

Executive summary

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

This report was commissioned by
Betsi Cadwaladr University Health Board

Report Author: Donna Ockenden
Director, Donna Ockenden Limited

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Donna**Ockenden**

1. Executive summary

1.1 What will this Executive summary do?

This Executive summary will:

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

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

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

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

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

its staff or to the organisation as a whole.

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

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

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

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

The Terms of Reference for the Ockenden review of governance were presented and discussed at the BCUHB Board on the 10th November 2015. The Terms of Reference for the Ockenden governance review also outline in some detail the work of the HASCAS review, which was previously discussed at the BCUHB Board on the 8th September 2015.

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

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

The Terms of Reference for the Ockenden review describe the need for an 'independent review into the wider 'ward to Board' governance arrangements in place at the time to identify any matters which may have had a bearing on events in Tawel Fan ward.' The Terms of Reference required the Ockenden team to 'review the systems, structures and processes (of governance) in place prior to the closure of Tawel Fan ward on 20th December 2013. The Ockenden team were then required to identify any failings in systems, structures and processes which contributed to the events/ may have contributed to the failings of care on Tawel Fan ward, and identify lessons for learning and actions to be taken within a timely and specified timeframe (BCUHB 2015, page 2.) Lastly, the Ockenden review of governance was also required to consider current governance arrangements in place for mental health services for older people at BCUHB.

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

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

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

"It is not therefore the role or remit of the Ockenden governance review to consider for example 'the treatment of individual patients and the actions of individual members of staff...'"

The Ockenden team visited North Wales as often as was required in order to meet current and former BCUHB staff, current service user representatives and attend as required meetings associated with the Ockenden governance review. Other than this the Ockenden team have worked at a geographically distant location to North Wales. In addition all administration of the governance review including transcription of interviews and written and telephone/ email contact with all interviewees including all staff service user representatives has been carried out by the Donna Ockenden and team at our offices. All interviewees and those participating in the governance review in any way have been able to make direct contact with the Donna Ockenden team at any time throughout the time the review has been underway.

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

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

1.8 Closure of Tawel Fan ward:

Evidence has been provided to the Ockenden review team that Tawel Fan ward closed in two stages, first being closed to admissions on the 13th December 2013. Secondly Tawel Fan ward was temporarily closed (and patients transferred to Bryn Hesketh unit in Colwyn Bay, approximately 10.5 miles away with a fifteen minute car journey time) on Friday the 20th December 2013. No evidence has been provided to the Ockenden review that the closure of Tawel Fan ward was formally discussed at a BCUHB Board meeting prior to closure as would be expected and usual practice. The Ockenden review team was provided with five documents dated between the 13th December 2013 and the 14th January 2015 that are relevant to an understanding of the events leading up to and after the closure. **These comprise:**

- a) An SBAR (Situation, Background, Assessment, Recommendation) paper for the Executive Nurse, written by the then ACOS Nursing (dated 13th December 2013)
- b) A further briefing for the Executive Nurse with authorship as above and dated 21st January 2014
- c) A briefing paper for Health Inspectorate Wales (HIW) from BCUHB, (authorship unknown) in March 2014
- d) An informal briefing paper for the Chairman of BCUHB dated 14th January 2015 by the then Executive Nurse.
- e) An 'In Committee' Board paper described as 'Briefing for the Health Board' dated 19th December 2013 and titled 'Mental Health Services.' The majority of the paper is devoted to issues within the Hergest Unit and Tawel Fan ward is mentioned only briefly on page 2. The section around Tawel Fan ward refers to the completion of an SBAR* (see below) document and the escalation of this document to Executive level. The information within this paragraph around Tawel Fan ward is presented as suggesting that decisions to a) stop admissions to Tawel Fan ward and b) 'planned discharge/ transfers of existing patients' had already occurred prior to this Board meeting.

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

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

"Five other services across Mental Health are described as 'in escalation' in addition to Tawel Fan ward."

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

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

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

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

"Tawel Fan ward is described as 'undoubtedly a ward in difficulty'"

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

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

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

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

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

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

1.11 Staffing:

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

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

Due to shortage of beds, (caused by the merging or joining together of wards, which had been necessary as a result of poor staffing) evidence was also seen by the Ockenden team of ward staff needing to consider admitting new patients to beds already allocated to those patients on home leave. Ward staff were described as reluctant to do that as the patients on leave were on their first weekend home and there was an increased risk of the patients needing to return to the ward early if difficulties arose at home. Staffing on Tawel Fan at the same time was described as ‘dire.’ In some wards staff describe patients discharged ‘before they were ready’ and difficulties in admitting patients when they required admission. As a result of poor staffing across OPMH extensive evidence has been seen by the Ockenden team of poor rates of compliance with annual appraisals and mandatory training.

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

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

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

Poor staffing appeared to be impacting on patient care on a number of fronts including a stated lack of meaningful activity described on the wards. This had also been clearly described in the Dementia Care Mapping¹ exercise undertaken on Tawel Fan in October 2013. These are both discussed in detail in the full report.

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

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

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

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

1 See glossary

1.13 What was the 'Vacancy Control Panel'² and how did this impact on staffing in OPMH?

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

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

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

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

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

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

Medical staff raised concern regarding the number of locum medical staff in post, as of the summer of 2017 the Ockenden review was advised that BCUHB did not have in place an induction programme for locum medical staff. Service users and their representatives reported a loss of continuity of care and having to repeat case histories and problems repeatedly over a number of appointments due to the high number of medical locums particularly in the 'West.' Staffing remains an area of considerable challenge for the MHL Division as of the end of 2017 and is impacting significantly on quality of care for service users and their families and on BCUHB staff morale.

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

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

"Service users and their representatives reported a loss of continuity of care and having to repeat case histories and problems repeatedly over a number of appointments due to the high number of medical locums particularly in the 'West'"

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

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

² See glossary

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

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

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

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

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

- Changes required to bathroom equipment
- Carpets and beds that needed replacing
- Cluttered areas with old furniture that needed removal
- Decoration that needed attention

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

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

Yes

From the perspective of a review of current governance arrangements across OPMH in BCUHB lack of beds and the poor quality of the estate has been (and remains) a key governance concern and is raised as a concern in a number of HIW reports over a prolonged period of time until late 2017. There is a continuing lack of action and very slow progress made by BCUHB to resolve estates concerns when raised as a governance, quality and patient safety concern by HIW and others over many years and to the current time. Following a visit to the Ablett unit in November 2017 HIW said of two wards Cynnydd and Dinas 'we found that the environment of the two wards we visited were not fit for purpose. Cumulatively, we believe that a number of the issues we identified during our inspection represent a risk to patient safety...' (HIW 2018, page 3.) Although Dinas was not a designated ward for care of the older person with mental health problems service users and advocates told the Ockenden team that it was often used to provide care and treatment for elderly people when Tegid ward in the Ablett unit was full.

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

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

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

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

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

To understand the creation of the systems, structures and processes of governance across BCUHB, the Mental Health and Learning Disabilities CPG and OPMH the Ockenden review team needed to understand the context in which BCUHB and its systems, structures and processes of governance was formed in 2009. A range of documents were considered by the Ockenden team and these are discussed in more detail in the main report. The Welsh Assembly document '**One Wales' – A progressive agenda for the Government of Wales' – 2007³** had identified that a redesign of NHS structures was required to deliver effective health care in and across Wales.

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

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

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

1.19 Outcome of the 2009 NHS Wales reorganisation:

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

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

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

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

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

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

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

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

As one of 11 CPGs at the time of merger, it could be said that the MHL D CPG, Mental Health and specifically Older Persons Mental Health was a relatively small part of the BCUHB Board's responsibilities. However older peoples mental health is a very significant issue in that it is acknowledged that people aged over sixty are the greatest users of the NHS and according to the Older Peoples Commissioner for Wales account for around 47%^{4 5} of acute inpatients; of these around 60% are expected to have a degree of cognitive impairment. Within a general hospital setting older persons mental health needs including depression and dementia can go undetected which can lead to longer inpatient stays, loss of independence and a reduction in the chances of the older person returning home to a pre hospital environment. All this can significantly increase care costs.⁶

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

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

Yes

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

1.22 The merger creating BCUHB:

Interviews with current and former Board members have described the arrangements put in place for the creation of BCUHB. It has been explained to the Ockenden review team that the merger was overseen by a project board chaired by the Chief Executive elect, with Chief

4 http://www.olderpeoplewales.com/Libraries/OPCW_Publications/Dignified_Care_Full_Report.sflb.ashx

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

6 [https://www.rcpsych.ac.uk/pdf/jcpmh-publicmentalhealth-guide\[1\].pdf](https://www.rcpsych.ac.uk/pdf/jcpmh-publicmentalhealth-guide[1].pdf)

Executives of the various contributing organisations leading on particular work-streams. Progress on the restructuring that ultimately led to the creation of BCUHB was described as being reported to the Boards of the organisations that would go on to form BCUHB and to Welsh Government.

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

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

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

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

- Change in Board members, (leavers, joiners, and interim positions)
- Significant periods where both Board members and interim Board members suffered ill health and other long absences
- 'Acting up arrangements' to cover the leavers, joiners and those absent for illness and other reasons.
- Insufficient management capacity and long standing recruitment issues.

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

It could have been, but it was not.

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

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

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

A number of current and former Executive Directors have reflected on the role of Executive Directors in being given Executive responsibility for 'oversight' of a number of CPGs. One Board member at the time explained that all the CPGs 'fed through' an Executive Director.

BCUHB had eleven CPGs and it was described that four Executive Directors had circa 3 CPGs each. This appeared to be an arrangement that again had not been thought through by the Board in how effective it could be.

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

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

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

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

"Long term concerns regarding the CPGs from the Independent members were not acted upon"

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

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

"This was a 'sticking plaster' approach to the equivalent of a major haemorrhage"

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

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

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

1.28 What were the reports and feedback around the systems structures and processes of governance from the external scrutiny, external reports and reviews into BCUHB from 2009-15?

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

The year 2012 saw the beginning of a long continuum of external reviews into BCUHB that continue to the present day. Some of these external reviews are seen to commence very shortly after the completion of the preceding review. There is little (if any) evidence of the BCUHB Board 'learning' from these external reviews and in some cases the external reviews do little more than 'commend' the recommendations from previous reviews and recommend that the BCUHB Board implement previously known about recommendations. Despite an extensive review of more than three thousand documents by the Ockenden team there is little evidence of BCUHB wide organisational learning from these multiple external reviews for a number of years after the closure of Tawel Fan ward. The most recent joint review by HIW/WAO published in June 2017 describes progress in a number of arenas but concludes 'several of the most pressing challenges that we identified in 2013 continue to remain evident, some four years after our original report..' (HIW 2017, page 4.)

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

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

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

There was an urgent and ongoing need to ensure effective lines of communication and accountability between the CPG(s) and the hospital management teams and then the Board in order that concerns which impacted on the quality and safety of patient care were identified and addressed. A key component of these concerns and found within many of the external reviews was a lack of Board action on estates that were not fit for purpose over a prolonged period of time. This was despite the creation of multiple action plans seen by the Ockenden team describing how these matters were intending to be 'put right.'

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

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

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

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

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

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

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

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

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

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

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

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

"External reviews in 2013 found evidence of repeated 'Never Events' where BCUHB had failed to investigate effectively and therefore failed to learn."

1.31 Summary:

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

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

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

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

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

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

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

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

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

1.34 The Francis Report⁷ (2013)

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

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

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

It was hugely significant.

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

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

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

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

7 http://www.wales.nhs.uk/sitesplus/documents/861/13_046.4%20francis%20report_findings%20of%20public%20enquiry%20mid%20staffs%20nhs%20foundation%20trust%20final.pdf (accessed on 28th January 2018)

publication of the Francis Inquiry.

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

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

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

In its response to the Francis report BCUHB showed itself to have an overall lack of systems, structures and processes of governance with which to drive forward, in a timely manner the Francis recommendations. This was further evidenced within the three reviews into maternity services in YGC in 2012 and 2013, the Public Health Wales Report, (2013) the Duerden report, (2013), the external reviews of the 'concerns' process throughout 2013, the Good Governance Institute Review (2014), the Ann Lloyd Report⁸ (2014) and both the first (2013) and second Joint HIW/ WAO review (2014). All of these reports had significant relevance to the delivery of Mental Health care and specifically Older Peoples Mental Health care as provided by BCUHB.

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

"BCUHB staff are frequently commented on in a positive way."

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

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

- Estates that are neither fit for purpose, maintained adequately or addressing risks to patients – e.g. ligature risks left in place for several years following on from HIW raising concerns about them in multiple visits
- 'Too many patients with too few beds' and a lack of availability of alternative models of care to inpatient care.
- Inadequate numbers of staff and staff not engaged in the appropriate work for their skillset.
- Long term concerns over medical staff numbers and ways of working.
- Lack of staff training (both mandatory and developmental.)
- Concerns regarding record keeping and formats – These concerns are found at all levels from Mental Health Act documentation to risk assessment, care planning and documentation of physical care provision.
- Lack of psychology, occupational therapy interventions and activities for patients
- Poor standards of cleanliness.
- Staff who demonstrate a lack of understanding of concepts of consent and capacity.

"Too many patients with too few beds' and a lack of availability of alternative models of care to inpatient care."

"Lack of psychology, occupational therapy interventions and activities for patients."

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

There is frequently no description of how the interventions are to be monitored nor do the local management systems within the CPG or the Division give any convincing evidence that

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

the reports are given much time, consideration or review. Response to HIW visits, reports and action plans appear to be largely thought of and treated as a necessary task to be completed after one visit. Action plans from 2009 to 2016 seem to be developed in isolation. There is no evidence to the current time that lessons learnt from an HIW inspection visit in one unit are transferred to other units or care settings although many problems found by HIW are repeated across many units e.g. training, documentation, estates, lack of patient activities and medical and nursing staffing.

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

In conclusion, all of the wards visited by HIW across BCUHB providing care to vulnerable elderly people have experienced very significant problems in the period of time reviewed (from 2009 to the current day.) There was little evidence found by the Ockenden team of any significant 'lessons learned' from events on Tawel Fan ward. Had lessons been learnt across the provision of elderly mental health care in the CPG as these visits and their subsequent action plans occurred many of the ongoing and recurring problems seen are likely to have been preventable. The role of HIW in ensuring that basic processes are in place to keep vulnerable elderly people safe has been strengthened to a degree over time but the resource implications and level of attention still required of HIW in monitoring the older persons mental health services at BCUHB at the level which still appears to be necessary in late 2017 are significant.

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

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

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

Some information regarding the Hergest unit and its long term issues is fed upwards through the then Health Board governance structures. This does not appear to have had a positive impact upon the process to support the Hergest unit. The reports presented to the Health

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

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

Board governance structure, both Committees and the Board outline the work done in a very bland way but do not accurately represent any of the significant difficulties experienced in making the changes required over many years. One BCUHB Board member told the Ockenden review team at interview 'I think to caricature it, you know, that actually we were doing alright in the West until we became part of this organisation...' Whilst this was not entirely true, in that some issues of concern were identified at the Hergest unit by HIW as early as September 2009 it is correct that review of extensive HIW and other external reports showed the failure of the BCUHB Board to support the Hergest unit in meeting multiple (and repeating) recommendations, as was clearly required over many years from 2010 to 2016.

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

It is of concern that HIW continually raised these issues with the Health Board often in a timely manner and always in a very clear manner. HIW subsequently received multiple action plans from BCUHB but changes did not happen. The period of time covered by these reports was one in which the HIW was under scrutiny from the Welsh Government which recognised some of these concerns and significant changes to the organisation have been made (see National Assembly for Wales Health and Social Services Committee Inquiry into the work of HIW (2013) and Marks (2014) An Independent Review of the work of Healthcare Inspectorate Wales; The way ahead to become an Inspection and Improvement Body⁹).

1.40 A Summary of Progress -Joint Review¹⁰ undertaken by Healthcare Inspectorate Wales and the Wales Audit Office' with recommendations that had significant relevance to a review of the current systems, structures and processes of governance at BCUHB. (June 2017)

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

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

9 http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board_Item_5.1a_Independent%20Review%20of%20HIW_Appendix%201_EXECUTIVE%20SUMMARY.pdf

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

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

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

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

(HIW/WAO 2017, page 4.)

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

1. Governance leadership and oversight.
 2. Mental health Services.
 3. Maternity services at Ysbyty Glan Clwyd
 4. GP and primary care services including 'Out of hours' services'
 5. Reconnecting with the public and regaining public confidence
- (HIW/WAO 2017, page 5.)

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

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

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

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

"HIW and WAO recognised the 'visible improvements' in the effectiveness of the Board and its Committees that had taken place since the 2014 review."

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

(HIW/WAO 2017 page 8)

In interview one Board member told the Ockenden governance review team 'It now feels like a much more active team of Independent Members, it's a much more balanced skillset..... we have very open transparent conversations.... and there's much more sharing of information and peer mentoring.... so it is a lot healthier state than when I first came in...' In interview (April 2017), another Board member, noted the improvement in Board papers 'they are a lot better, because the message has got through about what we want..' The Board member continued and discussed the current discipline around Board papers that still requires improvement

'You'll find that some people are saying oh, it's not ready today, we'll have to take it,..... so it's still getting people.... into that discipline..'

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

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

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

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

In summarising the position within BCUHB in June 2017 a member of staff working at Board level was asked if the views of some colleagues describing BCUHB's progress as 'green shoots' was accurate. The staff member responded to the Ockenden team 'I think it would be naïve and arrogant to think there is not significant further work to be done despite early "green shoots." We still have major challenges in relation to our financial position and do not yet have an approved 3 year plan. There is much to be done to rebuild the confidence of the public and our partners and all of that has an impact on the quality, safety and experience of care provided...'

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

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

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

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

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

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

The WAO had noted that the Board in the absence of the IMTP have developed a Corporate

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

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

The Board's overarching strategic approach had been set out in 'Living Healthier, Staying Well'¹¹.

There had been opportunities for the local population to become involved in the future direction of BCUHB via this initiative. The 2017 joint HIW/WAO Review cited a positive change in BCUHB's level of public engagement process and the current progress was found by the joint review¹² to be both comprehensive and continuing to develop.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(HIW 2017, page 23.)

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

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

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

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

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

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

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

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

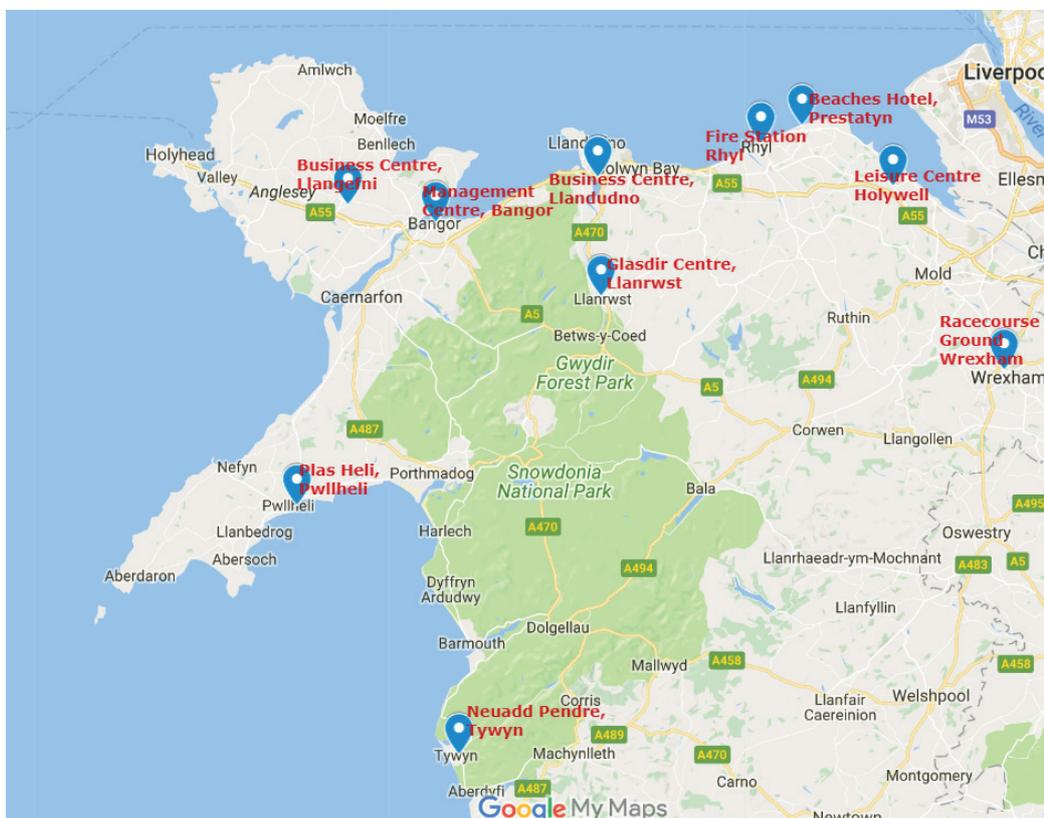
"They did not know the name of key post holders, (for example the BCUHB Executive Medical Director)"

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

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

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

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



"'Listening and Engagement' events took place at Llanrwst, Llandudno, Llangefni, Bangor, Tywyn, Pwllheli, Rhyl, Wrexham, Holywell and Prestatyn."

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

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

Some service user representatives said that they didn't know how to go making a complaint using the BCUHB complaints process and that they didn't know how to contact personnel

"Overall there was deep dissatisfaction and unhappiness amongst those attending the events about the 'concerns' and complaints system at BCUHB both overall and specific to older person's mental health care."

at BCUHB within the complaints system, (Bangor, Holywell). They described constant reorganisation and a high workload within the complaints team as an excuse for a poor service. The complaints service provided was described as 'shambolic' (Holywell, Prestatyn and Pwllheli) Complainants said they were made to feel like a 'nuisance' for complaining in Pwllheli and Wrexham and that elderly patients were turning to BCUHB for help at crisis point because there was no help until a crisis was reached, (Wrexham and Prestatyn). Service users across the six counties described complaint responses from BCUHB and being given assurances in those complaint responses that actions would be taken, but with no follow up.

Throughout 2017 service users were still requiring considerable support from their Assembly Members (AM's) and North Wales Community Health Council (NWCHC) to resolve complaints with BCUHB and the Ockenden team has seen extensive evidence of the support provided by NWCHC and AMs respectively. (For reasons of confidentiality these documents have either been provided directly from the service user/ service user representative or with the consent of the service user/ service user representative for information to be shared.)

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

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

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

1.51 Care Planning

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

1.52 Care Provision / Care Delivery:

"The complaints service provided was described as 'shambolic' "

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

(Holywell, Prestatyn and Pwllheli)

"Elderly patients were turning to BCUHB for help at crisis point because there was no help until a crisis was reached"

(Wrexham and Prestatyn).

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

enough staff employed by BCUHB to deliver the care required. Delayed transfers of care, out of area transfers to geographically distant areas and the lack of BCUHB inpatient beds and EMI residential homes were also discussed as concerns.

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

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

Some questioned why BCUHB was still not appearing to be visibly involved in speaking with and listening to service users and service user representatives. Discussion took place about the BCUHB system for engagement and its current and long term lack of visibility across many parts of Gwynedd and Anglesey. The role of Independent Members of the Health Board in engagement with service users and their representatives was queried. Attendees felt that there were too many organisations in North Wales dealing with the same issues – and as such there were too many structures and job titles which were difficult to understand and navigate. Some described difficulties in communicating with the Health Board and others talked about a lack of understanding about the services that are delivered in the many hospitals across the region. Poor communication between the BCUHB and the third sector¹³ overall was described.

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

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

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

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

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

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

"Many families and patients themselves described BCUHB as frequently resorting to providing 'colouring in pictures' as the only available activity on a repeated basis."

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

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

13 See glossary main report

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

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

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

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

With specific reference to the Mental Health and Learning Disabilities Division the last eighteen months since the formation of the Division had started to be seen more positively by some staff. One colleague told the Ockenden review team 'I do feel that there is some movement and there's some action and some things have changed that needed changing....' Acknowledging the significant length of the journey ahead for Mental Health as of April 2017 this staff member said 'I'd say we're probably about a third of the way there, we're not even halfway yet. ...' Communication within and outside mental health and the wider organisation of BCUHB and between the BCUHB Board and 'front line' staff continued to be problematic with many interviewees not knowing the name of Executive Directors as of mid-2017 and staff interviewees not able to name any independent members of the Board, other than the Chairman.

1.55 In conclusion:

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

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

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

Whilst senior managers and service leaders were able to describe clearly the systems, structures and processes of governance and strategies either being put in place or already in

place in the 'new' post special measures BCUHB service user representatives and carers were yet to feel the benefit of receiving care within this new system – with for example – a BCUHB concerns system that was still described as 'shambolic' and 'broken,' care planning that lacked any individuality and a lack of support for carers of older people with mental health difficulties.

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

It is clear that as BCUHB approaches its ninth birthday that it is still 'on a journey' but for the majority of service users, service user representatives and many clinically based staff the destination as of late 2017 remained uncertain and unclear. Communication between the 'ward' (i.e. clinically based staff and the service users and their representatives and carers) and the 'Board' (the Executive team, Independent members and senior managers) remained critically weak and many staff and service users lacked confidence in the ability of the BCUHB Board to navigate the long and difficult road ahead. Whilst some progress has undoubtedly been made (as is set out in a number of external reviews, particularly those carried out jointly by HIW / WAO in 2014 and 2017 and Healthcare Inspectorate Wales in late 2017) much more remains to be done.

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

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

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

Recommendations and Findings:

2.1 Introduction to recommendations and findings:

The findings and recommendations of the Ockenden review pertaining to failings in the systems, structures and processes of governance at BCUHB have been widely acknowledged in multiple internal and external reviews from 2012 to the current time (the end of December 2017). Much of this information is already in the public domain and has been extensively reviewed in the main report. Many of the recommendations made by the Ockenden review team have been made, at least in part by many external reviews preceding this review. In summary if an organisation such as BCUHB is underpinned by poor systems, structures and processes of governance (as BCUHB was from its creation) then there is very likely to be an inability of the organisation to identify and 'put right' failings. There will also be an inability to respond effectively to concerns from staff, service users and service user representatives and there will be an inability for an organisation such as BCUHB to ensure organisational learning from failings and concerns. This has been (and remains) the situation within BCUHB from 2009 to the end of 2017.

The Ockenden review of governance engaged with 135 current and former members of BCUHB staff and 105 current service users and service user representatives. 200 interviews were carried out, most face to face, a small number on the telephone. Extensive amounts of supplementary documentation were sent to the Ockenden team by the BCUHB staff, carers and service user representatives who engaged with the Ockenden review.

Current and former members of BCUHB staff, especially those engaged or associated with provision of (or direct line management of) front line patient care were more likely to have views that resonated and agreed with the views expressed by service users and their representatives. The Ockenden review team found that staff currently working at senior management and Board level were more likely to believe that significant progress had been made than either front line clinical staff or current service users.

The Ockenden team heard from very significant numbers of current and former BCUHB staff and current and recent service user representatives who all described from 2009 to the current day insufficient resources, (finance, staffing, training and equipment) to provide appropriate care to a very vulnerable patient group. Unfortunately despite an extensive review of evidence of over 4000 individual documents alongside over 200 interviews the Ockenden review has no assurance that these issues were resolved at anything more than a very embryonic stage.

Current service user representatives and current BCUHB staff highlighted to the Ockenden review their very significant concerns regarding the systems, structures and processes underpinning the patient pathway and delivery of patient care, response to concerns when they were presented to BCUHB and a current inability of BCUHB to evidence organisational learning from concerns, complaints and patient safety incidents.

As of the current time service user representatives and a wide range of BCUHB staff also held similar views on their ability to engage with BCUHB as an organisation. One staff member, number 56 summed up in interview in the summer of 2017 a situation described by service users and staff alike as 'It doesn't feel to me, as a member of staff, that there is a measureable and smart plan to even getting your act togetherso even when they are getting their act together it just feels like it's ever changing and the ground is almost slipping beneath your feet, you think you're getting to grips with things and then something else changes.....everybody has their own vested interests and priorities but there's no.... cohesion and different pockets of different works and departments will go off and do one thing, which could have a detrimental impact on another.'

The findings and recommendations of the Ockenden review can be understood at a pan Wales level, at an across BCUHB and North Wales level and finally at an individual level affecting

"The findings and recommendations of the Ockenden review pertaining to failings in the systems, structures and processes of governance at BCUHB have been widely acknowledged in multiple internal and external reviews from 2012 to the current time (the end of December 2017)."

"Current and former members of BCUHB staff, especially those engaged or associated with provision of (or direct line management of) front line patient care were more likely to have views that resonated and agreed with the views expressed by service users and their representatives."

"If an organisation such as BCUHB is underpinned by poor systems, structures and processes of governance (as BCUHB was from its creation) then there is very likely to be an inability of the organisation to identify and 'put right' failings."

individual service users, service user representatives, carers and staff.

2.2 Overview of the findings and recommendations of the Ockenden governance review:

The findings arising from the Ockenden review cover the period from the 'birth' of BCUHB in late 2009 to the end of December 2017. This is a lengthy period of just over eight years. In some areas staff and service user representatives have provided updates to the author on the progress of specific issues as late as May 2018 and where these progress reports have been provided they have been considered and included within the main report.

As discussed in the main report BCUHB has been subject to multiple external reviews from at least 2012 and on an ongoing basis to the current time. Scrutiny within mental health and specifically older persons mental health by Healthcare Inspectorate Wales (HIW) has occurred on a continual basis from autumn 2009 to the current day. Therefore at any one time BCUHB has been found to be working with the recommendations of multiple external action plans. In addition BCUHB was placed into Special Measures¹⁴ three years ago in June 2015 and remains under Special Measures at the current time. (April 2018.)

Consideration of all¹⁵ of the correspondence, reports and action plans (concerning the care of older people and specifically older people requiring mental health support) to and from HIW and BCUHB from 2009 to the current day and mapping and triangulation of those findings against many of the external reviews from 2012 onwards show a high degree of connectivity between the

- HIW findings and recommendations;
- Issues and concerns found on Tawel Fan ward;
- and multiple external reviews concerning BCUHB as a whole.

Disappointingly, the same findings and recommendations were repeated over and over again by HIW to BCUHB from 2009 onwards and to the current time. Unfortunately there has often been limited progress made by BCUHB from one HIW visit or external review to another, even when an action plan was developed and a number of years elapsed between one HIW inspection/ external review and another. In addition the Ockenden team found little or no organisational learning from the action plans developed from one HIW visit, inspection or external review to another. Generally HIW inspections across (for example) a range of inpatient mental health units found the same issues to be of concern on a repeated basis over very many years.

The Ockenden review team has reviewed multiple action plans and note that many actions are simply carried forward from one external review/ HIW inspection to the next. Most of the action plans seen are not SMART¹⁶, Going forward all action plans from the 'ward' to the BCUHB 'Board' will need to be

Specific as to the responsible persons, resources required and the oversight and scrutiny to be put in place;

Measureable, with performance monitoring arrangements clearly identified and followed and details where escalation should occur in the event of the required progress not being made;

Achievable with clarity around aims and objectives and how these integrate with other existing priorities ;

Relevant – with actions that refer specifically to the matter requiring resolution;

"The Ockenden review of governance engaged with 135 current and former members of BCUHB staff and 105 current service users and service user representatives. 200 interviews were carried out"

"It doesn't feel to me, as a member of staff, that there is a measureable and smart plan ... so even when they are getting their act together it just feels like it's ever changing and the ground is almost slipping beneath your feet, you think you're getting to grips with things and then something else changes.... everybody has their own vested interests and priorities but there's no... cohesion."

"Unfortunately there has often been limited progress made by BCUHB from one HIW visit or external review to another, even when an action plan was developed and a number of years elapsed between one HIW inspection/ external review and another."

14 See glossary main report

15 These have been provided to the Ockenden review by the CEO of HIW

16 See glossary main report

Timely with clarity around required timeframes and dates for completion and details of escalation where timelines are not met.

3.1 Finding 1

The patient pathway for service users of older people's mental health (OPMH) was fragmented from the 'birth' of BCUHB in 2009 and remains fragmented today from the perspective of many service users, service user representatives and carers (as of the end of 2017.)

The setting up of BCUHB with eleven (11) Clinical Programme Groups (or CPGs) who worked in an independent, disparate and often fragmented way had a negative effect on the delivery of care to older people from 2009 onwards. In the setting up of the CPGs there was a complete lack of strategic direction by the then BCUHB Board and a lack of effective Board oversight and scrutiny. Some Independent Members of the BCUHB Board produced evidence to the Ockenden review team showing that they raised concerns over many years with the then CEO and to Welsh Government but as described in the main report little action was taken in response to these concerns at the time.

The Ockenden review has reviewed extensive evidence that shows that this combination of a lack of Board effectiveness in oversight coupled with stringent financial restrictions meant that mental health and specifically older peoples mental health within mental health became a 'Cinderella' service. The MHLCD CPG was described by one Board member as being 'left to do its own thing'.

The 11 CPGs were allowed to operate as autonomous individual bodies within the wider BCUHB and were able to develop service provision as they saw fit rather than consider the 'connectivity' that should have happened across all CPGs and across BCUHB and North Wales. This was described in interview as 'eleven different versions of the world..' existing in BCUHB. This affected provision of services to vulnerable older people such as occupational therapy, physiotherapy, medical care and urgent care.

As a result service user representatives and carers described to the Ockenden review throughout 2017:

- Delays, distress and loss of dignity when seeking medical and urgent care,
- Over use of Accident and Emergency (A and E) departments (for 'simple' conditions such as urinary tract infections) that could and should be treated at/ close to home.
- Poor experience of care in A and E and Medical Assessment Units¹⁷ that was often delayed and where staff lacked the time, resources and skills to care for vulnerable older people.
- Out of area treatment – both within BCUHB but at a great distance from home, and outside North Wales in areas as far away as Southampton, London, Shrewsbury, South Wales and Coventry. Both of these scenarios have led to isolation from family, friends, familiar routines and support systems and in almost all cases has been described as hugely detrimental to vulnerable older people.

3.2 Recommendation 1:

As of the end of 2017 there has been insufficient evidence seen by the Ockenden review team that the patient pathway and the systems, structures and processes of governance underpinning service provision for vulnerable older people at BCUHB is improving. The current service model remains fragmented with multiple service providers across health, social care, the voluntary sector and other independent providers. This view has been reached following extensive documentary review and interviews and discussion with current BCUHB staff and recent and current carers, service user representatives and independent providers of care

"Some Independent Members of the BCUHB Board produced evidence to Ockenden review team showing that they raised concerns over many years with the then CEO and to Welsh Government but as described in the main report little action was taken in response to these concerns at the time."

"Delays, distress and loss of dignity when seeking medical and urgent care"

"Could and should be treated at/close to home "

"Poor experience of care in A and E and Medical Assessment Units that was often delayed and where staff lacked the time, resources and skills to care for vulnerable older people."

17 See <http://www.storiesofdementia.com/2018/04/research-report.html> for further detail and examples

across North Wales.

Many current BCUHB staff told the Ockenden review that they did not understand fully the complexities of current service provision and availability in older people's health care themselves and therefore felt unable to explain it to service users and carers. The review, redesign and development of a new service model for older people and those with dementia across the six counties of North Wales requires urgent prioritisation and action by the BCUHB Board and the Mental Health and Learning Disabilities Division as of May 2018. There will be the need for extensive multi-agency working between BCUHB and a range of partners with continuing oversight by the BCUHB Board and Welsh Government as this work progresses.

Progress on this work should be reported to the BCUHB Board on a quarterly basis, starting from the progress made by the end of quarter 2 of 2018/19, (the end of September 2018.)

"The review, redesign and development of a new service model for older people and those with dementia across the six counties of North Wales requires urgent prioritisation and action by the BCUHB Board and the Mental Health and Learning Disabilities Division as of May 2018."

4 Finding 2

The Ockenden team has very serious concerns regarding the management of the clinical workforce in mental health and older person's mental health, (OPMH) at BCUHB from 2009 to the current day. Conclusive evidence has been seen by the Ockenden review team that from the early days of BCUHB even when posts were deemed as clinically essential by the Mental Health and Learning Disabilities (MHL) CPG they were subject to a prolonged process of Executive led 'vacancy control.' This is described in detail in the main report. This left OPMH services chronically understaffed, at a time when patient numbers and acuity was increasing.

The Ockenden team has also heard and seen evidence of the random and indiscriminate application and prolonged use of a scheme known as 'VER' or Voluntary Early Release. This led to the significant loss of skilled and experienced staff from the clinical and managerial staff from within the MHL CPG and within older people's mental health over a number of years. It is likely that other wards, departments and CPGs were similarly affected but the Ockenden team has not considered that detail as its focus is on the governance of older people's mental health. There was no evidence seen of strategic Board oversight of this significant loss of skilled workforce via 'VER'. A senior member of staff in post at the time said 'If somebody asked for it, it was difficult to make a case for them not going...'

"The Ockenden team has also heard and seen evidence of the random and indiscriminate application and prolonged use of a scheme known as 'VER' or Voluntary Early Release. This led to the significant loss of skilled and experience staff from the clinical and managerial staff from within the MHL CPG and within older people's mental health over a number of years."

Unfortunately clinical staff in post at the current time within mental health and OPMH describe staffing as 'worse now' and referred in interview to 'constantly firefighting.' Clinical services were frequently described as existing on the 'good will' of staff with high levels of agency and temporary staff. There remained a high usage of locum medical staff as of the end of December 2017, with a high turnover within the locum medical workforce. This was described to the Ockenden review as impacting significantly on timeliness, quality and continuity of care to service users within OPMH. As of the summer of 2017 Dementia support workers described being frequently unable to do their own roles as they were 'pulled' on a regular basis to help with the physical care of patients in support of the 'health cares.' (Health care support workers.)

BCUHB have advised the Ockenden governance review team that as of May 2018 there are 23 WTE¹⁸Dementia 'support workers' across the three main hospital sites, community hospitals and in memory services with an additional 7 workers in post under contract with the 'Carer's Trust.'¹⁹ In the MHL Division there are 10 dedicated activity workers in OPMH inpatient wards and in addition to the Consultant Nurse there are three Dementia specialist nurses, one in YGC, one in OPMH and one in the safeguarding team.

18 Whole Time Equivalent or 'full time roles'

19 <https://carers.org/>

4.1 Recommendation 2:

- a) The financial position of BCUHB is well known to be of significant concern. The Ockenden review was informed that 'Quality Impact Assessments' (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB Board) were 'still in the process of refinement' (as of spring 2017.) This therefore is likely to remain an issue that will require evidence of focussed Board attention going forward.
- b) There will need to be further urgent and sustained Board attention to full integration of the systems, structures and processes underpinning financial, corporate and clinical governance and the Board will need to assure itself that it has effective integration and timely oversight and scrutiny of workforce planning, financial planning, performance and quality going forward.
- c) BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MHL and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MHL will need to utilise this support to creatively explore different ways of working and new and effective ways of recruiting and retaining staff. There will need to be efficient, (timely) and effective recruitment processes in place at all times to support the MHL going forward.
- d) There is currently only one Consultant Nurse in Dementia for the whole of BCUHB. With the currently extensive work plan this single post-holder is already likely to be stretched very thinly. Going forward there will not be sufficient Consultant Nurse resource to even begin to get to grips with the recommendations arising from this review and the HASCAS investigation. BCUHB should take active steps to appoint a second Consultant Nurse in Dementia.

"BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MHL and specifically OPMH with recruitment and retention expertise across medical, nursing and support"

Recommendations 4a to 4d should start with immediate effect and there should be evidence of significant progress by the end of quarter 2 2018/19, (the end of September 2018.) Taking into account recruitment times it would be anticipated all required post holders would be in place by the beginning of quarter 4 2018/2019 (January 2019)

5 Finding 3

From 2009 onwards to the current day the Ockenden team have seen many examples of both out of date policies within mental health care and former and current BCUHB staff have described to the Ockenden team lack of evidenced based policies and procedures. Also described to the Ockenden team has been the long term lack of sufficient access to IT equipment which will hinder the ability of staff to access electronic copies of policies and make it more likely that 'workarounds' will be created with wards creating their own 'paper' files of policies that have the potential to become out of date.

The Ockenden review team has not been provided with any evidence suggesting a consistent and systematic approach to the development of new policies. Many staff described the continuing use of 'paper copy' policies and the continuing use of 'legacy' policies. On some occasions clinical practice is said to be still decided by individual clinicians rather than by utilisation of BCUHB wide policies and guidance.

The Ockenden team notes with concern that evidenced based care of the older adult still appears to be at an 'embryonic' stage with care of the older adult at policy level (where it exists) still seen to be an 'add on' to existing policies.

An example is the 2011 BCUHB 'Restraint Policy' which includes sections on the Mental Capacity Act (2005) and consent but says little about capacity with only a single line on cognitive impairment stating 'Patients with cognitive impairment will often not understand oral explanations, and additional consideration has to be taken' (page 13). What this 'additional consideration' should be is not specified. This policy was due for updating in June 2014 but

had not been updated as of September 2017. An email received in the Ockenden team office from staff member 85 on the 26.9.17 stated 'For information, this policy is currently awaiting re-ratification on a corporate level.' It is of significant concern to the Ockenden review team that a policy of such significance to provision of mental health care across North Wales has been permitted to become out of date and is out of date by such a significant time period. This concern holds true regardless as to whether there are significant changes to the policy or not.

In addition the Ockenden team heard during numerous interviews with current BCUHB staff that there was a lack of comprehensive systems, structures and processes to underpin effective audit of clinical practice.

5.1 Recommendation 3:

If the situation above is found within mental health across BCUHB then it is reasonably likely to be existing in other specialities across BCUHB. Previous external reviews from 2012 onwards found the similar/same issues and concerns across multiple services, departments and CPGs. The Board should assure itself of the current situation by:

Ensuring a review of all clinical policies within all BCUHB Divisions. This review should include quality checks on how the policies and guidelines were ratified, their due date of review and a full understanding of those policies that are overdue for review.

This review will need to be undertaken of all BCUHB policies held on the intranet and a BCUHB Board 'amnesty' announced for submission of all paper copies of policies and guidance held within individual clinical areas in hospitals and across the community. Once an appropriate archive of these policies are created they should be destroyed so that they cannot be returned to clinical practice as a 'work around solution' to lack of access to policies and guidance electronically.

BCUHB should then undertake a comprehensive review of all existing BCUHB policies to ensure the needs of older adults are specifically considered within all relevant policies. (Clearly, some clinical areas would be exempt.) Policies should be rewritten, (or if required new policies created) to ensure that all policies utilise evidenced based practice in the care of older adults and older adults with dementia. These policies must be readily available to support clinical staff in the effective delivery of care to older adults. It is likely that BCUHB will require expertise from multi professional colleagues, carers and service user representatives to ensure these new BCUHB policies are fit for purpose. There will also need to be reviews of the IT systems available to all clinical areas in hospital, community and primary care since BCUHB must now move away from 'paper copy' guidelines. However to do so, means that all staff must have easy access to the BCUHB intranet. This is not currently said to be the case by all BCUHB staff.

"A BCUHB Board 'amnesty' announced for submission of all paper copies of policies and guidance held within individual clinical areas in hospitals and across the community. Once an appropriate archive of these policies are created they should be destroyed so that they cannot be returned to clinical practice"

"All staff must have easy access to the BCUHB intranet."

"The gap between the 'ward' and the 'Board' is still described by many frontline clinical staff as a 'chasm' and many service user representatives and carers described themselves as being aware of this."

6 Finding 4

The gap between the 'ward' and the 'Board' is still described by many frontline clinical staff as a 'chasm' and many service user representatives and carers described themselves as being aware of this. Current BCUHB staff were mostly unaware of the names of the Executive Directors, including the Executive Medical Director and the Executive Director of Nursing. Most staff knew of the CEO only via his weekly email 'My Week' (although readership of 'My Week' was varied. Some staff enjoyed reading it, others said they did not read it either due to pressure of time or volume of emails received. Some staff told the Ockenden review they made a point of deleting it without reading it, dismissing it as 'spin'.) The only Board member name universally known to staff was the current Chairman, with the Vice Chair known to some staff. Staff could not name any other Independent Members of the BCUHB Board. Overall the Ockenden review found that from 2009 to the end of December 2017 staff knowledge of and engagement with the BCUHB Board amongst clinical staff was (and remains) poor.

A similar situation was found within the MHL Division. From 2009 onwards most clinically

facing staff within the then CPG described limited visibility of the CPG senior leadership team. This can be partially explained by the fact that the role of the Chief of Staff was very part time and the role of the ACOS Nursing was combined with a clinical caseload for a number of years. There was also a very limited supporting management infrastructure between those roles and clinical services.

In the current time the Medical Director of the MHL Division is well known by the consultants interviewed as part of the Ockenden review. Other members of the senior management team are not as well-known and are considered to be less visible. Initial feedback from staff in the autumn of 2016 was that senior staff were seen in the ward areas 'on a Saturday' but this level of visibility, (seeing senior managers within the clinical areas, regardless of the day of the week) does not seem to have been maintained beyond the end of 2016. Local managers in wards, clinics and departments were often perceived positively. As an example, one staff member described at interview positively their local (departmental) management as 'fantastic line managers, but the people at the top, I don't think they really understand..'

Former and current staff working within frontline clinical services were (and are) of the opinion that the Board and senior managers within BCUHB do not understand the pressures faced by front line clinical staff delivering direct patient care. Front line clinical staff described a lack of engagement both with the Board and the former CPG, (current Division) senior management team. Many service users in the North Wales wide 'Listening and Engagement' events occurring in 2017 demonstrated considerable sympathy for front line staff working within older people's mental health services at BCUHB describing them as having a 'lack of opportunity for promotion,²⁰ 'working every hour God sends to cover the service'²¹ 'working in a system under siege'²², 'remote from managers'²³ and 'staff need 2 things, to be valued and to have the tools to do their job, BCU don't do any of these things...'²⁴. There is considerable additional feedback from service user representatives found within the appendices of the main report and the reader is advised to consider these to fully understand the views of service user representatives and carers on this and other issues.

6.1 Recommendation 4:

Staff engagement with an NHS organisation is known²⁵ to reduce staff absence and turnover, reduce patient mortality and morbidity and overall increase patient satisfaction. (Kings Fund 2012) There is an urgent need for both the BCUHB Board and the MHL Divisional senior management team to begin to effectively engage with staff. The Kings Fund (2012, page 7) describe an early NHS wide definition of engagement thus 'A measure of how people connect in their work and feel committed to their organisation and its goals. People who are highly engaged in an activity feel excited and enthusiastic about their role, say time passes quickly at work, devote extra effort to the activity, identify with the task and describe themselves to others in the context of their task (doctor, nurse, NHS manager), think about the questions or challenges posed by the activity during their spare moments (for example when travelling to and from work), resist distractions, find it easy to stay focused and invite others into the activity or organisation (their enthusiasm is contagious.)'

At the current time with the multiple challenges ahead BCUHB is in very significant need of a committed, excited and enthusiastic workforce. Many of those staff met with as part of the Ockenden review described 'going the extra mile' for their patients on a daily basis and some service user representatives did recognise that. However there was a marked difference between the 'going the extra mile' for patients in their care attitude heard from many staff and

"Staff could not name any other Independent Members of the BCUHB Board. Overall the Ockenden review found that from 2009 to the end of December 2017 staff knowledge of and engagement with the BCUHB Board amongst clinical staff was (and remains) poor."

"Fantastic line managers, but the people at the top, I don't think they really understand."

"Former and current staff working within frontline clinical services were (and are) of the opinion that the Board and senior managers within BCUHB do not understand the pressures faced by front line clinical staff delivering direct patient care."

"Staff need 2 things, to be valued and to have the tools to do their job, BCU don't do any of these things."

20 Service user representative 27, June 2017

21 Service user representative 24, June 2017

22 Service user representative 9, June 2017

23 Service user representative 22, June 2017

24 Service user representative 27, June 2017

25 <https://www.kingsfund.org.uk/sites/default/files/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf>

the feelings of apathy and disengagement many staff had towards BCUHB as their employing organisation.

“There was a marked difference between the ‘going the extra mile’ for patients in their care attitude heard from many staff and the feelings of apathy and disengagement many staff had towards BCUHB as their employing organisation.”

6.1.1 Recommendation 4a:

The BCUHB Board and the MHL Divisional Senior Management team is recommended first to ask of front line staff ‘what does the term ‘staff engagement’ mean to you, what would effective staff engagement look like for you?’ and then to develop a system of bespoke, meaningful and sustained staff engagement first across mental health and specifically older persons mental health. The Board may then wish to consider how effective their engagement is with staff across BCUHB and decide whether a new Board approach is required to staff engagement across the whole of BCUHB.

“what does the term ‘staff engagement’ mean to you, what would effective staff engagement look like to you?”

6.1.2 Recommendation 4b:

The Ockenden review team was informed that the NHS Staff survey across Wales is completed every three years and is next due in 2019. Welsh Government may wish to consider an annual staff survey in line with that carried out in England. A three year gap in formally ascertaining the views of NHS staff in Wales is considered by the Ockenden review team to be too long.

“The BCUHB Board should commence a formal annual BCUHB staff survey starting with the all Wales annual staff survey in 2019 and using the same methodology utilised for the all Wales NHS staff survey at BCUHB on an annual basis from 2020.”

6.1.3 Recommendation 4c:

Aside from any potential decision by Welsh Government, the BCUHB Board should commence a formal annual BCUHB staff survey starting with the all Wales annual staff survey in 2019 and using the same methodology utilised for the all Wales NHS staff survey at BCUHB on an annual basis from 2020. The actions and progress arising from the new annual BCUHB staff survey should be reported to the public BCUHB Board on a quarterly basis.

6.1.4 Recommendation 4d:

Following on from the failure of BCUHB's attempt of a clinically led organisation, which is well referenced in a number of external reports the BCUHB Board must now take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB. The recommendations a to c above refer to the need to improve staff engagement. BCUHB also needs to engage with a comprehensive BCUHB wide clinical leadership and management development scheme encouraging the widest range of clinical colleagues across medicine, nursing and professions allied to medicine to want to take responsibility for leadership and management of their individual services.

“The failure of the BCUHB CPG system must not be levelled simply at the door of the individual clinicians leading those CPGs.”

Any such scheme must learn the lessons from the failure of the BCUHB CPG system from 2009 onwards and ensure they are not repeated. The failure of the BCUHB CPG system must not be levelled simply at the door of the individual clinicians leading those CPGs. The failure of the CPG system is widely discussed in the main report and in multiple external reviews prior to the Ockenden review.

“Inpatient beds were lost before the service developments to replace the ‘lost’ beds were introduced. Staff describe that some inpatient beds were closed at short notice with little time to plan; ‘they just came in and closed us [over] a couple of days.”

7 Finding 5

The Ockenden team has seen and heard significant evidence that patient numbers and acuity on Tawel Fan ward and all other inpatient mental health wards across BCUHB increased significantly from 2009 onwards. This increase in patient numbers and acuity was exacerbated by the following features:

- Home treatment teams that were new and therefore embryonic in nature and could not care effectively at home for patients at crisis point. A number of service user representatives told the Ockenden review team of the distressing use of the Police to support admission of elderly relatives to hospital when situations at home had

reached crisis point and could not be de-escalated.

- A reduction in older people's mental health inpatient beds in order to facilitate the development of the home treatment teams and community services, i.e. inpatient beds were lost before the service developments to replace the 'lost' beds were introduced. Staff describe that some inpatient beds were closed at short notice with little time to plan; 'they just came in and closed us [over] a couple of days.'
- A loss of nursing home beds across North Wales from 2012 onwards despite (untested) assurances to the Board from members of the then CPG senior management team around 'Healthcare in North Wales is Changing'²⁶ (2012) that there were opportunities to 'commission' beds in EMI²⁷ homes. The reduction in EMI beds was happening at the time of the assurances to the Board around 'opportunities' to grow the numbers of EMI beds available to BCUHB but all of the recommendations made by the then CPG management team were fully accepted with very minimal challenge.
- Long term issues around access to out of hours GP provision which are well documented elsewhere.

"The reduction in EMI beds was happening at the time of the assurances to the Board around 'opportunities' to grow the numbers of EMI beds available to BCUHB"

"BCUHB staff, the third sector and carers and service user representatives all found the approach from BCUHB towards the third sector in 2017 to be fragmented, disorganised and chaotic with a lack of strategic approach."

Feedback to the Ockenden review team from current BCUHB staff and current carers and service user representatives at all of the 'Listening and Engagement' in 2017 events shows that in 2017 there still remains a mismatch between patient acuity, patient numbers and service provision across OPMH in BCUHB.

- EMI nursing home capacity remained a concern.
- Community based services for older people's mental health was still very underdeveloped.
- There was immense pressure on the voluntary sector to provide care and support to older people with mental health problems across North Wales.
- BCUHB staff, the voluntary sector and carers and service user representatives all found the approach from BCUHB towards the voluntary sector in 2017 to be fragmented, disorganised and chaotic with a lack of strategic approach. This was summarised by a current member of staff, who said of the approach by BCUHB in summer 2017: 'It creates pockets of gaps and then duplication and it doesn't allow people to access the support that is there....' The staff member continued: 'There's no cohesive approach and it's not that the work undertaken isn't good work, but it's just dotted around and people don't know that it's there....'
- One service user representative said 'There is a need to go back to basics to evaluate what services are required at the earliest times'
- There were believed to be insufficient inpatient bed numbers for older people with mental health issues in 2017
- Older people were frequently required to travel long distances for care and treatment either across North Wales (or in many examples provided by staff, service user representatives and carers) outside North Wales.
- 'Conversations between all should continue along the pathway – but everyone is stretched to the limit – GPs are drowning'; (service user representative 34)
- 'People are being ignored by the system. People should be asked what systems they would like. (service user representative number 9.)

"It creates pockets of gaps and then duplication and it doesn't allow people to access the support that is there...."

"Conversations between all should continue along the pathway – but everyone is stretched to the limit – GPs are drowning" (service user representative 34)

7.1 Recommendation 5:

BCUHB needs to work effectively at a strategic level with the voluntary sector and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales. Again the Ockenden team uses the word 'embryonic' to describe progress to date.

26 See glossary, main report

27 See glossary, main report

8 Finding 6

With reference to the safeguarding adults function at BCUHB the Ockenden review team considered significant evidence that showed the systems, structures and processes of governance underpinning safeguarding and the resources provided to it to be sub optimal from the formation of BCUHB in 2009 until at least late 2016. A number of current and former BCUHB senior staff described that the setting up of individual governance structures within the eleven CPGs, described as a 'broad architecture of governance' by one member of staff had considerable implications for the development of adult safeguarding in BCUHB from 2009 onwards.

In addition former senior staff described clearly that the formation of BCUHB across the six counties of North Wales caused significant disruption to relationships between internal safeguarding arrangements in the three main 'legacy' sites and external multi-agency working arrangements that were described as previously working effectively.

Senior staff within BCUHB describe the sporadic implementation of Datix²⁸ across BCUHB, without training in some areas and the difficulties across the CPGs of sharing information across SI's²⁹, complaints, Datix, POVAs³⁰ and safeguarding alerts. Staff also described the lack of an 'automatic flag' or alert system on Datix against ward, name or department. Much record keeping associated with safeguarding and risk was 'paper copy' rather than electronic and this simply ceased to work following the birth of such a large organisation. All of this made it difficult for staff working within safeguarding to identify and therefore act upon and subsequently learn from any potential trends from specific clinical areas or services.

Clinical staff across OPMH described to the Ockenden review that they rarely received feedback from submission of safeguarding alerts, Datix, clinical incidents or complaints meaning that it was both difficult to provide effective care to some vulnerable adults alongside an absence of organisational learning.

Review of all the BCUHB Annual Safeguarding reports from 2010 to the current day and the Corporate Risk Register³¹ (or CRR) from November 2013 to August 2015 and then from August 2015 to the current time (end of 2017) show that the 'risk' of potential harm to vulnerable people was recorded as a RAG rating³² of '20' (red/ high) in November 2013 and remained '20' (red/ high) in May 2015. Despite this safeguarding was 'de-escalated' from the Corporate Risk Register in August 2015 to be managed 'at a strategic corporate nursing level.' The reason for this de-escalation remains unclear to the Ockenden team since a diagnostic undertaken at the instruction of the then new Executive Director of Nursing found a number of very significant risks around safeguarding 'RAG' rated at 20 or 25.

Overall the Ockenden review found that Board scrutiny and oversight of safeguarding was weak and the BCUHB Board, (both Executive Directors and Independent Members) received poor quality information about the difficulties in safeguarding across BCUHB over a prolonged period of time from 2010 to the end of 2016.

8.1 Current position in adult safeguarding at BCUHB as of December 2017 and recommendation 6:

The BCUHB annual 'safeguarding report' for 2017- 18³³ still reports significant risk in the adult safeguarding function at BCUHB. The following challenges remain which are of a very urgent

"A number of current and former BCUHB senior staff described that the setting up of individual governance structures within the eleven CPGs, described as a 'broad architecture of governance' by one member of staff had considerable implications for the development of adult safeguarding in BCUHB from 2009 onwards."

"The 'risk' of potential harm to vulnerable people was recorded as a RAG rating of '20' (red/high) in November 2013 and remained '20' (red/high) in May 2015. Despite this safeguarding was 'de-escalated' from the Corporate Risk Register in August 2015 to be managed 'at a strategic corporate nursing level.'"

"The BCUHB annual 'safeguarding report' for 2017-18 still reports significant risk in the adult safeguarding function at BCUHB."

28 See glossary, main report

29 See glossary, main report

30 See glossary, main report

31 See glossary, main report

32 See glossary, main report

33 See main report for further detail

nature:

- Attendance at safeguarding training remains problematic and there is continued difficulty in achieving the required training at level 1 across BCUHB. BCUHB will need to review and update its safeguarding training and ensure it is up to date and incorporates relevant legislation. Where recent training was out of date, those who have had training since April 2016 will need appropriately updated training to be delivered.
- Where adherence to the standards required in the number of BCUHB staff accessing safeguarding training has been a chronic and long term problem, BCUHB need to develop a SMART³⁴ action plan with progress reported quarterly to the BCUHB Board. If there is not a significant and sustained improvement by the end of quarter 3 of 2018/19 the BCUHB Board should consider further external assistance including the potential of external assistance from Welsh Government.
- The current safeguarding database still lacks the ability to triangulate data from various databases across BCUHB. This is a continuing risk to the safety of vulnerable adults receiving care at BCUHB.
- There has been long term absence of key safeguarding personnel from the beginning of 2016 to the end of 2017. However the current Executive Director of Nursing has provided significant resource for a new safeguarding structure bringing together safeguarding adults and children, tissue viability and lymphoedema,³⁵ Deprivation of Liberty standards or DoLS³⁶ plus a safeguarding lead for dementia. The revised structure is described in more detail in section 12.7 of the main report.
- BCUHB should undertake a formal and externally led evaluation of the effectiveness of the new safeguarding structure by the end of the last quarter of 2018/ 19, i.e. to be completed by 31st March 2019.) The resulting report that should be presented to the BCUHB Board in public.
- BCUHB still needs to update its policies and procedures in line with the Social Services and Wellbeing Act 2014.³⁷ These BCUHB policy updates should have been in place prior to the implementation of the legislation in April 2016 and there has been very significant delay. This must proceed without further delay.

"The current Executive Director of Nursing has committed significant resource and provided energy and determination into developing sound foundations for the safeguarding structure going forward."

"The Ockenden governance review team is very clear that the 'concerns' (or PTR) process at BCUHB has been in a state of almost continual failure since the creation of BCUHB in October 2009."

8.2 Overview of progress to date made by BCUHB with reference to recommendation 6:

The current Executive Director of Nursing has committed significant resource and provided energy and determination into developing sound foundations for the safeguarding structure going forward. However for an organisation such as BCUHB approaching its ninth birthday a very significant amount of work still needs to be done. This will need continued Board scrutiny and oversight, may still yet require external support and **must** be reported to Welsh Government if (for any reason) progress in the future falters or slows down

9 Finding 7

The Ockenden governance review team is very clear that the 'concerns' (or PTR)³⁸ process at BCUHB has been in a state of almost continual failure since the creation of BCUHB in October 2009. The failures have been well documented in a number of external reviews from 2013 to the current day. This is discussed in greater detail in the main report. It is acknowledged that significant effort is being put into improving the management of concerns in 2017. However these efforts have yet to 'bear fruit' in terms of the actual experience of carers, service users

"There is always a delay in receiving a response to any concern/complaint – and when you get the response its quality is poor" (Bangor, May 2017)

34 Specific, Measureable, Achievable, Relevant and Timely

35 See main report glossary

36 See main report glossary

37 http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf

38 See glossary, main report for definition

and service user representatives who participated in the Ockenden review throughout 2106 and 2017.

Findings from service users included the following, (with further detail of service user viewpoints available in the main report.)

- There is always a delay in receiving a response to any concern/complaint – and when you get the response its quality is poor' (Bangor, May 2017)
- 'The health board is arrogant when it responds to complaints – there is an impression that they just don't care'; (Bangor, May 2017)
- 'The mantra 'say what you mean, mean what you say; doesn't apply'; (Bangor, May 2017)
- 'They (BCUHB) treat you like dirt. An advocate was asked 'who are you to be speaking on behalf of this patient?' (Bangor, May 2017)
- 'People just give up complaining'; (Bangor, May 2017)
- 'Elderly people in particular have just not been brought up to 'complain' – it is just not in their upbringing. They are often fearful to speak up and are therefore vulnerable'; (Bangor, May 2017)
- 'Leaders need to embrace change and lead from the front – they need to respond to change/criticism'; (Bangor, May 2017)
- 'Many people just don't know how to complain – and are fearful of doing so'; (Bangor, May 2017)
- 'Life is too busy in particular if you are caring for an elderly person – you are constantly overwhelmed with what you have to do – going through making a complaint is something that you just wouldn't have time to do'; (Bangor, May 2017)
- 'Families are in fear of reprisal for asking questions, or raising a concern or a complaint'; (Tywyn, May 2017, service user representative 20)
- We have to keep rattling cages – it's so frustrating, however we have power to change things if we continually rattle cages together. However people run out of puff and give up and all that is left is a nice paper trail and nothing else. (Llangefni June 2017, service user representative 34)
- 'Families are just too terrified to complain in case their relatives might get shipped off to England. They are just frightened to speak out'; (Llangefni June 2017, service user representative 30)
- 'People think – 'if I'm really nice to them then they will look after dad – best if I not complain'; (Llangefni June 2017, service user representative 26)
- 'People just don't make complaints in the first place – I think the number of complaints/ levels of dissatisfaction are grossly under reported'; (Llangefni June 2017, service user representative 30)
- 'Protracted timescales – people are hiding behind the 'volume of work' excuse. Often staff have moved on so it is difficult to investigate. Complaints are treated as a nuisance' (Pwllheli June 2017, service user representative 21)

"Elderly people in particular have just not been brought up to 'complain' – it is just not in their upbringing. They are often fearful to speak up and are therefore vulnerable" (Bangor, May 2017)

"Life is too busy in particular if you are caring for an elderly person – you are constantly overwhelmed with what you have to do – going through making a complaint is something that you just wouldn't have time to do" (Bangor, May 2017)

"Families are in fear of reprisal for asking questions, or raising a concern or a complaint" (Tywyn, May 2017, service user representative 20)

Most service user representatives and carers met with as part of the Ockenden review of governance had very little faith or confidence in the ability of BCUHB to 'put things right' with the concerns process as of the end of 2017 and into the spring of 2018.

The Ockenden review team met with and received communication from a number of North Wales Assembly Members³⁹ or AMs. Having gained consent from their constituents they shared with the Ockenden team communication from constituents showing poor systems, structures and processes of governance around complaints and concerns at BCUHB from 2009 onwards to the current day. Of great concern to the Ockenden review team is that North Wales AMs are still, as of late 2017 needing to become involved in supporting their constituents through the

39 See glossary, main report

complaints process at BCUHB.

*" People think – 'if I'm really nice to them then they will look after dad – best if I not complain"
(Llangefni June 2017 service user representative) '*

In addition it is clear to the Ockenden review team that the North Wales Community Health Council (NWCHC) also plays a very significant role, (on a regular basis) in supporting the resolution of complaints both inside and outside OPMH at BCUHB as of spring 2018. An experienced advocate told the Ockenden review in December 2017 that BCUHB in its management of concerns 'plod on for a couple of years as they are, and they get decidedly worse and then the Health Board gets someone in [who] stamps all over everybody, and then they become very proactive in..... well they try and get rid of all the backlog, then the new ones that are coming in, they become the backlog and then they toddle on a bit longer and then they get somebody else in. There seems to be this circle where they never seem to get it right, they never seem to be able to get to a position where they are actually smashing that thirty day, or even the six month timeline, really.'

An experienced advocate raised the following case study with the Ockenden review as of the end of 2017. This case had been previously raised with BCUHB and occurred in 2017. It was raised to illustrate the importance of the role of the advocate for vulnerable older people within the Ockenden governance review. Minor details have been changed from those supplied by the advocate to ensure anonymity. The case occurred at a BCUHB main hospital site, outside the MHL Division.

Miss S attended hospital following a fall and fracturing her patella. She was admitted initially in August, 2017. It was decided by the medical team that the injury would be treated conservatively and no surgery would be conducted due to the surgical risk she posed. On this admission a cast was placed on her leg. In early September Miss S was re-admitted to the DGH due to multiple pressure sores caused by the cast. She was moved to X Community Hospital a few days later.

No Advocate, (IMCA), was consulted on the decision to not treat her injury. Due to Miss S being deemed to lack capacity, because of her advanced dementia, and not having family or friends to act on her behalf, she should have been provided with an IMCA as per the Mental Capacity Act 2005.

As a result of the surgeons making their own decision and not liaising, as they should have done, with an IMCA, the decision to not treat Miss S was based on the presenting picture of her knee only and did not look at the overall effects to her. Miss S was in hospital for a number of weeks where she declined physically and mentally and was ultimately moved to another care home due to her increasing needs. The care home she was at previously knew her very well and she had been with them for a number of years. It is yet to be seen what effect moving homes will have on her further.

The sores caused by the cast were grade 3-4 on the vaginal area and grade 4 on the back of the thigh. She also had a graze on her inner ankle and a necrotic heel. There was an infection in her groin, which was treated with antibiotics too. It is not clear what thought was put in to Miss S's lifestyle when the cast was applied and the effects it would have on her. It could be argued that were an IMCA involved this would have been raised as a potential issue.' (Service user representative number 103.)

Service user 1 submitted a detailed timeline to the Ockenden review showing their efforts to resolve a complaint around poor care provided to their spouse with end of life care at YGC in 2017. Service user 1 said 'Seeing all the dates in front of me it makes me realise, how dare they keep a grieving widow, who had been through so much trauma, waiting for so long for the answers to why her husband was put through so much, leaving him without dignity when he was dying and so vulnerable. I think I was being given the run around, hoping I would just give up and go away.' (Service user 1, on reviewing the concerns 'timeline' in April 2018, as part of the factual accuracy process.)

This situation around management of complaints and concerns at BCUHB was reflected in the

2017 joint HIW/WAO report. Whilst HIW/WAO noted that BCUHB had 'started to improve the timeliness of responding to complaints.' HIW stated they had seen 'little evidence to suggest that the Health Board is learning effectively.' HIW also noted that which had been stated by a number of interviewees to the Ockenden review team, that there was limited evidence of 'lessons learnt' on a consistent and systematic basis across sites and divisions. (HIW 2017, page 10.)

"Of great concern to the Ockenden review team is that North Wales AMs are still, as of late 2017 needing to become involved in supporting their constituents through the complaints process at BCUHB."

9.1 Recommendation from finding 7:

Whilst it is acknowledged that on many occasions since 2009 BCUHB has made an effort to improve the timeliness of responses to concerns in line with the requirement of Putting Things Right (2011) this has not yet been sustained on an ongoing and long term basis. BCUHB needs to resolve this situation finally by the end of quarter 2 of 2018/19, (i.e. the end of September 2018)

"It is clear to the Ockenden review team that the North Wales Community Health Council (NWCHC) also plays a very significant role, (on a regular basis) in supporting the resolution of complaints both inside and outside OPMH at BCUHB as of spring 2018."

In addition the Ockenden governance review team heard from multiple service user representatives and individual families and carers of very poor and protracted experiences in trying to resolve complaints. Donna Ockenden personally escalated to Executive level three complaints characterised by poor responses over a very protracted timescale. Following that escalation there was a further extended period of time before any progress was made. In one case an external investigator has just been appointed (May 2018) following escalation of very serious concerns to the Executive team by Donna Ockenden in August 2017.

It is clear that the BCUHB Board have very little knowledge of the **actual** everyday experience of families, service users and service user representatives who try to make complaints to BCUHB as an organisation. Service user representatives also raised with Donna Ockenden the reluctance of families and service users to complain and the fear they have of complaining. This means that the number of complaints from older people and their families is highly unlikely to be an accurate illustration of the real views of service users and their families.

"Service user 1 said 'Seeing all the dates in front of me it makes me realise, how dare they keep a grieving widow, who had been through so much trauma, waiting for so long for the answers to why her husband was put through so much, leaving him without dignity when he was dying and so vulnerable. I think I was being given the run around, hoping I would just give up and go away.'" (Service user 1, on reviewing their concerns 'timeline' in April 2018).

Service user representatives and carers in mental health and older peoples mental health (and staff involved in service user and carer engagement) have described to the Ockenden review team how carers feel 'saturated' by the multiple ways in which BCUHB attempt to ascertain their views but then perceive that BCUHB do very little with those views and feedback. Therefore the Ockenden review is reluctant to recommend that the BCUHB Board and the MHL senior management team undertake specific and targeted further user engagement looking at complaints and concerns. However the BCUHB Board needs to be aware of the considerable and deep seated unhappiness expressed by a range of carers and service user representatives across a range of issues – one of which is the current inability of BCUHB to effectively respond to concerns in a timely manner.

10 Finding 8

10.1 The Ockenden review found communication with carers and service users to require significant improvement throughout the lifetime of this review and up to and including December 2017

The Ockenden team heard about difficulties in accessing information from BCUHB about dementia from a range of carers and accessed the BCUHB website to assess what information was available

There was considerable concern expressed by service users and their representatives about the delays in diagnosing dementia across North Wales. Once dementia was diagnosed service users and their representatives described an absence of advice and information for carers and families. There was particular concern around lack of support for those with younger onset dementia. Further concerns were expressed around care plans with care plans described as standardised with limited/no individuality. Carers stated that they saw little being done by BCUHB to ensure that the individual was at the heart of any care planned or delivered.

The BCUHB website has an area described as a 'Dementia Toolkit'⁴⁰ where very basic information can be accessed and printed on for example Alzheimer's disease⁴¹, Lewy Body dementia⁴², management of vascular dementia⁴³ and mild memory problems⁴⁴. These are provided in English with the option for Welsh translation⁴⁵ from the BCUHB website and the links are found below. The Ockenden review team noted that this information is in a very small font of circa a font sized 6, (it can be increased to circa font sized 12,) It requires IT skills to 'click through' multiple links, all in small font. The information as presented on the BCUHB website on dementia is unlikely to be helpful to elderly carers or service users. BCUHB has advised Donna Ockenden that 'a dementia handbook and memory training⁴⁶ guide produced by the Alzheimer's society' are given to patients and families on diagnosis. This is not available electronically but information is available in the link below.

A range of dates are found on the BCUHB for events associated with dementia from 'Monday 15th May' onwards⁴⁷. The year is not specified. In 2018 15th May is a Tuesday so it appears the events are from 2017 not 2018. The page has not been updated. Other information on the page⁴⁸ includes information on the 'Dementia RED - Information Service.' This is described as:

'Dementia RED (Respect, Empathy, Dignity) is a series of information centre points within GP surgeries throughout North Wales. The aim is to help people with concerns about dementia to access appropriate information and support. Available to registered patients at the practice hosting the Information Point.' The Ockenden review team could not find any further information on those GP surgeries hosting the information point, so this was unlikely to be of much help to carers, service user representatives or people with dementia themselves. A 2015 evaluation report was found on line⁴⁹ which indicates that this was potentially a short term project that has now concluded. This would not explain why there is still a reference to the scheme on the BCUHB website as of April 2018.

"Carers feel 'saturated' by the multiple ways in which BCUHB attempt to ascertain their views but then perceive that BCUHB do very little with those views and feedback."

"However the BCUHB Board needs to be aware of the considerable and deep seated unhappiness expressed by a range of carers and service user representatives across a range of issues – one of which is the current inability of BCUHB to effectively respond to concerns in a timely manner."

"The information as presented on the BCUHB website on dementia is unlikely to be helpful to elderly carers or service users."

"Significant further work still needs to be done by BCUHB in improving the information available to service users with dementia, their carers and service user representatives."

40 <http://www.wales.nhs.uk/sitesplus/861/page/65255>

41 <http://www.wales.nhs.uk/sitesplus/861/page/64863>

42 <http://www.wales.nhs.uk/sitesplus/861/page/64866>

43 <http://www.wales.nhs.uk/sitesplus/861/page/64868>

44 <http://www.wales.nhs.uk/sitesplus/861/page/64872>

45 <http://www.wales.nhs.uk/sitesplus/861/tudalen/64899>

46 <https://www.alzheimers.org.uk/research/care-and-cure-research-magazine/training-your-brain>

47 <http://www.wales.nhs.uk/sitesplus/861/page/65253>

48 <http://www.wales.nhs.uk/sitesplus/861/page/65331>

49 http://dscd.bangor.ac.uk/documents/DementiaREDMidtermevaluationreport_FINAL.pdf

The BCUHB 'Dementia Strategy' could not be found on the BCUHB website⁵⁰ as of April 2018 when the words 'dementia strategy'⁵¹ were repeatedly used to facilitate a search. A 2014- 2016 update was found as part of Quality, Safety and Experience papers instead. An updated 2018 'Dementia Strategy' was not available as part of the 'Dementia toolkit' area of the BCUHB website. The Dementia Strategy has been reviewed by the Ockenden governance review team. It remains very 'high level' and aspirational and there does not appear (as of spring 2018) to be a SMART52 action plan accompanying it which describes how the aspirations within it will be achieved and when.

BCUHB advises that dementia training for families has been 'road tested' with carers in 2017 and will be launched during 'Dementia Action Week' in 2018.

10.2 Recommendation 8:

Significant further work still needs to be done by BCUHB in improving the information available to service users with dementia, their carers and service user representatives. It is clear that an attempt has been made to provide information on the BCUHB website but the BCUHB Board now needs to ensure appropriate resources, skills and time are provided on a substantive basis to ensure a range of high quality and appropriate resources and information are easily available to service user, service user representatives and carers. Communications need to be easily accessible to patients and carers. There is a great deal of difference between the accessibility of the information available on the Alzheimer's Society⁵³ website and the information available on the BCUHB website. It is acknowledged that there will be a much greater range of information on the Alzheimer's Society website.

In order to ensure recruitment to this service the BCUHB Board should provide an update on progress by the end of quarter 2, (end of September 2018) with the launch of a new suite of bilingual (English and Welsh) resources available no later than the end of quarter 3, (the end of December 2018.) Front line clinical staff, carers and service user representatives need to be involved in the development of these resources from the earliest stage to ensure they are relevant and appropriate

The BCUHB Board need to commit the appropriate resources to ensure that the currently high level 'Dementia Strategy' becomes an achievable and relevant part of everyday care and clinical practice of people with dementia. It appears that as of April 2018 BCUHB still need to ascertain the workforce needed to deliver upon the 'Dementia Strategy' since the Ockenden team has not seen any evidence to suggest that this work is either underway or has already been completed. The 'Dementia Strategy' should also incorporate current and forward looking workforce and service plans for the provision of appropriate levels of therapy and non-medical care for people with dementia since again, the Ockenden team has not seen evidence to suggest that this aspect of the 'Dementia Strategy' has been completed.

This work needs to commence within quarter 2 of 2018/19 with significant progress reported to the BCUHB Board at the beginning and end of quarter 3, (October and December 2018) and quarter 4. (March 2019). Progress throughout 2019 will need to be monitored by the BCUHB Board to ensure it does not slip, falter or become delayed.

The 'Dementia Strategy' should be developed to work across all relevant clinical services across BCUHB, not just within the MHL Division. The 'Dementia Strategy' should incorporate care across home, primary care and secondary care.

"The BCUHB Board now needs to ensure appropriate resources, skills and time are provided on a substantive basis to ensure a range of high quality and appropriate resources and information are easily available to patients and carers. Communications need to easily accessible to patients and carers."

"The BCUHB Board need to commit the appropriate resources to ensure that the currently high level 'Dementia Strategy' becomes an achievable and relevant part of everyday care and clinical practice of people with dementia."

50 <http://www.wales.nhs.uk/sitesplus/861/Home>

51 http://www.wales.nhs.uk/sitesplus/documents/861/qs14_61.3%20bcuhb%20dementia%20strategy%202014_16.pdf

52 See glossary, main report

53 https://www.alzheimers.org.uk/?gclid=EAlaIqobChMIw4fVu4392gIVyLvtCh0YhgAuEAAAYSAAEgJZCPD_BwE

11 Finding 9

11.1 Deprivation of Liberty Safeguards or DoLS

The Ockenden review team has reviewed a significant amount of information indicating that BCUHB has struggled to provide an effective response to DoLS over the years from 2009. In the documentation seen by the Ockenden team there are multiple references to failures to ensure adequate and appropriate training and long term confusion over lines of responsibility for DoLS. In a recent report for BCUHB, (March 2017) it was stated that the majority of DoLS applications are urgent but only 1% of urgent decisions were made in the allotted time span (the average for Health Boards across Wales was 28%). (See page 12.) This shows BCUHB as a significant negative outlier when compared to other Health Boards across Wales. It is acknowledged by BCUHB that 'compliance with DoLS legislation remains a concern' (Quality, Safety and Experience Committee 29th March 2017 QS17/65.7)

The 2015-16 report states that overall 'the delays in decision making raise a serious concern about the effectiveness of the safeguards and the risk of unauthorised and unnecessary deprivations of liberty in hospitals....' (Page 12)

The 2017-2018 BCUHB 'Safeguarding and Protection of People at Risk of Harm, Annual Report' sets out an overview of progress to date and notes that progress to date has been 'gradual' A work plan around DoLS for 2017- 2018 is set out at 14.4 (BCUHB 2018, page 10.)

"The 'Dementia strategy' should be developed to work across all relevant clinical services across BCUHB, not just within the MHL Division. The 'Dementia Strategy' should incorporate care across home, primary care and secondary care."

"It is acknowledged by BCUHB that 'compliance with DoLS legislation remains a concern' (Quality, Safety and Experience Committee 29th March 2017 QS17/65.7)

11.2 Recommendation 9:

BCUHB will complete and report to the BCUHB Board in quarter 1 2018-2019, (by the end of June 2019) a review of the 2017- 2018 DoLS work plan as set out in the 2017- 2018 Annual Report.

Any remaining actions are required to be SMART and fully implemented within the third quarter 2018-19, (by December 2018,) with progress reported to the BCUHB Board throughout quarter 3.

"Some issues around estates, staffing, poor documentation, lack of meaningful activities, medicines management are repeated over multiple HIW visits to many sites over many years."

12 Finding 10

12.1 The Ockenden review found that BCUHB demonstrated a lack of an effective and sustained response to numerous external reviews and inspections of services at BCUHB from October 2009 to the current day. This included failure by BCUHB to act upon repeated concerns raised by HIW raised from 2009 to 2017.

The Ockenden review team has considered a vast volume of evidence that has shown that BCUHB was subject to extensive external review and scrutiny from 2009 to the end of December. This is described fully in the main report. HIW reviews and inspections happen in a large number of BCUHB services associated with the care of vulnerable elderly people over a period of time in excess of seven years. Some issues around estates, staffing, poor documentation, lack of meaningful activities, medicines management are repeated over multiple HIW visits to many sites over many years.

"With direct reference to BCUHB and in relation to mental health inpatient settings it is of concern that to the current time BCUHB continues to make slow progress in many of the recommendations made by HIW over

There are some examples of good practice found by HIW over the period of these reviews. Staff are frequently commented on in a positive way. Throughout these reports and over this prolonged period of time there are a long catalogue of issues at BCUHB that are similar across many of the HIW inspection reports. These are repeated across multiple inpatient units with very little assurance that the situation is improving.

One example is the lack of action BCUHB took following the Healthcare Inspectorate Wales (HIW) Mental Health Act visit to Tawel Fan ward in July 2013. Those receiving the feedback from the visit on the day failed to realise the seriousness of the issues raised. A member of the Board was not present for feedback, there has been no evidence seen by the Ockenden governance review team that the feedback was shared with either the CPG Chief of Staff or the Executive team. Finally, there was a significant failing in the systems, structures and processes within HIW at the time in that communication from HIW to the then interim CEO at BCUHB was also significantly delayed from July 2013 to October 2013. This is acknowledged by the CEO of HIW Dr Katherine Chamberlain in the following interview⁵⁴.

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

The Ockenden review team has seen evidence that HIW did improve their scrutiny of inpatient units providing care to vulnerable older people at BCUHB in the years after Tawel Fan ward closed. The Ockenden review has seen evidence of improved timescales in the issuing of communication to BCUHB following HIW visits and inspections, a more 'robust' tone to the communication and the repeated follow up of action plans where they were deemed by HIW not to provide sufficient assurance. These issues are all discussed in greater detail in the main report.

In March 2014 following concerns expressed by the Health and Social Care Committee of the National Assembly of Wales⁵⁵ an extensive review⁵⁶ of the work of HIW was undertaken by Ruth Marks. The 'executive summary' of the Marks (2014) report is available via the link below. It is not the role of this governance review to comment on the recommendations of the Marks report other than to say that they are extensive, (there are 42 recommendations) and comprehensive in nature with recommendations for HIW itself, Welsh Government and joint recommendations across health and social care and Community Health Councils.

"Some of the issues that we found during this inspection were also present during our last visit in June 2014, despite the Health Board developing a clear action plan in response to that visit stating that these issues would be resolved." (HIW 2018, page 3.)

With direct reference to BCUHB and in relation to mental health inpatient settings it is of concern that to the current time BCUHB continues to make slow progress in many of the recommendations made by HIW over many years. The most recent example of this was seen in the HIW⁵⁷ November 2017 visit to the Ablett unit where HIW said of two wards Cynnydd and Dinas 'we found that the environment of the two wards we visited were not fit for purpose. Cumulatively, we believe that a number of the issues we identified during our inspection represent a risk to patient safety...' (HIW 2018, page 3.) Although Dinas was not a designated ward for care of the older person with mental health needs service users and advocates told the Ockenden team throughout this review that it was often used to provide care and treatment for elderly people when Tegid ward in the Ablett unit was full.

HIW (2018) expressed its concern that 'some of the issues that we found during this inspection were also present during our last visit in June 2014, despite the Health Board developing a clear action plan⁵⁸ in response to that visit stating that these issues would be resolved.' (HIW 2018, page 3.) The external BCUHB response to the report is found within the link below as covered on BBC news⁵⁹ Whilst the headline that the Tawel Fan ward was to be possibly 'demolished' was extensively covered on the BBC Wales news there was little acknowledgement from BCUHB regarding the key issue that they had, (following a 2014 HIW inspection) developed an action plan that stated concerns raised in 2014 would be resolved. Three and a half years later HIW found this not to be the case.

The June 2017 joint HIW/WAO 'An Overview of Governance Arrangements' report concerning BCUHB stated that 'much effort and importance has been placed on ensuring that the

54 <http://www.bbc.co.uk/news/av/uk-wales-32939961/glan-clwyd-hospital-care-inspectorate-sorry-for-failings>

55 <http://www.senedd.assembly.wales/documents/s25533/Key%20conclusion%20and%20recommendation%20-%20March%202014.pdf>

56 http://www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Board_Item_5.1a_Independent%20Review%20of%20HIW_Appendix%201_EXECUTIVE%20SUMMARY.pdf

57 <http://hiw.org.uk/docs/hiw/inspectionreports/180222abletten.pdf>

58 <https://gov.wales/docs/hiw/inspectionreports/Ablett%20Unit%20-%20Inspection%20-%20June%202014%20-%20Letter%20-%20Management%20Letter.pdf>

59 <http://www.bbc.co.uk/news/uk-wales-north-east-wales-43789383>

inspectorate's reports are responded to in a timely and substantial way, with regular papers to the QSE Committee tracking progress against recommendations.' (HIW 2017, page 24.) This was clearly not the case as regards the 2014 visit to the Ablett unit

Recommendation 10:

- a) BCUHB needs to undertake a review of all external reviews (including those by HIW, the NHS Delivery Unit and others) where any findings, recommendations and requirement may have concerned older people and specifically the care of older people with mental health concerns. As a result of the November 2017 HIW inspection of the Ablett unit where assurances were given of actions to be taken more than three years earlier and this did not occur the BCUHB Board need to assure itself that there are no other 'legacy issues' remaining that could be causing a continued risk to patients as is set out in the above report.
- b) The exercise needs to be completed across all Divisions and all sites by the end of the second quarter 2018/2019, (the end of September 2018) and reported to the BCUHB Board by November 2018.
- c) As a result of the evidence presented within the Ockenden governance review that BCUHB repeatedly failed to deliver in a timely way upon multiple HIW recommendations concerning care of older people and care of older people with mental health needs Welsh Government should undertake and publish a review of progress against the Marks report (2014). Marks noted in 2014 that her report 'proposed a package of reforms and if implemented [Marks believed] they would place HIW at the cutting edge of healthcare regulation and inspection.' (Executive summary of Marks 2014, page 4.) Three and a half years of the three to five years Marks suggested would be required to meet the recommendations has passed since the publication of the Marks (2014) report. (Marks 2014, page 5.) The Ockenden governance review team believes it would be in the public interest (and the public would be interested) to understand the progress HIW has made to date against recommendations made with a three to five year timespan.
- d) The Ockenden governance review wishes to emphasise that there is no suggestion within the above recommendation to Welsh Government that HIW are not meeting the standards currently required of them.
- e) Marks (2014) considers that HIW can continue to develop along the lines of its counterpart in Scotland⁶⁰ (Marks 2014, page 17) The Ockenden review also considers that the model of regulation of healthcare in England by the Care Quality Commission⁶¹ should be further considered. The greater clarity obtained from the CQC around whether a service is considered 'Outstanding', 'Good', 'Requires Improvement' or 'Inadequate' can be supportive and useful to service users, staff, individual services within an NHS Trust as well as overarching NHS Trusts. Individual staff or teams working within a service that is rated 'Good' or 'Outstanding' in an otherwise poorly performing NHS Trust can feel proud of their individual efforts to provide good care. These ratings are awarded following the asking of five standard questions –are services safe, effective, caring, responsive to people's needs and well led?

"The BCUHB Board need to assure itself that there are no other 'legacy issues' remaining that could be causing a continued risk to patients as is set out in the above report."

60 http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care.aspx

61 <http://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards>

Finding 11

13.1 The Ockenden review found a long term failure by the BCUHB Board to ensure fit for purpose estates and equipment that would facilitate the provision of a high standard of mental health and older persons mental healthcare from 2009 to the current day. This remained a concern at the end of December 2017

"It is so important around estates because if you don't look after the estates it makes people feel they don't matter and that makes the patients feel they don't matter so it's really important.."

Evidence for this finding is discussed in great depth throughout the main report and this recommendation links in with recommendation 10, although recommendation 10 has a much wider remit.

Poor quality estates including delayed repairs which include chronic estates and equipment problems since 2009 up to and including the current day within a number of inpatient mental health units and units providing care to vulnerable older people and have been described by a wide range of external reports, current BCUHB staff and carers and service user representatives.

"BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly, this should include clarity and specificity of all outstanding estates issues including outstanding repairs and estates issues raised as concerns within internal audits and external reviews and inspections."

The provision of care within poor quality buildings and estates has been stated by the Kings Fund (2004) to affect the experience of care⁶², and will affect the ability of staff to deliver high quality care and is known to affect staff attendance and morale⁶³. The information found within the main report will not be repeated here. It can be found extensively throughout the main report. One senior staff member said in interview with the Ockenden team in October 2016⁶⁴ 'It is so important around estates because if you don't look after the estates it makes people feel they don't matter and that makes the patients feel they don't matter so it's really important..' The staff member continued: 'When you see gardens overgrown, it's just not right. It's not right the staff are feeling that they have to come in and I've seen staff come in on the weekends doing the gardening so it is hard and there's a lot of demands on estates and I think that mental health would be [regarded as] quiet but I don't think we're quiet anymore. I think we're probably the noisiest now..'

13.2 Recommendation 11:

BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly, this should include clarity and specificity of all outstanding estates issues including outstanding repairs and estates issues raised as concerns within internal audits and external reviews and inspections.

This estates inventory should be prepared for each ward, clinic, department, inpatient unit and hospital department where care is provided to older people and older people with mental health issues. This includes those areas where care is provided to people with dementia.

Secondly, the estates inventory must include for each area set out above an audit based on the work of Enhancing the Healing Environment⁶⁵ It is recognised that this is a substantial piece of work across BCUHB but the systems, structures and processes underpinning this work can be set up relatively quickly as it is based on work already proven to be successful elsewhere.

62 <https://www.kingsfund.org.uk/publications/enhancing-healing-environment>

63 https://www.bpf.org.uk/sites/default/files/resources/BPF-Quality-Buildings-Quality-Care-Nov-15-web_0.pdf

64 Excerpt from interview

65 <https://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-in-dementia-care>

Further information on the EHE programme and the NHS Trusts where it has been successful associated with dementia is found in the footnote^{66 67}

Thirdly, there should be an update to the BCUHB Board at the end of quarter 2 of 2018/19, (the end of September 2018 (the end of September 2018 for all elements of this work stream including progress on outstanding maintenance and estates issues,) and quarterly progress thereafter until the end of quarter 2 2019/20. To reduce the amount of time spent on getting projects off the ground BCUHB staff should be encouraged, supported and funded, (given the time) to undertake visits to NHS Trusts who have already been successful in this initiative.

"To reduce the amount of time spent on getting projects off the ground BCUHB staff should be encouraged, supported and funded, (given the time) to undertake visits to NHS Trusts who have already been successful in this initiative."

14 Finding 12

The Ockenden governance review has found a continuing lack of sustainable service development and a lack of clinical strategy development across older peoples care and care of older people with mental health (OPMH) six years after the 2012 consultation 'Healthcare in North Wales is Changing'

The 2012 consultation 'Healthcare in North Wales is Changing' is discussed in depth in the main report. The Ockenden governance review notes that multiple external reviews from 2012 onwards have highlighted to BCUHB the combined and long term challenges it still faces around the lack of a long term clinical strategy across BCUHB, not just older people, mental health provision. This means that at the current time BCUHB has a lack of a clear plan for how clinical services in North Wales should be shaped so that they are clinically and financially viable. This is set against a backdrop of

"It was described by staff and carers that there are 'specific pockets' of good practice but that almost all positive feedback from carers was obtained from individual staff making extra efforts to be 'carer inclusive.' Often these BCUHB staff were carers themselves."

- Increasing acuity of BCUHB's patients and therefore increasing clinical demand
- Long term issues with recruitment, particularly medical recruitment and a long term high reliance on agency and locum staffing
- 'Higher-than-desired service costs' (HIW 2017, page 10)

The combination of all of the above, means that concerns with the financial sustainability of the current services continue. In the documents reviewed by the Ockenden team there was little evidence seen of any integration between workforce design and workforce planning⁶⁸ and the development of a long term clinical strategy. HIW (2017) agree and say that they saw 'little evidence to indicate that workforce modelling is sufficiently informing the design of services [at BCUHB] (HIW 2017, page 17.)

"They were experiencing an 'over-saturation' of feedback to and from BCUHB with rarely seeing a 'tangible outcome.'"

14.2 Recommendation 12:

This has been and remains an urgent priority for the BCUHB Board to drive forward and one they are acutely aware of. BCUHB must continue to ensure it remains focussed on building and sustaining positive relationships with a wide range of partners going forward as this will be fundamental to success going forward.

66 The EHE programme to improve the environment of care for people with dementia was funded by the Department of Health. It involved 23 teams from acute, community and mental health NHS trusts who worked on a range of projects across the dementia care pathway and sought to make hospital environments less alienating for people with cognitive problems. Projects have demonstrated that relatively inexpensive interventions, such as changes to lighting, floor coverings and improved way-finding, can have a significant impact. Evaluation has shown that environmental improvements can have a positive effect on reducing falls, violent and aggressive behaviours, and improving staff recruitment and retention. The EHE schemes have shown that it is possible to improve the quality and outcomes of care for people with dementia as well as improve staff morale and reduce overall costs by making inexpensive changes to the environment of care.

67 <https://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia>

68 Workforce planning is getting the right number of people with the right skills employed in the right place at the right time to deliver an organisation's short- and long-term objectives. It covers a diverse range of activities, such as succession planning, flexible working, job design, and many more. Whatever its precise form, workforce planning should be linked to strategic business goals and viewed as an important part of the strategic business planning process. (CIPD 2016)

15 Finding 13

13.1 The Ockenden review has found little evidence of an effective system, structure or process in place to provide consistent assessment, support and advice to carers of people with dementia across the BCUHB catchment area.

The experience of service user representatives and carers is discussed in detail in the main report. Current BCUHB staff and carers and a wide range of service user representatives all told the Ockenden governance review the same thing as regards carer support and interaction. As of the summer and autumn of 2017 carers and service user representatives were described as 'very very dissatisfied.'⁶⁹ It was described by staff and carers that there are 'specific pockets' of good practice but that almost all positive feedback from carers was obtained from individual staff making extra efforts to be 'carer inclusive.' Often these BCUHB staff were carers themselves.

Carers told the Ockenden review of governance that they were experiencing an 'oversaturation' of feedback to and from BCUHB with rarely seeing a 'tangible outcome.' Staff, carers and service user representatives described the lack of a 'cohesive approach' to carers. Information provided to the Ockenden review from within the MHL Division described the culture within mental health towards carers as 'it's very closed doors and they're not very receptive to help or support or discussion even....' [about involvement of carers in service design and feedback]. HIW (2017) noted the following of the 'culture' within mental health at BCUHB saying 'a sustained effort will be required to ensure that a culture exists which encourages issues to be acted upon quickly and effectively.' (HIW 2017 page 23.)

The Ockenden review was provided with extensive evidence that the systems, structures and process of governance including the systems described as being in place for supporting carers were frequently not in place in reality. Multiple examples of this were provided. One example, (service user representative 86) submitted communication to and from themselves and BCUHB dated November 2017. This described a lengthy apology from BCUHB that includes the following:

- Acknowledgement that there were discrepancies in documentation, where it was documented that advice was given to the family at the point of diagnosis of dementia and it was not. BCUHB acknowledged that this was in line with feedback from other families/ carers.
- Referrals for support that were acknowledged by BCUHB as needing to be made were not made
- BCUHB acknowledged the lack of availability of support or activities for people with young onset dementia
- There was an acknowledgement from BCUHB of the lack of carer's assessment and lack of carers support
- BCUHB acknowledged a lack of clarity around the family's named point of contact at BCUHB
- BCUHB apologised for the lack of joined up working with social services
- BCUHB apologised for the lack of prior information and support for the family prior to attending two Mental Health Act assessment meetings. The family had no prior discussions to the purpose of the meetings

"There is currently (and has been across almost the whole time period of the Ockenden governance review) a 'perfect storm' of significant vacancies, long term high use of temporary and agency staff, (across medical and nursing positions), very recent long term absence amongst the senior leadership team, significant pressure associated with patient acuity, patient numbers and insufficient beds."

"The Ockenden review team has found little evidence of sustained Board leadership in dementia care. This should be the responsibility of every Board member, not just those Executives labelled as 'clinical.'"

"As leaders of BCUHB the Board must be able to demonstrate a significant knowledge base around dementia and this knowledge base at Board level should be framed according to the standards set by WHO, (already adopted by the Scottish Government.)"

69 Excerpt from a single staff interview but reflective of feedback from almost all service user representatives and many other staff.

15.1 Recommendation 13:

There will need to be sustained, visible (in the clinical areas), stable leadership within MHL Division over a long period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way. There is currently (and has been across almost the whole time period of the Ockenden governance review) a 'perfect storm' of significant vacancies, long term high use of temporary and agency staff, (across medical and nursing positions), very recent long term absence amongst the senior leadership team, significant pressure associated with patient acuity, patient numbers and insufficient beds. Some clinically based staff described that they believed that the senior management team within the MHL Division did not understand the pressures of providing clinical care over a prolonged period of time under such very significant pressure.

"Dementia is the only disease or condition and the only terminal illness that I know of where patients are told to go home, and give up their pre diagnosis lives, rather than to 'fight for their lives..'"
(Kate Swaffer 2014)

The cultural change that is necessary towards dementia needs to happen across BCUHB, and to happen from 'Board to ward'. This cultural change needs to happen not just within MHL Division but everywhere within BCUHB where care and treatment may be provided to persons with dementia, their families and friends.

"The voices of older people living with dementia and those who look after them need to be heard in a meaningful way..."
(United Nations 2014.)

15.2 Recommendation 14

Finally, The work of Kate Swaffer and the work of the World Health Organisation, (WHO) around a 'human rights' based approach to people living with dementia is recommended to BCUHB and it is recommended that understanding of this work should be introduced from 'ward to Board' and across all BCUHB healthcare facilities in hospital and community and into all staff orientation, training and development at BCUHB. As leaders of BCUHB the Board must be able to demonstrate a significant knowledge base around dementia and this knowledge base at Board level should be framed according to the standards set by WHO, (already adopted by the Scottish Government.)

"There needs to be a visible and accessible Board lead for dementia at BCUHB. Previous 'Champion' roles at BCUHB have not been completely successful because they are often not known to service users and front line staff. The BCUHB Board now has an opportunity to make a real difference and should seize this opportunity to do so."

Swaffer (2014) has developed a term called 'Prescribed Dis-engagement'⁷⁰ and describes her own experience, having been newly diagnosed with dementia being told to 'give up' a pre diagnosis life 'and put all the planning in place for the demise of herself as a person newly diagnosed with dementia. Swaffer describes being told 'to give up work, give up study, and to go home and live for the time I had left....' She says 'Dementia is the only disease or condition and the only terminal illness that I know of where patients are told to go home, and give up their pre diagnosis lives, rather than to 'fight for their lives..' (Swaffer 2014, page 1.) Swaffer states that the attitude and culture amongst healthcare staff of 'Prescribed Dis-engagement' sets up for the person with dementia 'a chain reaction of defeat and fear, which negatively impacts a person's ability to be positive, resilient and proactive....' This resilience, positivity and a proactive approach to living with dementia is crucial following a diagnosis of dementia.

The WHO⁷¹ describe the need for a human rights based approach to people living with dementia. The WHO approach known as PANEL (Participation, Accountability, Non-discrimination, Empowerment and Legality) has been endorsed by the United Nations and adopted by the Scottish Government. The approach states that 'The voices of older people living with dementia and those who look after them need to be heard in a meaningful way...' (United Nations 2014.)

The work of Swaffer and the WHO/ United Nations should be introduced to the Board in a Board seminar/ Development day in the second quarter of 2018-19 and a programme of introduction to the whole of BCUHB should commence in the third quarter of 2018- 19 with reports to the Board on the introduction and and utilisation of 'Prescribed Disengagement' and the WHO 'PANEL' approach across BCUHB every quarter.

70 TM <http://journals.sagepub.com/doi/pdf/10.1177/1471301214548136>

71 http://www.who.int/mental_health/neurology/dementia/en/

In conclusion, the Ockenden review of governance has found that the systems, structures and processes of governance, management and leadership introduced by the BCUHB Board from 2009 were wholly inappropriate and significantly flawed from their inception.

The significant flaws were alerted to the BCUHB Board both internally - by a number of Independent Members and externally by multiple external reviews before action began to be taken. Where progress has been made it has been far too slow. Since the birth of BCUHB the Board has failed to assure itself of a clear, consistent and effective line of sight from 'ward' to 'Board' with significant and deeply concerning consequences for its patients, their carers and many of its frontline staff.