substances down the oesophagus). The sedation associated with the antihistamine effects may also contribute. It was also noted that the risk of pneumonia increased with the use of antimuscarinic medication for extrapyramidal effects.

**10.250** The risk of pneumonia with the use of antipsychotics in older people seems to be highest at the beginning of treatment, from seven to 30 days from initiation and then starts to reduce.

**10.251** Table 4 provides a breakdown of antipsychotic prescribing on Tawel Fan ward; the patients were admitted over an approximate three-year period. It should be taken into account that a very small number of patients were on antipsychotic medication prior to admission and that prescribing was in the context of managing extreme aggression and other very challenging behaviours.

**Table 4: Numbers of Patients from the Investigation Cohort who were prescribed Antipsychotic Medication**

<b>Drug</b>	<b>Patient Numbers</b>	<b>Patient numbers where drug was stopped</b>	<b>Patient numbers were drug was continued after discharge</b>
<b>Olanzapine</b>	<b>34</b>	<b>10</b>	<b>24</b>
<b>Risperidone</b>	<b>25</b>	<b>12</b>	<b>13</b>
<b>Quetiapine</b>	<b>2</b>	<b>1</b>	<b>0</b>

**10.252** It can be determined that 58 percent of the Investigation patient cohort was prescribed antipsychotic medication on Tawel Fan ward.

<sup>76</sup> Chian Jue Kuo et al (May 2013) Second-Generation Antipsychotic Medications and Risk of Pneumonia in Schizophrenia. Schizophrenia Bulletin, Volume 39, Issue 3 PP 648–657, <https://doi.org/10.1093/schbul/sbr202>

- 10.253** The Investigation Panel found that this class of medication was prescribed appropriately for the symptoms identified and in accordance with NICE guidance. Medications were kept under careful review and although the length of time they were prescribed sometimes exceeded the 12 week advisory period this was usually for younger more aggressive patients. NICE guidance acknowledges that on occasions antipsychotic medication might need to be prolonged in excess of 12 weeks and so this practice should not be viewed as either unusual or unacceptable.
- 10.254** However the Investigation Panel found that the dosages tended to be conservative in nature (even when a higher dose might have been indicated). It was evident that a cautious approach was taken; this was good practice. If side effects were noted then drugs were nearly always withdrawn and antimuscarinic medication rarely used.
- 10.255** It is evident that ‘off license’ prescribing took place in relation to Olanzapine and Quetiapine. However whilst the rationales were not always provided in depth it could be ascertained that side effect profile was usually the deciding factor.
- 10.256** Once discharged back into the community it was evident that 37 patients continued to be prescribed antipsychotic medication for a period of time. It has not been possible to determine with certainty the process of either review or medication cessation for all of these patients. This is because:
- 15 out of the 37 patients are still living and their care and treatment is a dynamic process to which the Investigation Panel is not privy;
  - the clinical records for patients post discharge from Tawel Fan and/or BCUHB services were often difficult to access in their entirety.
- 10.257** From the records available it would appear that antipsychotic medication was kept under careful review for 24 patients; it continued to be prescribed as a response to continued acts of aggression and violence. However the Investigation Panel noted 13 patient cases where there was a lack of clarity as to what the review process was and how patients were followed up once discharged back to the care of their GP.

### ***Findings Relating to Antipsychotic Prescribing and Mortality***

- 10.258** Both stroke and aspiration pneumonia have been associated with the deaths of patients on Tawel Fan ward. A careful examination was undertaken of all case records together with the PRISM reports from the BCUHB Mortality Review.
- 10.259** The BCUHB Mortality Review and this Investigation found incidents of stroke and aspiration pneumonia amongst patients who had been admitted to Tawel Fan ward (at some stage of their care pathway), however these patients had not always been treated with antipsychotic medication.

- 10.260** For the majority of patients who had been prescribed antipsychotic medication, and who died of either a stroke or aspiration pneumonia, it was usually in the context of a gradual decline where antipsychotic medication had been reduced to a very low dose, or stopped altogether several months (or even years) before death occurred.
- 10.261** A close examination of the clinical records provided to the Investigation did not always detail cause of death. Death certificates were difficult to obtain; ‘cardiac arrest’ or ‘advanced Alzheimer’s disease’ were often transcribed in the clinical records which did not really assist beyond a certain point. Post mortem examinations were rare and so could not be used to provide any further information. The general impression given was that of ‘gradual decline’ which was not helpful when trying to ascertain any potential links between antipsychotic medications and cause of death.
- 10.262** It should be taken into account that at the time of writing this report 25 percent of the patients in the Investigation Cohort were still living. Of the 78 patients who died (either on Tawel Fan ward or following discharge) 37 appear to have never been prescribed antipsychotic medication. Of the remaining 41 patients 22 appear to have had their antipsychotic medication stopped several months, or even years, prior to death. Of the remaining 19 patients it remains unclear for four of them if their antipsychotic medication was maintained and/or what the cause of their death was.
- 10.263** The Investigation Panel found 15 patients who were still being prescribed antipsychotic medication at the time of death; their deaths were attributed to either stroke or pneumonia. These figures should be understood in context. The period of time between antipsychotics being prescribed and time of death ranged from six days to two years. In addition one of the individuals did not suffer from dementia and had been placed on Tawel Fan ward due to bed shortages elsewhere.
- 10.264** Eight patients were identified to have died either on Tawel Fan ward or within several weeks of being discharged from it. Seven patients died between two months and two years following discharge from Tawel Fan ward. These patients are included in the sample that has already been discussed in paragraphs 10.263 – 10. 264.
- 10.265** The 15 patients presented in a diverse manner. Ages ranged from individuals in their early 60s to those in their early 90s. Four of these individuals died of a stroke and 11 died of pneumonia. It was not always possible to understand whether the pneumonia was caused by aspiration, infection following a cold or flu, or a combination of the two factors.

**Table 5: Data for the 15 patients who died whilst on antipsychotic medication (the times of death have been estimated based on the records available)**

<b>Patient</b>	<b>Specific Information</b>
<b>Patient 1</b>	Risperidone: Vascular Dementia; stroke on Tawel Fan ward; died shortly afterwards
<b>Patient 2</b>	Risperidone: Alzheimer's disease; pneumonia; died nine months after discharge
<b>Patient 3</b>	Risperidone: Alzheimer's disease; pneumonia; died 12 months after discharge
<b>Patient 4</b>	Olanzapine: Vascular Dementia; pneumonia; died on medical ward after a period of decline
<b>Patient 5</b>	Olanzapine: Vascular Dementia; pneumonia; approx five months after discharge
<b>Patient 6</b>	Olanzapine: Mixed Dementia; died of a stroke shortly after discharge from Tawel Fan ward
<b>Patient 7</b>	Risperidone: Mixed Dementia; stroke; died five months after discharge
<b>Patient 8</b>	Olanzapine: Vascular Dementia; died two months after discharge
<b>Patient 9</b>	Risperidone; Mixed Dementia; pneumonia; died two years after discharge
<b>Patient 10</b>	Olanzapine: Alzheimer's disease; pneumonia; died four months after discharge
<b>Patient 11</b>	Risperidone: Alzheimer's disease; pneumonia; died following transfer to medical ward
<b>Patient 12</b>	Risperidone: Alzheimer's disease; pneumonia; died on Tawel Fan ward
<b>Patient 13</b>	Olanzapine: Bipolar Disorder; stroke on Tawel Fan ward
<b>Patient 14</b>	Risperidone: Alzheimer's disease; pneumonia; died on Tawel Fan ward
<b>Patient 15</b>	Risperidone: Alzheimer's disease; pneumonia; died on Tawel Fan ward

**10.266** The Investigation Panel cannot make speculative leaps and can only report the findings based upon the evidence available. There is a possibility that antipsychotic medication made a contribution to the deaths of these 15 patients. However to try and draw any further conclusions would be unsafe – each of these individuals had many other factors that needed to be taken into consideration and medication is only one part of the picture.

**10.267** Two findings however can be determined:

- a) On Tawel Fan ward.** The clinical records show antipsychotic medication was prescribed in keeping with appropriate symptomology. Where families were engaged consent was obtained and risk was discussed. Physical examinations took place prior to prescribing and observations and reviews took place on a regular basis. It was evident that titration was managed carefully and prescribing was (in general) conservative in nature.

However there was no evidence in the clinical records to suggest any other therapeutic or non-pharmacological interventions were trialled either prior to medication being administered or alongside it. Had this been done the need for medication might well have been reduced together with any associated risk.

- b) In the community.** The clinical records do not detail how medications continued to be observed, monitored and reviewed in care homes (the destination of the seven patients who died following discharge). The maintenance of antipsychotic medication for a period of up to two years is difficult to justify in view of the likelihood of decreased efficacy and increased risk.

### ***Concerns in Relation to Antidepressants and Benzodiazepines***

**10.268 Trazadone.** Trazadone is commonly used in the treatment of elderly people with dementia, a practice which is by no means restricted to BCUHB. There is however scarce evidence for its efficacy in this area although there have been reports that it is actually beneficial in terms of cognitive deficits; this very much remains to be proven.

**10.269** Trazadone is an antidepressant indicated for the treatment of agitation and anxiety. It is also sedative in its actions and it is this effect which is frequently sought in the elderly rather than its antidepressant properties. It seems that because of the way Trazadone is used in old age psychiatry the real use of this drug (which is an antidepressant) is not always taken into account; subsequently its mood elevating properties can take prescribers off guard.

**10.270** The Investigation Panel noted that on occasions the mood elevating effects of Trazadone might have led to increased agitation for some of the patients on Tawel Fan ward. The simultaneous prescribing of several different psychotropic medications at the same time meant that prescribers may not always have understood the cause of increased agitation and the potential effect Trazadone might have made to it.

**10.271 Benzodiazepines.** Families have expressed concern about the use of benzodiazepines; principally Lorazepam. Other benzodiazepines were also prescribed; namely Diazepam, Chlordiazepoxide, Temazepam and Zopiclone (a benzodiazepine derivative). The indications for this class of drug in the client group under examination are generally for the management of aggression, anxiety, agitation and insomnia. Whilst it is often necessary to use these drugs it is important consider the unwanted side effects.

- 10.272** Known side effects include the increased risk of falls, cognitive impairment, increased confusion, sedation and somnolence. In addition there is also the possibility of paradoxical disinhibition. The hazard of this is that instead of the escalation in behaviour being noted and recognised as an adverse side effect, additional doses can be prescribed in an attempt to gain control.
- 10.273** Two patients on Tawel Fan ward appear to have experienced this paradoxical effect. It has to be noted however that nursing staff observed this phenomenon, withheld medication, recorded their decisions in the clinical records and reported their concerns to medical staff.
- 10.274** The clinical records of the patients whose families raised concerns were examined in detail. Over sedation appears to have been noted rarely. When over sedation was recorded it usually detailed single occasions as a result of the medication initiation and adjustment process. On other occasions when patients appeared to be drowsy and difficult to rouse, the clinical records showed underlying illness or infection to be the cause. The contemporaneous records evidence patients who were able to engage in their activities of daily living seemingly unimpaired by the side effects of medication.
- 10.275** From a further examination of the clinical records of the other patients in the Investigation cohort (whose families had not raised concerns) little evidence was found to suggest over sedation. If over sedation was identified, it was in the context of the medication initiation process where adjustment and monitoring was ongoing. No evidence could be found across all 105 cases examined to suggest that over sedation was either an intended outcome (a chemical cosh), or the result of poorly managed prescribing; patients remained, in general, active, alert and mobile.
- 10.276** Of more concern was the risk of falls. The Investigation Panel found several examples where the use of benzodiazepines might have contributed to falls. Whilst medication reviews took place they did not always follow in a timely enough manner to prevent other falls from taking place. Whilst a definite link between Lorazepam and each fall that occurred on the ward cannot be determined, it was poor practice that medication was not always automatically reviewed as part of the falls care pathway.

## **Nurses: Knowledge of the Drugs Administered and Therapeutic Care Planning**

### ***Medication Monitoring***

- 10.277** The clinical records detail the day-to-day observations made by the qualified nursing staff on Tawel Fan ward. The entries appear to be diligently made and sufficiently detailed. It is apparent that any medication side effects were recorded and reported with immediate effect to the medical team. The nursing staff appeared to be knowledgeable about the side effects of psychotropic medication in general. The exception to this was the associated risks in relation to Risperidone, low blood pressure and the increased risk of falls; this was not always managed well or understood by various members of nursing staff over the years.

**10.278** It can be evidenced that qualified nursing staff were generally vigilant with regards to over-sedation and drowsiness and that they would not hesitate to withhold drug doses and report their concerns to the ward doctors if they assessed a patient to be over medicated. When this was the case entries were always detailed in the clinical record.

### ***Therapeutic Care Planning***

**10.279** A significant area of omission was the therapeutic care plan. Whilst care plans addressed Fundamentals of Care it was evident that they did not provide a sufficient level of therapeutic input in relation to the care and treatment of anxiety, dementia, depression and BPSD.

**10.280** It can be evidenced from an examination of the clinical records that the initial assessment of patients was conducted to an acceptable standard. In addition families were encouraged to complete the “*This is me*” proforma which provided the opportunity to share detailed person-centred information. However the assessment process and information provided by families did not appear to contribute to person-centred care planning to the extent that it should. It would appear that the process of assessment was sometimes an end in itself rather than part of meaningful care and treatment provision.

**10.281** Nurses have an essential role to play in providing care and treatment programmes. The Investigation Panel expected to see a more detailed level of knowledge applied (and person-centred approach taken) in relation to each individual patient.

- a) A detailed description of the person’s likes and dislikes should have been made explicit in each care plan in order to optimise both the patient experience and efficacy of the care approach.
- b) A checklist of symptoms should have been identified together with the measures to be taken to monitor, manage and review them.
- c) Specific instructions should have been detailed about the management of BPSD and the de-escalation of aggression. Care plans should have identified symptoms, triggers and interventions to encourage a reduction of the behaviours.
- d) Opportunities for individual 1:1 nursing time should have been available each day which did not focus upon personal care giving. This time should have been used for:
  - life story work and reminiscence therapy;
  - positive social interaction, such as frequent short conversations and walks;
  - a continuation of any hobbies and interests (where practical).
- e) Opportunities for meaningful group activities should also have been assessed, planned for and documented.
- f) Care plans to address sleep hygiene for those patients who routinely experienced insomnia and wandering at night should have been developed.

- 10.282** The Investigation Panel asked registered nursing staff from a variety of old age psychiatry wards (including those who had worked on Tawel Fan ward) about what would constitute good practice in relation to therapeutic dementia nursing care. They found it difficult to articulate what this would consist of. When pushed nurses described personal care tasks and an emphasis on trying to get the know patients' general likes and dislikes. The impression given was one of traditional, task-focused care which fell short of providing the level of skilled therapeutic input required.
- 10.283** Senior nurse leaders explained that the culture of nurse-led therapy and care planning in old age psychiatry inpatient units across BCUHB was underdeveloped at this time. Nursing as a profession had a low organisational profile and low levels of professional confidence.
- 10.284** As a minimum therapeutic care planning can reasonably be expected to lower the use of benzodiazepines at night and the need for medication to calm agitation during the day. Without this level of therapeutic care planning an important alternative (and supplement to) pharmacological interventions was not provided.

### **Mental Capacity, Consent and Best Interests**

- 10.285** Mental capacity, consent and best interest issues are addressed in detail in the Legislative Framework chapter subsection of this report. In order to prevent duplication it is not discussed here. However in relation to medication and treatment the Investigation Panel found:
- best interest decisions and processes were often recorded poorly (and are therefore difficult to understand) and rarely involved Independent Mental Capacity Advocates (IMCAs);
  - families were often asked to provide consent in relation to medication and treatment without understanding their rights and those of the patient;
  - in the face of inter-familial disagreement a confused process ensued with no clear clinical leadership or IMCA input to arbitrate on behalf of the patient;
  - the covert medication policy was usually used well and in keeping with the requirements of the Mental Capacity Act (2005) and Mental Health Act (1983).

## **Conclusions**

### **Patient and Family Experience**

#### ***Information and Support***

- 10.286** Families told the Investigation Panel that they did not always have sufficient knowledge about diagnosis and the understanding required to give informed consent about medication choices. Families were often deeply uncomfortable about subsequent prescribing decisions and the potential side effects of psychotropic medications. It should be noted that several families raised concerns after reflecting on the media reporting into Tawel Fan ward; this had led them to re-evaluate their loved one's treatment and they were left with feelings of anxiety and doubt.

- 10.287** The 2011 *National Vision for Wales: Dementia Supportive Communities* and 2012 *Together for Mental Health* strategy detailed the importance of education and information for the families and carers of people affected by dementia. BCUHB provided patient and carer education workshops and these appear to have been well attended. However it was apparent that whilst education was offered directly after a dementia diagnosis was given, little education or information continued to be offered once the dementia had progressed.
- 10.288** The dementia process is a journey which presents an ever-changing set of challenges along the way. Admission to an acute psychiatric admission ward is a major life event; the offer of education, information and support should perhaps be made available again at this stage so that families and carers have an opportunity to reframe their knowledge and thinking in the light of the disease progression.
- 10.289** From the evidence available it would appear that the doctors and nurses who worked on Tawel Fan ward provided information and advice to families. There is also evidence to demonstrate that both family consent and engagement was sought. However on admission to secondary care patients were in crisis and families were often distraught. Once again there was a gap between family need and the ability of service to meet it.
- 10.290** The new Welsh Government strategy *together for a Dementia Friendly Wales 2017 – 2022* seeks to address this gap with increased levels of practical support for families and carers. This will take the form of dedicated dementia care coordinators who will assist in education and signposting and maintain a consistent relationship throughout the course of the dementia journey. The strategy will also ensure increased levels of independent advocacy to support patients directly when decisions about care and treatment have to be made.

### ***The Tawel Fan Effect***

- 10.291** The strength of feeling and numbers of concerns raised by families in relation to medication should be set (to an extent) within the context of the ‘Tawel Fan effect’. The majority of families who raised concerns had no pre-existing doubts about the quality of service provided until they heard about the Tawel Fan ‘scandal’ via media reporting, or were contacted by the North Wales Police as a routine part of its Investigation.
- 10.292** There are significant lessons for learning about how untoward incidents are managed in the future. NHS organisations and their statutory partners have clear duties in relation to disclosure and transparency; however they also have responsibilities in relation to how these disclosures are communicated and how interested parties should be kept informed and supported thereafter.
- 10.293** The Investigation Panel concludes that a significant number of families in this sample have been distressed by media reporting and the contacts (however reasonable) made from statutory services. This has caused a significant level of anxiety. In the absence of a robust communication strategy concerns have been heightened and a growing sense of disillusionment and loss of confidence has resulted.

## Clinical Practice

- 10.294** The issues examined in relation to medication, therapy and treatment were multifaceted and complex. The patients admitted to Tawel Fan ward were in crisis and it had not been possible to manage them in a community setting; on admission they met the criteria for the prescribing of psychotropic medication. On balance the Investigation Panel concludes that prescribing practice on Tawel Fan ward fell within accepted good practice parameters. This was in relation to medication choices, titration, monitoring and review.
- 10.295** All psychotropic medications carry a degree of risk; however the Investigation Panel concludes that benefits and risks were assessed in an appropriate manner. There was no evidence of reckless prescribing or patients coming to harm as a result of failures to adhere to good practice guidance. It should be taken into account that admission to Tawel Fan ward was an effective intervention for the majority of patients who were treated there. In the main patients responded well to treatment and were subsequently discharged.
- 10.296** However the Investigation also concludes that there were cultural, resource and systemic factors which meant that prescribing practice could have been conducted in a more robust and systematic manner. Additional pharmacist support, access to a comprehensive range of evidence-based policies, corporate ownership of standardised documentation and the quality monitoring of clinical records could all have improved care and treatment delivery.
- 10.297** The Investigation Panel concludes that clinicians (both doctors and nurses) tended to assess by ‘eye’ rather than by system. By this we mean that there was often an over reliance upon impression and expertise rather than the use of algorithms and proformas; evidence-based practice requires the use of both. It should be understood that prescribing is not an exact science – there is an element of trial and error that cannot always be avoided. Had a more formal system been in operation then care and treatment could reasonably have been expected to be optimised, if not with the major treatment decisions, then with the more sensitive adjustments that were required along the way.

## Resource

- 10.298** This group of complex and vulnerable patients represents a relatively small, but significant, subset of people with dementia in North Wales. It was estimated in 2014 that BCUHB had 4,572 people with dementia on the NHS Quality and Outcomes Framework.<sup>77</sup> The numbers of admissions to Tawel Fan ward for the three-year period 2011 and 2013 has been estimated to be *circa* 200. However when the numbers from the other BCUHB old age psychiatry inpatient wards are also taken into account the numbers rise to a substantial cohort. These patient numbers, combined with the associated complexity of their presentations, merits a prioritisation of specialist service provision.

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<sup>77</sup> Alzheimer’s Society (2015) *Wales Dementia Diagnosis: Progress on Improving Diagnosis of Dementia 2014-2015*

- 10.299** When providing care and treatment options it is not enough to provide a focus on pharmacological interventions. Dementia can be a devastating condition. The disease progression can strip away a person's core identity and lessen their ability to engage with the world on their terms. It is essential that therapy and treatment options put the patient at the centre of the process to ensure not only a 'good clinical outcome' but quality of experience, dignity and wellbeing. In order for this to be accomplished a holistic and multidisciplinary range of inputs are required and need to be provided in settings that are adequately resourced.
- 10.300** The Investigation Panel found it unacceptable that this group of patients, with extraordinarily challenging needs appeared to have been admitted to an inpatient unit with resources too limited to provide the comprehensive range of therapy and treatment required. This omission was made more obvious by virtue of the fact that a very high level of therapy input had been provided prior to 2011. It is always the aim of NHS services to continuously improve and move forward; however due to financial pressures the service provided to patients on Tawel Fan ward experienced a retrograde step backwards.

#### **Underlying Factors: Root Cause Analyses**

- 10.301** Areas that were not optimal combined systemic, local service and individual practitioner factors. It is important to understand which factors were in play so that recommendations and actions for service improvement can be targeted appropriately. Appendix 3 provides information about root cause analyses factors.

#### ***Workforce Capacity and Capability***

- 10.302** The type of patient admitted to Tawel Fan ward represents the most challenging end of the spectrum in relation to need, risk, and symptomology. Whilst community-based services appeared to have access to both psychological and psychosocial therapy this was not extended to patients following admission. Matters were compounded further by the withdrawal of proactive occupational therapy and physiotherapy services on the ward.
- 10.303** This placed reliance upon psychotropic medication and a unilateral treatment model. This also placed additional pressures on the Tawel Fan ward nursing staff and potentially exposed any shortcomings in relation to workforce capacity and capability.
- 10.304** Nursing staff did not provide the level of therapeutic care planning and psychosocial interventions that could reasonably have been expected on a ward of this kind during the period of time under investigation. On balance the Investigation Panel concluded that this was due to a lack of organisational prioritisation, nurse leadership, and a culture of holistic care and treatment provision.
- 10.305** The responsibility for this omission cannot be placed directly onto the ward nursing staff. It is a more complex issue. It speaks to the organisation's understanding of the needs of patients, the role of specialist dementia nursing in secondary care, and the resource factors required when providing the required levels of service. The Investigation Panel concluded that due to a series of

service reconfigurations and financial pressures patients were, in effect, left in receipt of a traditional medical model of care.

**10.306** The Investigation Panel uses the term ‘Medical Model’ with caution. The term can be used in denigration when describing an old fashioned paternalistic approach to treatment and patient care; it can also be used to describe a process where illness is understood in terms of causation and remediation in contrast to a holistic and social care approach.

**10.307** The Investigation Panel uses the term medical model in relation to a causative and remediation approach. Service configuration and funding decisions appear to have been designed around traditional medical approaches and between 2011 and 2013 this appeared to be the overarching model of care for patients admitted to older peoples’ inpatient services at the Ablett Unit. The identified factors are:

- organisational (prioritisation and resourcing);
- team (leadership and role congruence);
- educational and training factors;
- working conditions (resourcing and capacity).

### ***Clinical Governance***

**10.308** There were poor levels of clinical standardisation in relation to policies and documentation. Whilst the Investigation Panel could not determine any links between this and any specific harm caused to patients, it was poor practice.

**10.309 Policies.** Policies relating to medicines often had an advisory tone or did not pertain to the older adult. Practice standards were often absent or non directive; this meant that clinicians were left to interpret policies as they saw fit. In addition policy development often occurred in a ‘vacuum’ as many were developed by local teams bypassing corporate ratification processes.

**10.310 Documentation.** Documentation formats did not provide any guidance in relation to content or process. Similar issues were found to those identified in the Diagnosis section of this report. Doctors wrote upon blank sheets of paper where content and quality could be variable; not just from practitioner to practitioner, but from case to case. Nurses worked without any corporately ‘owned’ care planning documentation; standardisation was entirely absent from ward to ward and unit to unit.

**10.311 Audit.** This lack of professional standardisation is of concern. Without clear practice benchmarks it would not have been possible to audit the effectiveness and safety of clinical practice. Without standardised policy and documentation it would also have been difficult to appraise and supervise individual practitioners.

**10.312 Culture and Ethos.** The Investigation Panel discussed the lack of general professional standardisation with some 80 doctors and nurses. A view prevailed amongst a small, but senior, group of clinicians (not from Tawel Fan ward) that policies were for guidance only and that practice was not (and should not be)

boundaried by it. These same individuals also expressed the view that NICE guidance was not binding and that it should not replace good clinical judgement.

**10.313** The Investigation Panel understands that on occasions clinicians have to use their experience and expertise outside of pre-existing guidance for difficult and complex cases; this is an accepted part of clinical practice. However what was described was an ethos of professional self-direction that, on occasions, resisted organisational governance process.

**10.314** It is evident from the many prior investigations and reviews held that BCUHB's clinical governance systems, structures and processes were weak during this period. That knowledge is already in the public domain. In addition the Investigation Panel concludes that underlying cultural issues, as well as structural and systemic issues, might also have been responsible. The identified factors are:

- organisational (policy, standardisation, safety culture);
- task (policy, procedure and professional standards);
- education and training (supervision and appraisal);
- individual staff factors (working preference and culture).

### ***Ethos, Vision and Strategy***

**10.315** During the period of time under investigation there is little evidence to demonstrate that BCUHB was implementing change to its services in keeping with the ethos of Welsh Government strategy. This was in relation to:

- patient-centred care and choice;
- carer education, information and support;
- holistic care and treatment approaches.

**10.316** Instead there is evidence to suggest that financial pressures were compromising the quality of the care and treatment provided. Older people's inpatient mental health services were neither resourced nor funded appropriately during this period. This had an impact upon the quality of experience of both patients and families. The identified factors are:

- organisational (strategic leadership, service configuration and resourcing).

### **Key Lessons for Learning**

**10.317** The main lessons for learning are:

#### **1 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.

- 2 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.<sup>78</sup> The process of ascertaining preferred options in relation to treatment (and gaining knowledge about the person) should begin from the first point of contact.
- 3 Patient-Centred Care and Treatment.** An in-depth understanding of the person with dementia will enable health care professionals to work with both them and their families. This will ensure the most efficacious use of medication, therapy and treatment. It will also ensure interventions are effective and respectful into the future.
- 4 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.
- 5 Psychotropic Medications – Documentation and Standardised Evaluation Processes.** Psychotropic medications carry an inherent degree of risk. It is always good practice to adhere to 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.
- 6 Clinical Governance.** 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.
- 7 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. 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

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<sup>78</sup> NHS Wales (2013) *Tools for Improvement 8: 1000 Lives: Co-Producing Services – Co-Creating Health*

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.

- 8 National Strategy.** The findings and conclusions of this report chapter support in full both past and present Welsh Government strategy thinking. The need for dementia care coordinators, education and information for patients and families, and holistic assessment and care provision is essential.
- 9 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.

## Clinical Management and Nursing Care

### Context

**10.318** This chapter subsection examines the issues relating to clinical management and nursing care. It builds upon the chapter subsections above and provides a primary focus on health, person-centred care and wellbeing. The following is included:

- clinical assessment practice;
- person-centred care planning;
- nursing practice and the Fundamentals of Care;
- the management of injury and physical illness;
- palliative and end of life care.

**10.319** Where specific national best practice guidance is available a summary has been set out below to provide context information for the reader.

### Clinical Assessment and Person-Centred Care Planning

#### *Assessment*

**10.320** NICE Guidance CG42, *Dementia: Supporting People with Dementia and their Carers in Health and Social Care* (2006) and the Accreditation for Inpatient Mental Health Service (AIMS) standards developed by the Royal College of Psychiatrists provides clear guidance in relation to the assessment requirements for the older adult admitted to inpatient care settings.<sup>79</sup>

- 1** Assessment should be conducted at the point of admission to determine the capacity of the patient to make specific decisions about care and treatment. This kind of assessment should be undertaken regardless of whether or not they have been detained under the Mental Health Act (1983).

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<sup>79</sup> Royal College of Psychiatrists (November 2014) Editors: Joanne Cresswell, Mark Beavon and Holly Robinson *Standards for Acute Inpatient Services for Older People – 3rd Edition*

- 2 Physical examinations should be conducted within 24 hours of admission; if this cannot be achieved (for example if the patient is too disturbed or refuses) the reasons should be recorded clearly in the case notes and a contingency plan put in place.
- 3 Targeted examinations should take place if the patient's history or presentation indicates this is necessary (including blood tests, urinalysis, ECG, EEG, x-rays and brain imaging); these should be undertaken promptly with a named clinician responsible for follow up.
- 4 If a patient is found to have a condition that might increase their risk of collapse or injury during restraint this should be documented clearly, communicated to all team members and kept under review.
- 5 Risk assessments should be conducted on admission and kept under review as part of a dynamic process. The AIMS standards require the following risks to be assessed for all patients:
  - the likelihood for them to be predatory and to abuse or offend;
  - the potential for physical, psychological and social risks to themselves and/or others;
  - self harm or suicide;
  - alcohol and substance misuse;
  - absconding and any resulting degree of harm should it happen;
  - potential physical risks (including those from falls, malnutrition, dehydration and pressure ulcer development);
  - the withdrawal of (or refusal to) consent to treatment;
  - sexual vulnerability;
  - financial vulnerability;
  - self neglect;
  - public protection and safeguarding issues.
- 6 Following admission holistic assessment and care planning should be undertaken by the allocated primary nurse or keyworker; initial plans should be developed within 72 hours and be kept under review.
- 7 On occasions specialist assessment inputs will be required that cannot be undertaken by clinicians on a particular ward or unit; if this is the case then referrals will need to be made to an appropriate service.
- 8 The clinical assessment of need is an ongoing process that should continue throughout the course of an admission. Professional communication and review is a key part of any dynamic assessment process. This necessitates:
  - daily handovers between nursing staff and other members of the multi-disciplinary team;
  - a pre-agreed set of standards for formal multi-disciplinary reviews;
  - regular multi-disciplinary meetings and ward rounds.

### ***Person-Centred Care and Treatment Planning***

- 10.321** United Kingdom guidance states that care and treatment planning should be based on an assessment of a person's life history, social and family circumstances, personal preference, mental health and physical needs, and current levels of functioning. The resulting plans should, whenever possible, be co-produced and discussed with the patient and their family members (where appropriate) and copies made available to them.
- 10.322** During the period under investigation the Wales Mental Health Measure was in place; Part 2 of the Measure states that "*all people who receive secondary mental health services have the right to have a Care and Treatment Plan*". It should be noted however that there was no specific guidance provided by the Measure in relation to care and treatment planning for older adult inpatient placements; it should also be noted that the Mental Health and Learning Disability CPG did not develop a standard care or treatment planning template and no professional standardisation was in place.

### **Fundamentals of Care**

- 10.323** Fundamentals of Care is a Welsh Assembly Government initiative included in the Plan for Wales as part of *Improving Health and Care Services*. The initiative was launched in 2003 to provide an integrated approach to improve the quality of health and social care across educational, commissioning and performance management frameworks. Fundamentals of Care standards apply to both NHS and Social Service provisions and consist of a whole systems approach, making them relevant to multi-disciplinary environments across organisational boundaries.<sup>80</sup>
- 10.324** The *Fundamentals of Care: Guidance for Health and Social Care Staff* (2003) describes and draws together twelve aspects of care which set out guidance on the quality of service people can expect from Health and Social Care providers in Wales. The document is informed by a composite set of indicators from a range of statutory, mandatory and professional requirements and national policies.
- 10.325** The document lists a set of twelve practice indicators; they relate to care provision across a wide range of settings and apply to all organisations who deliver health and social care. The Fundamentals of Care form an important part of the matters under investigation and so national expectations and guidance are detailed below. They are follows:
- 1 Communication and Information.** This includes all written, spoken and non verbal communication between staff and service users and their relatives and carers. The indicator recognises that many of the failures or complaints about health and social care are due to misunderstandings, inadequate information, or poor communication. The Principle is: "*People must receive full information about their care in a language and manner sensitive to their care needs*".

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80 Welsh Assembly Government (2003) *Fundamentals of Care: Guidance for Health and Social Care Staff*

- 2 Respecting People.** This indicator underpins all aspects of health and social care delivery; it describes the relationship between someone who is receiving a service and the person or people delivering that care. Services should always be provided with compassion and empathy for the person to whom they are being delivered. Respecting people recognises that everyone has a right to dignity, privacy and informed choice and that whilst those rights are common to all everyone is unique and has individual needs and wishes. The Principle is: *“Basic human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take into account the individual’s needs, abilities and wishes”*.
- 3 Ensuring Safety.** This includes the health, safety and welfare of an individual. When in receipt of health and social care they have the right to a safe environment, use of appropriate and adequately maintained equipment and protection from abuse. The Principle is: *“People’s health, safety and welfare must be actively promoted and protected. Risks must be identified, monitored and where possible, reduced or prevented”*.
- 4 Promoting Independence.** Maintaining independence improves quality of life and maximises physical and emotional well being. The Principle is: *“The care provided must respect the person’s choices in making the most of their ability and desire to care for themselves”*.
- 5 Relationships.** This aspect of care includes arrangements for people in hospital (and in residential settings) to receive visitors and maintain contact with families and friends; it also focuses on the needs of people who are at risk of social isolation. The indicator reminds staff to respect the boundary around their relationships with those they care for. They must not enter relationships that exploit people or compromise their professional judgement and objectivity. The Principle is: *“People must be encouraged to maintain their involvement with their family and friends and develop relationships with others, according to their wishes”*.
- 6 Rest and Sleep.** Sleep is essential for good health and recovery from illness. A period of ill health or change to environment can alter a person’s sleep pattern which can cause changes in an individual’s behaviour and overall quality of life. The Principle is: *“Consideration is given to people’s environment and comfort so that they may rest and sleep”*.
- 7 Ensuring Comfort and Alleviating Pain.** This aspect of care includes the basic requirements for comfort such as: body temperature; body positioning; and appropriate levels of exposure to stimuli such as light and noise. It includes attention to specific discomforts such as nausea and pain which are almost always able to be managed to an acceptable level for an individual. This aspect of care also includes emotional distress and psychological wellbeing as important aspects of a person’s overall health need. Access to specialist services to manage chronic pain, discomfort and distress should be available to help people cope as should access to specialist psychological services for people whose symptoms are related to a psychological cause or

specific treatment process. The Principle is: *“People must be helped to be as comfortable and pain free as their condition and circumstances allow”*.

- 8 Personal Hygiene, Appearance and Foot Care.** Personal hygiene is important for the maintenance of good physical health and psychological wellbeing. It is also important when maintaining confidence, dignity and self esteem. Foot health including nail cutting is necessary for maintaining mobility and preventing falls; poor foot care can contribute to a lack of independence and reduced mobility. Foot problems can occur in a range of medical conditions (such as Diabetes) and in those circumstances foot care should be undertaken by a State Registered Podiatrist. The Principle is: *“People must be supported to be as independent as possible in taking care of their personal hygiene, appearance and feet”*.
- 9 Eating and Drinking.** Proper nutrition is essential for recovery from illness, for wound healing and for maintaining good health. This includes the choice of food available, its presentation and ensuring assistance is available for people who need help to eat and drink. Some people will have problems chewing and swallowing food and may need an assessment from a Speech and Language Therapist and staff should be trained in helping them to eat and drink safely. An individual’s choice of food and the time of day they like to eat are influenced by cultural practices and religious beliefs which should always be taken into account. The Principle is: *“People must be offered a choice of food and drink that meets their nutritional and personal requirements and provided with any assistance they need to eat and drink”*.
- 10 Oral Hygiene.** This aspect of care includes care of the mouth and teeth (including dentures); it is of particular importance for people who are ill or receiving long-term care. Good oral health is essential to be able to eat and drink properly, poor oral health can also lead to infection. People who are unable to eat and drink normally and are debilitated or unconscious are particularly vulnerable. The care and safety of an individual’s dentures is important both in relation to good nutrition, personal dignity and self esteem. The Principle is: *“People must be supported to maintain healthy, comfortable mouths and pain free teeth and gums, enabling them to eat well and prevent related problems”*.
- 11 Toilet Needs.** This relates to bladder and bowel functions which are a personal and intimate part of people’s lives. Being dependent on others for help is potentially embarrassing and the maintenance of privacy and dignity is essential. The focus is on the promotion and maintenance of continence and includes assisting people to the toilet, helping people to use bedpans, commodes and urinals and other special devices, and helping people to manage clothing and clean and dry their skin. Specific procedures such as the management of catheters, stomas, administering suppositories and the management of incontinence are outside the scope of the indicators for this aspect of care. The Principle is: *“Appropriate, discreet and prompt assistance must be provided when necessary, taking into account any specific needs and privacy”*.

**12 Preventing Pressure Ulcers.** A pressure ulcer is a breakdown of the skin and underlying tissue and usually occurs over bony areas, for example, heels, sacrum and buttocks as a result of unrelieved pressure or friction to the skin. Pressure ulcers are serious and may become life threatening for an individual. Individuals at risk should be identified and the appropriate skin care and attention received in order to reduce the likelihood of an ulcer occurring. The risk of a pressure ulcer increases for a person if their mobility is limited by being confined to a bed or chair because of injury, illness or frailty. This risk increases with prolonged immobility, poor nutrition, obesity, being underweight, and debilitating illness. The Principle is: *“People must be helped to look after their skin and every effort made to prevent them developing pressure sores”*.

### **Palliative and End of Life Care**

**10.326** Dementia is a life limiting condition. The Alzheimer’s Society has this to say about palliative care:

*“Palliative care is for anyone diagnosed with a life-limiting illness, including dementia. It focuses on maintaining a person’s quality of life by relieving discomfort or distress (whatever the cause). Someone can receive palliative care for several years and it may be offered alongside other treatments, especially in the earlier stages of dementia. Any palliative care in place will continue alongside end of life care”*.<sup>81</sup>

**10.327** All health and social care professionals should support those with dementia and their families to develop palliative care plans at an early stage to ensure that people can live as well as possible and on their own terms.

**10.328** In relation to end of life care the Alzheimer’s Society advises:

*“End of life care aims to support someone in the later stages of a life-limiting condition to live as well as possible until they die. It also aims to support family and carers during this time and after the person dies. End of life care may last for weeks, months or occasionally years – it is often difficult to know exactly when a person with dementia is approaching the end of their life... For many people a ‘good death’ means:*

- *being treated with compassion and respect;*
- *being kept clean, comfortable and free from distressing symptoms;*
- *being in a familiar place surrounded by those close to them.*

*End of life care for a person with dementia can involve a number of different professionals working together, including the GP, community nurses, social workers or care home staff. Palliative care professionals at a local hospice or hospital may give specialist input if this is needed. This team of professionals should keep you updated as the person’s condition changes and involve you in any decisions.*

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<sup>81</sup> [https://www.alzheimers.org.uk/info/20046/help\\_with\\_dementia\\_care/80/end\\_of\\_life\\_care/2](https://www.alzheimers.org.uk/info/20046/help_with_dementia_care/80/end_of_life_care/2)

*The person should always have an up-to-date care plan that includes end of life plans and is shared with those involved in the person's care. Some areas have special staff who co-ordinate end of life care for people with dementia. Ask the GP, community nurse or local hospice (if you have one) about what is available in your area".*

## Findings: The Family Experience

- 10.329** 46 families raised concerns in relation to clinical management and nursing care; those concerns ranged from straightforward issues about poor access to laundry facilities to more complex issues about the quality of end of life care. Concerns were not confined to Tawel Fan ward but also included those relating to the Accident and Emergency Department and various medical wards at Glan Clywd Hospital.
- 10.330** Table 6 below provides a synopsis of the concerns raised; it should be noted that several families raised more than one.

**Table 6**

Type of Concern Raised	Numbers
Clinical management and general assessment	4
Management of physical conditions	11
Lack of appropriate and timely interventions for physical conditions	4
Poor management of 'Do Not Attempt Resuscitation' orders, palliative care and end of life care	9
Poor clinical management and nursing care on wards other than Tawel Fan	9
Nursing care Tawel Fan: personal care	27
Nursing care Tawel Fan ward: nutrition	18
Nursing care Tawel Fan ward: continence	14
Nursing care Tawel Fan ward: loss of dignity	11
Nursing care Tawel Fan ward: management of falls	6

### Assessment and Clinical Management of Physical Conditions

- 10.331** 15 families raised concerns in relation to the ongoing clinical assessment and management of their loved one's physical conditions; some of those conditions pre-dated their admission to hospital and some occurred during their time on Tawel Fan ward.
- 10.332** The concerns focused upon:
- the levels of information the Tawel Fan treating team had been able to access about pre-existing conditions at the point of admission;

- concerns that medications were withheld due to a lack of knowledge, and/or understanding, of those physical conditions;
- the potential for the Tawel Fan treating team to be lacking in the necessary expertise in relation to physical conditions meaning that diagnoses and treatments were delayed and harm caused;
- referrals for specialist inputs (such as speech and language therapy) being delayed resulting in a decline in physical health and wellbeing;
- transfers to specialist medical units being delayed resulting in distress and the worsening of physical conditions.

**10.333** The views of families varied, some thought that psychiatric wards were inappropriate places for physical conditions to be treated, and others thought that psychiatric wards should have been able to manage any physical condition in exactly the same manner as an acute general hospital. The view that was held in common, quite rightly, was that their loved ones deserved the very best of care and that physical health and wellbeing should have been regarded as a priority and addressed accordingly.

**10.334** Many of the families who raised concerns did not always understand the exact nature of their loved one's physical conditions, how those conditions related to the dementia process, and how they would contribute to the overarching prognosis. In keeping with the findings detailed in the Diagnosis chapter subsection above, it was evident to the Investigation Panel that some of the concerns raised were as a result of poor levels of understanding which could perhaps have been addressed (to an extent) by better communication between families and the treating team.

## **Do not Attempt Resuscitation Orders (DNAR), Palliative Care and End of Life Care**

### ***DNAR and Palliative Care***

**10.335** The Investigation Panel knows that DNAR orders and palliative care plans are two entirely different things. Whilst they might be discussed in a single conversation (when planning advance directives with dementia patients and their families) they are absolutely distinct in nature. However these two issues became conflated in the minds of some family members.

**10.336** Nine families raised issues about DNAR and palliative care. The families who raised those concerns did so in the belief that the discussions held with them by members of the Tawel Fan treating team were potentially 'sinister' in nature with the sole purpose of hastening death in what appeared to them to be physically healthy individuals. Concerns had been heightened following media coverage about the BCUHB Mortality Review.

**10.337** It was evident that (whatever the nature of the discussions that were held) some families were left with the belief that their loved ones were being 'eased out of life' prematurely.

**10.338** The families in this sample were highly anxious; it was evident that they had very limited levels of understanding about what DNAR orders and palliative care

plans actually were and that they had mistaken them for other pathways and processes (such as the Liverpool Care Pathway and end of life care) incorrectly.

### *End of Life Care*

**10.339** One family raised concerns about the quality of end of life care on Tawel Fan ward. In this particular case their loved one died at night and the family was of the view that both medical and nursing inputs were lacking in relation to the care that was provided. The family experienced poor levels of communication and inadequate access to out of hours medical cover.

### **The Quality of Care and Clinical Management in Placements other than Tawel Fan Ward**

**10.340** Nine families raised care and general clinical management issues in relation to other BCUHB wards and departments. Of particular concern were those relating to the Accident and Emergency Department and medical wards on the Glan Clywd Hospital site. The families in this sample were of the view that the needs of older adults with dementia were understood poorly and that dignity, respect and person-centred care were largely absent. The concerns raised included:

#### *Accident and Emergency Department*

- long waits for psychiatric and Mental Health Act (1983) assessments (at the point of crisis admission) with no nurse supervision or support whereby agitated and confused elderly patients were left in wet clothes and went without food and drink for hours at a time;
- a lack of timely intervention for the physically unwell elderly patient whose condition worsened as a result.

#### *Medical Wards*

- over sedation as a result of the wards not being able to cope with aggressive or disruptive behaviours;
- patients nursed in corridors so they would not disturb other patients and could be kept under supervision (this caused a loss of comfort, dignity and privacy);
- rapid transfers to community hospitals or psychiatric wards before physical conditions had been suitably investigated or stabilised due to bed shortages;
- increased levels of falls from beds and chairs as patients went unsupervised.

**10.341** Families recounted circumstances where it was evident that there was little join up between disparate BCUHB services with patients being moved around ‘like parcels’; patients were not at the centre of the care and treatment they received. Families were of the view that this caused distress to their loved ones, minimised the effectiveness of care, and led to a general loss of trust and confidence in the services provided.

### **The Quality of Nursing Care on Tawel Fan Ward**

**10.342** Families raised many concerns in relation to the quality of the nursing care that their loved ones received on Tawel Fan ward. Some families raised concerns about a single incident (such as finding their loved ones in wet clothing when

visiting the ward), others raised concerns about general issues for which they sought reassurance (such as nutrition and the potential connection to weight loss), yet others raised a series of consistent complaints about what they considered to be inadequate standards of nursing care.

### *Personal Care*

**10.343** 27 families raised issues about standards of personal care. As has been already stated, some families cited single incidents and others cited what they believed were consistent omissions. The issues included:

- male patients not receiving a regular shave;
- patients wearing a bizarre collection of clothing (such as two or three cardigans one on top of the other);
- patients not wearing their own clothing;
- patients wearing food stained clothing;
- incidents where patients appeared to be unkempt and/or smelt of body odour, urine or faeces;
- incidents when patients were observed to have faeces on their clothes, fingers or legs.

### *Nutrition*

**10.344** 18 families raised concerns about nutrition, mainly in connection with weight loss. Some families sought reassurance, whilst others were convinced patients went unfed and were neglected. The issues included:

- frustration about families not being allowed onto the ward during protected mealtimes;
- weight loss during the time patients were on the ward;
- weight gain during the time patients were on the ward;
- patients not receiving speech and language therapy assessments in relation to their ability to swallow;
- patients not receiving food and drink supplements to ensure weight gain.

### *Continence*

**10.345** 14 families raised issues in relation to continence management. Some families cited single occasions when they found their loved ones to have been incontinent and sitting in wet clothing, others were of the view that continence was managed poorly throughout the time their loved ones were on Tawel Fan ward. The issues included:

- the overuse of incontinence pads which deskilled patients in using the toilet;
- leaving a patient in a wet bed (on a single occasion) and others in wet clothing for prolonged periods of time;
- poor toilet facilities which did not meet the needs for patient dignity;
- patients urinating or defecating in places other than the toilet (such as cupboards, floors and sinks).

### ***Loss of Dignity***

**10.346** 11 families discussed issues whereby there was a loss of dignity and privacy in relation to their loved one's care and treatment. The issues varied widely and included:

- lack of privacy in shared bedrooms with inadequate curtain dividers being in place;
- urine soaked laundry being stored in bedroom cupboards which gave off a strong and unpleasant smell;
- patients stripping off their clothing in public parts of the ward where they could be observed in an undressed state;
- patients who engaged in inappropriate solo sexual acts in public parts of the ward;
- the loss or breakage of dentures, glasses, and hearing aids.

### ***Management of Falls***

**10.347** Five families raised specific issues in relation to the poor management of falls. Those families were of the view that the falls, and any resulting injuries, were the result of poor supervision on the part of the nursing staff. Families also expressed the view that the falls (and the consequences of them) had often been concealed from them with no suitable set of explanations having been given.

### **Summary of Concerns**

**10.348** The Investigation Panel identified a diverse range of concerns raised by families. Many of these concerns have been raised retrospectively whilst others were of a contemporaneous nature having been raised with ward staff at the time the events took place.

**10.349** Most of the families sought explanations and reassurance; however a small number of families were of the view that care and treatment had fallen below an acceptable standard and that their loved ones had come to emotional and physical harm as a result.

## **Findings: Identified by Investigation Panel**

### **Issues in Relation to Bias**

**10.350** The Investigation Panel reviewed the clinical management and nursing care for all 108 patients in the Investigation Cohort; 105 were found to be relevant to this subject. A careful examination of the casenotes was conducted in order to understand the quality of the care and treatment provided. It was estimated that around 200 patients were admitted to Tawel Fan ward over the three-year period primarily under review. It should be taken into account that they have not all been included in the Investigation Cohort either because their families gave positive accounts of Tawel Fan ward to the North Wales Police investigation and/or there was no archive material to suggest care and treatment had been compromised in anyway.

- 10.351** It should also be taken into account that of those 105 patients in the Investigation Cohort 31 of their families gave very positive accounts of the care and treatment provided under this theme (even though they sought reassurance about other matters).
- 10.352** 46 families raised a combination of general concerns and specific complaints; they did not all focus on the same aspects and the issues identified varied greatly in levels of severity. The remaining families from the cohort did not raise any issues (either positively or negatively) about clinical management or nursing care as the issues they wanted addressed did not fall into this category.

### **Background and Context**

- 10.353** There are national standards to guide the delivery of clinical practice which set out clear expectations in relation to quality; they have been summarised in the context section above. The standards set out the basic minimum requirements in relation to what patients and their families can expect from NHS and social care services. The standards create the benchmark against which the quality of care and treatment can be assessed in an objective manner.
- 10.354** However research across the United Kingdom demonstrates that the views held by patients and their families about what constitutes good general care and treatment varies enormously. The experiences people have, and their consequent reactions to them, are highly subjective in nature. Whilst it is possible to determine what good practice should consist of, it is not always so easy to ‘marry up’ patient and family expectation with practice reality.
- 10.355** In 2014 Professor June Andrews discussed this dilemma in her *Trusted to Care* report. The report details how sometimes care standards might fall due to the inevitable hazards that form part of the day-to-day management and running of the NHS. The challenge is to identify when those shortfalls are unavoidable and to be expected, and alternatively, where they are a result of poor management processes and deficits that constitute unacceptable levels of practice. The report made these important observations:

*“The Review Team have spoken to relatives who find it hard to understand that the basic care of older people in the hospital appears to be at a lower level than the care package that was being provided at home...”*

*... There is a popular misconception that care in hospital is more intense than care that can be provided at home and it is therefore, somehow, better and safer. It is important for the hospital to make clear that sometimes fundamental aspects of being cared for in hospital are inevitably worse than if care could be provided at home. A patient is only in hospital if care at home is not possible, not because care at home is worse. If this is made clear then families and the community can work to support those elements of care that are difficult to provide well in hospital settings...*

*...The management of public expectations by the hospital system is important as part of the culture of care. Embarrassment and concealment of failure to provide*

*care that is acceptable to or demanded by the public can only lead to time-consuming and debilitating arguments over things in the past that cannot now be changed. The Review Team found individual people, even those who were hurt and disappointed by what happened to them and their relatives, sympathetic to the difficulties that NHS staff face every day”.*<sup>82</sup>

**10.356** The *Trusted to Care* report set out (extraordinarily well) what would constitute realistic patient and family expectations whilst also describing the responsibilities of statutory services. The Investigation Panel took a similar stance in the relation to the findings and conclusions for this chapter subsection.

### **High-Level Findings**

**10.357** High-level findings were identified as follows:

#### ***Clinical Management***

- 1** Clinical assessment and management processes appeared to be of a good general standard for most of the patients in the Investigation Cohort. Assessment practice met NICE and Royal College guidance and, in many cases, exceeded them. The clinical records were noted to provide a detailed account of how those assessments were undertaken and what clinical treatment plans were developed as a result.
- 2** Structured risk assessment processes were relatively insubstantial and underdeveloped focusing on ward-based issues rather than incorporating a holistic overview. Consequently the resulting care plans developed to mitigate risk were also insubstantial and underdeveloped.
- 3** Physical health was monitored on a daily basis by ward nursing staff and on a weekly basis by medical staff (unless history and presentation required more regular input). Injuries resulting from accidents on the ward were detailed contemporaneously in the case notes and medical assessment sought in an appropriate and timely manner. Physical conditions requiring additional interventions were identified, assessed and monitored and with suitable referrals made to specialist services.
- 4** There is no evidence to suggest that either DNAR or palliative care processes were implemented inappropriately. However it is evident that those difficult topics might not have been communicated with families in an optimal manner leading to a series of misunderstandings and raised anxieties. There are no direct connections made between any act or omission and any death that could be deemed to be avoidable as a consequence in this regard.
- 5** The care pathway for the older adult with dementia was often suboptimal. This was apparent in relation to Accident and Emergency and medical ward episodes of care where behaviours that challenged were not managed well with services (on occasions) being unable to respond to the unique needs of the confused elderly patient. The care pathway was also unnecessarily

<sup>82</sup> Professor June Andrews and Mark Butler (2014) *Trusted to Care: An Independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board* PP 12-14

convoluted for those patients requiring transfers from psychiatric beds at the Ablett Unit to medical and other specialist beds within Glan Clywd Hospital. Multiple moves were commonplace and were often detrimental to those patients affected.

- 6 Quality of care was sometimes compromised by the Mental Health and Learning Disability CPG having to access occupational therapy, speech and language therapy and physiotherapy from the Therapies CPG. This meant that care and treatment provision was not integrated within the Tawel Fan multidisciplinary team and led to occasional delays in access which compromised levels of assessment and ongoing treatment provision.

### *Nursing Care*

- 7 All patients had assessments and (where appropriate) care plans in relation to personal care, continence, mobility, nutrition, risk and tissue viability. Care plan templates across BCUHB's older adults' services differed with no professional standardisation in place. This meant during the period under investigation the formatting and quality of documentation on Tawel Fan ward varied. However in 2012 Tawel Fan ward introduced its own standardised care plan format set against the Fundamentals of Care (apparently of its own volition); this was good practice.
- 8 The clinical records show that nursing care inputs were recorded on a daily basis and that patient need and ongoing nursing care was monitored and kept under regular review. A key finding is that the nursing care provided was of a good general standard during the period under investigation.
- 9 Tawel Fan was a mixed sex ward; this kind of environment presents unacceptable levels of challenge when maintaining dignity, privacy and safety. The Tawel Fan ward environment was also problematic in that it did not provide clear lines of visual access and observations and supervision were compromised as a result, exacerbated (on occasions) by ward staffing issues and patient acuity.
- 10 Many of the elderly patients on Tawel Fan ward had difficulties with mobility but did always have the ability to understand their limitations. Falls were frequent events on the ward, the management of which did not always conform to the extant Falls Care Pathway.

## **Clinical Assessment and Management**

### *General Clinical Assessment*

- 10.358 In total four families raised concerns about the quality of clinical assessment. The Investigation Panel found eight examples where clinical assessment was poor in relation to a single aspect of care, and 54 examples which demonstrated very high standards of clinical assessment practice across the entire episode of care. The remaining patients in the Investigation Cohort were found to have been in receipt of good general assessment practice which was unremarkable one way or the other.

**10.359** Following a careful examination of the clinical records of the 105 patients in this cohort it was evident that clinical assessment on Tawel Fan ward was managed in accordance with both NICE and Professional College guidance. The confounding issues were mainly due to delays in the Tawel Fan treating team being able to order specialist examinations (such as CT scanning and Doppler services) in a timely manner, coupled with the issues that arose as a result of patients experiencing multiple moves over short periods of time that interrupted the timeliness of assessment.

### ***Clinical Risk Assessment***

**10.360** Both at the point of admission (and throughout episodes of care) an area of significant omission was that of multidisciplinary risk assessment. Structured risk assessments did not feature explicitly in the medical record entries and neither did they inform care and treatment plans sufficiently; this was of particular note in relation to the Mental Health Act (1983), Mental Capacity Act (2005) and safeguarding frameworks.

**10.361** Whilst risk assessments were conducted they were not brought together as part of a diagnostic formulation and this reduced the efficacy of any subsequent approach taken. Structured risk assessments appear to have been conducted solely by the ward nursing staff; it was noted that significant risks were often identified and recorded but the process was 'tick box' in nature with no evidence of specific risk management plans being developed as a result. Consequently the process appears to have been an end in itself rather than an essential stage in maintaining safety and managing care.

**10.362** The risk assessment template that was used appears to have been fit for purpose however it has not been possible to determine how and why the template was adopted by the Tawel Fan treating team. It was evident from examining the case notes that a multitude of different templates were in use across BCUHB. The Investigation Panel could find no evidence to suggest clinical risk assessment was the subject of corporate audit or kept under review. The Investigation Panel was not provided with a contemporaneous clinical risk assessment policy and so it has not been possible to assess practice against any extant Health Board guidance. However practice as evidenced by an examination of the casenotes fell below that to be expected from both NICE and Royal College guidance.

### **The Management of Injury and Physical Illness**

**10.363** In total 11 families raised concerns about the management of physical conditions. The Investigation Panel found this to be a relatively complex area to investigate as the quality of care and treatment did not always depend upon the Tawel Fan treating team alone but relied upon other services (such as neuroimaging and diabetic clinics etc.). The impact made by multiple moves and the loss of continuity of care was another factor which was outside of the direct control of the Tawel Fan treating team but impacted (on occasions) upon the quality of the care and treatment given.

- 10.364** The Investigation Panel found six examples where physical management was poor on wards other than Tawel Fan, and 18 examples where an aspect of physical care was managed in a suboptimal manner by the Tawel Fan treating team (suboptimal care usually comprised inconsistent management of low blood pressure, and inconsistent care protocols for some patients with Diabetes). The Investigation Panel also found 37 examples where it was evident that very high standards of physical care and treatment were provided on the ward, particularly those in relation to pain control and the management of chest infections.
- 10.365** The Investigation Panel found that the ward nursing team was vigilant when detecting any changes in a patient's physical condition; this was due mainly to a systematic monitoring of observations and general wellbeing on a daily basis. Those changes would be reported to the medical team who would intervene in a timely manner (notwithstanding some of the out of hours issues already alluded to earlier in this report). There is ample evidence to demonstrate that any necessary tests (such as those for blood and urine analysis) required to detect any possible infections and underlying illness were carried out promptly. However it was noted that test results could often be significantly delayed requiring an assertive and consistent degree of follow up from the ward nursing staff.
- 10.366** In response to family concerns the Investigation Panel was able to determine that:
- the Tawel Fan ward doctors and nurses were suitably qualified and experienced to manage the majority of the physical problems of the patients in their care;
  - when required referrals were made to specialist services in an appropriate and timely manner;
  - there were relatively few treatment omissions (usually occurring at the point of admission); however they were relatively minor in nature and rectified in a timely manner.

### ***Care Pathway Issues***

- 10.367** The Investigation Panel found that a significant area of poor service provision was the lack of timely access to specialist acute secondary care services for the patients on Tawel Fan ward. There was limited facility for direct transfers (bed-to-bed) to take place. When a patient needed an intervention for a physical condition that required a transfer from the ward (for example: in the event of a significant acute physical illness requiring an intravenous drip, surgery, or end of life care) a convoluted transfer process had to be set in train routing them via the Accident and Emergency department (A&E) and/or the Medical Assessment Unit on the Glan Clywd site. Witnesses testimony and documentary evidence suggests (that on occasions) transfers could take anywhere between 24 and 48 hours to complete. This kind of situation is entirely unacceptable for elderly frail patients to endure.
- 10.368** The Investigation Panel could find only two examples where a direct assessment from a physician was made on Tawel Fan. This lack of access was due to there being no formal undertaking whereby medical registrars (for example) could come and assess a patient *in situ* rather than insisting they had to be assessed via A&E prior to a transfer being agreed.

- 10.369** There was no ‘shared care’ model in place for medical advice to be accessed for psychiatric inpatients; both for those that had been recently discharged from medical wards to places such as Tawel Fan, or for those who became acutely ill whilst on psychiatric wards requiring urgent transfer and/or specialist medical advice. It should be noted that there was a great deal of support that ‘went the other way’ provided by the psychiatric liaison service whereby medical and surgical patients could receive a psychiatric assessment ‘in their bed’ with subsequent direct transfers being made to psychiatric services. This appears to have been a one-way-flow.
- 10.370** In this regard the Ablett Unit was not considered to be an integral part of the service provision on the Glan Clywd Hospital site as any transfer of a psychiatric inpatient was not managed in the same way as any other transfer for a patient requiring an additional intervention. This situation is not unique to BCUHB, but if psychiatric inpatients cannot benefit from being in units that are co-located with acute secondary care provision then it is difficult to justify the benefits of keeping everything on the same site.
- 10.371** Although not strictly speaking a ‘Tawel Fan issue’ many of the patients who were admitted there experienced multiple ward moves along their care pathway. Some patients experienced in excess of five transfers over relatively short periods of time; many to meet the needs of the service, not the needs of the patient. On occasions this was found to be responsible for ‘hands off’ events where medication was not continued and physical and mental health conditions went misunderstood. As has already been determined in chapter 9 many patients experienced multiple moves as a means for the service to manage pressures on beds. The simple act of moving an elderly patient in itself can lead to a deterioration of physical and mental wellbeing; multiple moves will increase the risk of this occurring. The Investigation Panel found that for a small number of patients in the Investigation Cohort this was the case and harm occurred as a result; this was poor practice and placed patients at risk.

### ***Multidisciplinary and Inter-Service Working***

- 10.372** As has already been mentioned in chapter 9, the Mental Health and Learning Disability CPG relied upon other CPGs for essential clinical inputs (such as Speech and Language Therapy, Occupational Therapy and Physiotherapy etc.).
- 10.373** The Investigation Panel found that despite the difficulties encountered when trying to transfer patients to inpatient beds at Glan Clywd Hospital other kinds of referrals progressed reasonably well, although a few exceptions were noted.
- 10.374** The clinical records demonstrate that referrals were made by the Tawel Fan treating team in an appropriate and timely manner to the following services:
- palliative care;
  - speech and language therapy (SaLT);
  - occupational therapy;
  - physiotherapy;
  - the pain clinic;

- the diabetes service;
- the vascular team;
- neurology and neuroimaging;
- tissue viability;
- cardiology;
- the Care of the Elderly Service (COTE).

**10.375** The services listed above were able to provide inputs to Tawel Fan patients, either by seeing them in outpatient clinics, or by visiting the ward. On most occasions referrals were responded to promptly. However workforce pressures were significant and some referrals were not always responded to as rapidly as they should have been (this particular kind of problem was referenced in the case notes). Delays were notable in relation to the diabetic, SaLT and physiotherapy teams. It has not been possible to estimate what the impact was on any clinical outcomes on a patient-by-patient basis, but it would be reasonable to assume that care and treatment delivery (on occasions) would potentially have been compromised to some degree.

## **Palliative and End of Life Care**

### ***DNAR and Palliative Care***

**10.376** It is important to state at the outset that the Investigation Panel did not find any evidence to support the notion that the DNAR and/or palliative care processes put in place on Tawel Fan ward were either inappropriately applied or ‘sinister’ in nature. Whilst the two processes are entirely separate they have been conflated in the minds of several family members and therefore need to be addressed jointly. The main issues identified by the Investigation Panel are those in relation to family communication and ongoing information flows which appear to be responsible for any misunderstandings that took place.

**10.377** It was evident from reading the clinical records and from talking with family members that palliative care was not something that had been discussed with them prior to admission to Tawel Fan ward. This meant that families often had no prior understanding of what the term actually meant and how a palliative care plan could benefit their loved ones.

**10.378** By the time patients had been admitted to Tawel Fan ward the dementia process had usually progressed to an advanced stage, this meant that any ensuing discussions about palliative care were often about how to make a person’s last weeks or months of life as comfortable as possible. Seen in this context it is easy to understand why some family members thought palliative care was synonymous with end of life care as, indeed for a few patients, it was.

**10.379** It was evident that the palliative care discussions held with families were sometimes conducted at the same time as those for Do Not Attempt Resuscitation (DNAR) orders. Basically families could be told during the same discussion that resuscitation would be futile and that palliative care plans were advised. It is relatively easy to understand why some families might have conflated the two matters.

- 10.380** It should be understood that a DNAR order is a document issued and signed by a doctor, which tells the treating team not to attempt cardiopulmonary resuscitation in the event of a cardiac arrest. This is done when it is known that cardiopulmonary resuscitation (CPR) would be unsuccessful due to pre-existing conditions. A DNAR order only applies to CPR and does not extend to the withdrawal of any other kind of intervention or treatment. Some of the families who spoke with the Investigation Panel had (incorrectly) assumed that their agreement to a DNAR order had also automatically excluded any other medical intervention from taking place (such as the prescribing of antibiotic medication) hence hastening death.
- 10.381** As has already been discussed in the Diagnosis and Medication and Treatment subsections above, communication with patients and their families prior to admission to Tawel Fan ward was not always optimal. This meant that a great deal of information had to be given to them once their loved ones had already reached a point of crisis and were experiencing the most challenging consequences of the dementia process. It should be taken into account that this was not always the best time to initiate these conversations when they should have taken place in less traumatic circumstances several years earlier. That being said the Tawel Fan treating team had a duty to discuss these important matters with families and they could not be avoided.
- 10.382** It is difficult to understand why the families who engaged with the Investigation were so confused and conflicted unless communication processes had failed in some way. It is evident that a small group of families had not understood the information that had been given to them or the subsequent decisions that they thought they had taken. Those families had not thought it possible to seek any further clarification at a later date and so they continued with their misconceptions. Unfortunately in the absence of robust support and care coordination structures (already discussed in the Diagnoses subsection above) there is an increased risk that families will not be provided with the levels of ongoing discussion and information that they need.
- 10.383** In the light of the subsequent media reporting into Tawel Fan ward families became increasingly concerned that they had unknowingly colluded with ‘improper’ practice. This went on to cause them a great deal of anxiety and distress as they believed themselves to be responsible (incorrectly) for agreeing to processes which might have led to a hastening of their loved one’s death.

### ***End of Life Care***

- 10.384** Most of the families who had a loved one die on Tawel Fan ward were full of praise for the care and treatment provided. There was one exception to this where a family described a deeply distressing experience on the night their relative died which was due to what they described as a lack of professional care giving on the part of the ward staff combined with a lack of out of hours medical cover.
- 10.385** The reasons why end of life care should not be routinely provided on an acute psychiatric admission ward have already been discussed in chapter 9. This kind of care provision on Tawel Fan was not ideal and was due to a systemic failure to

provide a more suitable alternative. However it should be noted that the end of life care arrangements on the ward appear to have been of a good general standard and that the ward treating team worked as best it could to ensure a comfortable, pain free and dignified experience for all concerned. This is borne out by the statements of families and from an examination of the case notes.

## **Person-Centred Care planning**

### ***Nursing Assessment***

- 10.386** Good assessment has to be holistic in nature taking into account the cultural, emotional, mental health, physical, social and spiritual needs of the patient.
- 10.387** In general the Investigation Panel found that nurse-led assessment on Tawel Fan ward was comprehensive and holistic in nature having been conducted appropriately. The assessment process followed a clear set of guidance which included standardised templates relating directly to the requirements of the Fundamentals of Care. It was evident that assessment information was collected from a variety of sources such as care homes (where appropriate), community mental health teams, GPs and family members. Nurse-led assessments dovetailed into those undertaken by the medical staff ensuring that a unified approach was taken. Each patient was reviewed by nursing staff everyday with medical staff reviewing patients at last once a week or more frequently if indicated.
- 10.388** Where the Investigation Panel identified relatively poor standards of assessment practice they were connected to specific nurse practitioners. It was possible to ascertain that those individuals' poor levels of performance had been both identified and managed contemporaneously by the Ward Manager. The poor standards in question related to:
- incomplete assessment forms;
  - a lack of documented consultation with family members.
- 10.389** In addition to the poor practice identified in relation to specific nurses there were two further issues that lessened the effectiveness of the assessment process.
- 10.390 First:** it was evident that formal risk assessment processes were always conducted by nursing staff on behalf of the multi-disciplinary team. However in reality those risk assessments appear to have been uni-professional in nature and it was difficult to assess how well the risk assessment process actually tied into medical and/or multidisciplinary care and treatment plans. It was also evident that risks were often not explored in enough detail and did not always take into account community-based safeguarding issues which were usually held in abeyance during inpatient admissions. This was poor practice.
- 10.391 Second:** out of the 105 sets of patient records under review spirituality was mentioned in only two sets of notes; this was also poor practice.

### ***Patient and Carer Involvement***

- 10.392** Most of the patients in the Investigation Cohort were in the advanced stages of the dementia process; this limited their ability to contribute to their own assessment. However where patients were deemed to have capacity they made a significant contribution with full ongoing consultation taking place, and documentation being both signed by them and shared with them. This was good practice.
- 10.393** The *This is Me* assessment tool was used on the ward, particularly for those patients without capacity and with severe cognitive impairment; families were supported to input fully. *This is Me* was developed in 2010 for those with dementia by the Northumberland Acute Care and Dementia Group with support from the Alzheimer's Society and Royal College of Nursing; it was originally designed for people being admitted to hospital.<sup>83</sup> The tool provides a person-centred approach to the care of those with dementia and aims to make hospital admissions less bewildering providing a practical means of support “*in an unfamiliar place*”. The tool focuses upon:
- needs;
  - likes;
  - dislikes;
  - interests;
  - preferences.
- 10.394** During the period under examination the Investigation Panel could determine that the use of the *This is Me* tool steadily increased over the years. However not all of the patients had an assessment completed as this relied heavily upon family members and carers being able to support the process and it should be taken into account that not all patients had families or carers. Just prior to the ward being closed internal reviews noted the need for a more even coverage and more work to be undertaken for those patients without access to people who knew them well pre-admission. However that being said *This is Me* was used to good effect on the ward for the majority of patients. This was good practice.

### ***Care Planning***

- 10.395** There was no standardised care planning format for older adult services within the Mental Health and Learning Disability CPG during the period under investigation. However between 2012 and 2013 Tawel Fan ward staff adopted a series of core care plans which adhered to Fundamentals of Care principles. The templates were available as electronic documents which were written using the ward computer, printed out and then placed in the hard copy patient records. The advantages of this were that a comprehensive set of issues were always considered with prompts provided to the nursing staff about essential elements of care.

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83 In Partnership with the Royal College of Nursing and the Alzheimer's Society (2017) *This is Me*  
[https://www.alzheimers.org.uk/download/downloads/id/3423/this\\_is\\_me.pdf](https://www.alzheimers.org.uk/download/downloads/id/3423/this_is_me.pdf)

**10.396** However it would appear that on occasions a ‘cut and paste’ approach was taken (by a specific member of the nursing staff) whereby the care plan for one patient would be copied and used as a care plan for another. This in itself would not have been a problem if the care plans were relevant, however this was not always the case, and the Investigation Panel noted that this practice was responsible (in part) for the commingling of patient records where the names and clinical details of one patient would inadvertently be cut and pasted into the notes of another. Whilst this only applied to one particular nurse practitioner this was poor practice and appears to have happened (on occasions) without detection.

**10.397** That being said, the Investigation Panel found that all patients had appropriate care plans in relation to the Fundamentals of Care. The care plans were kept (in general) under regular review and documentation was maintained in an appropriate manner. There is also ample evidence to suggest that family consultation and engagement was a key part of the care planning process with all major decisions being made in conjunction with families and their preferences and wishes being accommodated whenever possible.

**10.398** Two main issues were identified in relation to areas that required improvement.

- 1** There was a relative lack of connection between accidents and incidents and the need to review care plans in ‘real time’; for example – it was evident that falls did not always lead to a well-documented review (and/or alteration) of the care plans in a timely enough manner – this is explored in more detail in the relevant section below.
- 2** Whilst families were engaged with appropriately, the use of Independent Mental Capacity Advocates (IMCAs) was not always considered when their input was most definitely indicated – this is addressed further in the Legal Frameworks subsection below.

**10.399** The Investigation Panel found 21 distinct examples of very good person-centred care – some of which were exemplary. These included:

- ward staff visiting Sainsbury’s every day (over a prolonged period of time) to purchase special food (that could not be sourced by catering) for a patient who had distinct food preferences;
- the sensitive management of sexual disinhibition;
- gentle and constant reassurance given to a patient who could not bear to ever be left alone;
- compassionate end of life care that demonstrated excellent nursing inputs that ensured patients were comfortable and supported.

### **The Quality of Nursing Care on Tawel Fan Ward**

**10.400** It was not possible for the Investigation Panel to observe the nursing practice on the ward and so had to rely upon the statements from families and ward staff and the evidence provided within the clinical records.

**10.401** It is important to take into account the fact that the statements provided by both families and ward staff often concurred entirely. This should come as no surprise; many of the limitations in relation to care and treatment were based on incontrovertible facts such as:

- the lack of laundry facilities;
- the ineffective care pathway;
- the poor ward layout;
- staffing issues;
- patient acuity.

**10.402** Chapter 9 sets out some of the background and context issues in relation to the challenges and pressures that Tawel Fan ward had to manage; they should be taken into account here.

***Personal Care (including oral hygiene and foot care)***

**10.403** 27 families raised concerns in relation to personal care; the concerns focused mainly on clothing, and the general appearance and cleanliness of their loved ones. The Investigation Panel was able to ascertain that every patient included in the Investigation Cohort had comprehensive assessments conducted in relation to personal care and hygiene needs together with (where appropriate) care plans to address them.

**10.404** Hospitals do not provide routine personal laundry services, however wards like Tawel Fan will often launder the clothing of patients who have no relatives and no other access to this kind of facility. Once admitted to a ward patients are dependent upon their relatives (or social services and ward staff if they do not have any) to provide for their ongoing clothing and toiletries needs.

**10.405** Following a close examination of the clinical records it was evident that some patients had engaged families who lived relatively near to the Ablett Unit and who visited regularly providing for their loved ones needs. Other patients had families who could not engage regularly due to extreme old age or because they lived long distances away from the ward. For those patients accessing sufficient clothing (especially in the quantities required to support levels of incontinence) was an ongoing challenge. This was exacerbated by the intermittent withdrawal of housekeepers to the ward meaning that nursing staff had to launder patients clothing taking them away from other duties.

**10.406** The Investigation Panel was told that, despite regular requests (on the part of the Ward Manager) there were no lockable cupboards in the patients' bedrooms which meant that items of clothing would regularly be picked up and worn by any passing patient who had taken a fancy to it. Individual patient clothing was not labelled, unless families saw fit to do so, this meant that it was sometimes difficult to determine whether one patient was (for example) wearing another patient's cardigan or jumper.

**10.407** Patients would often try to dress themselves, and this was (quite rightly) encouraged in order to maintain independence. However as a result cardigans and jumpers could often be put on inside out and multiple layers of clothing were often chosen lending a somewhat bizarre appearance to the wearer. Whenever possible adjustments would be made to clothing by the nursing staff, but on occasions (especially if a patient was agitated and aggressive) they would be left as they were (as long as they were appropriately covered, safe and warm) until such time as their mood was amenable to intervention.

**10.408** In situations of this kind it is important to ask the question ‘whose standards are we adhering to?’ Patient-centred care does not necessarily conform to pre-established norms (whatever they might be) and interventions need to consider:

- comfort;
- contentment and wellbeing;
- the avoidance of embarrassment and fear (when insisting clothing is adjusted with a confused patient who could find this intimidating);
- the unnecessary increased risk for resulting levels of agitation and aggression;
- the maintenance of daily living skills (no matter how limited when washing and dressing) for as long as possible.

**10.409** Of particular note were the attempts by staff to use personal care as an opportunity for meaningful and relaxing engagement. For those patients who were able to engage there was the facility for them to have their hair cut on the ward, beauty treatments to be administered and nail care to be provided on a regular basis. This was good practice.

**10.410** However there was insufficient evidence to demonstrate how mouth care and oral hygiene needs were addressed; whilst general personal care was detailed it was difficult to understand how this extended to the care of dentures and teeth. What could be evidenced were the dental appointments that had been made (for some of the patients in the cohort) and the levels and quality of mouth care for the dying patient (which was found to be good). However the Investigation Panel found that the lack of specific care planning in relation to mouth care and oral hygiene to be a significant omission and something that should have been subject to careful and regular monitoring and review, which it clearly was not.

**10.411** In contrast foot care appears to have been managed well with routine assessments conducted as part of the admission procedure. Overgrown and ingrowing toenails were a regular feature for many of the patients admitted from the community; ward staff were well attuned to the potential for this as a consequence of months (if not years) of self neglect for those patients who had grown increasingly unable to look after themselves. Ward staff were vigilant about foot care in relation to mobility and also in relation to the risks for those patients with Diabetes. The Investigation Panel was able to track multiple referrals to Podiatry Services. This was good practice.

**10.412** As has already been determined, most of the patients on the ward were highly agitated and confused presenting with behaviours that challenged. A key reason for their admission to Tawel Fan ward was that their families (if still living at

home) or carers (if living in care homes) could no longer manage or address their personal care needs. It was evident from an examination of the clinical records that prior to admission many patients had been extremely resistant to receiving personal care and were considered to be at risk of neglect. It should be understood that the act of admission (in itself) does not automatically change behaviours and that extensive assessment is required in order to both identify and manage patient needs. It should also be understood that the act of admission (in itself) does not automatically confer 'special powers' that allow nursing staff to intervene with patients beyond those provided by the relevant legislative frameworks.

**10.413** From a careful examination of the clinical records it was evident that most of the patients came onto Tawel Fan ward with pre-existing histories of aggressive behaviours (and general resistance) in relation to personal care interventions. Once admitted to the ward it was the duty of the nursing team to provide a comprehensive approach in order to meet any identified care deficits. In relation to personal care this process should identify:

- the levels of self-care still present and the actions required to maintain independence for as long as possible;
- deficits in functioning and the required levels of intervention required to address them;
- the potential for aggression and resistance to interventions and how they should be managed to ensure continued dignity, health, safety and wellbeing.

**10.414** Whilst it is never acceptable for patients to be dirty and malodorous the following has to be taken into account when carrying out personal care interventions, or (as importantly) when deciding not to use them:

- the safety of the situation;
- the levels of patient autonomy and capacity;
- risks versus the benefits of having to physically restrain patients in order to carry out personal care;
- legislative frameworks;
- the building and maintenance of the therapeutic relationship.

**10.415** It is evident from an examination of the clinical records that omissions in personal care were usually as a result of resistance and refusal on the part of the patient. Refusals to cooperate with personal care were recorded in a contemporaneous manner within the case notes, together with plans and instructions for the following shift as to what still needed to be done. It was evident that the issues of non-cooperation were ever present requiring a high degree of nursing expertise and intervention.

**10.416** It should be taken into account that refusal and resistance to personal care interventions will (on occasions) require some kind of physical involvement often necessitating safe holding or restrictive physical intervention techniques. The consequences of these kinds of interventions are something that families and lay people might not be familiar with.

- 10.417** Regardless of the legal permissions given to nursing staff to intervene in personal care (Mental Health Act and/or the Mental Capacity Act) patients who become aggressive, resistive and violent at the point of personal care intervention will require risk assessment in order to preserve the dignity, health, safety and wellbeing of all concerned (staff and patient alike). On some occasions physical interventions will be decided upon, but on others the decision will be taken to delay intervention.
- 10.418** Physical interventions can require up to four nursing staff having to ‘lay hands on a patient’ six or seven times a day. No matter how well legal frameworks are adhered to or how well safe holding or resistive physical interventions are deployed it is distressing for all involved and carries a high degree of risk to both the patient and staff. In these situations a judgement call has to be made (preferably in conjunction with family members) as to the approach that needs to be taken and the levels of personal hygiene that need to be maintained during an acute or difficult phase of a patient’s illness.
- 10.419** Whilst it is never good practice to allow elderly patients with dementia to be dirty and malodorous; neither is it acceptable for them to become highly distressed (both mentally and physically) and placed at risk in an attempt to keep them clean. This is the perennial dilemma of nursing care in this kind of situation.
- 10.420** What was evident to the Investigation Panel was that on Tawel Fan ward this dilemma was understood and also taken into full account on a patient-by-patient basis. The following approaches were routinely used:
- personal care was provided (where possible) by those staff who had a good relationship with the patient;
  - de-escalation and distraction techniques were used;
  - if a patient was highly resistive to care (but not soiled with faeces or wet with urine) then personal hygiene needs would be re-assessed and perhaps postponed;
  - if a highly resistant patient was soiled with faeces and/or wet with urine a decision would sometimes be taken to leave the patient for a short while (perhaps five – ten minutes) and then return and try to intervene again once they had settled;
  - if a patient was soiled with faeces and/or soaked with urine (consistently refusing all interventions) then actions such as safe holding and restrictive physical interventions would be considered.
- 10.421** During the course of the Investigation it was noted that the clinical records should have contained more detail in relation to the rationales for using safe holding techniques and other kinds of restrictive physical interventions on these occasions. It was not clear what formal processes were followed and it was evident that linkages were not always made with Capacity Act and Best Interests frameworks as clearly as they should have been.
- 1** It would have been good practice for the associated risks and benefits for intervention/non-intervention to have been articulated more clearly and for a multidisciplinary record to have been made to the effect that the whole team was in accord with the approach taken.

- 2 It would have been good practice for those issues to have been discussed in an open and transparent manner with families so that they could a) understand the dilemma faced by all concerned and b) agree to the plan of care.
- 3 It would have been good practice for an IMCA to have been involved thus ensuring that any planned acts or omissions were in the patient's best interests.

**10.422** Whilst there were some areas where practice could have been improved in relation to personal care, the Investigation Panel could not find the evidence to support the notion that nursing inputs fell below an acceptable standard or that any omissions were as a result of neglect or substandard nursing practice.

### ***Continence***

**10.423** 14 families raised concerns in relation to continence management; the Investigation Panel did not identify any additional issues in relation to any individual patient cases. Most of the concerns raised by families were about the use of continence pads and the fact that patients were sometimes found in wet clothes, and on a single occasion, in a wet bed.

**10.424** People with dementia can often experience problems with continence; the likelihood of this is increased if a person is placed in an alien and unfamiliar environment (such as being admitted to a ward like Tawel Fan) where impaired cognition and memory can make locating a toilet difficult. In addition many older people have continence problems due to a range of other factors; these include:

- prostate enlargement in men;
- weakened pelvic floor muscles in women as a legacy of childbirth;
- urinary tract infections (UTIs);
- constipation and/or diarrhoea (sometimes caused by pre-existing conditions such as irritable bowel syndrome);
- prescribed medications (such as Frusemide) which can lead to a regular and urgent need for the toilet.

**10.425** People with dementia often experience incontinence because:

- they need someone to remind them to go to the toilet;
- they cannot find or recognise the toilet;
- they resist the help and assistance offered to them due to confusion or embarrassment;
- they cannot walk to the toilet quickly enough;
- the fastenings on their clothing might be too difficult to undo in time;
- those with an advanced stage of dementia might no longer have the cognitive ability to understand when they need to go to the toilet, why they should do so in the proper place, or where they would need to go to access it.

**10.426** Consequently many people can urinate or defecate in places other than a toilet. Waste bins, sinks and cupboards are frequently misinterpreted by people with impaired cognition and memory as being an appropriate place to relieve themselves. Some people in the advanced stages of dementia can become entirely disinhibited and relieve themselves whenever and wherever they see fit (for example on the floor or against a wall) and in full public view. Several families complained about this kind of behaviour as they were shocked to see people acting in this way; the implication being that patients were being neglected and that ward nursing staff were somehow complicit or uncaring. The Investigation Panel found that there were several factors that increased the likelihood of patients relieving themselves in inappropriate locations on the ward:

- the complex ward layout made finding a toilet a challenge for memory impaired patients;
- the complex ward layout meant that patients who were not on designated 1:1 observations could not always be seen by ward staff on a continuous basis meaning that random acts of incontinence could not be observed immediately and the necessary interventions made to preserve dignity;
- patient acuity was high meaning that on occasions the entire patient cohort was doubly incontinent (of both urine and faeces) requiring heightened levels of assistance.

**10.427** At any one time a significant majority of the patients on Tawel Fan ward experienced continence problems, many being regularly incontinent of both urine and faeces. This was due to a multitude of factors, but was principally due to most of the patients being in the advanced stages of their dementia and having been incontinent for many months, if not years, prior to their admission.

**10.428** Following assessment all of the patients on Tawel Fan ward deemed to have continence issues were provided with a care plan. Those care plans appear to have been somewhat standardised in nature but in essence the content was entirely reasonable; they would include:

- the use of continence pads for those with frequent and irregular continence problems;
- regular prompting to visit the toilet;
- particular issues relating to personal hygiene;
- tissue viability and skin care;
- a recognition where an individual might be routinely aggressive when interventions had to be made and the necessary interventions listed.

**10.429** The majority of families raising concerns discussed single events in relation to continence. It was evident that for most patients incontinence pads were not routinely used (which can be seen as good practice); hence the occasional accident whereby an individual would wet through their clothes. The decision to use incontinence pads is a judgement call that has to be made on an individual basis – if a person is prompted to go to the toilet regularly then the likelihood of ‘accidents’ can be avoided. This requires good nursing care and knowledge of the

patient coupled with a degree of vigilance so that any cues from the patient can be picked up and acted upon. It also has to be taken into account that people with dementia are often confused and embarrassed by interventions of a personal nature; this means that they can reject offers of help misinterpreting the actions of carers and nurses when they attempt to remove clothing, insert incontinence pads, and/or carry out necessary personal hygiene activities.

**10.430** If a person's cognition is severely impaired and their incontinence is of longstanding, then they will on more regular occasions either wet or soil themselves before being able to access the toilet. For those individuals, and for those with significant mobility problems, the judicious use of incontinence pads can improve quality of life and help to maintain dignity. Obviously there are always concerns that the overuse of incontinence pads will lead to:

- people not being taken to the toilet regularly thereby becoming de-skilled;
- people being left in wet incontinence pads for long periods of time, in effect being ignored, because they are not posing an immediate nurse management 'problem';
- a breakdown of the skin if people are left in wet and soiled incontinence pads for prolonged periods of time.

**10.431** There is no evidence to suggest that the patients on Tawel Fan ward were routinely placed in incontinence pads; it would appear that patients were taken to the toilet on regular occasions and that continence was maintained and managed in this way. For those who required incontinence pads there is evidence to suggest they were also taken to the toilet on a regular basis, encouraged to use it, and if required, their pads would be changed.

**10.432** It should be taken into account that the difference between wet and dry clothing and/or bed linen is approximately seven seconds, the time it takes for a person to empty their bladder. On occasions it is possible for a patient to urinate or defecate and for this to not be immediately obvious – whilst this is regrettable it is not always avoidable. There is no evidence to suggest that those relatively few occasions described by families indicate poor nursing care, or that patients were neglected in any way.

### ***Respect and Loss of Dignity***

**10.433** The Investigation Panel found it difficult to make any robust assessment about respect as it was not possible to observe the ward in action to form a general impression. The evidence provided by families was so contradictory in nature that it in effect 'cancelled itself out'. An examination of the clinical records demonstrated a patient-centred approach which was respectful in nature; however it was noted that on occasions the language used showed a degree of stereotyping, which although not uncommon to find in clinical records of this kind, is not good practice. However that being said, there is limited evidence to suggest that staff were disrespectful to patients and it would appear that on the whole acceptable practice standards were maintained.

- 10.434** Families were (quite rightly) concerned about the preservation of their loved one's dignity. Families found it highly distressing to witness their loved ones (and also other patients) in a state of undress or touching themselves inappropriately in public areas of the ward.
- 10.435** Many of the patients in the Investigation Cohort were found to have high levels of disinhibition, sometimes of a sexual nature; this applied to both male and female patients alike although those who were sexually disinhibited were usually female.
- 10.436** On occasions patients with dementia may remove their clothes in public places or remove their clothes in bathrooms and bedrooms and then walk into a public space such as a ward dayroom. For some patients this forms a consistent and repetitive set of behaviours which can happen on a regular basis repeatedly throughout the day and night.
- 10.437** Certain kinds of dementia can also lead to an increased likelihood of sexual disinhibition which can range from solo sexual acts and inappropriate touching of the self in public, to predatory sexual behaviour where patients might fondle and inappropriately touch other people (including nursing staff, fellow patients and visitors alike).
- 10.438** The nature of the ward layout, combined with patient acuity issues, meant that patients could not be kept under general observation all of the time. In most cases constant lines of visual access were not always required (and neither would they be possible on most NHS wards throughout the United Kingdom), however on occasions it became apparent that a patient's behaviour was escalating requiring increased levels of observation and supervision.
- 10.439** There is no 'magic formula' for this; however, in conjunction with risk assessment, heightened levels of observation can be utilised on NHS inpatient wards to reduce risk and to protect patients.
- 10.440** The Investigation Panel noted that the BCUHB Therapeutic Observation Policy (2011 – 2013) was basic in nature with the minimum of guidance offered; nowhere in the policy were the needs of the older adult with dementia mentioned; once again a Mental Health and Learning Disability CPG policy was written primarily for the adult of working age with the general assumption that it would be fit for purpose for all patient groups – this was poor practice. It set out observations as:
- **Level 1:** general observations where no immediate risk is present, this is the basic minimum level required – it would be usual for patients to be observed at least every three hours.
  - **Level 2:** intermittent observations where there are potential risks identified or where a patient has a history of high risk behaviour – observation intervals should be set at a maximum of once every 15 minutes to a minimum of once an hour.
  - **Level 3:** close observations where a patient is considered to be at significant risk and where they need to be kept within eyesight at all times.

- **Level 4:** arms length observations where a patient is considered to present with the very highest levels of risk.

**10.441** Observation policies for the management and supervision of dementia patients in mental health units usually recommend a more detailed set of considerations and approaches; for example those patients requiring more than a general level 1 set of observation should have:

- a written risk assessment determining the level of observation required together with the skill set of the staff needed to conduct the observation;
- a written observation and support care plan including monitoring and review process;
- informed consent/Mental Health Act/Mental Capacity Act/Deprivation of Liberty considerations taken into account;
- meaningful activities for the patient identified for the duration of the observation;
- referrals to management of aggression specialists and/or clinical psychology considered if persistent aggression is a feature;
- the regular ‘relief’ of nursing staff conducting observations to lessen fatigue and the risk of harm.

**10.442** The BCUHB policy in place at the time did not provide the comprehensive range of guidance as listed above. That being said; patients who presented a risk to themselves or others were usually nursed using increased levels of observations (mostly levels 2 and 3). Costs in relation to staffing budgets did not appear to prevent additional staff being allocated to the ward. However the staff used to conduct observations were often from the bank or an agency and did not always know the ward or patients well (this became an increasing problem during 2013). This affected the therapeutic relationship between staff and patients and also meant that the interventions provided during observations were not always as patient-centred as they could have been.

**10.443** There appears to have been little in the way of more proactive supervision measures such as ‘cohort’ observations (where wards are zoned during the day to ensure groups of patients at risk can be nursed in particular areas that are under constant observations at all times). This could have ensured patient dignity and safety were maintained better notwithstanding the difficulties presented by the ward layout.

**10.444** In reality enhanced levels of observation were used on Tawel Fan ward following incidents and/or safeguarding reviews and were therefore mostly reactive in nature. The prevention of some incidents could perhaps have been managed better had a different and more effective model of observation been in place.

**10.445** However with few exceptions (those are addressed in the Safeguarding chapter subsection directly below) the Investigation Panel found that every effort appears to have been made to maintain dignity and safety. It is evident that the ward staff were not ‘institutionalised’ and accepting of patients being naked in public or conducting themselves inappropriately in a sexual manner. An examination of the clinical records demonstrates that all incidents were taken seriously and

(where appropriate) incident forms and safeguarding alerts were raised. Whilst there were some areas where practice could have been improved the Investigation Panel could not find the evidence to support the notion that nursing inputs fell below an acceptable standard or that any omissions were as a result of neglect or substandard nursing practice.

### ***Tissue Viability and Pressure Ulcers***

**10.446** Pressure ulcers (sometimes referred to as sores) are localised injuries to the skin usually over bony prominences (such as heels and sacral areas) as a result of pressure and/or pressure in relation to a shear (such as friction caused by clothing or bed linen). This type of ulcer can be very painful, life threatening (due to resulting conditions such as sepsis) and difficult to treat. There are many factors associated with the development of pressure ulcers such as:

- prolonged inactivity (in either a chair or bed) where bony prominences are in constant contact with firm surfaces (such as a mattress) restricting blood flow;
- low body weight and/or obesity;
- poor nutrition;
- incontinence;
- smoking;
- excessive exposure to moisture (including perspiration);
- pre-existing skin conditions;
- underlying physical illness (such as diabetes) and general frailty.

**10.447** The severity of pressure ulcers are graded into four grades or stages:

- 1 Grade 1:** intact skin with non-blanchable redness of a localised area usually over a bony prominence; the area may be painful or tender.
- 2 Grade 2:** partial thickness loss of the dermis presenting as a shallow open ulcer with a red pink wound bed usually without slough (dead skin).
- 3 Grade 3:** full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss.
- 4 Grade 4:** full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed.

**10.448** However whilst the causes are multifactorial (and research is still unable to address the relationships between them) for over a century pressure ulcers have been associated with substandard care and treatment and as such have been monitored by successive government inspections and reviews. Indeed Florence Nightingale in 1859 wrote *“If he has a bedsore, it’s generally not the fault of the disease, but of the nursing”*. In 2010 BCUHB issued revised guidance relating to the reporting of grade 3 and 4 pressure ulcers under the then ‘Adult Protection’ requirements. The guidance stipulated that all incidents should be subject to adverse incident reporting where the potential for neglect would be considered and the necessary actions taken.

**10.449** It could be evidenced from an examination of the clinical records that every patient on Tawel Fan ward had a Maelor risk assessment conducted on admission. Those assessments were completed to determine the likelihood of the development of pressure ulcers and the degree of care planning required in accordance with extant BCUHB policy. At this time all patients considered to be at risk were expected to have a care plan that addressed:

- ongoing assessment;
- regular skin inspections and skin care;
- pressure relieving equipment;
- good nutrition;
- the management of incontinence.

**10.450** If a patient was identified to have specific risks (or had been admitted to the ward with a pre-existing pressure ulcer) referrals would be made to Tissue Viability and Physiotherapy services. This was done with immediate effect so care and treatment plans could be developed using specialist advice and appropriate equipment, such as pressure relieving cushions and mattresses, could be accessed.

**10.451** It should be noted that very few patients developed pressure ulcers whilst on Tawel Fan ward. Those that did had significant mobility problems combined with ill health and physical frailty. Those patients were all nursed on pressure relieving cushions and/or mattresses with the full support of tissue viability nurses and physiotherapy services. All pressure ulcers were reported under Protection of Vulnerable Adults (PoVA) processes as required and kept under review. At no time did the resulting investigations suggest that there had been poor care and treatment involved.

**10.452** It has not been possible to determine whether any acts or omissions on the part of the Tawel Fan ward team led directly to pressure ulcers forming – it is evident some three patients developed them whilst on the ward. However it was evident that appropriate assessment took place to prevent such occurrences where possible and that appropriate referrals were made in a timely manner with the necessary actions being implemented.

### ***Nutrition***

**10.453** In addition to the 18 families who raised concerns about nutrition the Investigation Panel identified a further nine patients whose cases required investigation. Of those:

- six patients required Speech and Language Therapy assessments which did not take place in a timely manner (most commonly due to the service not responding);
- six patients experienced a loss of appetite and a subsequent decline in weight with referrals to a dietician being either delayed, or not taking place at all.

- 10.454** Following an examination of the case notes for the 105 patients in the Investigation Cohort it was possible to determine that they had all undergone a nutritional assessment on admission which was kept updated throughout their stay on the ward. BCUHB used the Malnutrition Universal Screening Tool (MUST) during the period under investigation. This tool required the following to be conducted:
- **Step 1:** measure height and weight to estimate Body Mass Index;
  - **Step 2:** note any unplanned weight loss;
  - **Step 3:** establish the effect of any acute disease process (for example any loss of appetite due to fever);
  - **Step 4:** analyse the findings;
  - **Step 5:** develop the care plan.
- 10.455** The MUST requirements appear to have been followed in full for each patient. It is evident that patients were weighed on a regular basis and any weight gain or loss was recorded. All patients on the MUST diet (those deemed to require care plans) had their food and fluid intake recorded at meal times on a daily basis. For those whose appetites were poor, and/or were losing weight, supplementary foods and snacks were offered throughout the day.
- 10.456** The Investigation Panel noted that protected mealtimes were in operation; this ensured patients had the time to eat their meals at their own pace with limited interruptions taking place. The dining room was light, airy and comfortable. Where necessary staff would be allocated to individual patients to assist them with eating and drinking, it would appear that no patient was ever left with food or drink out of reach going hungry or thirsty as a result.
- 10.457** On a ward of this kind a key challenge is the management of the restless very active patient. This type of patient can become dehydrated and malnourished very quickly due to the calories being expended, exacerbated by the fact that they will not settle long enough to eat or drink preferring to stay in constant motion. The clinical records detail the approach taken where finger foods and drinks would be prepared with staff walking alongside the patient to ensure that it was consumed and nutritional needs were met.
- 10.458** It should be taken into account that patients with dementia usually experience a loss of appetite during the advanced stages of the disease process; this can often lead to dramatic and sudden weight loss. It should also be understood in these cases that high calorie dietary supplements (such as Ensure) will have limited efficacy as the underlying causes of appetite loss can not be remedied; this can also (on occasions) make the input from a dietetic service of limited value.
- 10.459** The Investigation Panel could not discover why a small number of patients were not referred to a dietician; further speculation would be inappropriate as there is no contemporaneous clinical rationale recorded. However the vast majority of patients were referred in an appropriate manner and, even if weight gain could not be achieved, a concerted effort was made to ensure nutritional needs were maintained at all times.

**10.460** In common with a loss of appetite individuals with dementia often experience difficulties in swallowing; this can lead to incidents of choking on food and drink accompanied by vigorous coughing fits. Whilst there is little that can be done to improve the swallow reflex the input of Speech and Language Therapy (SaLT) is invaluable as specialist dietary advice can be given together with advice on techniques to support the swallow reflex. From an examination of the clinical records it would appear that referrals were routinely made by the ward but that (on occasions) the SaLT service could not always respond in a timely manner leading to delays in assessment and advice being given. However it was not possible to determine that any individual patient came to harm as a result of these delays during their admission to Tawel Fan ward.

**10.461** In summary, the Investigation Panel found that the nutritional needs of the patients on Tawel Fan ward were managed in a diligent and thorough manner. In relation to the specific concerns raised by families the Investigation Panel found weight loss to have been connected to the progressive nature of the dementing process rather than to 'neglect' or poor nursing care on the ward. It should also be noted that in most of those cases gradual and steady weight loss was found to have pre-dated admission to Tawel Fan ward thus supporting further the notion that it was part of the dementia process rather than any kind of mismanagement on the ward.

### ***Management of Falls***

**10.462** Six families raised concerns about the management of falls; particularly in relation to supervision and prevention. The Investigation Panel found a further 17 patients where the management of falls did not always adhere (in full) to the extant BCUHB Falls Care Pathway. However 11 cases were identified where extremely good management was evident.

**10.463** Falls were identified across the provision (Tawel Fan, Glan Traeth, Bryn Hesketh, medical wards on the Glan Clywd site, and community hospitals). On medical wards and in community hospitals the incidents were associated with unobserved falls from beds and chairs. On Tawel Fan and other mental health wards falls were mostly associated with a loss of balance, trips and slips, or people being pushed to the ground by fellow patients.

**10.464** The BCUHB Falls Care Pathway for the period under investigation (issued in February 2011) stated that:

- 1** All older people should be assessed using the Falls Care Pathway algorithm on admission. Should a significant level of risk be identified patients should be placed on the pathway as a preventative measure and a care plan devised.
- 2** Following a fall the following had to be conducted:
  - a check for injury;
  - vital signs and neuro observations;
  - medical team notification;
  - family contact;

- incident form completion;
- commencement of the Falls Care Pathway.

**10.465** For those patients on the Falls Care Pathway it was advised that the following be considered:

- a risk assessment;
- a referral to pharmacy, physiotherapy, podiatry etc. as indicated;
- an environmental and footwear assessment;
- regular blood pressure monitoring;
- enhanced observations.

**10.466** The Falls Care Pathway was a relatively clear and well-written document. However the guidance (and accompanying recommended documentation templates) did not appear to have been adopted by any of the wards reviewed by the Investigation Panel and where patient falls were known to have taken place. This suggests that the pathway documentation might not have been readily available on the Glan Clywd Hospital site as different assessment scales and paperwork appear to have been used.

**10.467** The Investigation Panel found little evidence to suggest that the medical wards on the Glan Clywd site (and those in local community hospitals) assessed a patient's risk of falls on admission, or adhered to the Falls Care Pathway following incidents. This is of concern as most of the falls the Investigation Panel identified in those locations consisted of repeated unobserved falls from beds and chairs. There is no documentation to suggest that either environmental or equipment assessments were conducted as a result. This meant that multiple (seemingly preventable) falls continued to take place; sometimes leading to direct harm (such as fractures). In addition there is limited evidence to suggest that families were notified or that incident forms were completed. This was unacceptable practice.

**10.468** In relation to Tawel Fan ward it was evident from an examination of the case notes that a falls assessment was routinely conducted on admission. It could be determined that directly following a fall on the ward all appropriate physical checks would be undertaken, the medical team contacted, families notified and an incident form completed. This was good practice.

**10.469** However there were key areas where practice could have been improved even if direct harm could not be attributed to any lack of intervention. The Investigation Panel found that there was (on occasions) a lack of timely intervention in relation to the following:

- physiotherapy inputs for those patients identified with a risk of falls;
- physiotherapy inputs for those patients once they had experienced a fall;
- documented care plans to manage identified risk;
- understanding about the relationship between particular psychotropic medications (such as Olanzapine), low blood pressure and the increased risk of falls;
- (on occasions) a review in relation to medication (particularly Benzodiazepines) following a fall.

**10.470** It should be taken into account that a dementia diagnosis, combined with psychotropic medication, would have automatically raised the risk of falls for the patients in the Investigation Cohort, whether or not there were any relevant comorbidities or mobility problems identified. Therefore a ward like Tawel Fan will always have to be as proactive as possible in relation to the management of falls; however there were challenges. The withdrawal of physiotherapy services to the ward in 2011/2012 made an impact on proactive falls reduction management. The Modern Matron had this to say about the consequent reduced levels of service:

*“Whilst referrals would be dealt with in a number of days, it did not have the same prophylactic effect that being on the ward to witness problems as they arose had.*

*It also meant that the exercise groups to help strengthen patient’s legs, arms etc did not take place. The nurses undertook activities as and when they could, however they are not trained to do exercises with patients and therefore, physical activity may have been just playing catch with a ball. The other issue was that even when a physiotherapist showed a nurse and patient what exercises to do, due to the patient’s memory loss, lack of ability to process the information and possibly challenging behaviour, it was sometimes difficult to perform the exercises on a regular basis. I am not aware of a falls clinic available to OPMH (Older Persons Mental Health) in-patients ...*

*... Other difficulties would arise as patients often did not remember that they needed to walk with a walking stick or Zimmer frame, and would leave them behind. Also, patients would take them but use them inappropriately causing a potential hazard”<sup>84</sup>*

**10.471** The Modern Matron was able to provide a clear history for the work that the Mental Health and Learning Disability CPG conducted in relation to falls management and prevention. This included a review of falls which was conducted to look at incidents between March 2013 and March 2014. The review stated that *“the BCUHB falls pathway identifies 1-1 supervision for patients who are prone to wandering and cites NICE guidelines as a source for this. However, the NICE guideline makes no recommendation for this”*.

**10.472** The review noted that there was a lack of research evidence to demonstrate level 3 and 4 observations were appropriate interventions (in themselves) to prevent falls. It identified that these kinds of observations had a limited efficacy as individuals could not practically be prevented from falling as all a nurse could do was try to ‘catch’ the patient which could result in injury to both the patient and the nurse alike and was to be discouraged strongly from a health and safety point of view. It was also understood that 1:1 observations specifically to prevent falls could trigger agitation and aggression as patients could feel ‘crowded’ and claustrophobic having someone follow them everywhere at all times; something to be avoided.

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84 Witness Statement excerpt

- 10.473** The CPG review considered all of the potential interventions that could be made in the light of best practice guidance and research evidence. This was good practice. It was noted that the National Patient Safety Agency (NPSA) had identified hip protectors and assistive technology (such as movement alarms) to have limited benefits in preventing falls and the subsequent injuries from them. After careful consideration these options were discounted for the future. The Investigation Panel concurs with the findings of the BCUHB review.
- 10.474** The CPG review noted that the number of fall-related incidents on Tawel Fan ward were no greater than those across the rest of the BCUHB provision – from the data available it would appear that Tawel Fan ward was not an ‘outlier’ in any way. The Investigation Panel found that, in general, practice on Tawel Fan ward was of an acceptable standard notwithstanding the areas that required improvement as listed above. From the evidence available it would appear that the majority of falls on the ward could not be deemed to be avoidable and that any potential breaches in care were minimal.
- 10.475** However the Investigation Panel found that practice on medical wards (Glan Clywd and community hospitals) fell short of extant policy guidance and that some patients came to harm from incidents that might have been avoided had better assessments been conducted and management plans been put in place.

### ***Rest and Sleep***

- 10.476** The Investigation Panel found this aspect of the Fundamentals of Care to have been managed poorly on Tawel Fan ward. There were very few examples of care plans being developed in this regard even though nocturnal agitation and waking was a regular feature for many of the patients (in keeping with the key signs and symptoms of dementia). It would appear that person-centred plans in relation to good sleep hygiene were neither developed nor the need for them properly understood. This was a significant omission in that it possibly contributed to an increased reliance on the use of Benzodiazepines at night to help relax patients and get them to sleep. This aspect has already been examined in the relevant Medication and Treatment chapter subsection above. Whilst the Investigation Panel found the use of Benzodiazepines to have been both prescribed and administered within acceptable parameters, it is always good practice to try to either limit their use or avoid them entirely if at all possible. This could have been achieved better with good sleep hygiene practice.

### ***Comfort and Pain Control***

- 10.477** This is an aspect of care and treatment that was managed well on most occasions. Nursing staff were vigilant and the clinical records detail the measures that were taken such as referrals to the pain clinic, palliative care and physiotherapy.
- 10.478** It should be taken into account however that the ward environment did not always lend itself to the kinds of patients that were admitted. Those patients with significant physical frailties and those who required end of life care could not always access the levels of comfort that they required despite the best efforts of the nursing staff.

## Summary

**10.479** There are two other Fundamentals of Care indicators that have not been addressed in full in this chapter subsection; they are communication and safety. Communication is a theme that runs through the whole of chapter 10 and therefore cannot be addressed in isolation; safety is addressed in detail in the Safeguarding subsection directly below.

## Conclusions

**10.480** The Investigation Panel is required to provide its conclusions in a fair and balanced manner based on the evidence available. It would be unreasonable to assess care and treatment against unattainable ideals that do not bear any relation to the realities of day-to-day practice. The key tasks are to identify:

- where and why practice fell short;
- whether patients came to harm; and
- how improvements to services can be made.

**10.481** It is evident that on occasions some aspects of the care and treatment provided on Tawel Fan ward fell below those to be hoped for; but in this the ward was probably no different from many others of its kind throughout the United Kingdom. The Investigation Panel concludes that (overall) a good general level of care and treatment was maintained under very challenging circumstances which were largely systemic in nature. There is no evidence to support the notion that patients were neglected or that their care and treatment was compromised in any significant way. Neither is there evidence to support the notion that nursing care was institutionalised or of an unacceptable standard allowing patients to be degraded and their dignity lost as a result.

## Patient and Family Experience

**10.482** When drawing conclusions the Investigation Panel took into account the fact that the nature of the concerns raised by families varied significantly across a broad range of topics. Whilst some families made distinct allegations and complaints about care and treatment, the majority raised more general concerns seeking explanations and reassurance. The ‘Tawel Fan effect’ was a major factor whereby families questioned prior events in the light of present-day media coverage together with their contact with the North Wales Police inquiry. The Investigation Panel also took into account the significant number of families who found the care and treatment their loved ones received on the ward to be of a good standard with nothing but praise and positive experiences to recount.

**10.483** The Investigation Panel understands that many of the concerns raised by families resulted from the distress they felt as they witnessed their loved one’s increasing decline and change of behaviour as a result of the dementia process. Many of those families told the Investigation Panel during interview that they had never visited a psychiatric inpatient ward before their relatives were admitted to Tawel Fan and they found the experience to be devastating as the full impact of the dementia process became obvious to them.

- 10.484** It was evident that prior communications about diagnoses and prognoses had not been held with many of the relatives and this increased their confusion and general levels of concern that something ‘was not right’ as it was outside of their experience. As has already been mentioned in the Diagnosis subsection above the ‘snapshot’ syndrome was evident in many cases. Most of the family members who became involved on the ward were sons and daughters who had not always realised (until the point of admission) the severity of the decline their parents had been experiencing.
- 10.485** It is not the intention of the Investigation Panel to diminish in any way the levels of concern and distress felt by family members however a key underlying issue was the mismatch of some families’ expectations when set against the realities of a dementia diagnosis and methods available to both manage and support it. This was exacerbated by communication processes that on occasions failed to ensure families were brought to a proper understanding of all of the issues. It was evident that more support was required for families together with opportunities for open and honest discussions. It was also evident that most family complaints and concerns were not raised with the ward team during their loved one’s period of admission; with the benefit of hindsight this did not necessarily mean that they were happy with the service received.
- 10.486** It is an important lesson to learn that silence does not necessarily imply acquiescence, satisfaction or understanding and that an admission to a ward like Tawel Fan is a major life event for patients and families alike requiring ongoing levels of support that cannot always be accommodated by ward staff alone.

### **Clinical Practice**

- 10.487** The Investigation Panel concludes that the clinical assessment, management and nursing care provided on Tawel Fan ward were of a good general standard. This was made more remarkable by the levels of patient acuity in relation to physical frailty and end of life care that the Tawel Fan ward staff had to absorb in the wake of pressures throughout the care pathway. The concerns and complaints raised by families, whilst deeply distressing, were not found to be avoidable in the main and did not constitute unacceptable levels of care or treatment beyond those to be expected in a clinical area of this kind; neither was it possible to identify patients coming to any significant harm as a result. However it should be recognised that whilst the Investigation Panel concluded that care and treatment delivery was provided by suitably motivated and skilled ward staff the therapeutic atmosphere on the ward could be compromised by the levels of patient acuity and the competing needs of the different patients on the ward.
- 10.488** Several areas were identified that required improvement in relation to professional standardisation and policy adherence. There were policies and procedures (principally the Falls Care Pathway) which did not appear to have been used on the Glan Clwyd site, begging the question as to how such guidance was implemented and monitored for effectiveness and how patient safety was assured. There were also significant omissions noted in relation to clinical risk assessment and the use of the Mental Capacity Act (these are addressed in detail in the chapter subsections below). As has already been identified policy access

and adherence appears to have been inconsistent with clinical staff being left to interpret standards as they saw fit with the minimal levels of oversight and scrutiny from either corporate or CPG governance mechanisms.

**10.489** The areas of care and treatment provision that fell below acceptable standards were mainly systemic in nature relating to the care pathway and the CPG service model; they were not specific to Tawel Fan ward or to any acts or omissions on the part of the treating team. It is evident that on occasions patients came to harm during the transitions and multiple ward moves they experienced. Elderly patients were often subjected to:

- long waits in Accident and Emergency departments;
- a loss of continuity of care;
- placements in inpatient beds that could not provide for all of their care and treatment needs;
- restrictions to the timely access of therapy and other specialist inputs.

**10.490** The available evidence supports the conclusion that the care and treatment on Tawel Fan ward was provided to a satisfactory standard. However no service is provided in a vacuum and the patients who were admitted to the ward experienced many service inputs that both predated (and for many) post-dated their time there.

#### **Underlying Factors: Root Cause Analyses**

**10.491** Areas that were not optimal combined systemic, local service and individual practitioner factors. It is important to understand which factors were in play so that recommendations and actions for service improvement can be targeted appropriately. Appendix 3 provides information about root cause analyses factors.

**10.492** Many of the factors set out below have already been examined in depth in chapter 9; a concise summary is provided below.

#### ***Care Pathway and Systemic Issues***

**10.493** Pressures in the system created the circumstances whereby the quality of care and treatment was often compromised. There were three main underlying issues:

- 1** There was a lack of synergy in relation to service development and planning. The Health Board did not have an integrated strategy that aligned its services in order to place the patient at the centre of the care pathway as they moved between episodes of care. This was most evident when patients needed to move between services managed by disparate CPGs.
- 2** Financial constraints and service modernisation led to pressures on inpatient beds. This meant that patients would often experience multiple ward moves in order to manage those pressures and the quality of care and treatment could be compromised as a result due to a loss of continuity of care coupled with an often suboptimal placement.

- 3 Financial constraints made a direct impact on the capacity and capability of the workforce. During the period under investigation the levels of therapy services were reduced to wards like Tawel Fan; this meant services were either withdrawn or limited in nature. As a consequence nursing staff had to perform many therapeutic inputs that they were not skilled enough to undertake and delays occurred when trying to access specialist assessments on the ward.

10.494 The identified factor is:

- organisational and strategic (structure and prioritisation).

### *Patient Acuity*

10.495 As a consequence of care pathway and systemic issues the levels of patient acuity on Tawel Fan ward rose. This was a steady and incremental process which took place over a two-year period; it was not something that had been planned intentionally as the situation was the result of numerous service pressures throughout the system.

10.496 Tawel Fan ward and its treating team was required to adapt as necessary. However the environment could not adapt to the increasing demands placed upon it and neither could the ward team (beyond a certain point) due to recruitment controls and workforce challenges.

10.497 The complex presentations of the patients on the ward could create a somewhat chaotic atmosphere. This created heightened levels of challenge which could compromise the quality of the experience on the ward for patients, families and staff alike. Whilst this did not appear to diminish the essential delivery of the Fundamentals of Care, the peace and calm of the therapeutic environment was (on occasions) eroded. The identified factors are:

- patient (in relation to clinical need and presentation);
- equipment (in relation to the environment and specialist items required);
- working conditions (capacity and capability of the workforce);
- organisational and strategic.

### *Communication and Education*

10.498 Acute psychiatric admission wards for the older adult suffering from dementia can be bewildering places for those who have never visited them before. On most occasions a ward of this type will be a place of calm with a homely atmosphere, but on others it can be a place full of noise, unpleasant smells and patients who are showing disinhibited behaviours that most people would never encounter going about their ordinary day-to-day business. It is distressing for families to see their loved ones placed in this kind of environment and disturbing for them to witness their loved ones acting 'out of character' and in ways that they find embarrassing or difficult to explain.

**10.499** It was apparent that families experienced a range of emotions when their loved ones were admitted to Tawel Fan ward. Some had feelings of overwhelming relief whilst others felt shock and dismay. From what families told the Investigation Panel there did not appear to be a consistent process of welcoming new patients and families onto the ward; particularly out of hours. It was evident that communication, education and support had not always been provided at an earlier point in the care pathway leaving the way open for a series of miscommunications and misalignments of expectation once secondary inpatient intervention was necessary.

**10.500** The families who made allegations and who raised concerns and complaints all had important points to make and feedback to give about the experiences both they and their loved ones had on Tawel Fan ward. Open and honest conversations should have been encouraged at the time about any challenges to care and treatment giving and the co-production of care plans could have provided the platform upon which to balance expectations with realistic patient management strategies that could be agreed by all concerned. The identified factors are:

- patient and family (expectation, levels of education and support needed and active involvement and decision making);
- communication and education (for both patients, families and staff alike);
- task and team (in relation to whose responsibility good communication was and how ongoing support could be provided).

### **Lessons for Learning**

**10.501** Some of the lessons for learning align to those already identified in the Diagnoses and Medication Treatment subsections above. The main lessons for learning are:

**1 Education, Information and Support to Patients and their Families.**

Consideration needs to be given as to how education, information and support can continue to be provided and tailored to each stage of the dementia journey; particularly at key points of transition such as admission to acute inpatient wards. On those occasions patients and their families need time to adjust to what is a major life event and they will need additional input to help them engage with services to best effect.

**2 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 is of paramount importance on inpatient units where difficult decisions often have to be made; in such circumstances ward staff should work with families to clarify all of the issues under consideration to ensure informed consent is given by families.

**3 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.

- 4 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.
- 5 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, 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.
- 6 Access to Medical Assessment.** psychiatric inpatients should not experience lower levels of medical assessment access than those to be expected in a community setting.
- 7 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.
- 8 Strategic Planning.** 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.
- 9 Multiple Moves.** 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.
- 10 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 patient experience can be compromised and suboptimal practice and/or unsafe practice provided.

- 11 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.

## Safeguarding

### Context

#### National Background

- 10.502** In July 2000, the National Assembly for Wales produced *In Safe Hands*.<sup>85</sup> This followed a decade of increasing focus on the protection of vulnerable adults within health and social care policy. This document provided a guidance framework that built on a Social Services White Paper *Building for the Future* (1999) which had identified protection and promotion of the welfare of vulnerable adults as a priority.<sup>86</sup>
- 10.503** *In Safe Hands* was developed following the work of a multi-agency advisory group and wide consultation across Wales. There had also been close liaison with the Department of Health who were developing similar guidance (*No Secrets* 2000) in England.<sup>87</sup> The guidance was issued under Section 7 of the Local Authority Social Services Act (1970) and gave Local Authority social services departments the co-ordinating role in developing local policies and procedures for protecting vulnerable adults from abuse. Other agencies and organisations, including NHS bodies and the police, were expected to work co-operatively with Local Authorities.
- 10.504** The guidance provided a detailed framework for the identification, investigation and prevention of abuse and all “*agencies and organisations*” were expected to work co-operatively together to achieve these tasks. The document did not have full force of statute but the expectation was that it would be complied with unless there were “*exceptional reasons*”. The aim of the document was to achieve a consistent approach across Wales but also to allow flexibility in relation to diverse local interagency arrangements and local circumstances. The core agencies named in the framework were:
- commissioners of health and social care services;
  - providers of health and social care services;
  - providers of sheltered and supported housing;
  - regulators of services;
  - the police and other law enforcement agencies;
  - voluntary and private sector agencies.

<sup>85</sup> National Assembly for Wales (July 2000) *In Safe Hands: Implementing Adult Protection Procedures in Wales*

<sup>86</sup> Welsh Assembly Government (March 1999) *Building For The Future: A White Paper For Wales*

<sup>87</sup> Department of Health and Home Office (2000) *No secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*

**10.505** In relation to social services departments, it was made clear that the Directors of Social Services would have a particularly important role. It was expected that they would ensure Local Authority members were aware of issues relating to the protection of vulnerable adults at a strategic level *“as well as those relating to cases of institutional and individual abuse”*. It was recognised that the comparatively small unitary authorities in Wales would make representation on interagency working groups problematic and, in addition, these small authorities would encounter fewer cases of abuse. The document therefore suggested that small authorities should work closely with their neighbouring authorities in order to *“streamline arrangements for their partner agencies”*.

**10.506** *In Safe Hands* outlined a definition of a vulnerable adult, provided by the Law Commission, as a person over 18 years of age who:

*“Is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation”*.

**10.507** Abuse was defined as *“a violation of an individual’s human and civil rights by any other person or persons”*. Types of abuse were listed as physical, sexual, psychological, financial or material, and neglect. In addition, racially motivated and stranger abuse, were also highlighted. However *In Safe Hands* stated:

*“Multiple forms of abuse are often seen in ongoing relationships or an abusive service setting, making it important to look beyond single incidents or breaches in standards to underlying dynamics and patterns of harm. Any or all of these types of abuse may be perpetrated as the result of deliberate intent or targeting of vulnerable people, negligence or ignorance”*.

**10.508** The Law Commission concept of significant harm was raised as an important threshold when considering the nature of the intervention required *“ill treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of, or an avoidable deterioration in physical or mental health; and the impairment of physical, emotional, social or behavioural development”* (Law Commission Report 1995).

**10.509** It was noted that significant harm *“may comprise a series of incidents which, when regarded in isolation, seem insignificant, but when frequent or continuous become serious”*. The document went on to note that abuse occurring within an institutional setting *“often includes more than one form of harm as a result of rigid and insensitive routines, unskilled, intrusive or invasive interventions or an environment which allows inadequate privacy or physical comfort”*. It is stated that this type of abuse falls within the remit of regulators as well as purchasers of care. Institutional abuse is therefore *“not a separate category of abuse but a particular manifestation of, and context for, it”*.

**10.510** *In Safe Hands* provided organisations with detailed guidance and a six-stage process to follow in the investigation of allegations of abuse. In 2003, a further supplement to *In Safe Hands* was issued to provide additional detailed guidance

in relation to financial abuse and set out minimum practice standards which had to be met.

- 10.511** In 2007 the Care and Social Services Inspectorate in Wales (CSSIW) was formed from the merger between the Care Standards Inspectorate and the Social Services Inspectorate. This organisation was tasked with the improvement in social care and social services by regulating, inspecting and reviewing performance across the whole sector. The aims of the organisation included *“developing an integrated view of social services and care from strategy to delivery, by making better use of the combined resources of the two former organisations. The inspectorate along with other statutory bodies and partners has a key role in offering public assurance”*.
- 10.512** In March 2010, the Healthcare Inspectorate Wales (HIW) published *Safeguarding and Protecting Vulnerable Adults in Wales: A Review of the Arrangements in Place across the Welsh National Health Service*. Against a backdrop of year-on-year increases in the number of alleged cases of abuse being reported across Wales, during 2007-2010 the HIW had undertaken thematic reviews, inspections, investigations, Mental Health Act monitoring visits and unannounced privacy and dignity spot checks. These had highlighted under-developed adult safeguarding arrangements and processes across NHS Wales.
- 10.513** The HIW document highlighted that the legislation for vulnerable adults continued to lack clarity. The main driver for improvements to adult safeguarding arrangements across the United Kingdom was seen as the Human Rights Act 1998 as *“it ensures that the force of law is used to drive respect for the rights of individuals and provides a framework that encourages public bodies to have high standards of practice; place a general common law ‘duty of care’ on them”*. In addition, two other pieces of legislation were seen as useful:
- 1** The Care Standards Act (2000) and related regulations placed requirements on care providers outside of the NHS to ensure they had procedures in place to protect individuals in their care from harm or abuse.
  - 2** The Mental Capacity Act (2005) introduced two new offences of mistreatment and wilful neglect in respect of people who are considered to lack ‘mental capacity’.
- 10.514** The HIW document went on to state that *“Many consider a key gap to be the development of legislation that places a statutory duty on the agencies involved in safeguarding adults to cooperate and work together”*.
- 10.515** The findings outlined a wide variation in Protection of Vulnerable Adult (PoVA) knowledge amongst NHS staff in Wales and a number of recommendations were made to NHS organisations. They included:
- mandatory training for all staff including general practitioners and those in wider primary care services (dentists, pharmacists and optometrists) and regular evaluation of this training;

- Health Boards should work with primary care contractors to ensure their engagement in adult protection multiagency groups;
- Health Boards should ensure that at least one person in every Accident and Emergency and Minor Injury Department has PoVA training;
- Mental Capacity Act and Deprivation of Liberty safeguard training should be in place for all staff;
- the Board of every Welsh NHS organisation should ensure sufficient resources to drive the agenda forward, sustainable structures to be put in place, individual staff to be clear about their roles, and clear lines of accountability for adult safeguarding from the Board to front line staff;
- Boards should ensure learning from PoVA incidents and audits are used to improve arrangements;
- NHS organisations should show commitment and support to Regional Adult Protection Forums and Area Adult Protection Committees and ensure that a senior member of staff attended who could commit resources on behalf of the organisation;
- NHS organisations should review their arrangements for the management of gender mix to ensure safety and dignity;
- NHS organisations should have clear ‘locked door’ and ‘leave from ward’ policies in place to comply with Deprivation of Liberty safeguards and best practice in patient safety;
- NHS organisations should have robust risk assessment, management and care planning processes to ensure those who are vulnerable are subject to safeguards; this to include carer assessments;
- all healthcare staff and contractors should have systems and processes in place to ensure patient sensitive information is not visible to the public;
- NHS organisations should ensure vulnerable people are given ‘a voice’ through advocacy arrangements and opportunities to discuss issues without carers or relatives present;
- NHS organisations should ensure guidance was in place to support staff to raise concerns about colleagues;
- NHS organisations should publicise how concerns about treatment or potential abuse of a vulnerable adult within the NHS can be raised;
- NHS organisations should ensure that service users and their carers or families are given the opportunity for involvement in adult protection processes and kept fully informed.

**10.516** The document stressed that proactive leadership and management in the NHS were necessary to ensure that safeguarding was understood fully and vulnerable adults were safeguarded properly. Also in March 2010, CSSIW published *National Inspection of Adult Protection All Wales Overview*. This report set out the findings of inspections undertaken between July and December 2009 and highlighted deficits in the system.

**10.517** In September 2010 a review of *In Safe Hands*’ was published. This document was produced by the Welsh Institute for Health and Social Care and the University of Glamorgan. The review assessed the continuing effectiveness, appropriateness and robustness of the guidance and made recommendations about where improvements could be made. The review found the following:

- 1 **Effectiveness:** the evidence suggested that some groups of people were “referred to more readily” within the guidance than others. Those with mental health problems, who misused drugs or alcohol, were homeless, in receipt of direct payments or funded their own care, appeared to be disadvantaged. In addition, some agencies worked together and shared information more effectively than others and were not all working together with Local Authorities as well as they could be.
  - 2 **Appropriateness:** the title *In Safe Hands* sounded out-dated and implied people were passive and dependent. This did not reflect policy aspirations to co-produce services with empowered citizens. The evidence also found that people did not like being labelled as ‘vulnerable’. Finally there should be more emphasis on prevention as well as protection “*The phrase ‘Safeguarding Adults’ has a broader scope than ‘adult protection’ that better reflects this wider agenda and is the preferred term in this policy area*”.
  - 3 **Robustness:** interagency working and the regulatory system needed to be strengthened, particularly in relation to institutional abuse.
- 10.518 The review concluded that due to the fast developing legislative framework and policy environment between 2000-2009 *In Safe Hands* was only partially effective, no longer appropriate and not sufficiently robust, and made recommendations to improve the system of safeguarding adults in Wales.
- 10.519 In November 2010, the Wales *Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse* was published. This document was commissioned by the four Adult Protection Fora across Wales and was intended as a handbook for practitioners who were managing adult protection work, those investigating allegations of abuse or who have other direct responsibilities in adult protection across the whole of Wales. It was clear that there were national discussions related to changes in adult protection underway, but it was viewed that the existing *In Safe Hands* guidance required updating in the interim period until the overall national policy direction was agreed.
- 10.520 In February 2011, the *Report of the Protection of Vulnerable Adults Project Board* was published. This Board had been established in February 2008 by the Deputy Minister for Social Services to consider what changes were needed to ensure that adult protection arrangements in Wales remained effective in protecting vulnerable people from abuse.
- 10.521 The Board reviewed the reports from CSSIW, the Welsh Institute for Health and Social Care/University of Glamorgan and HIW. The aim of this review was to create a more cohesive legal framework for social care. The report recognised the significant changes that had taken place in the field of adult protection over the previous ten years and made two overarching recommendations to Welsh Assembly Government that:
- legislation must be reviewed and have the same status and priority as protecting children;

- *In Safe Hands* guidance should be replaced by new guidance for local authorities, health boards and trusts and all other agencies involved in adult protection work.

**10.522** In 2013, the *Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse* was reviewed and reissued with minor amendments to reflect legislative changes. There were also changes made to the definition of a Vulnerable Adult which no longer included “*a person who had social or emotional problems*”. It was recognised that a major re-write of the document would be required following “*the enactment of the Social Services (Wales) Bill, which will be published in 2013*”.

**10.523** In April 2016, the Social Services and Well-being (Wales) Act 2014 was implemented. This Act in Part 7, and the accompanying Welsh Government guidance, replaced all previous guidance for social services and other key agencies in safeguarding. The Act put on a statutory footing much of the pre-2015 safeguarding guidance and the terminology changed from PoVA to adult safeguarding. The Act also provided a new definition which replaced the term ‘vulnerable adult’ used previously. This definition states:

*“An “adult at risk” is an adult who:*

- a) Is experiencing or is at risk of abuse or neglect;*
- b) Has needs for care and support (whether or not the authority is meeting any of those needs); and*
- c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it”.*

## **Local Context**

**10.524** In north Wales, the structure for adult protection arrangements was consistent with most other geographical areas in Wales during the period under Investigation. Each of the six north Wales Local Authorities had a multiagency adult protection committee and a PoVA coordinator in place. A Regional PoVA Forum sat above these structures. The Regional PoVA Forum was mainly a forum for support and the development of practice and not part of any governance structure in relation to the adult protection committees.

**10.525** A paper was taken to the BCUHB Board in June 2009 (Policy and Procedures for the Protection of Vulnerable Adults) in order to make clear the arrangements for the newly established organisation. It can be seen from the paper that the organisation had a Head of Adult Protection in place. This post was responsible to the Assistant Director for Safeguarding (Children and Adults) who, in turn, reported to the Director of Nursing, Midwifery and Patient Services. The responsibility for adult protection was devolved to the Assistant Director of Safeguarding at both an operational and strategic level.

- 10.526** The Head of Adult Protection had lead responsibility for ensuring that the core principles and values of *In Safe Hands* were delivered consistently across all areas of BCUHB. PoVA issues were reported to the Safeguarding sub-committee which reported to the Quality and Safety Committee of the BCUHB Board. The Mental Health and Learning Disability CPG also had a Safeguarding sub-committee which was designed to feed into the corporate structure.
- 10.527** The Head of Adult Protection expected to be notified regarding all adult protection activity within BCUHB. PoVA training was mandatory and provided on a sliding scale of intensity (Levels 1-1V) dependent on the role of the staff member and their contact with patients. CPGs were responsible for determining the level of training required for their staff however those staff working in mental health, learning disability, community services, care of the elderly and primary care were recommended to undertake Level III training; refreshers were provided for everyone every three years. In addition, it was intended that adult protection ‘champions’ would be present within each clinical area to disseminate information and provide advice.
- 10.528** The CPGs were allowed to determine their staffing structures and this meant that the priority placed on adult protection work across the organisation was not consistent. Most CPGs had a safeguarding champion or lead in place, either employed into a role which included this responsibility (usually as part of their portfolio) or in a voluntary capacity. The central adult protection team reported to the Director of Nursing, Midwifery and Patient Care. Whilst it liaised with the adult protection leads and Associate Chief of Staff Nursing within each CPG, the influence it had within this new and untested structure was limited.

### ***Policy and Procedure***

- 10.529** The policy in place during the period under investigation was the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (first version 2010 and second version 2013). The document provided very clear and comprehensive guidance. A flow chart sets out a clear ten-stage process which is provided as appendix 4.
- 10.530** The policy set out key principles that included:
- protecting vulnerable adults was everyone’s concern;
  - all staff had an ethical and professional duty to act if they witnessed abuse, were told about abuse, or had suspicions about either abuse or inappropriate care.
- 10.531** The guidance explained that abuse could be:
- a single or repeated act, or multiple acts;
  - a lack of appropriate action;
  - perpetrated as a result of deliberate intent, negligence or ignorance; and/or
  - an act of omission (failing to act) or neglect;
  - perpetrated by one vulnerable adult against another.

**10.532** Physical abuse was noted to include the prescription of inappropriate medication or misuse of medication, for example to sedate a vulnerable adult to make it easier to care for them when this has not been assessed and agreed to be in their best interests. It was also noted to include inappropriate restrictive physical interventions (formerly known as restraint, care and control). The guidance stated that agencies should:

- recognise that it is illegal to use physical or mechanical restraint as a means of punishment;
- develop, implement and monitor their own agency procedures on the use of restrictive physical intervention;
- ensure their employees understand and discharge their professional and moral duty to protect and promote the wellbeing of vulnerable adults; and
- develop care plans with the vulnerable adult and their carer/s, health and social care professionals that are explicit about when and how restrictive physical intervention methods can be used.

**10.533** Emotional and psychological abuse was defined as the:

*“Infliction of mental suffering by a person in a position or expectation of trust upon a vulnerable person. Emotional/psychological abuse may also be perpetrated by one vulnerable adult upon another. Emotional and psychological abuse includes bullying, which is typically deliberate, hurtful behaviour repeated over time, which can include physical abuse but often is verbal (name-calling and threats). It can undermine self-confidence, may cause the victim to become more isolated and sometimes leads to self-harm”.*

**10.534** Neglect was defined to be the:

*“Failure of any person for whom there is an expectation of trust and/or the responsibility, charge, care or custody of a vulnerable person to provide that degree of care which a reasonable person in a like position would provide. Neglect may be criminal or non-criminal. It may also be as a result of intentional or non-intentional acts or omissions... Wilful [neglect] has been defined as a result of case-law in the criminal courts as; ‘deliberately doing something which is wrong, knowing it to be wrong, or with reckless indifference as to whether it is wrong or not’. Unintentional neglect includes the failure of a carer to fulfil their caring role or responsibilities because of inadequate knowledge or understanding of the need for services”.*

**10.535** Institutional abuse was described as occurring:

*“In institutions as a result of regimes, routines, practices and behaviours that occur in services that vulnerable adults live in or use and which violate their human rights. This may be part of the culture of a service to which staff are accustomed. Thus such practices may pass by unremarked upon by staff. They may be subtle, small and apparently insignificant, yet together may amount to a service culture that denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of vulnerable adults”.*

**10.536** The guidance provided clear direction in relation to vulnerable adults perpetrating abuse on each other. It was noted that in some settings this had historically been either tolerated or ignored; this guidance categorically stated that “*this is not acceptable and must no longer happen*”.

### ***The Roles and Responsibilities of Health Boards***

**10.537** Health Board responsibilities were:

- work to prevent abuse;
- work jointly with other agencies to protect vulnerable adults;
- ensure the availability of an IMCA service as needed;
- ensure all staff receive appropriate adult protection training;
- immediately notifying any concerns or incidents to Social Services and the police, particularly if there is reason to believe that abuse or a crime has been committed;
- provide any relevant background information;
- ensure action is taken under the *All Wales Policy and Procedures for the Protection of Vulnerable Adults* if there are any adult protection concerns;
- contribute to adult protection investigations where health expertise may be required;
- provide appropriately trained staff to manage referrals and undertake investigations;
- coordinate the process of planning, investigation and case conferencing;
- contribute to the aftercare and support for the victims of abuse where this falls within Health Service functions.

### ***In Summary***

**10.538** The guidance provided a clear set of expectations with an emphasis on the prevention of abuse, inclusion of service users and their families, and the minimisation of risk. All statutory agencies, third sector and independent sector providers were required to train staff to the standards required, ensure that everyone was aware of their roles and responsibilities and that the required systems and processes were implemented, quality assured and monitored.

## **Findings: The Family Experience**

**10.539** 35 families came forward with concerns about general safeguarding issues and of those 18 also raised allegations and/or concerns in relation to potential abuse and/or neglect.

**10.540** The majority of the 35 families in the sample did not express concerns at the time their loved ones were patients on Tawel Fan ward but had reflected upon their experiences following their interviews with the North Wales Police. It was evident that some of those families had ‘recast’ their experiences in the light of what they had heard about the ward subsequent to the Ockenden external investigation and media reporting. This group of families was often anxious about having ‘missed something’ and the majority sought reassurance in relation to bruising or injuries now fearing they had been inflicted intentionally or

through rough handling, rather than being the result of an accident or fall on the ward as they had believed previously.

**10.541** Some of the allegations, concerns and complaints detailed below have already been addressed in the chapter subsection above. However they are revisited here as a small sample of families believed ‘wilful abuse and neglect’ had taken place and that acts of deliberate cruelty had been perpetrated. The range of concerns followed a consistent set of themes. Table 7 below provides a synopsis of the concerns raised and allegations made; it should be noted that several families raised more than one.

**Table 7**

<b>Type of Concern Raised</b>	<b>Numbers</b>
Patients locked in bedrooms	<b>5</b>
Patients restrained in the ‘stroke’ chair	<b>3</b>
Patients exhibiting bruising and/or injuries for which no explanation (or no adequate explanation) was given	<b>15</b>
Ward staff being flippant and disrespectful towards patients	<b>1</b>
Torture (including burning with cigarettes)	<b>2</b>
Rough handling and assault	<b>6</b>
Improper restraint	<b>4</b>
Lack of proper supervision and a failure to keep loved ones safe from other patients	<b>10</b>
Lack of proper nursing care leading to (what families described as) neglect	<b>8</b>

**10.542** It should be taken into account that an additional 31 families provided evidence to the effect that they had absolutely no concerns in relation to either safeguarding, abuse or neglect and, to the contrary, claimed the ward had provided a high standard of care with compassion and kindness shown to their loved ones.

**10.543** In the interests of balance Table 8 sets out the feedback from those families who had positive things to say about their experiences of Tawel Fan ward – these points were provided in either general conversations about their experiences on the ward and/or in the statements they provided to North Wales Police.

**Table 8**

<b>Feedback</b>
Patients were always shown dignity and respect, kindness and compassion
staff had time for families and communicated well and sensitively
Staff showed skilled and compassionate care for those patients who were aggressive and had behaviours that challenged
Patients were clean, well kempt and well cared for

## Failures to Keep Patients Safe

- 10.544** The two main issues that the 35 families in this sample raised were unexplained bruising and injury, and the lack of supervision (which in their opinion) had led to harm.
- 10.545 Issue 1.** In relation to unexplained bruising and injuries some families were of the view that these had not always been explained to them properly and that, on occasions, had been entirely concealed from them. It should be noted that families were often extremely vague about the nature of the bruising and injuries their loved ones received and also when exactly they occurred; this made investigation challenging. Following examination it was evident that on occasions the events families referred to actually took place on different wards (not Tawel Fan) and during entirely different episodes of care.
- 10.546** A careful review of the clinical records was undertaken in an attempt to match up the family accounts with any recorded incidents. It was evident that ward staff would routinely contact the designated next of kin in a timely manner. It was reassuring to note that most of the incidents families recounted could be identified within the clinical records – this was because the ward staff were diligent in recording events (even the most minor) and raising incident forms for them. In the overwhelming majority of cases it was evident the designated next of kin had been informed of accidents and injuries at the time they took place with full explanations having been given.
- 10.547** In relation to the concerns raised about communication some of the misunderstandings appear to have occurred because the complainant (who engaged with this Investigation) was not always the designated next of kin. They were quite correct when they said they had not been notified about falls or bruising – but unbeknownst to them other members of their family had been.
- 10.548** What the Investigation Panel came to understand was the extent to which family members retrospectively felt information had been concealed from them. They were worried that they might have been lied to, or that important information had been withheld from them. They sought independent verification to ensure that nothing had been ‘covered up’, missed, or was substantially different to what they had been told at the time the injuries occurred.
- 10.549 Issue 2.** As has already been determined, patient acuity was challenging with a diverse range of ages and difficult to manage conditions. The ward comprised a relatively large spatial area with a complex layout which did not assist with lines of observation. The two things combined together led to a situation where patients could often encounter difficulties both with each other and with the environment. Several of the families in this sample made the suggestion that the ward was under-staffed and that there were not enough nurses on it to maintain safety; for example they offered the view that falls could have been prevented had the patients been supervised better with more staff on duty.

**10.550** The families of four elderly frail female patients were particularly concerned about the aggressive and sexually disinhibited younger male patients on the ward. Four situations were recounted whereby inappropriate suggestions of a sexual nature had been made to their relatives within their hearing. It should also be noted that the families of two male patients also brought forward concerns relating to sexually disinhibited female patients who had attempted to engage in sexual acts with their loved ones.

**10.551** Other concerns in relation to supervision were those of patient-on-patient physical assault. Several of the families in this sample gave examples where their loved ones had been pushed to the ground or hit by another patient sustaining a degree of shock, and on occasions, physical harm in the form of bruising and scratches.

### **Concerns in Relation to Neglect**

**10.552** The word neglect was chosen by eight families to describe their concerns in relation to their loved one's general care. Those families were not just raising concerns about low standards of care; they were making distinct and significant allegations of abuse and neglect.

**10.553** Those families described their loved ones being dirty, unkempt and malnourished and described feelings of anger and outrage in relation to their general presentation; they were adamant that this was evidence of a 'broken system' and institutional abuse.

### **Specific Allegations of Abuse**

**10.554** Specific allegations of abuse and assault were made by a relatively small number of families. The allegations ranged from acts of deliberate physical torture to illegal restraint and seclusion.

**10.555** It is always distressing to hear accounts from families where they believe acts of abuse and cruelty have taken place. However it is important to remain objective and investigate in an evidence-based manner. All of these cases merited a very detailed investigation; in particular those in relation to deprivation of liberty, restraint, torture, and purported rough handling. These cases have been difficult to investigate as once again families were non-specific as to time and place and could not always pinpoint an actual event choosing instead to discuss a 'fear' or an 'impression' rather than anything they actually witnessed or knew as a fact to have taken place. Not surprisingly families found it very difficult to name any staff that they thought might have been responsible for any potential abuse as specific events had not been witnessed by them.

**10.556** On close examination some of the issues raised turned out to be based on a series of misunderstandings, others we are sorry to report, were based on misconceptions (rigidly adhered to despite strong evidence to the contrary) and falsehoods. A complicated situation arose whereby some of the abuse had in fact been perpetrated by the very family members who had raised the allegations and complaints. This has made for a very difficult and challenging set of circumstances for the Investigators and has required very careful management.

## In Summary

- 10.557** Some of the concerns raised by families have been straightforward to investigate, such as the locking of bedroom doors and the use of chairs as restraint. The issues in relation to bruising, injury and supervision have also been relatively easy to investigate (the findings of which are detailed in both this chapter subsection and the one directly above).
- 10.558** However it is always a challenge to investigate circumstances when the evidence available is contradictory in nature. The evidence from one family cannot be placed above that of another, especially when their loved ones were on the same ward at the same time being cared for by the same ward team. The Investigation Panel was presented with entirely differing accounts from families in relation to the ward atmosphere and the conduct of staff.
- 10.559** The Investigation Panel investigated in an objective and thorough manner based on all of the evidence available; the findings and conclusions are set out below.
- 10.560** Patient specific explanations are provided in full in the confidential reports prepared as part of the Wales *Putting Things Right* process.

## Findings: Identified by the Investigation Panel

### High-Level Findings

- 10.561** The Investigation Panel examined the case notes of 108 patients of which 105 were relevant to the subject of safeguarding. These case notes included those of the patients whose families had raised concerns. High-level findings were identified as follows:

#### *Systems*

- 1** 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.
- 2** Tawel Fan ward staff appear to have raised safeguarding alerts in an appropriate and timely manner in accordance with policy guidance.
- 3** 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.
- 4** 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.

### ***Patient Specific Issues***

- 5** There is no solid evidence to support the notion that patients were ever locked in their bedrooms or that chairs were routinely used as a method of mechanical restraint. However there is evidence to suggest that the use of the ‘Stroke Chair’ took place without the required protocols *in situ*. This meant that patients who lacked full mobility were on occasions sat in the chair without the appropriate assessments having taken place giving rise to concerns that there was potential for their liberty to be improperly restricted.
- 6** Whilst several of the younger male patients were sexually disinhibited and would often make lewd suggestions (which could be intimidating), there is no evidence to suggest that any female patient was ever compromised physically. However during the three-year period under investigation there were three female sexual predators on the ward who repeatedly tried to engage in sexual acts with male patients. It would appear that Local Authorities and BCUHB managers did not always take this kind of issue seriously enough and that the risks pertaining to mixed sex wards were both understood and managed poorly.
- 7** Patient-on-patient assaults occurred in two distinct ways. First: there could be random acts of violence caused by misunderstandings and a misinterpretation of the environment; these kinds of assaults could be neither predicted nor prevented. Second: there were cohorts of young aggressive male patients who presented a consistent level of risk to both themselves and those around them. The acts of violence perpetrated by those patients were predictable to a degree and required escalation from both a risk and safeguarding management point of view.
- 8** Physical restraint and safe holding techniques as deployed across BCUHB were not tailored to the needs of the older adult. This meant that on the rare occasions Restrictive Physical Interventions (restraint) was required practice was not always optimal; this potentially placed the older adult at risk.
- 9** There is no evidence to suggest that patients were not cared for properly or were neglected in any way. On occasions patients presented as unkempt, but it was recorded in the clinical records when a balance had to be reached between the undue distress caused to some patients in the acute phase of their admission and the need to provide personal care.
- 10** The escalation of patient acuity issues were not always addressed well. Due to the lack of beds across north Wales, and the reluctance to spend money on out of area transfers, patients could be kept on Tawel Fan when a more specialist placement was indicated. The failure to place appropriately and to manage ever-increasingly difficult presentations meant that safety and dignity was, on rare occasions, compromised.

### *Allegations of Abuse*

- 11** 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.
- 12** The Investigation Panel found that where staff made allegations of staff-on-patient abuse these were (in the main) based upon unreliable accounts. It was evident that on several occasions the truthfulness and best intentions of the witnesses could be called into doubt and that the claims were either made mistakenly or with the deliberate intention to mislead.
- 13** Some of the allegations made by families were put forward driven by anxiety and fear with the need for reassurance to be given. Other families retained deeply held beliefs that the Investigation Panel could not support. Yet other families (a small number) provided incorrect information either intentionally or unintentionally.

### **Safeguarding Structures and Processes**

- 10.562** There were challenges in implementing adult safeguarding systems and procedures from an early stage in the life of BCUHB. The predecessor NHS Trusts had only embryonic safeguarding processes in place and had relied heavily upon their Local Authority partners to provide both guidance and training. At the point of the merger in 2009 there were no pre-existing governance or reporting frameworks mature enough to point the way forward for the new organisation.
- 10.563** At this stage there was little organisational awareness about the importance of adult safeguarding and a lack of individuals at Health Board level experienced enough to take a strategic lead. Consequently there was no clear organisation-wide development plan or guidance given to the CPGs who were left to set up their own arrangements as they saw fit.
- 10.564** In the event the Health Board set up a Safeguarding Children and Vulnerable Adults sub committee which reported into the Health Board's Quality and Safety Committee. Initially there was direct input from Independent Members of the Health Board but this was withdrawn shortly after its inception.
- 10.565** This group relied upon the data generated by the CPG equivalent committees to provide a line of sight to the Health Board in relation to safeguarding matters. However CPGs were faced with significant financial restrictions and 10 out of the 11 chose not to recruit a dedicated post holder to adult safeguarding; this meant that the data collected was variable and at times inherently unreliable. The only exception to this was the Mental Health and Learning Disability CPG where a fulltime Head of Safeguarding was appointed who reported directly to the Associate Chief of Staff Nursing. This was a complex and demanding role; it should be noted that this individual managed all safeguarding across the CPG and also had to relate directly to six Local Authorities.

- 10.566** In 2010 an Associate Director of Safeguarding was appointed to provide a corporate lead for safeguarding across BCUHB; this person reported to the Executive Director of Nursing. The corporate function was managed by 1.6 whole time equivalents; this rose to 2.6 in 2013 but one of the post holders went on long-term sick leave meaning that in real terms the available resource remained the same. A key challenge was that of relating to the six north Wales Local Authorities (each of whom managed safeguarding differently) and to provide strategic direction across BCUHB and the 11 CPGs who did not always regard adult safeguarding as a priority. During the period under review adult safeguarding did not feature on the corporate risk register and there were limited opportunities for information to be provided to the Health Board directly.
- 10.567** In 2010 a corporate Safeguarding Assurance Framework was developed which identified and included all legislative and best practice activities to ensure robust governance and reporting. Each CPG was required to develop its own governance framework to provide evidence against the identified requirements. However senior witnesses told the Investigation that the uneven use of incident reporting and the lack of uniform adult safeguarding systems and structures across BCUHB ultimately limited its effectiveness.
- 10.568** Another key difficulty was that of safeguarding training. Senior witnesses told the Investigation Panel that financial restrictions and the service replacement of staff meant that there was often poor attendance at training events; consequently many events were cancelled. E-learning was considered as an option but in 2012 it was determined that there was no funding and progress in this regard was only made in 2015. During the period under investigation the Mental Health and Learning Disability CPG safeguarding training levels ran just below 50 percent; however it should be noted that ‘PoVA level 3 training’ on Tawel Fan was reported to be 100 percent in October 2012 which (despite the ongoing workforce challenges that faced the ward) was commendable.

### ***Local Authority Partners***

- 10.569** Senior BCUHB witnesses told the Investigation Panel that the six Local Authorities across north Wales all had different safeguarding referral ‘thresholds’ which changed depending upon their individual pressures and strategic direction. The six Local Authorities also had different referral templates which provided a degree of challenge to BCUHB services. A further complicating factor was that Local Authorities would only record individual patients by name and address, not the place of the alleged incident or abuse; this affected the efficiency of escalation and transparency. Due to the highly mobile nature of patients on a dementia pathway there was potential for an individual’s safeguarding history to be understood poorly as the Local Authorities did not run a shared information referral network and individuals could not be tracked across a north Wales system. In addition the following challenges were identified:
- Local Authorities often regarded patient-on-patient assault as not requiring further action – between 2012 and 2013 50 percent of the referrals sent from Tawel Fan ward in this regard were deemed not to meet the safeguarding threshold;

- over time Local Authorities did not see omissions in care as potential harm;
- the collation and mapping of information was weak meaning that trends and potential alerts could be missed;
- Local Authorities had no joint means to monitor the number of referrals about an individual as they moved across north Wales on a care pathway.

### *System*

- 10.570** Senior witnesses told the Investigation Panel that day-to-day practice within BCUHB often bypassed the expectations of policy and procedure. A key issue was the recording of safeguarding information in relation to individual patients.
- 10.571** The expectation was that copies of safeguarding referrals and all other related paperwork would be filed in the patient's case notes; however wards within the Mental Health and Learning Disability CPG often resisted doing this citing confidentiality and the protection of whistleblowers. Consequently this information was on occasions 'scattered' and difficult to access. This 'scattering' of safeguarding information was problematic for two reasons:
- 10.572 First:** none of the information was available in the contemporaneous patient case notes. This meant that members of the treating team had no easily accessible written information as to how a case was being progressed or what the content of any subsequent protection plan was. The Investigation Panel examined 108 case notes and none of them contained any safeguarding information whatsoever apart from basic references that logged when a referral had been made or when a Local Authority lead telephoned the ward to say that a referral had not been accepted. Neither was any mention made in the case notes about any outcomes from strategy meetings or case conferences. It is evident that the safeguarding process did not appear to close the loop sufficiently well and it was difficult to chart how patients were kept safe as a result of formal due process.
- 10.573 Second:** the documents could not be easily located during the course of this Investigation. The Investigation Panel relied upon BCUHB and the Local Authorities to trace this documentation so that a comprehensive investigation could be conducted on a patient-by-patient basis. The process to assemble the documentation took the best part of 18 months. It is evident that a significant amount of the paperwork has been permanently lost and this has made it very difficult to track how safeguarding was managed in relation to individual patients on Tawel Fan ward. The Investigation Panel found that the missing paperwork on occasions related to living individuals and it is our opinion that this is unacceptable and is evidence that multi-agency processes might not always be relied upon to chart patients through the system and ensure their ongoing safety and wellbeing.

### **Safeguarding Reporting Practice on Tawel Fan Ward**

- 10.574** A careful examination of the clinical records has shown that out of the cohort of 105 patients under review 26 had Protection of Vulnerable Adults (PoVA) referrals raised by staff during the time they were on Tawel Fan ward; some of those patients had more than one PoVA referral raised. Of those 26 patients 12 pertain to the families who raised concerns in the sample identified above; of

those some patients had more than one referral made. It should be noted that due to the gaps in the documentation provided to the Investigation Panel some of the information below is based on the ‘best estimates’ that can be made in the circumstances.

**10.575** Over a three-year period the staff on Tawel Fan ward raised PoVAs in relation to the following:

- pressure ulcers – four patients;
- concerns relating to familial abuse (financial, physical and sexual) – four patients;
- sexual disinhibition – *circa* ten referrals;
- patient-on-patient assault – *circa* 15 referrals;
- potential staff on patient assault – three referrals.

**10.576** The Investigation Panel formed the view that, in the main, Tawel Fan staff identified risks correctly and made appropriate referrals in a timely manner in at least 85 percent of the cases under examination. The remaining 15 percent of cases applied to patient-on-patient assault both physical and sexual. It would appear that in these cases the failure to make referrals was often as a result of initial Local Authority feedback intimating that this kind of incident did not meet safeguarding thresholds. It should be understood, that for those cases where PoVAs were not raised incident forms were still completed. This was good practice.

**10.577** Staff raised PoVA and incident alerts in an entirely appropriate manner. This is made more remarkable by virtue of the fact that safeguarding systems and procedures were understood poorly across BCUHB at the time and that Local Authority support was variable. The Investigation Panel could find no evidence to suggest that incidents were ignored or that any kind of cover-up was attempted. In fact Tawel Fan ward staff were often ‘rebuked’ for over reporting and advised accordingly; it is to their credit that they continued to report in accordance with policy and procedure guidance.

### **The Loss of Connectivity between Process and Protection**

**10.578** Ward staff told the Investigation Panel that both the reporting of incidents and the raising of PoVAs often felt like *“throwing information into a black hole”*. The registered nursing staff persistently adhered to reporting guidance but reflected that they rarely ever received any feedback.

**10.579** It has not been possible to reassemble all of the records and so it can only be a matter of conjecture exactly how safeguarding processes worked on a case-by-case basis. The Modern Matron told the Investigation:

*“To make a PoVA referral depended on which area the patient was in at the time of the concern, i.e. whether the referral was made to Conwy or Denbighshire Social Services. As soon as a concern was raised ... the referral would be completed and faxed to a secure number at the appropriate Social Services office. From there the process was lead by Social Services. There would be a strategy meeting where a decision would be made as to whether the issue needed*

*to be progressed to full investigation. Also at these meetings allocation of an investigating officer would be discussed. There would then be follow up meetings arranged by Social Services. This could be a very lengthy process which at times was very frustrating. It appeared to be dependent on the workload of the investigator; the complexity of the case and the availability of the Social Services PoVA lead. There were differences in the way both counties managed the process, and at times appeared to lead to delays in progressing some of the issues. This was difficult to work with, even when I phoned the PoVA offices to try and ascertain why processes were so prolonged there was little that could be done on our part, and I can understand why families were dissatisfied”.*<sup>88</sup>

**10.580** The former Tawel Fan ward Manager told the Investigation:

*“Staff would fill in PoVA forms and fax them to Social Services and the BCUHB PoVA lead as per protocols and wait for the next stage to be implemented. This could take some time. We would wait for the next stage to be implemented. This could take some time. We would provide whatever information was requested and participate in meetings as required. Feedback was minimal and we had no influence on the process... We would at times contact PoVA representatives [from Local Authorities] to ask advice on whether an incident would qualify for PoVA investigation. Their general stance was that if it was for example one person who suffered from dementia assaulting another in an unprovoked incident, then what would be the benefit of a PoVA? That we already knew what had happened and that there was little that could be done to prevent such unpredictable behaviour from occurring. Even with more complex issues there could be initial reluctance to become involved”.*<sup>89</sup>

**10.581** From reading the clinical records and talking to witnesses it is evident that on occasions safeguarding processes appeared to be an ‘end in themselves’ rather than being a means to protect adults at risk. The Investigation Panel found an appropriate level of PoVA reporting from Tawel Fan ward staff but (on occasions) an entirely inadequate response from those who were charged with managing the process. Safeguarding practice was often rendered ineffective for the following reasons:

- safeguarding thresholds were placed too high to protect some adults at risk;
- investigation processes were too slow to provide the level of protection required in a timely manner;
- strategy meetings, when they did take place, were sometimes non specific and did not provide enough guidance as to how individuals were to be kept safe;
- there were no escalation or trend alert processes that could indicate when a ward like Tawel Fan was experiencing difficulties that required managerial intervention.

**10.582** Examination of the strategy meeting documentation sent to the Investigation Panel was limited due to the incomplete number of cases made available and the partial nature of the records that were provided.

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88 Witness statement excerpt

89 Witness statement excerpt

**10.583** However one complete set of safeguarding strategy documentation was provided and it was possible to track the actions that the ward team had proactively put in place. It has to be said there is no documentation that suggests any investigation was undertaken and there is nothing to indicate that the strategy meeting added any value to the process as the ward staff had already implemented a risk management plan. What this single example illustrated was:

- the lack of BCUHB management that was present at the meeting – the only BCUHB employees were members of the ward staff;
- the dependence of the strategy meeting on the ward staff having already made the situation safe;
- the absence of any trend analysis as this particular PoVA was one of a sequence of similar events indicating that a mixed ward environment was potentially compromising dignity and safety.

### **Issues Relating to Specific Safeguarding Concerns**

**10.584** The Investigation Panel found there to be occasions where the care and treatment provided on Tawel Fan ward was suboptimal. However it is essential that these occasions are understood in context; it is the considered view of the Investigation Panel that these circumstances were not unique to Tawel Fan ward and that they are replicated in similar wards the length and breadth of the United Kingdom. The Investigation Panel does not seek to be ‘an apologist’ for the practice on the ward where it fell below an acceptable standard, but it is important that any acts or omissions are understood in context and that no unreasonable benchmark standards are applied.

#### ***Locked Bedrooms***

**10.585** Five families raised concerns that their loved ones *might* have been locked in their bedrooms both during the day and at night. One family also raised a concern that a chair might have been placed under a bedroom door handle in order to prevent the occupant from being able to open the door from the inside. Families could not give any specific dates for any occasions when they thought doors were locked and neither were they able to provide the names of any staff who were on duty. The cases brought to the attention of the Investigation Panel focused in general on concerns about what might have happened rather than events that were actually witnessed. In order to investigate these concerns the Investigation Panel visited the ward on several occasions to examine fittings and fixtures.

**10.586** All bedroom doors on Tawel Fan ward were fitted with locks. The Investigation Panel was told that it was routine practice to lock bedroom doors during the day time in order to prevent patients from wandering into each other’s bedrooms; due to the complex layout of the ward doors were also locked to ensure that patients could be observed more easily as they walked around the facility. On these occasions the bedrooms would be locked only when empty. If a patient was poorly or tired and required bed rest during the day then they would be given access to their bedroom so they could lie down. On these occasions they would not be locked in their rooms and staff would observe them to ensure their safety.

- 10.587** Bedroom door locks on all psychiatric units throughout the United Kingdom are designed to be opened from the inside even if they have been locked shut from the outside; there is always an automatic override system. The only exception to this are the arrangements made in relation to Seclusion Rooms; none of which were provided on Tawel Fan ward. Ward staff told the Investigation that patients were not locked in their bedrooms either during the day or the night. There had been rare occasions when capacious patients had been admitted to the ward who had requested that the doors be locked at night to prevent other patients from wandering inside; however in this situation the patient could override the lock at will from the inside of the bedroom, and so whilst other patients were locked out, the patient making the request was not locked in.
- 10.588** It is possible that if a patient with limited cognitive ability was locked into a bedroom on Tawel Fan ward then they would find it difficult to operate the door handle in order to facilitate release. In theory it was entirely possible for patients to be locked into their bedrooms; however there is no evidence to suggest this ever took place. None of the reviews and unannounced inspections that took place on the ward ever found a patient to have been locked in their bedroom, either during the day or night, and this is something staff categorically denied.
- 10.589** Although the ward was closed in December 2013 a variety of bedroom, dining and lounge chairs were retained on the ward. It was evident that the backs of these chairs were either too low or too high to be able to be wedged under the bedroom door handles which were of a lever design; it was also noted that the handles were too ‘shallow’ to allow anything as substantial as a chair back to be wedged beneath them. Whilst this is not conclusive evidence that chairs were not used in this manner, it was apparent that the range of chairs routinely used on the ward could not provide the means of wedging doors closed. This does not mean that a chair could not have been used – but the Investigators were unable to replicate the effect described.
- 10.590** It has not been possible to prove beyond all reasonable doubt patients were never locked in their bedrooms. However on balance the evidence would suggest that this is a practice that did not occur on the ward and there is no reason to disbelieve the ward staff and there is no other independent evidence to suggest this kind of practice ever took place.

### ***Restrictive Physical Interventions and Restraint***

- 10.591** The Investigation Panel was told by senior witnesses that at the point of BCUHB’s inception in 2009 matters relating to restraint and safe holding practice underwent a review throughout the new organisation. Prior to this time the west and central-based NHS Trusts had not advocated restraint for the older adult instructing staff instead to use de-escalation, diversion and safe holding techniques. However at the point of merger policies and procedures were in disarray and as a consequence the culture from the east of the new organisation was seen to be dominant. The former NHS Trust in the east had always advocated the use of restraint for the older adult. Consequently this approach was rolled out across the organisation with the centralised Aggression Management Department teaching a restraint process to be utilised for all patients regardless of age.

**10.592** The BCUHB Restraint Guidelines (June 2011 – 2014) in operation during the period under investigation aimed to provide guidance to staff for the management of short-term disturbed or violent behaviour in inpatient settings and Accident and Emergency Departments. The guidance focused on the ethical and legal issues underpinning safe practice; it stated that:

- the Health and Safety at Work Act (1974) had to be implemented and the health, safety and welfare of employees had to be ensured;
- information and training had to be provided to staff;
- the Human Rights Act (1998) should be enforced and that restraint should only be used in an emergency situation in order to ensure protection and safety;
- the Mental Health Act (1983), the Mental Capacity Act (2005), Deprivation of Liberty Safeguards and Safeguarding Vulnerable Groups Act (2006) frameworks had to be adhered to;
- a risk versus benefit balance always had to be established prior to any intervention taking place;
- all restraint interventions had to be proportionate to the risks.

**10.593** It was stated that “*The purpose of restraint is first to take immediate control of a serious, significant or dangerous situation and second to contain or limit the person’s freedom for no longer than is necessary to end or reduce significantly the threat*”. Restraint was to be used as a last resort and was deemed to be reasonable when there was a risk of:

- physical assault;
- dangerous or destructive behaviour;
- non-compliance with lawful treatment;
- likely or actual self harm;
- sexually inappropriate behaviour;
- extreme and prolonged activity that was likely to lead to physical exhaustion;
- absconding or the risk of absconding.

**10.594** The guidance highlighted the risks of using restraint and provided instructions to ensure safety. The use of prone restraint (when a person is laid on their front on the ground) was to be avoided as it could impede breathing and lead to death; the only exception cited was for short periods of time when intramuscular injections had to be given in the buttocks.

**10.595** In general the document provided an evidence-based approach; however there were some significant omissions. The guidance (in keeping with most other BCUHB policies and protocols) did not make particular reference to the older adult except to say cardiac and pulmonary complications were more common and that those patients with cognitive impairments would need “*additional considerations*” although it was not noted what they would be. It should also be noted that the training in place during the period under investigation did not differentiate between the needs of adults of working age and those of the older adult during RPI. This was poor practice.

**10.596** The Investigation Panel was concerned to find that the guidance did not incorporate the *National Audit for Violence: Standards for In-patient Mental Health Services* (March 2007) developed by the Royal College of Psychiatrists. The standards pointed out that the NICE guideline *Violence: the Short-term management of Disturbed/Violent Behaviour in Psychiatric Inpatient Setting and Emergency Departments* (2005) had explicitly excluded services for older people with dementia. Consequently additional best practice standards were provided. The March 2007 standards stipulated that:

- care planning and person-centred de-escalation techniques should be identified as the first line of management;
- specific rapid tranquilisation algorithms had to be provided for the older adult and that those for adults of working age should not be applied;
- training in safe holding and restrictive physical interventions should be provided specifically in relation to the needs of the older adult;
- older adults should require minimal hands-on restraint and should never be taken to the floor during interventions.

**10.597** The Mental Health and Learning Disability CPG produced a series of ‘Aggression Services’ annual reports. It can be seen from the statistics that the central region of the BCUHB provision (where Tawel Fan ward was sited) had the lowest RPI incidents across north Wales. Considering the higher number of beds that Tawel Fan had (compared to other wards of its kind within BCUHB) and coupled with the challenging behaviours of the patients admitted, the number of RPI incidents were significantly lower than for other similar wards within the CPG.

**10.598** A total of five families raised concerns with the Investigation Panel in relation to restraint (including both RPI and the inappropriate use of chairs to restrict their loved one’s movements). It should be noted that two of those families had already raised concerns with BCUHB and they had been investigated prior to Tawel Fan ward being closed.

- 1 The families who raised concerns about RPI expressed their shock in relation to this kind of physical intervention and queried the legality of such measures. They were also concerned that the nature of the intervention might have caused lasting harm to their loved ones.
- 2 The families who raised specific concerns in relation to the use of chairs as restraint devices were of the view that they had been used as a means to restrict movement and that this constituted abuse.

**10.599** The Investigation Panel examined all of the individual incidents of RPI to be found in the case notes for each of the patients in the Investigation Cohort. There were a total of 16 incidents reported over a two-year period (January 2012- December 2013); it should be noted that eight of them related to a single patient who was very disturbed over a seven-day period. From the contemporaneous documentary evidence it would appear that RPI was always put in place in accordance with extant BCUHB policy guidance and that the interventions were indicated. Staff who were appropriately trained (often the ‘off ward’ RPI team) conducted the RPI, every event was recorded appropriately,

incident forms were completed, and reviews conducted by the Violence and Aggression Unit. This was good practice. However there were four issues that the Investigation Panel found to be of concern:

- 1 There were no detailed and specific risk assessments or care and treatment plans in place for those patients at risk. It would have been good practice to have identified trigger points, to have articulated clearly the de-escalation methods to be used, and to adjust the requirements of observation levels. Instead interventions appeared to have been reactive in nature and it is possible that a more planned approach might have prevented the need for some of the interventions.
  - 2 Patients appear to have been restrained in the prone position on occasions. Whilst there is no United Kingdom guidance to prohibit this practice it has been known for many years that this is a hazardous method, especially when restraining the older adult. It would appear that this position was chosen so that intramuscular injections could be given.
  - 3 Whilst most of the restraints conducted on the ward were for less than four minutes there were two incidents (involving two different patients) that were for prolonged periods of time exceeding 60 minutes (apparently in the prone position for some of the time). Both individuals were in their 60s and physically very strong and violent; however it is never good practice for a situation such as this to arise. The inability of the service to access medical input and a prescription for rapid tranquilisation were major factors in one case. It is important to note that BCUHB conducted its own internal investigation into this particular incident so that lessons could be learnt and similar situations prevented in the future. This investigation identified that ward nursing staff and the RPI team had acted professionally throughout whilst maintaining patient safety – but it had nevertheless been classified a ‘near miss’ incident.
  - 4 It was determined that patients across the BCUHB older adult inpatient units (including Tawel Fan) routinely took older adults ‘to the floor’ during RPI. On Tawel Fan this practice was noted by the Investigation Panel. It appears to have been what staff had been trained to do and it should also be taken into account that (on most occasions) the patients involved were actually adults of working age or within a year or two past it. However this is of concern as some of the patients who experienced this kind of intervention were significantly older and this practice should not have been either advocated or sanctioned by the organisation.
- 10.600** However, regardless of the issues listed above, the Investigation Panel found that RPI was used relatively rarely on Tawel Fan ward despite the number of very aggressive patients who were relatively young, physically strong and frequently of a threatening and actively violent demeanour. This was good practice. It was also found that although there were difficult and distressing circumstances around the two RPI interventions mentioned above no physical harm appears to have occurred to those patients as a result.

- 10.601** The concerns relating to the use of chairs as restraint were raised by a small number of families. The main issues related to the use of the ‘Stroke Chair’ (a picture is provided as appendix 5). During most of the time under investigation there was one ‘Stroke Chair’ in use on the ward.
- 10.602** Chairs of this kind are designed to provide a comfortable and supportive seating option for patients who are frail and/or have mobility problems. It is common for such patients to slip and fall out of ordinary chairs which can result in injury; it is a fact that the Investigation Panel was able to identify multiple examples of this occurring on all of the wards examined during this Investigation (in particular on the medical wards).
- 10.603** The particular chair in question was a small padded chair on wheels with a seating position with a tilted design so that once seated in the chair the patient would be reclined at a slight angle. It should be understood that there were no straps or trays or devices that locked patients into the chair. It should also be understood that any able bodied person (taking into consideration the frailties of old age) could both seat themselves into the chair (and most importantly) get up out of the chair with relative ease.
- 10.604** Those patients who were immobile would not be able to get out of the chair independently; however it should be taken into account that a person who was immobile would not be able to get out of any kind of chair (‘Stroke’ or otherwise) without assistance.
- 10.605** The kind of patient that would require special consideration when nursed in a chair of this type would be the individual with limited mobility who would be prevented (or find it difficult) from getting up of their own volition when normally able to do so from an ordinary chair.
- 10.606** The Investigation Panel was told by the families in this particular sample that in their view patients (not always their loved ones) were kept in the ‘Stroke Chair’ by staff with the deliberate intention of not allowing them to get up, thus restraining them.
- 10.607** The Investigation Panel has examined the use of the chair as rigorously as was possible. The clinical records combined with witness statements revealed the following:

#### **Positive Factors**

- 1** Frequent references were found in the clinical records referring to the use of the ‘comfy’ chair (the ‘Stroke Chair’). The patients who were placed in this chair were either immobile, frail, ill, or in need of a comfortable place to sit if feeling tired and not wanting to be in bed.
- 2** Those immobile patients nursed in the chair were seated on a pressure cushion to minimise the occurrence of pressure ulcers and had supportive cushions etc. placed inside the chair to ensure maximum comfort. The chair was usually placed in the dayroom so that the patient could be surrounded by

the activity of the ward – on occasions the patient would be sat in their bedroom if they wanted some peace and quiet and kept under observation.

- 3 Many able-bodied patients chose to sit in the chair because it was comfortable.
- 4 Immobile patients, or those with impaired mobility, would not be left alone in the chair – a nurse would sit next to them or be in the same room ensuring their wellbeing.
- 5 On occasions the chair would be pulled up to a table so the patient could partake of crafts or other such activities.

#### **Factors Suggestive of Poor Practice**

- 6 Some families were of the view that patients were left in the chair on occasions (unsupervised) and could not get out on their own appearing to be distressed.
- 7 A suggestion was made (by families) that the chair if pulled up to a table meant that the patient was in effect restrained.

**10.608** It was not possible to determine one way or the other if the ‘Stroke Chair’ was ever used *intentionally* as a device to inappropriately restrain patients with poor mobility. It would appear that on the majority of occasions the chair was used in an entirely appropriate manner and that it provided a comfortable seating alternative for those patients who needed it.

**10.609** It is relatively easy to understand a situation on the ward where a patient could be left alone in the chair whilst the supervising nurse was called away; whatever the reason it could have been distressing for the patient.

**10.610** What was evident was that the qualified staff were aware of the potential for the chair to be used improperly and they were adamant that it was not. Some of the unqualified staff were not so aware with one staff member stating that sitting in the chair ‘calmed’ restless patients when they were seated at the table so they could they could focus on their activities (such as jigsaw puzzles and crafts); these kinds of statements described circumstances whereby a restless patient might have initially been ‘coerced’ into activities – but this is speculation. However there were no protocols in place for the use of the chair on the ward – this would have been good practice to ensure that it was always used appropriately. Chairs of this kind have many benefits for frail patients by providing a comfortable place to relax. However chairs of this kind are also fraught with potential risks if they are not used correctly.

**10.611** In the event the Investigation Panel determined that only a small number of patients could have had their movements restricted if placed in the chair. The clinical records for those patients demonstrate that they were walking around the ward most of the time (as evidenced by their relatively frequent falls). It is *possible* that the chair was used inappropriately on occasions, but the

Investigation Panel was not able to identify positively if this was the case, and if so, when or by whom.

### ***Supervision of Patients***

- 10.612** The Clinical Management and Nursing Care chapter subsection above has already set out findings and conclusions in relation to supervision; they do not need to be repeated here.
- 10.613** However there were a small number of patients on Tawel Fan ward whose level of risk could not be addressed adequately by supervision and/or other risk management processes. The issues were multifactorial and were exacerbated by ward environment, general patient acuity and workforce factors. However these factors alone were not sufficient to create the circumstances in which the risks continued.
- 10.614** On rare occasions patients were admitted to the ward whose general risk status was so high that supervision alone could not maintain dignity and safety to the required standards. Alternative arrangements should have been considered; for example:
- nursing in relative isolation in a low stimulus environment (by finding a suite of rooms where care could be provided away from other patients) until such time as the levels of disinhibition and/or extreme aggression could be assessed and managed; and if this was not possible;
  - consideration given to an out of area transfer to a place where appropriate levels of supervision and intensive nursing care could be provided.
- 10.615** These alternatives were neither considered nor explored and as a consequence on occasions:
- the therapeutic *milieu* of the ward was severely disrupted and eroded for other patients;
  - dignity and safety were compromised;
  - the safety and wellbeing of staff was compromised.
- 10.616** It should be recognised however that these patients were afforded all due respect and every effort was made to ensure care and treatment was provided in keeping with the Fundamentals of Care, nevertheless the situation was far from ideal. Safeguarding referrals were made, incident forms completed, and care plans developed. The ward team did not ignore the situation and neither did they try to conceal the dilemmas that were faced.
- 10.617** However there appeared to be a culture whereby services ‘consumed their own smoke’ and wards like Tawel Fan were expected to accept every patient that was referred to them; this was made more problematic as pressures on beds and finances across the system in north Wales rose during 2013.

**10.618** In the event the Investigation Panel could determine the periods of challenge were transitory in nature and that these patients were stabilised on Tawel Fan ward and went onto care home placements in the community. However during the period of heightened challenge and disruption there was no apparent flex within the service to manage such cases in a more appropriate and intensive manner.

### *Allegations of Neglect*

**10.619** The Clinical Management and Nursing Care chapter subsection above has already set out findings and conclusions in relation to allegations and concerns about poor nursing care. The evidence available suggests strongly that both medical and nursing inputs were of a good general standard and that there were no acts or omissions that would indicate either institutional abuse or neglect on either an individual patient or cohort basis.

**10.620** The Investigation Panel could find no evidence to support the notion that patients were neglected in any way or that the care provided fell below an acceptable standard.

### **Abuse: Allegations and Findings**

#### *Prior Investigation Processes*

**10.621** In keeping with the findings of the extensive North Wales Police inquiry process and the five internal and two external reviews that took place in the months prior to the closure of Tawel Fan ward (reported in chapter 9) the Investigation Panel could not replicate the findings of abuse from some other prior investigation and review processes. After a detailed examination of those prior processes the Investigation Panel established:

- reported incidents of abuse were found not to have occurred in the manner reported previously; and/or
- incidents did occur but the interpretation of events (once a full examination had taken place) differed from those given previously; and/or
- suboptimal care was identified to be Tawel Fan ward on occasions, but this did not meet the thresholds for either abuse or neglect *per se*.

**10.622** The Investigation Panel considered why its findings and conclusions differed from those of other prior investigation and review processes; the reasons were multifactorial. In the main the evidence that prior processes depended upon was anecdotal in nature, went untriangulated by any other kind of supporting facts, and was obtained in circumstances that did not meet the standards of Salmon and Scott investigation requirements making them inherently unsafe.

**10.623** Following a careful case-by-case examination of the evidence available, the Investigation Panel found that:

- 1** The experiences and views of most families, no matter how accurate and sincere, on most occasions fell short of identifying potential abuse or neglect. The incidents they wanted investigated and the issues that they raised went

largely unwitnessed by them and were often speculative in nature; they were often also unspecific as to time, place and person. The incidents and issues that were witnessed directly by families, whilst distressing, on their own did not necessarily constitute abuse and had often been reported and investigated out of context. The Investigation Panel found that family accounts had been taken as factual accounts and accepted at face value as proof of abuse without further examination taking place or the necessary tests applied.

- 2 Clinical records were not examined and neither were contemporaneous incident and safeguarding reports. Most of the incidents and issues reported by families were recorded contemporaneously (and in great detail) in the clinical case notes and an examination of those notes sets both the incidents, issues and actions of staff in context. Had this information been accessed by all prior investigation processes then a more ‘three dimensional’ picture would have emerged with accurate patient histories and clear rationales provided for both case and incident management.
- 3 BCUHB staff witnesses did not have specific incidents and issues put before them in an appropriate and transparent manner either in writing or during interview. This meant that staff were not given the opportunity to address the issues raised as they were (as described by several witnesses) “*shrouded in mystery*” and remained largely unknown to them. Had BCUHB staff witnesses been afforded the professional courtesy to address the direct allegations of abuse, then they might have been able to provide robust evidence to either support or refute those allegations. In the event they were not afforded this right and subsequent findings and conclusions were based on incomplete and biased evidence.
- 4 It is regrettable, but following a detailed and careful examination of the evidence available (that included a triangulation of all prior investigation archives, 350,000 pages of clinical records, and witness interviews and statements) it was evident that some witnesses (both families and BCUHB staff) gave either incorrect or misleading information to prior investigation processes; some of it was simply not true. It is not the function of this Investigation to decide whether or not this mis-information was provided with the deliberate intention to mislead (that will take place if thought necessary by other processes at a future date) but it is a key factor in the subsequent misinterpretation of information and unsafe findings and conclusions that appear to have been made previously.

**10.624** The determination of a small but voracious cadre of families and BCUHB staff to establish the findings that wilful abuse and neglect took place on Tawel Fan ward at the hands of cruel, uncaring and unprofessional staff (and exacerbated by deficient organisational systems) must be resisted. The evidence available does not support this view, no matter how sincerely held.

## Conclusions

- 10.625** The Investigation Panel was commissioned to undertake a thorough and evidence-based investigation. An essential part of this commission was to examine the archive documentation from all prior investigation and review processes, to examine the clinical records of the patients in the Investigation Cohort, and to interview and take statements from families and BCUHB members of staff. This has been done in an objective and systematic manner by an experienced Investigation Panel of national standing.
- 10.626** The Investigation Panel had to conduct its work against the background of heightened public anxiety and expectation with media reporting referring to patients being treated like “*animals in a zoo*” and stating that the activities on Tawel Fan ward amounted to the most serious healthcare scandal Wales had ever seen. Due to the inherent unreliability of some of the evidence extreme caution had to be deployed to ensure that ‘factoids’ were not perpetuated and proportionality was maintained in the interests of learning lessons and establishing a coherent account of the safeguarding issues for the patients on Tawel Fan ward.
- 10.627** Whilst it is evident that (on occasions) care and treatment (and safeguarding systems and practice) might have fallen below the standard that all NHS services strive to achieve, there is no evidence to support the notion that this amounted to abuse or neglect (wilful or otherwise) on the part of individual practitioners or managers. Neither did any incidents or omissions meet the threshold that would indicate institutional abuse or systemic failures to the point where service provision was compromised and patients came to harm on a repeated and regular basis beyond what could reasonably have been expected on a ward of this kind.
- 10.628** Section 127 of the Mental Health Act (1983) created offences in relation to staff working in either the NHS or mental health nursing homes where there is ill-treatment or wilful neglect:

*“127(1) It shall be an offence for any person who is an officer on the staff of, or otherwise employed in, or who is one of the managers of a hospital or independent hospital or home:*

- a) To ill-treat or wilfully to neglect a patient for the time being receiving treatment for mental disorder as an inpatient in that hospital or home; or*
- b) To ill-treat or wilfully to neglect, on the premises of which the hospital or home forms part, a patient for the time being receiving such treatment there as an outpatient.*

*127(2) It shall be an offence for any individual to ill-treat or wilfully to neglect a mentally disordered patient who is for the time being subject to guardianship under this Act or otherwise in his custody or care (whether by virtue of any legal or moral obligation or otherwise)...*

*...Wilfully means that the act is done deliberately and intentionally not by accident or inadvertence, but so that the mind of the person goes with it".<sup>90</sup>*

**10.629** The Mental Capacity Act (2005) also introduced two new criminal offences:

*"Ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions. These offences are known as Section 44 of the Act and applies to anyone caring for a person who lacks capacity – this includes; family carers, healthcare and social care staff in hospital or care homes and those providing care in a person's home..."*

*... Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, they must either:*

- *have deliberately ill-treated the person; or*
- *been reckless in the way they were treating the person.*

*It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health. The meaning of 'wilful neglect' varies depending on the circumstances but it usually means that a person has deliberately failed to carry out an act they knew they had a duty to do".<sup>91</sup>*

**10.630** It is important to state that family allegations in relation to abuse and neglect could not be substantiated by the North Wales Police (in meeting criminal thresholds), the North Wales Safeguarding Board, and the Conwy and Denbighshire Local Authorities (in meeting non-criminal thresholds) as they concluded their investigation and inquiry work. This Investigation, which has been run entirely independently from those of the North Wales Police, North Wales Safeguarding Board and Conwy and Denbighshire Local Authorities, concurs with their findings and conclusions in this regard.

### **Patient and Family Experience**

**10.631** The majority of families represented in this sample sought explanations and reassurance from this Investigation in relation to abuse and neglect. It is the sincere hope of the Investigation Panel that this has been achieved.

**10.632** A minority of families in this sample told the Investigation Panel about what they firmly stated to be wilful abuse and neglect; including torture. The Investigation Panel could not substantiate those allegations after an extensive and thorough examination based on all the evidence that was available.

**10.633** It was also evident that several of these families had already raised complaints with BCUHB, and PoVAs with the relevant Local Authorities. The Investigation Panel found that many of these cases had already been investigated to the point of conclusion prior to this Investigation being commissioned. It was also evident that in some cases, the same complaints had been raised by families (and

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<sup>90</sup> <http://www.legislation.gov.uk/ukpga/1983/20/section/127/2009-03-28>

<sup>91</sup> <https://www.suffolk.gov.uk/assets/Adult-social-care-and-health/mental-capacity-and-deprivation-of-liberty-safeguards/2013-09-11-S44-Summaries.pdf>

investigated again) more than once. The Investigation Panel concludes that this constituted poor practice and the families should have been referred to the Ombudsman for a final determination. Because this was not achieved many families have continued over the years to pursue cases hoping to finally obtain the findings that they believe to be correct. This is not helpful to families and it is not the best use of NHS resource.

## Safeguarding Practice

### *The System across North Wales*

**10.634** The Investigation Panel concludes that safeguarding processes as managed and overseen by both the Health Board and the relevant Local Authorities were often not robust enough to confer the levels of protection that could reasonably have been expected for the patients on Tawel Fan ward. Even though this Investigation has not been able to find any links between any weaknesses in those processes and any consistent and/or significant levels of harm that went undetected (and therefore unmanaged) it was poor practice.

**10.635** The Investigation Panel concludes that the safeguarding systems and processes in place during the period under investigation were not operating in an optimal manner and that the expectations and requirements of the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (first version 2010 and second version 2013) were not met in full. This was of particular concern in relation to:

- a lack of ability for the system to detect trends on a ward-by-ward and service-by-service basis;
- the inability of the system to track an individual's safeguarding history as they moved through disparate health and social care service across north Wales;
- unevenly applied PoVA thresholds (particularly in relation to patient-on-patient assault);
- delays to PoVA investigation and review timescales.

**10.636** Of particular concern in the here and now was the inability of the system (that included all partner agencies) to assemble complete sets of safeguarding documentation for many of the patients in the Investigation Cohort. This hindered the Investigation Panel's ability to complete its work on a patient-by-patient basis. It was evident that the documentation provided was not always complete (despite claims made to the contrary) because police and GP records often referred to meetings, referrals and action plans that (in the event) could neither be accessed nor traced. This is problematic in that it illustrates the following:

- currently patient safeguarding histories cannot be reliably accessed and tracked; for those patients still living this carries an obvious set of risks;
- the system retains a general lack of 'join up' whereby factors known by one part of it are still not known by another; this places patients at potential risk as they move from one service to another.

### ***The System in Particular Relation to BCUHB***

**10.637** During the period under investigation BCUHB operated with an under-resourced safeguarding system that functioned with the minimum of corporate oversight and scrutiny. It is a fact that senior BCUHB witnesses struggled to provide a coherent account of how this essential system worked and where the main accountabilities rested for its ongoing assurance and management.

**10.638** The Investigation Panel concludes that this had a detrimental effect on the processes that were followed – from those that commenced on the ward once a PoVA was raised, through to the investigation and protection plan processes, and the eventual reporting to CPG committees and the corporate Health Board.

### **Underlying Factors: Root Causes**

**10.639** Whilst examples of abuse and neglect were not found the Investigation Panel identified issues in relation to safeguarding and clinical governance systems, that both could, and should, have been managed better in order to ensure patient safety and wellbeing were maximised. Areas that were not optimal combined systemic, local service and individual practitioner factors. It is important to understand which factors were in play so that recommendations and actions for service improvement can be targeted appropriately. Appendix 3 provides information about root cause analyses factors.

**10.640** Many of the factors set out below have already been examined in depth in chapter 9; a concise summary is provided below.

### ***Safeguarding Processes***

**10.641** Safeguarding systems and processes across north Wales were lacking in coordination and robust multiagency working. This was due to:

- complex geographies;
- six Local Authorities (each working in different ways);
- the BCUHB matrix system not always aligning with its multi-agency partners;
- organisational development issues within both the NHS and Social Services;
- financial constraints within BCUHB reducing the capacity of services to manage safeguarding processes;
- dynamic national requirements in relation to Adults at Risk policies and procedures.

**10.642** These issues all had an impact on the effectiveness and quality of the safeguarding systems and processes that were put in place. The identified factors are:

- organisational (across health and social care);
- team (general guidance, policy and procedure);
- patient (as a result of growing acuity and increased movement between county boundaries).

### ***Clinical Governance***

**10.643** Inpatient services have to provide care and treatment in an environment that is safe, well-resourced, and equipped with comprehensive and evidence-based policy guidance. The Investigation Panel found examples where clinical practice and service delivery fell short of best-practice standards because these factors had not been addressed appropriately.

- 1** The ward environment became increasingly unfit for purpose due to the diverse range of patients that were admitted there. Mixed sex wards are unacceptable environments for patients to be nursed in; this is made more unacceptable when disinhibition (and the associated sexual and physical assaults) are predictable events. There is no evidence to suggest that the CPG conducted environmental risk assessments that took these factors into account.
- 2** Patient acuity and the implications from both an aggregated service risk and a workforce management point of view were not taken into full account in a timely enough manner. Whilst it was evident the CPG was working to address these issues throughout 2013, the challenges presented by concurrent financial constraints and service modernisation meant there were limitations to what could be achieved at this time.
- 3** Clinical policies and procedures were not fit for purpose in relation to the older adult. It is poor practice to assume that the evidence-base in relation to adults of working age can be interchangeable with that for older people. This consistent stance adopted by the Mental Health and Learning Disability CPG meant that on occasions the quality of the care and treatment provided was compromised. The policies of particular concern in relation to safeguarding were:
  - restraint;
  - rapid tranquilisation;
  - therapeutic observations.

**10.644** The identified factors are:

- organisational (safety culture);
- task (policies and procedures);
- working conditions (environment and workforce).

### ***Patient Management***

**10.645** The Investigation Panel has established that patient acuity on Tawel Fan ward rose steadily between 2012 and 2013 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.

- 10.646** The impact was a concentration of patients on Tawel Fan ward with a) complex and challenging presentations and b) behaviours that placed both themselves and others at significant risk. It should be remembered that hospitals are not the best places for older people to be placed for prolonged periods of time. However the circumstances in north Wales meant that this was often the case for many individuals; even once they had been stabilised and were ready to be discharged there was often nowhere for them to go. In these circumstances the maintenance of a calm and safe therapeutic environment was of even more importance.
- 10.647** A small number of patients were nursed on the ward whose needs were so intense that alternative arrangements and/or out of area placements should have been considered in order to maintain the safety and integrity of the therapeutic environment. However the custom and practice of the CPG was for wards to ‘consume their own smoke’. This meant that escalation was virtually unheard of even when there were patients whose presentation was beyond the capacity of the ward to manage in an optimal manner.
- 10.648** On these rare occasions it was evident that the service had exhausted its flexibility to respond to patients who represented severe and significant risks. This is a key factor when understanding the challenges that the ward faced as it was expected to accept every referral and manage every challenge that was presented as a consequence. It should be understood that in these unusual circumstances additional ward staff and increased supervision alone were not always adequate measures to address the patient management issues that arose. The identified factors are:
- organisational (safety culture and financial constraints);
  - team (leadership);
  - patient (acuity).

### **Lessons for Learning**

**10.649** The main lessons for learning are:

- 1 Family Communication and Support.** The requirement for consistent and robust communication and support is essential when working with families whose loved ones have behaviours that challenge, where incidents (such as falls and assaults) are more likely, and where Restrictive Physical Interventions might be needed. Whenever possible families should be invited to co-produce care plans and to work with the treating team on management strategies. When difficult messages have to be communicated, or when there are aspects of care and treatment that might have fallen below an acceptable standard it is essential for complete honesty and transparency.
- 2 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.

- 3 Connectivity between Multiagency 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.
- 4 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 Clinical Governance and Evidence-based Practice.** Clinical Governance is the foundation of patient safety in NHS organisations. Health Boards have a duty to ensure that current, evidence-based clinical policy guidance is available to its staff. Without it the quality and safety of care and treatment can be compromised and patients put at risk. The requirements of clinical interventions for the older adult are often significantly different to those for adults of working age and the two should not be conflated.
- 6 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.
- 7 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

### Context

**10.650** The two primary pieces of legislation that are addressed in this chapter subsection are those relating to the Mental Health Act (1983) and the Mental Capacity Act (2005).

#### **The Mental Health Act (1983)**

**10.651** The Mental Health Act (1983) is an Act of the Parliament of the United Kingdom and applies to England and Wales. The Act states what legal powers doctors and Approved Mental Health Professionals (AMHPs) have to detain a person against their will. These powers can only be used if a person has a mental disorder and is placing either themselves or others at risk. There are different sections of the Act under which a person can be detained; depending on the section treatment can sometimes be given against their will.

**10.652** The Mental Health Act (1983) and its 2007 amendments confers specific protections and rights to those individuals who are detained. Individuals can appeal against their detention and have the right to access the help of an Independent Mental Health Advocate (IMHA).

#### ***Designated Nearest Relatives***

**10.653** ‘Nearest Relative’ is a legal term used in the Mental Health Act (1983). It is not the same as the ‘Next of Kin’ although (on occasions) the next of kin and the nearest relative can be the same person, but this is not always the case. Unlike the nearest relative the next of kin has no legal rights under the Act.

**10.654** Nearest relatives can ask for an assessment under the Act, they can also request for their relative to be discharged from hospital. An application can be made to a County Court to have a nearest relative ‘removed’ if it is thought that they are unsuitable in anyway. The nearest relative has no automatic rights to have confidential information shared with them about the patient. The designated nearest relative is determined by the general rule of who ‘comes highest’ on the list below:

- husband, wife or civil partner (to include a partner of a couple who has been living together as husband or wife for more than six months);
- son or daughter;
- father or mother;
- brother or sister;
- grandchild;
- uncle or aunt;
- niece or nephew.

**10.655** Men and women are regarded as equal, however whoever is the eldest would be deemed to be the nearest relative (for example: the eldest child or sibling).

## The Mental Capacity Act (2005)

**10.656** The Mental Capacity Act (2005) is an Act of the Parliament of the United Kingdom and applies to England and Wales. The primary purpose of the Act is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make them on their own. Individuals have the right to the support of an Independent Mental Capacity Advocate (IMCA). Five statutory principles are outlined in the Section 1 of the Act. These are designed to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making as far as they are able to do so.

- 1 *“A person must be assumed to have capacity unless it is established that he/she lacks capacity.*
- 2 *A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.*
- 3 *A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.*
- 4 *An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/ her best interests.*
- 5 *Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action”.*<sup>92</sup>

## When to Use the Mental Health Act (1983) and When to Use the Mental Capacity Act (2005)

**10.657** The Law in England and Wales allows for individuals with mental health problems requiring hospital assessment and treatment to be admitted to hospital on an informal basis under Section 131 of the Mental Health Act 1983 (MHA (1983)).

**10.658** There are however occasions where such individuals will have to be admitted into hospital on a formal basis (detained under section) either because they have the capacity to decide as to admission and treatment and refuse, or because they lack the capacity to consent to their admission and the circumstances of their admission will amount to a deprivation of liberty.

**10.659** In its decision in *HL v United Kingdom (Bournewood)* 2004 the European Court of Human Rights held that reliance on the Common Law doctrine of necessity to detain informal patients incapable to consent to their admission, did not comply with the requirement in Article 5(1)(e) of the European Convention of Human Rights. It confirmed that detention of persons of unsound mind must be through a procedure prescribed by law.

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92 The Mental Capacity Act Section 1

- 10.660** Subsequently the Mental Capacity Act 2005 (MCA (2005)) allows, if certain defined criteria are met, for the lawful deprivation of liberty of individuals in hospitals and care homes who cannot consent to their admission and treatment. This deprivation of liberty can be authorised by way of administrative procedure, in other words without requiring attendance at Court, which is now known as the DoLS regime.
- 10.661** The MCA (2005) extends, in principle, the ability to detain individuals in hospital for treatment for their mental disorder, and there is, therefore an overlap between MHA (1983) and MCA (2005). That overlap is regulated by the provisions of Schedule 1(a) of MCA (2005).
- 10.662** In the Judgment of the Supreme Court in *P v Cheshire West and P&Q v Surrey County Council (2014)*, there is clarification of the circumstances under which a person would be considered to be objectively deprived of their liberty. In this Judgment the Supreme Court, in particular Lady Hale set down an ‘acid test’ namely that the individual must be under continuous control or supervision and not free to leave (arguably Tawel Fan). Further, the Supreme Court made clear that absence of objection from the individual is irrelevant when deciding whether they are objectively deprived of their liberty. If the individual does not have the capacity to consent to the objective deprivation of their liberty then the State Body responsible will be acting unlawfully if it does not take steps to:
- obtain authorisation under the DoLS regime;
  - detain the individual under MHA (1983);
  - obtain a Court Order.
- 10.663** Subsequently the article provided by Sorinmade *et al* provided a flowchart to guide clinicians in the process of deciding which jurisdiction applies in the care of patients either at the point of admission or during their stay on the mental health unit and is based on provisions of the MHA (1983) and MCA (2005) as well as their Codes of Practice and Case Law.
- 10.664** For individuals about to be admitted (or already in hospital), and where they are (or will be) deprived of their liberty, guidance as to which regime ( MCA or MHA) should be applied, has been given in the Judgment in *AM v South London & Maudsley NHS Foundation Trust and the Secretary of State for Health (2013)*. The Judgment emphasised that it is only where an individual lacks capacity to decide whether to be admitted to a mental health hospital for purposes of receiving care and treatment and is not objecting either to being admitted to hospital, or at all, that there is a genuine choice between the two regimes.
- 10.665** If the patient who lacks capacity is objecting to treatment, or admission, the only route is MHA (1983). If there is a genuine choice, then it will be for the decision makers to determine which regime is the least restrictive way of achieving the objectives of assessment and treatment of the individual patient. The Code of Practice accompanying MHA (1983) (Chapter 13) gives guidance on the interaction between MHA (1983) and MCA (2005). This also has a flowchart which highlights when to use MHA or MCA (appendix 6).

**10.666** The Judgement of the Supreme Court has highlighted even further the importance that clinicians consider with care whether a patient in question has the capacity to consent to admission and treatment, because this will, in many cases, be key to determining whether they can be admitted informally, or whether the formal routes outlined above must be adopted. The key points are:

- 1** The test for decision making capacity set down in Section 2 MCA (2005), namely whether, at the material time, the person is unable to make the decision for himself because an impairment of, or a disturbance of functioning of the mind or brain.
- 2** The relevant decision – or the relevant question – for purposes of determining whether a patient has the capacity to consent to what would otherwise be an objective deprivation of their liberty as set down at paragraph 15 of Schedule A(1), namely *“whether or not he should be accommodated in the relevant hospital ... for the purposes of being given the relevant care or treatment”*.
- 3** Table 1 (included in the flowchart at appendix 6) provides more details of the information relevant to the question – in other words, the information that the patient must be able to understand, retain, use/weigh and thereafter communicate their decision.
- 4** It is important to remember that even if a patient is unable to understand or retain or use/weigh the relevant information or communicate their decision, this only establishes a lack of capacity if that inability is because of the impact of or disturbance in the functioning of the mind or brain.
- 5** Even if a patient has capacity to consent to admission, such consent must be voluntarily given, in other words, the use of force, duress or implied use, would vitiate any consent to admission as an informal patient. The Courts have emphasised the particular vulnerability of informal patients at psychiatric facilities and hence the need for particular care in assessing whether they are truly consenting to remaining there.

**10.667** There may be some instances in which neither the MCA (2005) nor MHA (1983) can be used to authorise the deprivation of a patient’s liberty in a psychiatric hospital. These are:

- 1** Where a patient is detained under MHA (1983) but requires treatment for physical disorder to which they cannot consent and which would involve further deprivation of liberty (for instance, forced feeding).
- 2** Where there is a ‘stand-off’ that cannot be resolved between the decision makers under the MHA (1983) and those under MCA (2005) as to which route to use to authorise the deprivation of liberty.

**10.668** In either case, in order to ensure that deprivation of liberty is lawful, it is necessary for the treating organisation to make an Application to the High Court for an Order to be granted under the inherent jurisdiction of the Court.

- 10.669** In summary, individuals with the relevant decision making capacity can be admitted to and treated on a mental health unit on an informal basis, whether or not the circumstances on that ward amount to an objective deprivation of their liberty. If the individual does not consent, or if they lack the capacity to consent, then it will be necessary for the deprivation of liberty to be authorised in order for it to be lawful.
- 10.670** Healthcare professionals on Tawel Fan ward would always need to be satisfied as to what authority they have to deprive individuals of their liberty for purposes of providing them with care and treatment. The authority can be either derived through the patient's consent, or from provisions of MHA (1983) (such as Section 63) or MCA (2005) (such as Sections 5 & 6).
- 10.671** It should always be remembered that authority to treat patients may not derive from the same source, as there will be instances where individuals might be deprived of their liberty under the MHA, but receive certain aspects of their treatment under the MCA. An example of this is when an individual lacks treatment consenting capacity for physical health problems (for example: washing), that are otherwise unrelated to their mental health problems.

#### **Treatment of Patients under the Mental Capacity Act for Day-to-Day Interventions**

- 10.672** In *Aintree University Hospitals NHS Foundation Trust v James* (2013) Lady Hale confirmed that a treatment that may bring some benefit to the patient, even though there is no effect on the underlying disease or disability would be lawful under the Act. The benefit could be the resumption of quality of life which the patient regarded as worthwhile.
- 10.673** MCA (2005), Section 5, allows for acts in connection with care or treatment. *Mental Capacity Act Manual* by Richard Jones (6th Edition) at paragraph 1-089 confirms that Section 5 Acts, which could be performed by a range of professional and lay people are not limited to 'day-to-day' or emergency situations, so they could include, for example, performing a serious planned operation on the patient. Without the protection of this Section, such acts could amount to civil wrongs, such as trespass, or crimes such as assault. The authority for undertaking Section 5 Act is found in the Common Law doctrine of necessity and also in the case of *JO v GO* [2013] EWHC 3932 (COP). *This issue is likely to be clarified by the Supreme Court in the New Year when it rules on Re Y* [2017] EWHC 2866 (QB).
- 10.674** Section 5 MCA (2005) confirms that if a person ('D') does an act in connection with the care or treatment of another person ('P'), the act is one to which this section applies if:
- 1** Before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question; and when doing the act, D reasonably believes:
    - that P lacks capacity in relation to the matter; and
    - that it will be in P's best interest for the act to be done.

2 D does not incur any liability in relation to the act that it would not have incurred if P:

- had had capacity to consent in relation to the matter; and
- had consented to D doing the act.

**10.675** Jones continues to say that the person who undertakes the Section 5 act (D) can only act on a reasonable belief that P lacks capacity, having concluded there are reasonable grounds for believing that the decision or act is in P's best interests. The steps taken to affect the reasonableness of the belief and the reasonableness of the grounds will reflect the status of the decision maker and the significance of the decision being taken: the healthcare professional would be expected to adopt a more rigorous approach than a lay carer, and routine care intervention would require less investigation than a serious medical decision. It will also be the case that the urgency of the act required, for example, the provision of emergency medical treatment, will dictate the extent of the steps that could be taken.

**10.676** From this paragraph, it can be taken that if a patient does not have capacity to consent to washing etc, then washing can be provided under Section 5 of the Mental Capacity Act, ensuring the dignity and respect for privacy of the patient are maintained at all times.

**10.677** Jones goes on to say that the Code of Practice of MCA (2005), at paragraph 4.44 states that the carers "*whether family carers or other carers*" and care workers do not have to be experts in assessing capacity. It follows that professionals who act as assessors should be held to a higher standard than non-professionals. In practice, formal assessments of capacity will rarely be required with most day-to-day decisions, but D must be able to identify objective reasons to explain why he or she believes P lacks capacity. A formal capacity assessment should be undertaken where a decision is contentious, significant, or likely to be challenged. Professional assistance should be sought by a lay carer in the circumstances.

**10.678** Given the above, MCA (2005) would have allowed the staff on Tawel Fan ward to undertake care such as washing, assuming it was appropriately carried out.

**10.679** Jones goes on to say that the protection provided by this action will apply in any setting where P is being cared for, or where services are being provided to him/her (for example: at P's home, care home, day centre or hospital). As one person is not allowed to act to the exclusion of others it is likely that a number of persons will be acting under the powers contained in this section during the course of the day. Jones confirms it is unrealistic to expect lay carers, the majority of whom are unlikely to have received any training on the Act, to undertake a capacity assessment and the best interest determination in respect of the decisions that need to be made in respect of P. These expectations are confirmed by the Code of Practice at paragraphs 6.27 and 6.28.

**10.680** The Code of Practice at paragraph 6.5 confirms the actions that might be covered by Section 5 include:

**1** *“Personal care*

- *Helping with washing, dressing and personal hygiene;*
- *Helping with eating and drinking;*
- *Helping with communication;*
- *Helping with mobility (moving around);*
- *Helping someone take part in education, social or leisure activities;*
- *Going into a person’s home to drop off shopping or to see if they are all right;*
- *Doing the shopping or buying necessary goods with the person’s money;*
- *Arranging household services;*
- *Providing services that help around the home;*
- *Undertaking actions relating to community care services;*
- *Helping someone to move home;*
- *Healthcare and treatment;*
- *Carrying out diagnostic examinations and tests;*
- *Providing professional medical, dental and similar treatment;*
- *Giving medication;*
- *Taking someone to hospital for assessment or treatment;*
- *Providing nursing care (whether in hospital or in the community);*
- *Carrying out any necessary medical procedures;*
- *Providing care in an emergency”.*

**10.681** In the circumstances, as long as the staff on Tawel Fan ward considered the patient did not have capacity to consent to day-to-day activities, then they would be covered under the umbrella of Section 5 MCA (2005).

**10.682** Section 6 MCA (2005) confirms some limitations to Section 5 and states:

**1** If D does an act that is intended to restrain P, it is not an act to which Section 5 applies unless two further conditions are satisfied:

- it is reasonably believed that it is necessary to do the act in order to prevent harm from P;
- the act is a proportionate response to paragraph (1) the likelihood of P suffering and (2) the seriousness of that harm.

**2** For the purposes of this section D restrains P if he:

- uses or threatens to use force to secure the doing of an act which P resists;  
or
- restricts P’s liberty of movement, whether or not he resists.

**10.683** Jones confirms at paragraph 1-079 that restraint can only be used when:

- 1 The person using it reasonably believes it is necessary to prevent harm to P. and
- 2 It is used and is proportionate both to the likelihood and seriousness of the harm. The restraint, which can include restraint on those who are subject to deprivation of liberty and authorisation granted under Schedule A(1), must also be in P's best interest. Restraint that does not meet the conditions is not rejected by Section 5. The practical result is that only the minimum amount of restraint for the shortest duration should be used to prevent the harm occurring.

**10.684** Jones confirms that although this provision does not provide further restraint of P in order to prevent harm to others, such action is authorised under Common Law powers to prevent breach of the peace. In *Albert v Lavin [1981]* the House of Lords confirmed that under Common Law “every citizen in whose presence a breach of the peace is being, or reasonably appears to be about to be, committed has the right to take reasonable steps to make the person who is breaking or threatening to break the peace refrain from doing so: and those reasonable steps in appropriate cases will include detaining him against his will”. A breach, which can take place in public or private property occurs when “harm is actually done or likely to be done to a person or in his presence to his property or person in fear of being so harmed through an assault, an affray, a riot, an unlawful assembly or other disturbance” (R v Howell [1981]). Restraining P from causing harm to others could be justified under this provision if it was considered P's actions would provoke a reaction that will cause harm to P.

**10.685** In the circumstances, Jones clarifies that if staff are required to use restraint in order to provide day-to-day care, as long as they reasonably believe restraint was necessary to prevent harm to P, and it was proportionate both in the likelihood and seriousness of the harm, then they would have complied with Section 5 of the Mental Capacity Act as to when restraint can be used in all day-to-day tasks. There will however need to be some evidence for this, such as Witness Statements, or confirmation in the medical records.

## Findings: The Family Experience

**10.686** In total 20 families raised concerns relating to legislative framework processes. 19 raised concerns in relation to the Mental Health Act (MHA 1983) and eight raised concerns in relation to the Mental Capacity Act (MHA 2005). It should be noted that some families raised issues about both frameworks.

**10.687** It was evident that several of the family members who raised concerns with this Investigation were not the designated ‘Nearest Relative’ and that many of the communication issues they encountered with professionals on Tawel Fan ward were as a result of this. It should be taken into account that several family members had been (and in some cases were still) in dispute with each other about what was in their loved one's best interests; this is reflected by the nature of some of the concerns that they wanted to have investigated. Table 9 below sets out the nature of the concerns raised.

**Table 9**

<b>Type of Concern Raised</b>	<b>Numbers</b>
Families not consulted prior to patients being detained	<b>17</b>
Lack of communication and information giving	<b>17</b>
Familial disputes about nearest relative and next of kin status	<b>2</b>
Concerns that patients were detained illegally	<b>8</b>
Services making decisions about patients without full family consent and involvement (principally care home placement and other decisions in the context of familial dispute)	<b>15</b>

**Mental Health Act (1983)*****Admission***

- 10.688** 19 families raised issues in relation to the Mental Health Act (1983). It was evident that they had not encountered the Act prior to their loved one's admission to Tawel Fan ward and that (in the main) they regarded detention under the Act as a punitive and shameful measure. Consequently they perceived Tawel Fan ward to be a "secure lock up" where peoples' rights were removed with patients being somehow 'lost' to their families.
- 10.689** However on a close examination of the clinical records it was evident that approximately 50 percent of the families raising concerns about their relatives being detained under the Act were labouring under a false assumption. They had assumed that their loved ones had been detained when in fact they had not. It should be taken into account that no one had actually told the families that their loved ones had been sectioned – this was an assumption made by families.
- 10.690** Soon after admission a small number of these families had come to realise that their relatives had been admitted informally to Tawel Fan ward (when they had thought otherwise) and were distressed to hear that they could not automatically take them home. This gave rise to the concern that their loved ones had been detained illegally.
- 10.691** Families told the Investigation Panel that the admission process had often been a traumatic experience taking place during a time of crisis. Consequently admissions were often disorganised and rushed with police and social services involvement and/or an urgent Accident and Emergency visit.
- 10.692** During this chaotic time families were of the view that they had not been communicated with appropriately and that the rights of their loved ones had been breached as a result. Families wanted the Investigation to clarify:
- whether their loved ones had been detained under the Act or not;
  - whether their loved ones had been illegally detained and their rights breached;
  - why families had not been communicated with better.

### ***Nearest Relative Issues***

- 10.693** As has already been mentioned in this report, many of the family members raising concerns and complaints with this Investigation were not necessarily the next of kin or (more importantly in relation to the Act) the nearest relative. In the case of large, extended families a single patient who had been admitted to Tawel Fan could have up to eight family members trying to be actively involved in the care and treatment planning of their loved one. This could lead to confusion on the part of the ward team (as to who to communicate with) and familial disputes.
- 10.694** Many family members were shocked to find that they had no ‘legal status’ in relation to their loved one’s stay on Tawel Fan ward. This built up tensions and frustrations both with the ward treating team and (on occasions) with other members of their families. This also explains to a large extent how many (if not all) of the communication difficulties with family members arose in relation to their relative’s status under the Mental Health Act.

### **Mental Capacity Act (2005)**

- 10.695** The main issues that families wanted to raise in relation to the Mental Capacity Act (2005) were:
- Deprivation of Liberty;
  - Best Interests decisions;
  - the rights of family members versus those (as they saw it) of the treating team.
- 10.696** Many family members were ambivalent about their loved ones being admitted to (and remaining on) Tawel Fan ward. They were distressed to see their loved one’s confusion and unhappiness, as due to the dementia process patients could not always understand where they were or why they could not go home. Family members were often shocked to see the deterioration in their loved ones shortly following admission (particularly if they had not seen them for several months previously) and thought that the deterioration was caused by the admission alone rather than being the reason for it. Many families were of the view that their loved ones should be allowed to go home where they hoped their condition would improve. Families could not understand why informal patients could not be automatically discharged and were of the view that they had been deprived of their liberty.
- 10.697** It was also evident that on frequent occasions families disagreed with the treating team in relation to ongoing clinical management and discharge placement decisions. Families were of the view that their wishes should always have been conceded to and that they had an automatic right to determine what was in their loved one’s best interests. On occasions family members had a Lasting Power of Attorney in relation to finances and/or welfare. It was evident that those family members thought this always gave them the final say in any matters regarding best interests and clinical care. Some of those family members wanted the Investigation Panel to determine whether or not their own rights had been breached.

## **Familial Disputes and Disagreements**

- 10.698** It was evident that familial disagreements were common and family relationships often complicated. This was particularly the case for those patients who were divorced, separated, or living with partners. It was also the case for those patients with numerous children and siblings who did not always agree with each other.
- 10.699** In those cases it was not uncommon for the ‘nearest relative’ to not be the ‘next of kin’. This diverted communication flows and led to some family members believing themselves to be excluded from key communication and decision making processes. On occasions family members had asked for their relative to be admitted to Tawel Fan ward, only to have other family members demand an instant discharge. These kinds of situations were very difficult to manage.
- 10.700** During these often heated altercations care and treatment decisions still needed to be made on behalf of patients; families did not always understand that they could not postpone indefinitely care and treatment decisions until such time as inter-familial agreement had been reached. The families who raised complaints and concerns with this Investigation sought clarification as to what their rights were and whether or not the Tawel Fan treating team had overridden them improperly.

## **Findings: Identified by the Investigation Panel**

### **High-Level Findings**

- 10.701** The Investigation Panel examined the case notes of 108 patients of which 105 were relevant to the subject of legislative frameworks. These case notes included those of the patients whose families had raised concerns. It should be taken into account that the *P v Cheshire West and P&Q v Surrey County Council (2014)* ‘Gilded Cage’ ruling of Lady Hale came after Tawel Fan ward was closed and it is important not to judge a service based on more recent rulings to those that applied contemporaneously. High-level findings were identified as follows:

#### ***Mental Health Act (1983)***

- 1** The Mental Health Act (MHA 1983) was applied on frequent occasions; at all times it was applied appropriately. However the decisions to assess and detain were often not taken quickly enough and earlier interventions were indicated on occasions.
- 2** Most of the patients admitted informally to the ward appear to have met the threshold for assessment under the Act. Due to the levels of care and treatment intervention patients required it would have been good practice to have assessed, and potentially detained them, under the MHA (1983) which would have been the most appropriate legal framework for interventions to have been made.
- 3** Once detained sections were often rescinded at an early stage before assessments were completed and before patients were stabilised. Due to the levels of risk most patients continued to exhibit (and due to their consistent

wish to leave the ward) longer periods under detention were often indicated. It was evident that the treating team was attempting to keep people on Tawel Fan ward using the least restrictive legal means available (which was their duty to do); however on occasions this was misguided.

- 4 Every detained patient had their rights under the MHA (1983) explained to them in an appropriate manner and in accordance with the Act. It was evident that the patients concerned did not have the cognitive ability to understand what was being explained to them and IMHAs regularly came onto the ward to ensure that every measure was taken to protect their rights. This was good practice.
- 5 The nearest relative would always be written to following every detention. Leaflets and information were provided together with an open invitation to meet with the BCUHB Mental Health Act Manager.
- 6 From an examination of the clinical records it would appear that communications with families were always conducted in relation to admission (usually at the point of admission) and the reasons for it. There is ample evidence to support the view that families had the difference between an formal and informal admission explained to them. However in the context of designated nearest relative and next of kin issues there was potential for mis-communication and misunderstandings to occur.

#### ***Mental Capacity Act (2005)***

- 7 In accordance with the Act every ‘informal’ patient (who had not been detained under the MHA 1983) had a ‘locked door’ assessment at the point of admission. This took into account the fact that patients could not leave the ward of their own volition due to the front door being electronically locked. The assessment reviewed their capacity to consent to admission and also directed the treating team to consider detention under the MHA 1983 or the DoLS process if patients repeatedly tried to leave the ward.
- 8 DoLS processes were not understood to the same level that are now required following the 2014 ‘Gilded Cage’ ruling. On frequent occasions informal patients tried to leave the ward and a DoLS process should have been followed. DoLS processes should also have been followed for all informal patients (regardless of whether they wanted to leave the ward or not) as they were in fact being deprived of their liberty.
- 9 The use of IMCAs was poor – in part due their lack of availability. Every patient should have had access to this kind of input especially when significant Best Interest decisions had to be taken (such as risk versus benefit assessments and care home placements).
- 10 It was evident that on occasions families and the ward treating team disagreed strongly as to the manner in which a patient should be managed. On those occasions it was evident that the treating team tried to accommodate the families’ wishes but that ultimately had to place the patient at the centre of

the decision and sometimes go against them. It should be understood that the ward treating team often delayed decisions in order to accommodate families; however on occasions the patient's best interests suffered as a result and a more assertive use of IMCAs was indicated.

- 11 An examination of the clinical records demonstrates that the capacity of each patient to agree to care and treatment on the ward was conducted. Assessments were usually conducted by the patient's Consultant Psychiatrist on a Capacity Assessment form. This was done following detailed cognitive and diagnostic examination.

### **The Mental Health Act (1983)**

**10.702** The Investigation Panel found that none of the patients in the Investigation Cohort had been detained under the MHA 1983 inappropriately. There was no evidence to suggest that people's rights were being overridden in any way, or that assessments and detentions were applied when thresholds had not been met. The requirements of the Act and Code of Practice guidance appear to have been followed in full; the only exception to this was that MHA 1983 documentation did not appear to have been routinely filed within the main patient record which was poor practice.

**10.703** For any patient with a mental disorder requiring an admission to a psychiatric facility, assessment under the Act should always be considered when they:

- are a risk to themselves;
- are a risk to others;
- require intensive care and treatment interventions;
- are resistive to admission and/or remaining in hospital;
- cannot consent to admission and/or remaining in hospital.

**10.704** It was evident that older adult services (both NHS and Social Services) were cautious when triggering assessments under the MHA (1983). On occasions patients were left in the community beyond the stage when it was reasonably safe to do so and when an assessment under the Act was clearly indicated. It was also evident that once detained under a section of the Act there was often a reluctance to maintain patients on them and sections were frequently rescinded before the risks had been addressed and the patient stabilised.

**10.705** The MHA (1983) is the most appropriate legislation under which to admit and treat patients under the circumstances bulleted above. It would appear that on occasions the Tawel Fan treating team thought that the Mental Capacity Act could be used as an alternative. However the Investigation Panel found that on many of these occasions this was not the case as the mental disorder and the specific need to treat it was paramount. In these circumstances the MHA (1983) was the most appropriate legislation and should have been used more frequently. It should be understood that in these circumstances the Act (far from being a punitive measure) is the best legal means to confer the protection of a patient's basic Human Rights. Whilst it is always good practice to use the least restrictive legal means possible it is poor practice not to use the Act when it is indicated.

### ***Patient Communication and Support***

**10.706** All of the patients who were detained under a section of the MHA (1983) on Tawel Fan ward had significant cognitive impairments to the extent where they could not understand the information given to them about their detention. For those patients it was evident that every attempt was made to help them understand their rights and to explain the circumstances around their admission and enforced stay in hospital.

**10.707** Due to the severe cognitive impairment of the patients concerned IMHAs were always involved and they visited the ward to ensure that all detained patients were afforded their rights and supported appropriately. In the rare occasions that Hospital Managers' Reviews and Mental Health Act Tribunals were called the IMHA continued to provide support for the patient throughout the process. This was good practice.

### ***Family Communication and Engagement***

**10.708** As has already been mentioned families found it difficult to understand how to engage with services in relation to their rights (and those of their loved ones) under the MHA (1983).

**10.709** The main point of confusion appears to have occurred at the point of crisis in the community when admission decisions were made. Many of the families told the Investigation Panel that they had been asked (by either Social Workers or members of the NHS assessment team) for their consent to admission. At this stage these families reported that they had been given an option which was basically 'consent to admission or we will have to detain your loved one under the MHA (1983)'.

**10.710** Families were left feeling confused. This was because many of them:

- had refused consent but their loved ones had been admitted informally to hospital;
- had given consent but their loved ones had still been detained under the MHA (1983).

**10.711** On these occasions it would appear that families had been given choices which in reality were not theirs to make. The patients concerned were in crisis and could no longer be managed safely in the community, care and treatment options were diminished with an inpatient admission being the only viable way forward.

**10.712** Asking families for their consent led to confusion as it was not clear what families were being asked to consent to or what would happen if they refused to provide it. The Investigation Panel was of the view that too much emphasis was placed on families to make difficult decisions in crisis situations which they were ill equipped to understand or authorised to take. It was also evident that no matter what some families decided, they were in effect ignored as services had to place the patient's needs at the centre of the process. In this way families had their expectations raised (because their consent was asked for) and then dashed

(when it was ignored). This contributed to the growing sense of unease and powerlessness that many families described to the Investigation Panel.

**10.713** Once patients had been admitted onto the ward communication and engagement problems with some families continued, particularly in relation to nearest relative and next of kin issues. In the context of highly emotional and distressing circumstances, family members were often shocked to find that they did not have the level of legal rights that they thought they did. This was made more problematic when family disharmony existed and agreements could not be reached as to what was in their loved one's best interests and which family member was ultimately responsible for what.

**10.714** In relation to the MHA (1983) it was evident that family members could not always agree with each other and this meant that the ward treating team had to manage this dynamic together with the ongoing MHA (1983) issues for the patient. The Investigation Panel found that on occasions the designated nearest relative status afforded to a particular family member came as a shock to the others. However despite the disputes, the Investigation Panel found that in all cases the nearest relatives had been identified correctly and in keeping with the requirements of the Act.

### **Mental Capacity Act (2005)**

#### ***Deprivation of Liberty (DoLS)***

**10.715** The Investigation Panel found that DoLS issues were managed poorly on Tawel Fan ward. There was an ongoing confusion about how and when the MHA (1983) and the MCA (2005) should be used and when one should assume primacy over the other.

**10.716** The assumption appeared to be that if an informal patient wanted to leave the ward sporadically, or if they never tried to leave the ward at all, then there were no DoLS issues to address. It should be understood that most NHS older adult facilities across the United Kingdom were struggling to interpret the legislation at this time, hence the need for the 'Gilded Cage' ruling in 2014.

**10.717** Whilst it would not be reasonable to judge a service and its actions against subsequent Court determinations, the Investigation Panel found that, on occasions, some patients were improperly deprived of their liberty whilst on Tawel Fan ward. It has to be said that this finding also relates to the other wards (both mental health and medical) that patients were admitted to throughout their care pathway indicating that during the period under investigation this approach to DoLS was widespread throughout BCUHB.

**10.718** However it should be noted that all of the patients whose liberty was deprived (had they been assessed) would have met the thresholds for either detention under the MHA (1983) or a formal decision to be taken to keep them on the ward/s under the DoLS framework. It was the process, rather than the underlying decision, that was at fault.

### ***Capacity and Best Interests***

- 10.719** Capacity assessments were routinely conducted on Tawel Fan ward to determine a patient's ability to consent to care and treatment; this applied to both informal patients and those who were detained under the MHA (1983). This meant that the ongoing care and treatment interventions that took place were undertaken in good faith and under the requirements of the extant legislation.
- 10.720** However the Investigation Panel was of the opinion that on occasions additional best interest assessments and considerations should have been undertaken with the support of an IMCA. This was of particular importance when more challenging and difficult decisions had to be taken.
- 10.721** As has already been determined, the patients on Tawel Fan ward were complex and many had behaviours that required skilled interventions which were sometimes difficult to deliver due to aggression and /or resistance. It would have been good practice to have ensured that the decisions in relation to risks versus benefits (for example: aggressive behaviour and the challenges as to how care and treatment could be practically delivered) were assessed with an independent advocate representing the patient at the centre of the process.
- 10.722** For the majority of the patients in the Investigation Cohort it was evident that family members and the ward treating team worked together well and were in accord with care and treatment decisions; whilst this was a positive thing patients, with impaired cognition and no capacity to make key decisions, still had the right to IMCA input which was neither sought, nor readily available.
- 10.723** It should be noted that the absence of input from an IMCA was even more marked when it was evident that family members and the ward treating team were in disagreement as to how to manage key aspects of care and treatment. The Investigation Panel could chart from the clinical records that referrals to IMCAs were made in such circumstances, but that these referrals were sometimes declined meaning that patients had no independent advocacy and support during disputes. This was poor practice.

### ***Family Engagement and Involvement***

- 10.724** As has been said, in general the ward treating team worked well with families. On those occasions where disputes occurred the following factors were often in play:
- families were given complex information that was difficult to absorb and were often required to make rapid decisions based on it;
  - on occasions it was not made clear to families exactly what their authority was to make decisions and this created confusion;
  - families were sometimes in dispute as to who was the designated next of kin and on occasions families could not agree amongst themselves as to the best way forward for their loved ones;
  - family members (incorrectly in the case of the MHA 1983) were of the view that any Lasting Power of Attorney they had would automatically overrule any decisions made by the treating team;

- family members were of the view that they would automatically know what was in their loved one's best interests and, (whilst this might have been the case) were not always willing to accept or consider any alternatives.

**10.725** The themes of communication and family engagement have run throughout the Investigation Panel's findings and conclusions in relation to all of the care and treatment themes discussed in this report. There is nothing to add here in relation to the importance of good ongoing communications and support except to say that at pivotal milestones on a patient's care pathway it is essential to take stock and to ensure that families understand all of the issues involved and how they can best contribute to the process, and challenge when necessary.

**10.726** It is also important to establish the designated next of kin and for services to acknowledge the difficulties that can be encountered in the face of familial disagreements and disputes. It was evident that several families have been left with feelings of frustration about how they were treated and the levels of involvement that they had. It is also evident that due to the disagreements that were ongoing (either between family members or between family members and the treating team) important decision making was sometimes postponed. On occasions this led to delays to patients being discharged and interruptions to the care and treatment provided. Treating teams are required to ensure that the patient is always placed at the centre of any decision to be made and they retain a duty to ensure that disagreements are managed in an assertive manner so that the best interests of the patient are not inadvertently affected as a result.

## Conclusions

**10.727** The Investigation Panel is aware that during the period under investigation practice in relation to the Mental Capacity Act (2005) and DoLS was still in the process of being interpreted. Between 2005 and 2014 United Kingdom guidance on when to use the Mental Health Act (1983) and when to use the Mental Capacity Act (2005) underwent dynamic shifts and changes. In 2006 (a year after the Mental Capacity Act came into being) the Social Care Institute for Excellence (SCIE) recognised that:

*“Most older patients enter psychiatric hospital on an informal basis with detention being reserved for those who actively object to admission. However, as a consequence of advanced dementia, many older patients require constant supervision and may even need to be restrained from leaving hospital for their own safety... This status is described by the Mental Health Act Commission as ‘de facto detention’: the older person has no practical means of exercising his/her theoretical right to leave hospital, yet they have not been ‘sectioned’ under the Act and so do not have the rights of a detained patient”.*<sup>93</sup>

**10.728** During the period under investigation it was not uncommon for the older adult to be admitted to hospitals and/or care homes outside of any legal framework. Clarification was finally provided by the ‘Gilded Cage’ ruling in 2014 which post-dated the closure of Tawel Fan ward.

<sup>93</sup> <https://www.scie.org.uk/publications/guides/guide03/law/leg.asp>

### **Mental Health Act (1983)**

- 10.729** The Investigation Panel concludes that when patients were detained on Tawel Fan ward under the Act processes were managed appropriately and in accordance with the legislation and MHA Code of Practice.
- 10.730** 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 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.
- 10.731** Over the past four years (and since the ward closure) further clarification has been given in England and Wales in relation to adults who (for one reason or another) cannot agree to their admission, placement, and care and treatment in either hospitals or care homes. Whilst (on occasions) practice was not robust enough on Tawel Fan ward it is evident that this issue applied across many services in the two countries to which the Act applied during the period under investigation. It would not be reasonable to judge the service on how it worked between 2011 and 2013 when frameworks were under review and subject to Court rulings. The question will be how BCUHB has developed its services since in response to the 2014 ‘Gilded Cage’ ruling.

### **Mental Capacity Act (2005)**

- 10.732** It was evident that patients were (on occasions) admitted and treated on Tawel Fan ward without the clarity of a legislative framework; this would have deprived patients of their liberty on occasions. However the Investigation Panel is of the opinion that had the appropriate assessments been undertaken all of the patients identified in this regard would (as far as they can tell) have met the threshold for either detention under the MHA (1983) or placement under the MCA (2005).
- 10.733** Capacity assessments were conducted appropriately and it was evident that consent issues were addressed in accordance with the Act. It would appear that clinicians on the ward possibly thought that this process alone acted as a substitute for full DoLS processes but of course it could not.
- 10.734** Of particular note was the fact that DoLS and mental capacity arrangements did not appear to have been adhered to by the Accident and Emergency Department and medical wards on the Glan Clywd site. It was evident from the clinical records that capacity assessments, DoLS and best interests’ processes were not recorded and the Investigation Panel concludes they were not addressed appropriately when indicated.

## **Family Communication and Support**

**10.735** The general concerns raised by families were found to be similar to those already examined elsewhere in this report. Communication and ongoing engagement was at times fraught, exacerbated by legal framework requirements which sometimes exposed complex family dynamics. Once again this Investigation has highlighted the need for clear and consistent communication with families, combined with ongoing support, especially during periods of crisis and when complex and difficult decisions have to be made.

**10.736** One of the key factors that requires consideration is that of stigma. It was evident that many family members had never been inside a psychiatric facility before and that they were often deeply shocked by what they regarded as a potentially shameful situation. Those feelings were heightened if a loved one had been detained under the Act and placed in a “*secure lock up*” as one family put it. Family members reflected on their loved ones’ lives prior to dementia and could not equate the capable and proud people they had been all of their lives with the person who had been ‘committed to an asylum’. They spoke of their pain and distress, made worse by their feelings of powerlessness.

**10.737** The Investigation Panel concludes that for some families the concept of stigma was markedly significant in relation to detention under the Act. This is an important aspect that should be considered when working with families (especially older family members) who often carry the preconceptions of the shame and stigma of the old fashion asylum with them.

## **Underlying Factors: Root Causes**

**10.738** The underlying factors are simple.

- 1** The evolving levels of understanding (in England and Wales) regarding the relationship between the MHA (1983) and MCA (2005) were relatively slow to develop. This led to continued ambiguity and the potential for patients to be improperly deprived of their liberty. This made the application of legal frameworks difficult to interpret and understand for both services and families alike.
- 2** The requirement for family communication and engagement is of paramount importance. The matters regarding legislative frameworks are particularly difficult in that there are associated issues in relation to preconceptions and stigma. Legislative frameworks also have the potential to ‘override’ pre-existing family arrangements and expectations which can cause heightened levels of anxiety and confusion.

## Lessons for Learning

**10.739** The main lessons for learning are:

- 1 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.
- 2 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.
- 3 The Need for Clarity Regarding Legal Frameworks.** NHS organisations must provide clear guidance to services about the use of the MHA (1983) and the MCA (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.
- 4 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.
- 5 The Protections that Legal Frameworks Afford to the Patient.** The MHA (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.

- 6 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.
- 7 The Importance of the IMCA.** Under the MCA (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.

# 11 Mortality Review and End of Life Care

## BCUHB Mortality Review

- 11.1** The BCUHB Mortality Review report was cited in Welsh media reporting throughout 2016 and 2017. There was a great deal of interest and speculation with regard to the content and calls went out from families and politicians alike to have the findings and conclusions placed in the public domain. The report (which is still in draft) courted a great deal of controversy and misgiving; a view that prevailed was that significant findings about patient safety had been withheld and that it was in the public interest for them to be disclosed. The BCUHB Mortality Review report remained unpublished at the time of writing this report.
- 11.2** Because of this the Investigation Panel has neither quoted, nor reported directly, from the draft report as this would be publishing by default and the final decision about whether or not it is eventually placed in the public domain is for BCUHB alone to take. However basic statistical information has been provided as without it there is no context in which to place the findings and conclusions from this Investigation. Individual patient cases are not discussed here as they are part of the *Putting Things Right* process and will be shared with families directly and in confidence.

### Context: BCUHB Commissioning Process

#### Background to the Commissioning of the BCUHB Mortality Review

- 11.3** Throughout the course of this Investigation it was noted that the exact purpose and status of the Mortality Review was understood poorly by the Health Board and senior clinicians and managers within BCUHB. This has given rise to a high degree of confusion and the sending and receiving of mixed messages; in particular those involving families.
- 11.4** The Investigation Panel was able to ascertain that on 19 March 2014 the Assistant Medical Director for Secondary Care Central was approached by Donna Ockenden directly to conduct a review into the deaths of four patients who had been admitted to Tawel Fan ward. This was at the instigation of the East Area Director of Clinical Services who had been engaged with both the Tawel Fan families and the Ockenden external investigation.
- 11.5** In response to further advice given by Donna Ockenden the BCUHB Executive Medical Director in post at the time initiated a Mortality Review on 1 June 2014 via an internally commissioned process. The review examined the cases of 23 patients who had either died on Tawel Fan Ward or within 28 days of discharge. This work was also led by the Assistant Medical Director for Secondary Care Central who used the review template BCUHB had previously adopted for such work; and which had been developed in conjunction with colleagues across Wales as part of the 1,000 lives patient safety campaign.

- 11.6** On the 15 September 2014 a report was completed and sent to both the BCUHB Executive Medical Director and Executive Director of Nursing. The author very sensibly explained that there should be no “*over-reading*” of the findings; the recommendation was that a more detailed review of each of the patient cases should be undertaken. The report was shared with the North Wales Police and the author stressed that the review, such as it was at this stage, was to understand themes and areas for service improvement “*rather than [to provide] a more forensic analysis of care*”.<sup>94</sup>
- 11.7** On 5 October 2014 the BCUHB Executive Medical Director wrote to the Assistant Medical Director for Secondary Care Central advising him that the Mortality Review needed to address two key questions:
- did patients come to harm when under the care of BCUHB? If so;
  - did the harm contribute to a premature death?
- 11.8** The Assistant Medical Director for Secondary Care Central replied that the methodology used to date could not address these questions. He advocated a more thorough review by those expert in managing the kind of patient admitted to Tawel Fan ward. He suggested advice was sought from the Royal College of Physicians and the Royal College of Psychiatrists in order to ensure both external oversight and expert input. In the event the Royal Colleges could not support the work within the timescales deemed necessary by BCUHB.
- 11.9** On 17 November 2014 a second Mortality Review commenced to examine some 56 individuals who were understood to have been inpatients on Tawel Fan ward between November 2011 and November 2013. This patient cohort was purported to include all deaths that had occurred on the ward and also included those that had occurred beyond 30 days of discharge. The second-stage Mortality Review was conducted following advice taken from the University of Cardiff in relation to methodology and was led once again by the Medical Director for Quality and Transformation.
- 11.10** When interviewed by this Investigation the former BCUHB Executive Medical Director and the Assistant Medical Director for Secondary Care Central were both of the opinion that the review findings and conclusions were never intended for publication and that the work was conducted as part of an internal audit designed to promote learning and service improvement. The Investigation Panel was also told that the Mortality Review was at no time meant to replace a forensic examination into care and treatment (should one be deemed to be necessary). This is important in relation to:
- the methodology that was chosen;
  - the purpose that any such methodology could be put to; and
  - the reliability and utility of any subsequent findings.

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94 Witness statement excerpt

**11.11** The Mortality Review Terms of Reference required:

- a focus on the period between November 2011 and November 2013 to determine whether the standard of care was reasonable;
- an outline of the instances where care fell below those standards and to make a judgement as to whether the patient suffered as a consequence;
- reviewers to address the specific question whether there was any evidence to suggest sub-standard care contributed to or had been causative of death.

**11.12** However it was not made explicit what further action would be required if reviewers considered there to be either contributory or causal factors in relation to a death. Quality assurance and validation processes were not defined and it would appear that there was limited understanding on the part of the BCUHB Executive Medical Director as to the limitations of any Mortality Review process and what would need to be conducted in addition if serious concerns were identified. Basically it would appear that the Mortality Review was regarded as a 'stand alone process' rather than being the first part in a continuum of activities.

### **BCUHB Methodology and Process**

**11.13** At the inception of the second Mortality Review it was decided to use a Retrospective Case Record Review methodology and the Preventable Incidents, Survival and Mortality tool (PRISM 2) was chosen. In the event BCUHB was unable to source the clinical records for four of the patients and this reduced the numbers in the study from 56 to 52.

**11.14** The reviewers were comprised of a medical nurse, a pharmacist, and a physician; none of whom came from a mental health background. They each spent between 40 minutes and eight hours per patient reviewing the clinical records and filling in the PRISM 2 forms.

**11.15** On 1 January 2015 the BCUHB Mortality Review first draft report was completed; the second and final draft was completed in September 2015. It would appear that the report was never taken out of draft and did not go through any quality assurance, validation or formal sign off process.

## **Context: Evaluation of the Methodology**

### **Using Retrospective Case Record Review to Review the Care of Patients who Die in Hospitals: The United Kingdom Context**

**11.16** Learning from hospital deaths is an important component of good clinical practice, but current approaches and measures are complex, controversial and difficult to understand. Numerical measures of mortality such as the Hospital Standardised Mortality Ratio (HSMR), the Standardised Hospital Mortality Index (SHMI) and the Risk Adjusted Mortality Index (RAMI) are considered unhelpful by many patient safety experts and may even give false reassurance, as accuracy of measurement is strongly influenced by factors apart from quality of care.<sup>95</sup> Despite this, various such measures are used in the NHS across the

95 Stewart K, Choudry M, Buckingham R. Learning from hospital mortality. *Clinical Medicine* 2016 Vol 16, No 6: 530-4

United Kingdom, although it should be noted that the NHS in Wales stopped using the RAMI in 2014.<sup>96</sup>

- 11.17** An alternative to numerical measures is for experienced, independent clinicians to examine the case records of all (or a sample of patients who die) to determine if there have been patient safety problems. Informal approaches to case record review have existed for many years, but these have been of variable quality and by their nature subjective. In attempts to reduce subjectivity and increase standardisation of the process, Retrospective Case Record Review (RCRR) methods have been developed. Most RCRR methods have been developed from instruments used by patient safety researchers (for example those used in the Harvard Medical Practice Study).<sup>97</sup> These methodologies guide case record reviewers to structure their decisions in a standardised way and prompt them to seek common patient safety problems. They also allow for easier analysis of the outputs of multiple reviews to identify common themes that may have affected a number of patients. Typically they detect issues such as delays in medication administration, inadequate response to abnormal observations, or delays in accessing diagnostic tests at certain times of the day.<sup>98,99</sup>
- 11.18** Since most patient safety problems are due to system failures, and not the actions or inactions of individuals, applying RCRR to a large number of case records enables common themes to be identified at the level of a ward or hospital. RCRR has neither been developed, nor designed, to provide an in-depth analysis of the care of an individual patient; when specific concerns about the care of an individual patient arise during the RCRR process this usually triggers a requirement for a more in-depth expert review and a separate serious incident investigation.

### Development and Validation of RCRR Methods

- 11.19** The Institute for Healthcare Improvement's Global Trigger Tool (GTT) was one of the first RCRR methodologies to be used for Mortality Review and has been used widely throughout both the United States and the United Kingdom. However, it was developed for acute hospital use in the United States' healthcare system and some NHS organisations have found it difficult to adapt for a different kind of patient population and care provision models.<sup>100</sup>
- 11.20** The researchers conducting the PRISM (Preventable Incidents, Survival and Mortality) studies developed their own methodology based on that used in previous international research. The PRISM methodology includes a six-point scale for reviewers to judge 'preventability' of death. This system was developed to study the case records of a representative sample of 2,400 patients who had died in English general hospitals, and to determine if there was any correlation between high HSMR and percentage of 'preventable' deaths in each hospital as

96 "Hospital death data not meaningful" BBC news <http://www.bbc.co.uk/news/uk-wales-28319122> 16 July 2014

97 Hutchinson A, Coster JE, Cooper KL et al. Comparison of case note review methods for evaluating quality and safety in healthcare. *Health Technology Assessment* 2010; Vol 14: No. 10

98 Hogan H, Healey F, Neale G et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. *BMJ Qual Saf* 2012; 21: 737 – 45

99 Hogan H, Zipfel R, Neuburger J et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015; 351: h3239

100 <http://www.ihl.org/resources/Pages/Tools/IHIGlobalTriggerToolforMeasuringAEs.asp>

judged by RCRR (no correlation was found). The PRISM studies were restricted to acute general hospitals, and did not include Mental Health units. Several dozen reviewers were recruited through Royal Colleges and patient safety research groups; all were senior experienced doctors who had current or recent experience in acute care. They were given a single day of training in the methodology, telephone access to more experienced expert reviewers and to other clinical specialists where necessary. If reviewers determined that there was a greater than 50 percent probability that a death was preventable, then they were required to seek a second opinion from, and the subsequent agreement of, an expert reviewer. In addition 10 percent of records were randomly selected for second review by expert reviewers to ensure validity of the process. Although the PRISM methodology was developed as a research tool it has subsequently been used and adapted by some organisations to conduct routine RCRR.

- 11.21** Professor Allen Hutchinson and colleagues developed and validated an alternative RCRR methodology, the Structured Judgment Review (SJR). This differs from PRISM in that it requires clinicians to make explicit statements about quality of care and state justifications for their judgments. Reviewers are all senior experienced clinicians, and although the majority are doctors they also include some senior nurses and other clinical professionals.<sup>101</sup>
- 11.22** The SJR forms the basis of a programme commissioned by the NHS and led by the Royal College of Physicians to provide a standardised approach to RCRR in all acute hospitals in England and Scotland.<sup>102</sup> While based on SJR methodology, it also includes some aspects of the PRISM methodology including the ‘preventability’ scale for deaths in hospitals in England (but not in Scotland). Although the SJR has been developed and validated in acute hospital populations, Professor Hutchinson and colleagues are currently trialling its use in mental health settings but have not published results or validated it for use in these clinical areas as yet.

## Benefits and Limitations of RCRR

- 11.23** The Benefits are:
- 1** RCRR is a useful way of structuring and analysing clinical judgments, and can help detect system-level safety issues that would not be apparent through the review of individual case records in isolation. For example: PRISM studies found patient safety problems in around 15 percent of deaths in general hospitals; most commonly deficiencies in clinical monitoring, diagnostic errors and inadequate drug or fluid management. On a separate case-by case analysis this might not have been made apparent and trends not identified.
  - 2** Although RCRR is time-consuming it is less so than an in-depth review of each individual case; even after a relatively small number of reviews common themes begin to emerge, even if some clinical records are found to be incomplete.

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<sup>101</sup> Hutchinson A, Coster JE, Cooper KL et al. A structured judgement method to enhance mortality case not review: development and evaluation. *BMJ Qual Saf* 2013;22:1032 – 41

<sup>102</sup> <https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme>

**11.24** The limitations are:

- 1 It is a useful tool for hospitals to detect system-wide safety issues, but not sufficient on its own to allow definitive judgments about the care of individual patients.
- 2 All clinical reviewers are subject to bias; some tend to judge the actions of their colleagues too harshly, others judge them too leniently. In addition hindsight bias is common in mortality reviews since the outcome is, by definition, known. Bias is mitigated in research studies by using a large number of reviewers and having a process of escalation and second or in-depth review where concerns about management of individual patients arise.
- 3 The quality of RCRR is dependent on the quality of the clinical records. Poor quality, inaccurate or incomplete clinical records hamper the process, and most RCRR does not routinely seek other sources of information (for example: GP or social care records – this was the case with the BCUHB Mortality Review).
- 4 RCRR was not designed for the in-depth analysis of individual cases or a small number of cases; it is not reliable enough to do this, and requires a different process.
- 5 RCRR methods in current use were all developed, tested and validated in acute general hospitals but none have been validated in inpatient mental health settings. Given that the case-mix of the inpatient mental health population is significantly different and the patient safety issues are different, then it is likely that the methodology needs modification to account for this.
- 6 Determination of ‘preventability’ of death in individual cases using RCRR is difficult and highly variable between reviewers. To this end access to validation and quality assurance is required.<sup>103</sup>

**Using RCRR to Detect ‘Preventable’ Deaths**

**11.25** In research studies in general hospitals, up to 5 percent of deaths have been thought to be potentially preventable. Whilst it is sometimes evident that death was possibly preventable (for example: in low risk patients having day surgery) it is not so clear-cut when reviewing most other deaths in general hospitals, the majority of which are in elderly patients with multiple, complex medical problems and limited life expectancy. Levels of agreement between reviewers on whether a death is more likely than not to be preventable are low. Research studies use large numbers of reviewers and examine the case records of large numbers of patients to balance out these effects, but this is not a practical approach for everyday practice. Dr Helen Hogan, the lead researcher on the PRISM studies, estimates that using PRISM it would require five separate reviewers to be in agreement in order to be 90 percent certain that a death was preventable.

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103 Hogan H The problem with preventable death. *BMJ Qual Saf* 2016;25:320–3

**11.26** For this reason the Royal College of Physicians-led programme for England requires RCRR reviews to take place within an infrastructure which triggers a second review (and a separate serious incident investigation) if a reviewer considers that a death was more likely than not to have been preventable. The final decision on ‘preventability’ would not therefore be made by the RCRR reviewers, but only after much more detailed expert clinical investigation. The RCRR methodology is used as a prompt for a more in-depth investigation; it is not one in itself. Because of these complexities, the NHS in Scotland has commissioned an RCRR programme identical to that of the English one except it does not ask reviewers to make a ‘preventability’ judgment at all.

## Findings: The Family Experience

- 11.27** Shortly after the Ockenden external investigation was published a decision was taken by senior BCUHB officers to share the PRISM 2 forms with families. At this stage the only families that BCUHB was in regular contact with were those who attended the Tawel Fan Families group. There was no wider communication strategy in place and at this stage the Mortality review had neither been quality assured nor validated.
- 11.28** Eight families raised concerns with the Investigation Panel in relation to the Mortality Review. Five of these families had been contacted by BCUHB directly and told that their loved one’s deaths had been avoidable. These families were given copies of the PRISM 2 forms completed by the Mortality Review team. In addition there were three other families who had been told by BCUHB their loved ones deaths had not been avoidable; they were of the view that the Mortality Review had not been conducted properly and they wanted this investigated further.
- 11.29** It was evident that the Mortality Review purpose and limitations had not been discussed with families and they thought the findings, such as they were, were definitive and binding.
- 11.30** By the time the Investigation Panel met with these families their levels of both anger and frustration were profound. Those families who understood that their loved one’s deaths had been reviewed and found to have been ‘preventable’ were angry and demanded ‘justice’. Those families who loved one’s death had been reviewed and deemed not to have been ‘preventable’ wanted a second opinion.

## Comment

**The Investigation Panel understands that Senior BCUHB Officers sought to be outward facing in accordance with Duty of Candour responsibilities. However BCUHB took the decision to share unvalidated findings with families.**

**The findings, such as they were, had been determined from a Mortality Review process that was never intended for the purpose to which it was**

**ultimately put by BCUHB. Families could not be expected to understand this when presented with an apology from BCUHB and a statement of fault.**

**The premature sharing of this information has caused undue distress for families, defined their expectations and ultimately weakened public confidence in BCUHB as leaks to the media have provided misleading information which has in turn raised further concerns and levels of disquiet.**

## Findings: Identified by the Investigation Panel

### Review of the Methodology Chosen by BCUHB

- 11.31** BCUHB chose the same version of the PRISM methodology that had been used in Dr Hogan's research including the six-point scale for judging 'preventability' of death. Three reviewers were appointed; a consultant physician, a senior nurse and a senior pharmacist, all of whom had a single day's training on the use of PRISM. The reviewers examined case records independently of each other, and drew conclusions about deficiencies in care and preventability of death in accordance with the PRISM methodology.
- 11.32** The Investigation Panel remains uncertain as to how experienced the reviewers were in caring for patients with the sorts of problems that would be found in an environment like Tawel Fan ward, or if they had experience working in similar environments.
- 11.33** In cases where at least one reviewer determined that death might have been preventable, this was highlighted. However it is not clear what further work was envisioned. It would be usual practice when making a finding in relation to the potential preventability of a death for this to signal a formal concern. This level of concern should then trigger a more in-depth, definitive investigation of an individual case. This is the usual practice for acute general hospitals using RCRR when part of the Royal College of Physicians' programme.
- 11.34** However it is evident that BCUHB used the output of the PRISM reports alone as the basis of information that was passed to both executive directors and families that 'preventable' deaths had occurred. The findings were neither validated nor investigated at this stage.
- 11.35** The Investigation Panel found the following:
- 1** When BCUHB was attempting to understand patient safety issues on Tawel Fan ward it was reasonable to have selected a standardised RCRR approach, like PRISM (despite the methodology's limitations).
  - 2** It was also reasonable to use reviewers who were independent of the ward, to increase objectivity and to give external assurance.
  - 3** However the review team (in conjunction with the University of Cardiff) should have considered adapting the PRISM methodology for use in an older people's mental health inpatient setting. There are significant differences

between the settings in which PRISM was developed and Tawel Fan ward including a different patient population, different patient safety problems and different clinical guidelines (for example: those around venous thromboembolic disease management).

- 4 Reviewers should have been selected to include those with experience in caring for the sorts of patients who were on Tawel Fan ward, or in the same sort of environment. Research studies usually recruit reviewers who are experienced clinicians, who are familiar with the sorts of patients being cared for, and the environments in which care is being examined. RCRR methodology guides clinical judgments but is not a substitute for them.
- 5 Definitive conclusions about whether deaths were preventable should have only been drawn after detailed, individual case review by at least one senior clinician with relevant experience. PRISM methodology, especially in the circumstances in which it was used, is not robust enough to draw any firm conclusions about this on its own.

### **Challenges for the Mortality Review Team**

- 11.36** It was evident that the Mortality Review team were not used to reading mental health records. This presented a challenge to the reviewers as they had not expected a 'narrative' approach to clinical record keeping; consequently they found tracking admissions and discharges difficult. The reviewers also cited missing records together with a jumbled and chaotic presentation; something they thought might be due to poor record keeping processes on Tawel Fan ward, but was in fact due to the scan and collate process used to copy the records; this was the point where the disorganisation occurred.
- 11.37** Having read the PRISM 2 forms and the BCUHB Mortality Review report it was evident to the Investigation Panel that the reviewers did not have access to all of the clinical records and that many of their findings and conclusions are based on incomplete information; this obviously casts doubt on the validity of the work as the reviewers could not access all of the evidence they needed to complete the review properly.
- 11.38** The Investigation Panel spent on average seven days per case reading through clinical records. Comprehensive timelines were developed which provided a full account of each patient's clinical history. From this it was a relatively straightforward task to assess the accuracy of the information recorded on the PRISM 2 forms.
- 11.39** It was evident that the Mortality Review team experienced difficulties in determining where certain episodes of care had taken place. This was due in part to the chaotic presentation of the records which were jumbled and out of chronological sequence. This was exacerbated by pages within the clinical records often bearing no indication as to the ward or service. In simple terms this meant that on occasions the potential for avoidable death and problems relating to healthcare were attributed to the wrong clinical area and episode of care.

- 11.40** The time each reviewer had to examine the clinical records averaged out at 103 minutes for each patient. Given the time limitations and the incomplete and chaotic nature of the clinical records is not surprising that some of the information recorded was misinterpreted and on frequent occasions was either misleading or incorrect.
- 11.41** For an internal audit into mortality this would not have been problematic as key themes would still have emerged about potential care and treatment issues. However it became a problem due to the fact the information on the PRISM 2 forms was taken to be a definitive study into each individual patient's cause of death.

### **Patient Deaths on Tawel Fan Ward**

- 11.42** When the Investigation Panel first read the Mortality Review draft report concerns were raised in relation to the relatively high numbers of deaths that had been identified for the study. The numbers comprised around 35 percent of the total admissions for the two-year period under review; the rate of death appeared to be one in three.
- 11.43** However on close examination of the clinical records a very different picture emerged and the following became apparent:
- 13 percent of the patients had actually died on Tawel Fan ward; several of whom had terminal conditions such as cancer, renal failure and coronary heart disease;
  - 8 percent of the patients in the study died from completing suicide following discharge from Tawel Fan ward (however there is no evidence to suggest that three of these patients had ever been admitted to Tawel Fan Ward in the first place);
  - 10 percent of the patients died within 30 days of discharge usually in a care home or medical ward setting;
  - 69 percent of the patients died between two months and one year from the date of discharge from Tawel Fan ward.
- 11.44** From the findings above the title of the Mortality Review "*A Review of Deaths Associated with Tawel Ward*" could be seen to be highly misleading; whilst Tawel Fan ward was the common denominator analysing any potential causes of death and any association they might have had with Tawel Fan ward up to a year post discharge might not have been either realistic or good audit practice.

### **Governance**

- 11.45** The Investigation Panel found the governance arrangements by which the Mortality Review was commissioned and managed to be unsatisfactory. The then BCUHB Executive Medical Director, quite rightly, thought there was a duty to investigate the deaths associated with Tawel Fan ward, especially in the face of growing family concerns.

- 11.46** However the work appears to have been commissioned outside of any formal clinical governance arrangements within the Health Board. Once the work had been completed there was no process for validation, quality review or Board-level reporting.
- 11.47** The draft report was completed in September 2015, however it did not get shared widely or go through any formal clinical governance committee structure; in effect it was an unadopted piece of work with uncertain status.
- 11.48** Against this backdrop the PRISM 2 reports started to be shared with families but the Health Board still had no line of sight and was unaware of the potential seriousness of the findings (such as they were thought to be at the time).
- 11.49** Eventually the report (still in draft) went to the Quality Assurance Executive and the Medical Director's meeting. At one stage it went to the Quality Assurance Committee and was placed briefly on the BCUHB intranet (but was taken down after 24 hours). The report and its findings continued to bypass all formal process including reporting to the Board; this was remiss.
- 11.50** The Mortality Review was intended to identify problems in healthcare and to promote learning. It would appear that no one knew how to manage the findings once they had been made as the former BCUHB Executive Medical Director told the Investigation Panel:

*“I think we did get tied in a bit of a knot... there wasn't a culture of Quality Improvement... the Mortality Review, was well intentioned. I think it lacked the systematic structure that the severity of the circumstances of Tawel Fan deserved. It felt very much like we were doing this on top of all the other stuff that was going on... because in amongst all of that were the family meetings, and the media, and I think a real desire to actively engage with the families and genuinely try and be as open and honest as possible, although, again, I think with experience now, I think I would have managed that rather differently”.*<sup>104</sup>

- 11.51** He also described the growing impetus of the Chair of the Health Board and other senior officers to be public facing and publish the Mortality Review. As this decision took on momentum the decision was taken to share the PRISM 2 templates with families first.
- 11.52** The Assistant Medical Director for Secondary Care Central told the Investigation Panel that he was concerned to hear that the PRISM 2 reports had been shared with families, especially as this had occurred in some instances prior to the completion of the Mortality Review report. He was at pains to say that the PRISM 2 template is simply a method of collecting data in a systematic manner. It was not designed to be shared with families or to serve as a communication tool. Another concern raised was that he never received any feedback on the draft report which he had not written in a format for publication. He said:

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104 Witness transcript excerpt

*“There was an attempt to discuss it at our Quality Assurance Executive, a group that exists below Quality and Safety – called QSE now, Quality, Safety and User Experience Committee. That was the one time that it got to a committee like that. You might well challenge why a document so raw is even getting to that committee, but it was fed through to that committee, and it’s getting pulled at the table, it’s scrubbed, taken away. Halfway through the meeting, start to present it, stop, the family haven’t seen it, it’s removed, delete it from your laptops, delete it from the record, it’s removed at that point. There isn’t the opportunity even for it to be challenged or to be peer reviewed in any way there”.*<sup>105</sup>

**11.53** It is of concern that senior officers at BCUHB thought it correct to share information with families first before the validation process had been completed through the formal channels within BCUHB. This was remiss; it is absolutely not the way to conduct good governance and neither is it a responsible way of discharging Duty of Candour responsibilities.

**11.54** The Assistant Medical Director for Secondary Care Central described a great deal of upset in September 2016 in relation to Health Board Members, a year after the draft report had been submitted:

*“It transpires that for the first time Board members were seeing the document, and the printed document was handed to them on the day just in the break, because it moved from being on the public agenda to an in camera agenda. We turned up in the afternoon, the meeting was delayed, but they’d broken up and they went off to read the report as it stands. I understand the reason why they are so annoyed: they’ve heard about this for so [long] and presumably there’s some chatter going on and they’ve never seen the document. Indeed, I’m not sure that it’s been Board-ready”.*

**11.55** It is apparent that the Mortality Review:

- was not commissioned under the appropriate clinical governance or patient safety mechanisms;
- methodology and limitations were not understood by senior BCUHB officers;
- did not get taken through a quality assurance or validation process;
- was not received by any formal sub committee of the Health Board in an appropriate or timely manner;
- was shared with families in an inappropriate manner;
- was not made known to the Health Board until one year after the report was first submitted by its author in draft and then at the instigation of this Investigation when it was apparent that non-executive Health Board members did not even know of its existence.

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105 Witness transcript excerpt

## Conclusions

### Methodology

**11.56** The Investigation Panel concludes that it was reasonable for BCUHB and the University of Cardiff to select the PRISM 2 methodology when attempting to understand and quantify patient safety issues on Tawel Fan ward. However the process would have been improved had the original methodology been adapted for use in an inpatient elderly mental health setting. The process followed should also have included reviewers who had experience of working with patients in settings like Tawel Fan ward and who understood the kinds of patient safety issues which were common in that setting; the methodology is not a substitute for experienced clinical judgment.

**11.57** It was also reasonable for reviewers to highlight potential concerns about ‘preventable’ deaths following PRISM reviews, consistent with their professional experience and expertise. However, the Investigation Panel concludes that it was poor practice for BCUHB to regard this as a definitive judgment on the ‘preventability’ of individual deaths. The methodology (even when used by experienced reviewers) is not robust enough and was not designed to do this. Concerns raised by PRISM reviewers should have prompted in-depth, detailed investigations including expert clinical reviews of case records, and reviews of other relevant records and material, before concluding that individual deaths were preventable. In summary:

- the methodology was not developed or designed to be sensitive enough to assign causation or preventability of death without further in-depth expert investigation of individual cases;
- the methodology had not been adapted for use in a mental health setting or in a patient population like that found in Tawel Fan ward;
- the reviewers were not supported by clinical experts from mental health backgrounds with clinical experience in this sort of patient population.

### Governance

**11.58** The Investigation Panel concludes that the learning from the Mortality Review provided important and useful information in relation to patient safety; this was good practice. The review was conducted in a careful and systematic manner by the Assistant Medical Director for Secondary Care Central and the reviewers in his team.

**11.59** However BCUHB did not manage the project appropriately in relation to factual accuracy, validation and Board ratification processes. It is of great concern that a Mortality Review of this kind bypassed formal clinical governance systems and structures. The aims and objectives were ill defined together with the ultimate purpose to which such a piece of work would be put. It is regrettable that formal quality assurance processes were not inbuilt into the work and that the Health Board was not advised of the work at its inception. In the event there was a total lack of coordination and ownership of the process.

- 11.60** There was a misguided belief that everything should be laid in front of families prior to any internal quality assurance processes had been undertaken. The communications with families were both inappropriate and premature. Many of these families have described themselves to be in great distress as a result of the findings being shared with them. For many this distress might have been caused unnecessarily based on insufficient information and a process that was ultimately used in a way it was not designed for; the Investigation Panel concludes this to have been unacceptable practice no matter how well intentioned.

### **Underlying Factors: Root Cause Analyses**

- 11.61** Areas that were not optimal combined organisational and strategic, communication and task factors. It is important to understand which factors were in play so that recommendations and actions for service improvement can be targeted appropriately. Appendix 3 provides information about root cause analyses factors.

### ***Clinical Governance and Corporate Oversight***

- 11.62** It is evident that clinical governance structures were bypassed in relation to the Mortality Review. This speaks to a culture where the importance of system, structure and process was understood poorly leaving individuals to decide what should and what should not be shared and with whom.
- 11.63** The concept of clinical audit was also understood poorly. Instead audit was synonymous with the ‘old fashioned’ notion of medical audit and this was the route down which the Mortality Review seemingly went, circumventing formal patient safety structures.
- 11.64** In the absence of formal process, quality assurance and validation the Mortality Review failed to achieve its potential and instead became a hostage to fortune used for purposes that were never intended.
- 11.65** The patient safety culture was understood poorly and the Health Board had a limited grasp on how the investigation processes in relation to Tawel Fan ward were instigated, managed and quality assured. The identified factors are:
- organisational and strategic;
  - task design, purpose and procedure;
  - communication.

### ***Communication Strategies***

- 11.66** The Mortality Review required a detailed communications strategy at the outset; one that included as a minimum the North Wales Police, the relevant north Wales Coroners, Local Authorities and safeguarding partners. The strategy should also have taken into account internal sign off processes and Health Board notifications.
- 11.67** In the absence of a clearly thought out process communications became muddled and everything was determined through the lens of perceived family expectation, whether this was the most appropriate thing to do or not.

**11.68** It would appear that whilst the first-stage Mortality Review was shared with the North Wales Police and the North Wales Coroner, the second-stage Mortality Review was not; it took the intervention of this Investigation to ensure that this took place. In the absence of a strategy important stakeholders were not kept updated and the resultant confusion meant that everything was managed out of sequence and to the detriment of the process, the families, and to an extent, BCUHB's reputation. The identified factors are:

- organisational and strategic;
- communication.

### **Key Lessons for Learning**

**11.69** The main lessons for learning are:

- 1** Complex audits should always be adopted as part of a formal quality improvement programme. They should not be commissioned by an individual or group of individuals outside of due process. Complex audits also require a clear remit and a formal organisational undertaking that findings will be used to promote patient safety.
- 2** When commissioning a Mortality Review it is essential that it is understood that it should be seen as a part of a multi-step process which might require further investigation and expert review. It is important that this kind of review is adequately resourced and placed within an organisation's patient safety agenda and where appropriate on the corporate risk register.
- 3** A communication strategy is essential when managing complex and high profile investigations. The process for both internal and external communications should be made explicit and the release of information should take place in a structured manner with full corporate board oversight.
- 4** Communications with families involved in complex and high profile investigations must be bounded and conducted with a clear purpose. The decision to share information should always be because it is the right thing to do and within the boundaries of a communications strategy.

**Part Four**  
**Overview of Conclusions and**  
**Recommendations**

## 12 Overview of Conclusions and Recommendations

### Overview of Conclusions

#### Investigation Context

- 12.1** 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.
- 12.2** 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.
- 12.3** 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.
- 12.4** 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.
- 12.5** 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 Emergency Department inputs and the difficulties patients and families encountered on medical wards and with other BCUHB services.
- 12.6** 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 there and for the kind and compassionate care provided by members of the treating team.

**12.7** 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 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.

## General Conclusions

**12.8** 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.

**12.9** 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.

**12.10** 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

**12.11** 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. 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.

**12.12** 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.

**12.13** 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**

**12.14** 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.

**12.15** 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.

**12.16** 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.

- 12.17** The challenges for BCUHB and its multiagency partners in 2018 are 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**

- 12.18** 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.
- 12.19** 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.
- 12.20** 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.
- 12.21** 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**

- 12.22** 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.
- 12.23** 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.

**12.24** The Investigation Panel could not replicate the specific findings of abuse from any of the earlier investigations and reviews that did; the reasons for this have already been discussed in the safeguarding section above. 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.

**12.25** 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.

**12.26** 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

**12.27** Adult safeguarding frameworks exist purely to provide protection for adults at risk of abuse and neglect; they work at two levels. First: at a multiagency 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 multiagency framework and legislation, and deliver adult safeguarding services to protect adults at risk of abuse or neglect.

**12.28** 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 multiagency policy documentation of the time were not met in full. At a multiagency 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.

- 12.29** 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.
- 12.30** 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.
- 12.31** 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.
- 12.32** 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 multiagency 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.
- 12.33** 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

- 12.34** 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.
- 12.35** 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.
- 12.36** 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.
- 12.37** 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.
- 12.38** 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.
- 12.39** 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

- 12.40** 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.
- 12.41** 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.
- 12.42** 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.
- 12.43** 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.
- 12.44** 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 multiagency partners also need to make significant contributions to planning, process and service provision.

**12.45** 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

**12.46** 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

**12.47** 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

**12.48** 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

**12.49** 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**

**12.50** 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**

- 12.51** 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.
- 12.52** 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.

<b>Safeguarding</b>
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### **Progress Made**

- 12.53** 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

**12.54** 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 multiagency 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**

- 12.55** 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**

- 12.56** 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

**12.57** 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 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**

**12.58** 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

**12.59** 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.

<b>Legislative Frameworks: Deprivation of Liberty Safeguards (DoLS)</b>
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**Progress Made**

**12.60** 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**

**12.61** 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

- 12.62** 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”.*

- 12.63** 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

- 12.64** 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

**12.65** 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”.*

**12.66** 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

**12.67** 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.

**12.68** 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.

## 13 Glossary

### Acetylcholinesterase inhibitors

<b>Patient Acuity</b>	Acuity has 2 main attributes. 1. Severity, which indicates the physical and psychological status of the patient. 2. Intensity, which indicates the nursing needs, complexity of care and the corresponding workload required by a patient, or group of patients.
<b>Contemporaneous</b>	Existing at, or in, the same period of time. In the case of clinical records this describes an entry made at the same time as the event being recorded.
<b>Computerised Tomography Scan (CT or CAT)</b>	A CT or CAT scan makes use of computer-processed combinations of many X-ray measurements taken from different angles to produce cross-sectional (tomographic) images (virtual “slices”) of specific areas of a scanned object, allowing the user to see inside the object without cutting
<b>Delirium</b>	This is when a person can become very confused and agitated due to a fever or infection.
<b>Electrocardiogram (ECG)</b>	An ECG is a test which measures the electrical activity of the heart to show whether or not it is working normally.
<b>Electroencephalography (EEG)</b>	An EEG is a test used to find problems related to electrical activity of the brain. An EEG tracks and records brain wave patterns.
<b>Functional Mental Illness</b>	This type of illness has a predominantly psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.
<b>General Medical Council (GMC)</b>	The General Medical Council is a public body that maintains the official register of medical practitioners within the United Kingdom. Its chief responsibility is “ <i>to protect, promote and maintain the health and safety of the public</i> ” by controlling entry to the register, and suspending or removing members when necessary. It also sets the standards for medical schools in the United Kingdom.
<b>GP</b>	General practitioner: a person who provides general medical care.

<b>Half Life</b>	This is the time it takes for half the dose of a drug to be eliminated from the bloodstream.
<b>Holistic</b>	The word ‘holistic’ is used in health and social care when describing how a person should be viewed. A holistic approach will take into account a person’s emotional, mental, physical, social and spiritual needs.
<b>Independent Mental Capacity Advocates (IMCAs)</b>	The IMCA role is to support and represent the person in the decision-making process. Essentially they make sure that the Mental Capacity Act (2005) is being followed.
<b>Maelor Assessment</b>	This is an assessment process by which the likelihood and risk for developing pressure ulcers are determined.
<b>Magnetic Resonance Imaging (MRI)</b>	An MRI scanner uses magnetic and radio waves to create pictures of tissues, organs and other structures within the body which can then be viewed on a computer to aid diagnostic processes.
<b>Hospital Managers Reviews (Mental Health Act 1983)</b>	‘Hospital Managers’ are in effect lay people appointed on behalf of hospital managers. They can hold a review to determine whether or not a patient can be discharged from their Mental Health Act (1983) Section. This applies to: Section 2; Section 3 and Section 37. There are no legal or medical members on the panel. Patients can apply for a Hospital Managers’ review at any time during tier detention.
<b>Medication Reconciliation</b>	Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking. This should include: drug name, dosage, frequency, and route. This should be done at the point of all transitions (admission, transfer and discharge) with the goal of providing correct medications in a timely manner.

- Mental Capacity Act (2005)** The Mental Capacity Act (2005) applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework by:
- empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
  - allowing people to plan ahead for a time in the future when they might lack the capacity.
- Mental Health Act (1983) Tribunal** A Mental Health Tribunal is an independent body who can review a service user's detention. It is the primary mechanism for appeal against detention under specific sections of the Mental Health Act (1983) in hospital or a Community Treatment Order, Conditional Discharge or Guardianship order in the community.
- Natural Justice** In English law, natural justice is technical terminology for the rule against bias and the right to a fair hearing. Put simply it is the duty to act fairly.
- National Institute of Health and Care Excellence (NICE)** NICE provides national guidance and advice to improve health and social care. In April 2013 NICE was established in primary legislation, becoming a Non Departmental Public Body (NDPB).
- As an NDPB, NICE is accountable to its sponsor department, the Department of Health, but operationally it is independent of Government. Its guidance and other recommendations are made by independent committees.
- The way NICE was established in legislation means that its guidance is officially England-only. However, it has agreements to provide certain NICE products and services to Wales, Scotland and Northern Ireland.
- Nursing and Midwifery Council (NMC)** Nursing and Midwifery Council: an organisation set up by Parliament to ensure that nurses, midwives and health visitors provide high standards of care to their patients and clients. All practising nurses, midwives and health visitors have to be registered with the NMC.

<b>Organic Mental Illness</b>	<p>This type of illness is usually caused by a disease directly affecting the brain. Dementia (such as Alzheimer’s disease) is an example by which changes in the structure of the brain cause loss of cognition, memory and the ability to carry out general day-to-day activities of living.</p>
<b>Out of Hours services</b>	<p>These are services that are provided outside of those provided between 9.00-5.00 Monday to Friday</p>
<b>Primary Care</b>	<p>The NHS England website states the following <i>“Primary care services provide the first point of contact in the healthcare system, acting as the ‘front door’ of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services”.</i></p> <p>Primary care is delivered principally in the community rather than in a hospital setting.</p>
<b>Public interest</b>	<p>A term referring to the wider ‘common interest’ of society as a whole, rather than the interest of a particular person, group or organisation.</p>
<b>Pulmonary embolism</b>	<p>An obstruction of a blood vessel in the lungs usually due to a blood clot which blocks a coronary artery.</p>
<b>RAG rated risk register</b>	<p>RAG stands for Red, Amber and Green. Each colour indicates the level of risk identified. Green indicates low or no risk through to red indicating a very high level of risk is present.</p>
<b>Root Cause Analysis (RCA)</b>	<p>Root Cause Analysis: a methodology for identifying underlying causes when investigating serious incidents in the NHS.</p>
<b>Royal College of Psychiatrists (RCPsych)</b>	<p>The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.</p>
<b>Secondary Care</b>	<p>A patient who has been provided with primary care may go on to need a secondary care referral. This is usually because input from a specialist with additional expertise is required. Secondary care services are usually consultant-led services which include psychology and psychiatry.</p> <p>Secondary care is usually delivered in a hospital or clinic with the referral being made by a primary care professional.</p>

**Single-photon Emission  
Computed Tomography Scan  
(SPECT)**

SPECT is a nuclear medicine imaging technique using gamma rays. It is very similar to conventional nuclear medicine planar imaging using a gamma camera and is able to provide true 3D information.

**Special Measures**

In exceptional circumstances, officials of the Welsh Government (including the Chief Executive of Healthcare Inspectorate Wales) and the Auditor General for Wales may identify concerns in relation to an NHS body in response to which the Welsh Ministers may take Intervention as set out in the NHS (Wales) Act 2006 (sections 26-28) and associated regulations. The circumstances for special measures are set out in the Welsh Government *NHS Wales Escalation and Intervention Arrangements* (March 2014).

**Statutory Organisation**

A statutory organisation is one that has been established by an Act of Parliament and has set legal responsibilities and powers.

**Titration**

Titration is the process of determining the medication dose that reduces symptoms to the greatest possible degree while avoiding possible side effects.

**Whistleblowing**

A term used to describe a situation where a concerned employee raises issues with their employer in a confidential manner and with protection for that employee put in place.

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# **Part Five**

## **Appendices**

# Appendix 1

## Organisation and Investigation Panel Members Biographies

### Health and Social Care Advisory Service (HASCAS) and HCL Consultancy Ltd

- 1** The Health and Social Care Advisory Service (HASCAS) is an evidence-based service development organisation working across the health and social care continuum. HASCAS has a 49-year history of providing expert, impartial and authoritative advice in relation to investigation, analysis and challenge to NHS and social care organisations. HASCAS is a registered mental health charity and HCL Consultancy Ltd is its trading arm.
- 2** Founded initially as the Hospital Advisory Service (HAS) we have evolved over time into the Health and Social Care Advisory Service. The organisation was established originally by Andrew Crossman (Secretary of State for Health and Social Services) in 1969 following the Ely Hospital scandal in Wales; at this time the organisation was established as part of the Department of Health. The organisation's key functions were to:

  - inspect mental health providers;
  - alert Ministers to basic failures; and
  - provide advice.
- 3** In 1997 the organisation left the Department of Health; a consortium comprising the Royal College of Nursing, the Royal College of Psychiatry, the British Geriatric Society and the Office of Public Management took responsibility for our service. It was at this stage the organisation became a registered mental health charity. Since 2005 we have operated independently bringing to an end prior consortium management arrangements.
- 4** HASCAS has evolved into an organisation that has made an important contribution to improving the quality of services by reporting independently on practice and offering advice and support to local services.
- 5** During this time, HASCAS has built up a wealth of experience in undertaking service reviews and independent investigations commissioned by a diverse range of organisations. We are proud to have been the early pioneers of the use and adoption of evidence-based standards and systematic methodology when conducting service reviews, investigation and inquiries. HASCAS continues to provide independent investigation, inquiry and review services in England, Wales and Northern Ireland with a brief that includes mental health services, children's services, and vulnerable adults' services. HASCAS is entirely independent of all NHS and Department of Health functions.

## Investigation Panel Member Biographies

### **Dr Androulla Johnstone: Investigation Panel Chair and Lead Investigator**

Androulla Johnstone has 38 years of experience in mental health care and has been the Chief Executive at the Health and Social Care Advisory Service since 2004 and is also the Chief Executive of HCL Consultancy Ltd. She has a background in NHS clinical and operational service delivery as well as in strategic planning and commissioning. She has held three executive Board level positions and has been a Chair of many independent investigation panels. Androulla is a registered mental health nurse and holds a particular interest in the mental health of old age. Androulla has:

- chaired and/or quality reviewed a total of 77 independent homicide (HSG (94) 27) and unexpected death investigations;
- chaired the Jimmy Savile Stoke Mandeville Investigation (2015);
- led/taken part in some 45 service reviews;
- led/taken part in several hundred internal investigation processes;
- led thematic reviews into mental health service user homicides and suicides.

Another particular area of interest is that of governance, both clinical and corporate. Androulla has been responsible for setting up new governance structures in several NHS organisations and in one independent company.

### **Christine Dent**

Chris has 24 years of experience working in the NHS. Her career has mostly been at a Health Authority and Strategic Health Authority level, working in the field of corporate governance, and historically in a Primary Care Trust that also had responsibility for mental health provision. Latterly an Associate Director for NHS North of England, she was responsible for leading the corporate governance aspects of the abolition of the three Strategic Health Authorities and the Primary Care Trusts in the North of England.

For the majority of her career, Chris has been responsible for areas that have involved working directly with patients and their families, including management of NHS complaints, independent review of NHS decisions on NHS Continuing Healthcare, and the commissioning and publication of independent investigations. This included liaison with the women and families affected by the External Review into the case of Roy Murray, a case relating to a GP who had abused women over a 20-year period. A trained investigator, Chris has been responsible at a senior corporate level for handling complex investigations on behalf of NHS Boards, Chairs and Chief Executives and has extensive experience across NHS Board and committee governance, information governance, data protection, designing and implementing systems and processes such as independent review panels for NHS Continuing Healthcare.

Chris most recently worked as a panel member on the Jimmy Savile Stoke Mandeville investigation and is currently a Director of HCL Consultancy Ltd.

### **Ruth Dixon**

Ruth is a qualified social worker experienced as a practitioner, manager and leader in Adult Social Care with significant experience in working across all adult care groups, with a particular experience and interest in adult mental health services. Ruth is an experienced commissioner of services and strategy lead for service redesign and transformation; in these roles she has led the commissioning of nursing homes and community development projects for Hampshire County Council.

### **Gill Duncan**

Gill Duncan has 37 years experience of health and social care, with 20 years in senior management. Most recently, from 2008-2015, she was a Director of Adult Services at Hampshire County Council, a large Local Authority in the South of England covering a population of 1.2 million.

Prior to moving into social care, Gill was a Primary Care Trust Chief Executive and had been a Director of Nursing in a Mental Health and Community Trust. Alongside her extensive management and leadership experience she has a clinical background as a nurse, midwife and district nurse.

Gill has extensive experience of service transformation, integration of health and social care and understands the challenges of leading and managing large and complex organisations. She remains grounded in individual outcomes for patients and service users and their families and was a member of the Prime Ministers Nursing and Care Quality forum which was established in 2013-2014.

### **Jane Duncan**

Jane Duncan has 34 years experience in both health and social and has worked across local authority social services, a primary care trust, a health authority and acute trusts and has worked as Assistant Director of Adult Social Care, Head of Adult Safeguarding and Care Governance (spanning adult services including learning disability and mental health) and Operations Director for In-house services (1,200 nursing and residential home beds for older people) for a large County Council; Director of Nursing and Primary Care at a Primary Care Trust; Supervisor of Midwives and Commissioning Manager at a Health Authority; General Manager and Head of Midwifery within an Acute Trust.

Jane has significant experience of professional, operational and strategic leadership of services and has developed skill and expertise in the following areas; leading investigations; working with individuals who are patients and service users to review and redesign services; development of simple, safe quality systems and processes; commissioning services; change management and development of integrated health and social care approaches to service delivery.

Jane has undertaken the Kings Fund Top Managers Programme and trained as a Nurse and Midwife.

### **Dr Tracey Eddy**

Tracey is an experienced consultant in old age psychiatry. At present she works at Parklands Hospital in Basingstoke which is part of the Southern Health NHS Foundation Trust.

### **Camilla Flomen**

Camilla's specialist field is pharmacy with a specialist interest and training in psychiatric pharmacy. Camilla's experience includes positions as Acting Chief Pharmacist, Lead Clinical Pharmacist for Mental Health and lecturer on Psychopharmacology to Post Graduate health and social care students.

### **Dr Mike Gill**

Mike is an experienced Consultant Physician in Care of the Elderly, Clinical Leader, and Medical Director. He currently divides his time between *Health 1000* a new pilot Primary Care Practice set up to manage patients with multiple long-term conditions and Nursing Home residents based in East London and Essex and Whipps Cross Hospital (Barts Health).

In other roles he is Deputy Chair of the London Clinical Senate Council, Chair of Ealing Transformation Steering Group, subject expert for a Health Education England Frailty Clinical Fellow Programme, and member of the NICE Acute Medical Emergencies Guideline Committee.

He was Medical Director of Barking Havering and Redbridge University Hospitals NHS Trust from July 2012 to November 2013, and prior to that Medical Director at Newham University Hospital NHS Trust (now part of Barts Health) for ten years. Mike was also Joint Clinical Director for the Health for the north east London programme which looked at the configuration of services in east London.

He has recently finished a three-year term as an elected Councillor of the Royal College of Physicians.

### **Professor Moira Livingston**

Moira has worked across the NHS for over 30 years as a senior doctor in strategic, management and policy settings covering medical leadership, healthcare education and training, quality assurance, strategic workforce planning, healthcare regulation, policy making, quality improvement and service transformation. During this time she has held positions as:

- a Post graduate Dean;
- a Director of workforce;
- the National Transition Lead for Workforce for the Department of Health;
- a Director in the NHS National Improvement Body: NHS Improving Quality.

Moira has worked in senior medical roles with NHS England and the Care Quality Commission and works currently as a Non Executive Director at Leeds Teaching Hospitals NHS Trust and is the Chair of the Board of Trustees for Dementia Care.

### **Tim Parry**

Tim has significant experience in all aspects of human resource and workforce management at both an operational and strategic level.

Tim is an experienced human resource professional with an extensive career history in the NHS where he has held several executive director positions. Tim also has significant experience in the higher education sector where he holds associate lecturer positions with the Open University and the Southampton Solent University.

### **Will Smith**

Will is a mental health nurse with experience working clinically, operationally and strategically. He has held senior roles with NHS South of England Strategic Health Authority and then worked with NHS England from the point of its inception until 2015.

Will has extensive experience working in the development and quality assurance of mental health services and in corporate governance.

Will is an experienced investigator and reviewer with a particular interest in patient safety, complaints management and human resource investigations.

### **Dr Kevin Stewart**

At the time of working on this investigation Kevin was Consultant Physician in Elderly Care at Hampshire Hospitals NHS Foundation Trust and the Director of the Clinical Effectiveness & Evaluation Unit with the Royal College of Physicians London.

He has held previous roles as Medical Director with the National Safe Care Team, QIPP Programme with the Department of Health and has also held Medical Director and Deputy CEO roles with the Winchester and Eastleigh NHS Trust.

Kevin has led significant work with the Royal College of Physicians developing and disseminating a standardised approach to mortality reviews for all hospitals in England and Scotland.

### **Kennedys**

Kennedys is a specialist national and international law firm with expertise in litigation and dispute resolution. It has over 1,700 people globally, across the United Kingdom and Europe, Asia Pacific, the Americas and the Middle East. The firm's lawyers provide a range of specialist legal services for many industries including: insurance and reinsurance; aviation; construction; healthcare; maritime and international trade; public sector; retail; transport and logistics and travel – with a particular focus on dispute resolution and litigation.

The firm has particular expertise in relation to clinical and professional negligence.

### **Bridget Dolan QC**

Bridget's practice covers all aspects of mental illness, injury and death throughout the civil courts. She is well known as a leading practitioner in the Court of Protection and Coroners Courts and also specialises in psychiatric negligence, as well as bringing and defending civil claims related to mental health legislation or under human rights law.

In addition to her Court of Protection practice, which covers the entire range of serious cases that come before the CoP, Bridget is regularly instructed in high profile inquests and inquiries of significant complexity and sensitivity. Her experience of managing countless heavyweight cases engaging rights under Articles 2, 3, 5, 8 and 9 ECHR means she is particularly sought after when public bodies are facing difficult and searching inquiries.

Bridget also has considerable experience of acting as Counsel to the Judge/Coroner in inquests and inquiries heard under intense media scrutiny; most recently in the fresh inquests into the deaths at Deepcut Barracks of Private Cheryl James (held in 2016) and Private Sean Benton (to be held in early 2018). In 2015 she was Counsel to the Coroner in the seven British inquests following the murders of 40 men by Al-Qaeda linked terrorists at the In Amenas gas plant in Algeria – a role which earned her The Lawyer's 'Barrister of the Year' award.

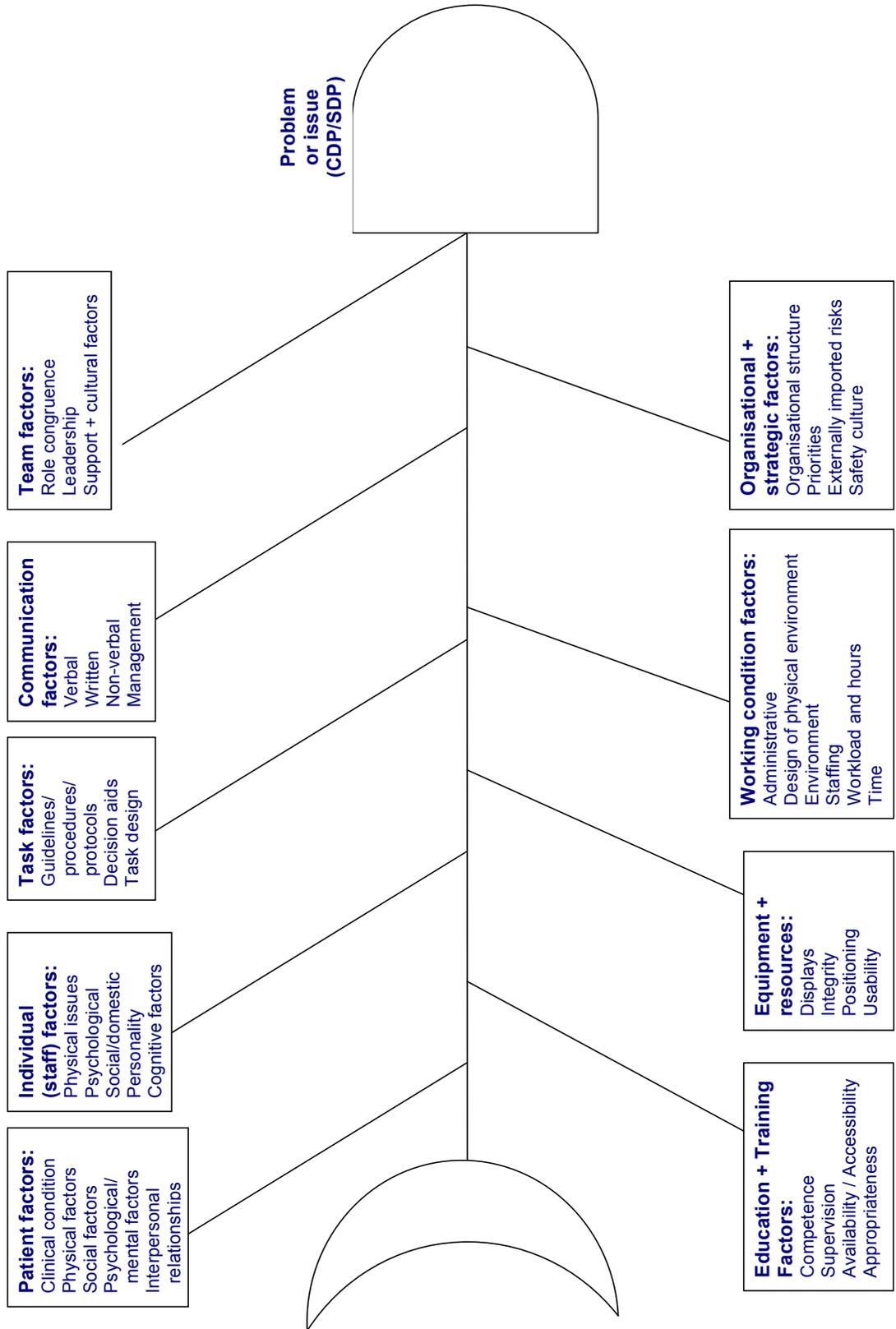
Bridget also has extensive public law experience, advising and appearing in judicial review cases related to Coronial Law, Human Rights Law and the Mental Health Act. That she sits part-time as a Coroner and a Mental Health Tribunal Judge gives Bridget a particular insight into how to approach the most challenging of cases. Her extensive legal knowledge is put to good use as editor of the Inquest Law Reports and the popular United Kingdom Inquest Law Blog.



# Appendix 3

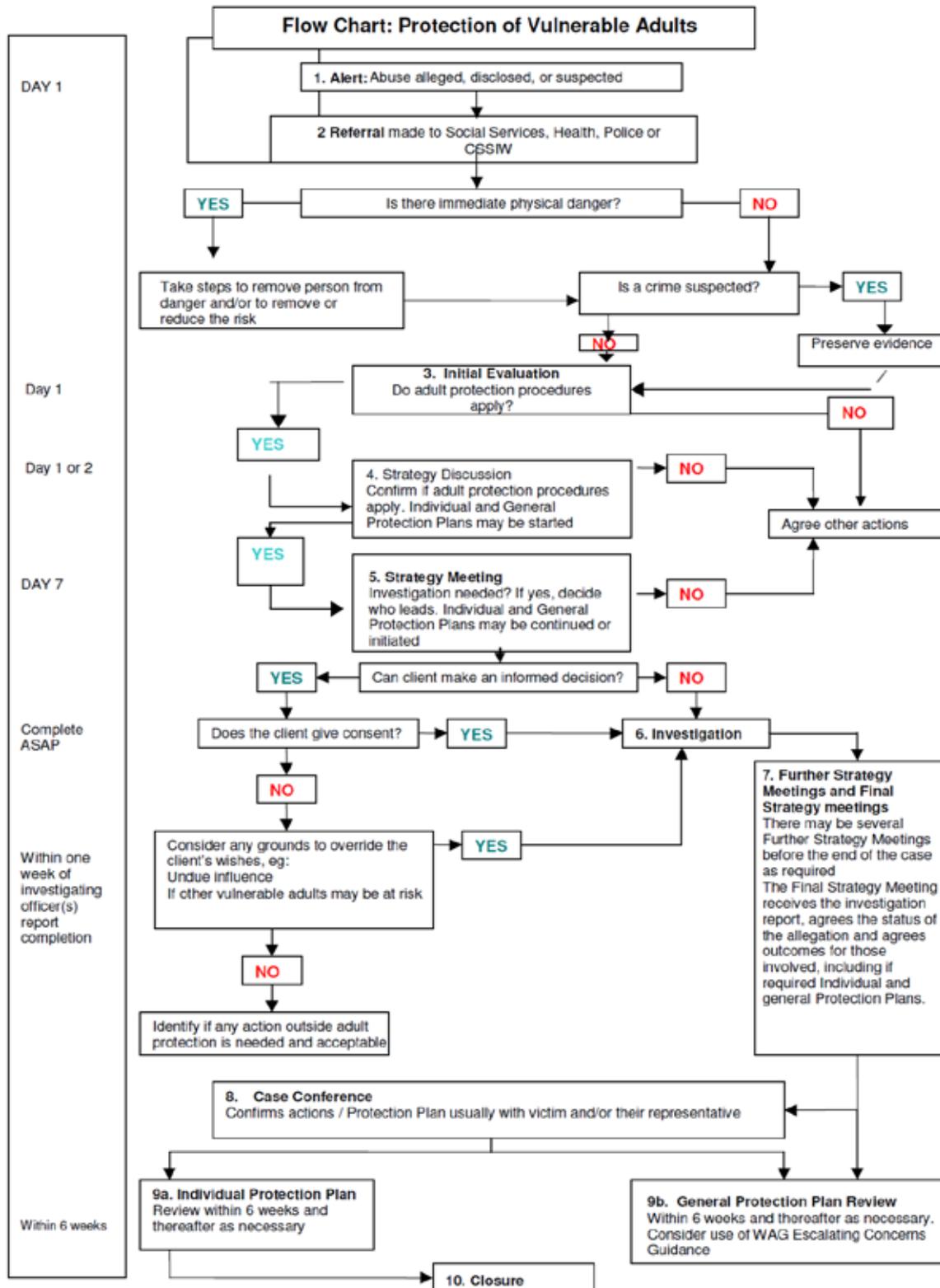
## Root Cause Analysis Fishbone Indicators

Root Cause Analysis Investigation  
**Fishbone Diagram - tool**



# Appendix 4

## The Ten Stages and Timescales in the Adult Protection Process (2011 – 2013)



## Appendix 5

### Photograph of the 'Stroke Chair'



# Appendix 6

## MHA Code of Practice guidance

Figure 6: Deciding whether the Act and/or MCA will be available to be used

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