MENTAL HEALTH AND LEARNING DISABILITIES COMMITTEE
Thursday 11th April 2019, 2:00pm
in the Executive Meeting Room,
Aneurin Bevan University Health Board Headquarters,
St Cadoc's Hospital

AGENDA

1	**Preliminary Matters**				**2:00**
	1.1	**Welcome and Introductions**	Verbal	**Chair**	**5 mins**
	1.2	**Apologies for Absence**	Verbal	**Chair**	
	1.3	**Declarations of Interest**	Verbal	**Chair**	
	1.4	**Minutes of the Meeting held on 7th February 2019**	Attachment	**Chair**	**10 mins**
	1.5	**Action Log of Meeting held on 7th February 2019**	Attachment	**Chair**	
2	**Governance Matters**				**2:15**
	2.1	**Tawel Fan Task and Finish Group Report**	Attachment	**Lin Slater/ Ana Llewellyn**	**20 mins**
3	**Agenda Items**				**2:35**
	3.1	**Performance:** • **Performance Report for Primary Care and Mental Health Measure**	Attachment	**Ian Thomas**	**15mins**
	3.2	**Mental Health Act Managers Update**	Verbal	**Katija Dew**	**5 mins**
	3.3	**Key Risks and Issues**	Attachment	**Ian Thomas**	**15 mins**
	3.4	**Benchmarking**	Verbal	**Nick Wood**	**15 mins**
4	**Final Matters/For Information**				**3:25**
	4.1	**Items for Board Consideration** To agree agenda items for Board consideration and discussion	Verbal	**Chair**	
	4.2	**CMHT Review**	Attachment	**Dr Chris O'Connor**	
5	**Date of Next Meeting**				
Thursday 13th June 2019, 2:00pm in the Executive Meeting Room, ABUHB Headquarters, St Cadoc's Hospital					**Chair**

Mental Health & Learning Disabilities Committee
Thursday 11 April 2019
Agenda Item: 1.4

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Mental Health and Learning Disabilities Committee held on Thursday 7 February 2019 at 3:00pm in Conference Rooms 1 & 2, Headquarters St Cadoc's Hospital, Caerleon

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Present:

Frances Taylor	-	Independent Member (Chair)
Katija Dew	-	Independent Member

In Attendance:

Dr Chris O'Connor	-	Divisional Director for Mental Health and Learning Disabilities
Nick Wood	-	Executive Director of Primary, Community and Mental Health Services
Richard Bevan	-	Board Secretary
Ian Thomas	-	General Manager, Mental Health and Learning Disabilities
Ana Llewellyn	-	Divisional Nurse, Mental Health and
Angela Fry	-	Head of Service Planning
Claire Barry	-	Committee Secretariat

Apologies:

Emrys Elias	-	Vice Chair of the Board
Martine Price	-	Interim Director of Nursing
Cllr Richard Clark	-	Independent Member of Local Government

MH&LDC 0702/01 Welcome and Introductions
The Chair welcomed members and guests to the meeting.

MH&LDC 0702/02 Apologies for Absence
Apologies for absence were noted.

MH&LDC 0702/03 Declarations of Interest
There were no Declarations of Interest in relation to items on the Agenda

MH&LDC 0702/04 Minutes of the Meeting held on 10 October 2018
The Minutes of the meeting held on 10 October 2018 were approved as an accurate record subject to the following amendments:

MH&LD 1010/06 Update on Tawel Fan Progress and remit of QPSC/Mental Health and Learning Disabilities

The Committee agreed that the following section should be removed from the minutes "The recommendations to be looked at are:

- Safeguarding and end of life care
- The use of restrictive practice and restraint"

The Committee agreed that that the following minute should be added to replace the original paragraph. "The recommendations to be looked at are:

- Dementia Care Pathway and Service Redesign
- Care Home Provision
- Safeguarding
- Clinical Records
- Medications Management and Monitoring of Anti-Psychotic Medications
- Evidence Based Practice and Clinical Guidelines
- Legislation Frameworks and Deprivation of Liberty Safeguards
- The Management of Aggression in the Elderly and Restrictive Practice
- End of Life Care

MH&LDC 0702/05 Action Log of the Meeting held on 10 October 2018

The Committee considered the Action Sheet from the meeting held on the 10 October 2018, and noted that all actions had been completed or formed part of the forward work programme.

MH&LDC 0702/10 IMTP SCP 4

Angela Fry provided a progress update and assurance on the delivery of the work programmes within the Health Board's 2018-21 IMTP for SCP 4 – Mental Health and Learning Disabilities.

It was reported that the work programmes were broadly on track, and that two programmes would be taken off the SCP 4 for 2019:

- Learning Disabilities Residential Services Review

would be completed at the end of the year and was on track to finish at the end of quarter four, as a result this would come off the transformation programme in 2019.

- Older Adult Mental Health Service Redesign had progressed and would continue via Divisional level activity.

It was highlighted that two new work programmes would be scoped for inclusion within SCP 4. One was on Integrating Physical and Mental Health Care and one on improving Mental Health and Learning Disabilities transition pathways for the age group 15-25 year olds, both of these programmes had been described in more detail within the report that had been presented to the Committee.

The Committee discussed the issues relating to the In Patient model and recognised that further work was needed to be undertaken and noted that a programme of engagement would be developed before the model was embedded into the service. The Committee agreed that they would like a progress update on the programme of engagement at a future meeting. **ACTION: Ana Llewelyn and Angela Fry**

The Committee received the report.

Angela Fry left the meeting.

MH&LDC 0702/06 **Revised Terms of Reference**

A copy of the draft revised terms of reference was provided to the Committee for comment and discussion.

The Committee considered the draft terms of reference of the committee, and agreed that they would provide feedback via email to Richard Bevan, Board Secretary who would then revise them into a final set of terms of reference which would be submitted to the Board for approval. **Action: Richard Bevan**

Richard Bevan left the meeting.

MH&LDC 0702/07 Update on Tawel Fan Task and Finish Group

Ana Llewellyn provided a brief update on the Tawel Fan Task and Finish Group.

It was highlighted to the Committee that Bronagh Scott, Director of Nursing and Executive Lead for the Tawel Fan Task and Finish Group had left the Health Board and Martine Price had replaced her as the Interim Director of Nursing and Executive Lead for this group.

It was reported that all the information provided through the groups SBARs had been reviewed and no other issues had arisen. It was recognised that a lot of work was being done in relation to all of the recommendations, and a copy of the full report when finalised would be provided at the next Committee meeting and then would also be presented at the Quality and Patient Safety Committee meeting.
Action: Martine Price

The Chair commented that although the Committee acknowledged all of the work that was being done to improve ways of working. However, in the absence of a full report, the Committee was not in the position to give the Board assurance at this time on progress against recommendations. The Board will receive a full report meeting in March but this will not have been considered by MHLD.

MH&LDC 0702/08 Performance

Performance Report for Primary Care and Mental Health Measures

Ian Thomas provided a report on the performance against key Mental Health and Learning Disabilities targets.

It was reported that it had been a significant challenge to maintain the Primary Care Intervention targets month to month because of the nature of services that are delivered in many practices, and even though it was predicted that the target would be missed as of December and January, the Division had overall hit the targets.

It was highlighted that CAMHS had a target to see 80% of patients for routine assessments by Specialist CAMHS within 28 days of referral, and this target was consistently being met. It was reported that as at 31 December 2018, there were no patients waiting for routine assessments.

It was noted that in Psychological Therapies an investment of three quarters of a million pounds had been received to improve performance against the referral to treatment target. A meeting was due to take place on 14 February 2019 to develop a plan of actions and agree trajectories and improvements.

The Committee received the report.

Mental Health Act Report

The report provided the Committee with an update on the use of the Mental Health Act within the Division.

It was noted that the report was based on the historic annual reports and focused on detentions, and at a very high level to provide assurance that the Division was detaining people lawfully.

The Committee discussed the key issues that had been highlighted in the report and agreed that going forward further discussions were needed with the Chair of Mental Health and Learning Disabilities Committee to ascertain what was required to go into the report.

The committee discussed the Mental Health Act and concluded that all Board members and in particular Mental Health and Learning Disabilities members would benefit from training on the Act and their statutory responsibilities. **ACTION: Richard Bevan/Ana Llewellyn**

MH&LDC 0702/09 Mental Health Act Managers Update

Katija Dew provided a brief account on Mental Health Managers Update.

It was reported at the last Committee meeting that an advert had gone out to recruit into the service and 3 applications had been received. It was confirmed that all 3 applicants had been appointed and would

commence their work subject to the formalities being successfully completed.

MH&LDC 0702/11 Key Risks and Issues

Ian Thomas provided a report on the current highest level risks and issues identified by the MH&LD Division and CAMHS Service.

It was reported that the risk profile for the Mental Health Service was a dynamic process which continued to be reviewed and revised on a regular basis within the service. The report provided the Committee with a summary of the high level risks, concerns and issues that had emerged since the last reporting period.

It was noted that prioritisation of the Health Board's discretionary capital was linked to the risk rating and the risks on the current risk register were related to the capital and estates. Since the last meeting it was reported that a significant amount of capital investment had been received enabling works to be completed. These are as follows:

- A&T Unit flooring risk removed from the register following completion of refurbished unit.
- Contaminated flooring risk at Ty Siriol removed following re-flooring work.
- Talygarn Staff Alarm System had been replaced, even though the risk remains on the register pending completion of the audit on all other inpatient facilities.
- PICU scheme completed, so risk related to reduced PICU capacity over construction period had been closed.
- An additional allocation of £180,000 had been provided to deal with HIW inspection estates priorities picked up during recent visits. A number of these would remain on the register until all work had been completed.

The committee noted that the division was carrying a number of risks – principally linked to estate. It was agreed that these might be reconsidered, to enable the most pressing risks – to present as such. The Committee also noted that ligature risk was a significant priority. However, in terms of ligature risk the Board will always carry a level of risk which is very difficult to mitigate and we need to be proportionate in

our response. We also need to support and reassure our staff working in difficult and volatile environments. It was agreed that the Division would check that risks were balanced and are in line with priorities. **ACTION: Nick Wood/Ian Thomas**

The Committee received the report, noting the issues around the time it was taking for works to be carried out by Works and Estates and felt that this was needed to be brought to the attention of the Board.

MH&LDC 0702/12 National Benchmarking

This item had been deferred to the next Committee meeting. **Action: Secretariat**

MH&LDC 0702/13 Items for Board Consideration

- Ligature Risk
- Minor Works and Estates

MH&LDC 1010/14 Date and Time of Next meeting

The next meeting of the Mental Health and Learning Disabilities Committee will be held on Thursday 11 April 2019 at 2.00pm in the Executive Meeting Room, ABUHB Headquarters, St Cadoc's Hospital.

Mental Health and Learning Disabilities Committee
Thursday 11 April 2019
Agenda Item: 1.5

Mental Health and Learning Disabilities Committee
Action Log – 7 February 2019

(The Action Sheet also includes actions agreed at previous meetings of the Mental Health and Learning Disabilities Committee which are awaiting completion or are timetabled for future consideration by the Committee. These are shaded in the first section. When signed off by the Mental Health and Learning Disabilities Committee, these actions will be taken off the rolling action sheet.)

Agreed Actions – 7 February 2019

Action Reference	Action Description	Lead	Progress
MH&LDC 0702/06	**Revised Terms of Reference** It was agreed that an updated revised set of the Terms of Reference would be circulated to members of the Committee.	**Richard Bevan**	The Chair of the Health Board and Board Secretary are conducting a full review of all Committees and an updated version of the Terms of Reference will be circulated once this evaluation has been completed. This is due to be considered by the Board in May 2019.
MH&LDC 0702/07	**Update on Tawel Fan Task and Finish Group** It was agreed that a copy of the full report would be provided at the next meeting.	**Martine Price**	A paper is on the April 2019 Committee agenda.
MH&LD 0702/08	**Mental Health Act Report** It was agreed that Mental Health and Learning Disabilities member would benefit on training on the Act and their statutory responsibilities	**Richard Bevan/ Ana Llewellyn**	The awareness raising and training for Board members on their responsibilities under the Act is scheduled for May 2019.

Action Reference	Action Description	Lead	Progress
MH&LDC 0702/10	**IMTP SCP 4** It was agreed that once the programme of engagement had been developed it would reported at a future meeting.	**Angela Fry/ Ana Llewellyn**	A verbal update to be provided at the meeting.
MH&LD 0702/11	**Key Risks and Issues** It was agreed that the Division would check that risks were balanced and are in line with priorities.	**Nick Wood/ Ian Thomas**	This has been completed in readiness for the submission of the risk report to the April Committee.
MH&LD 0702/12	**National Benchmarking** This item had been deferred to the next Committee meeting	**Secretariat**	This item is on April's agenda.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Mental Health and Learning Disabilities Committee 11th April 2019 Agenda Item: 2.1

2.1

Aneurin Bevan University Health Board

Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: A lesson for learning

Executive Summary			
To provide the Mental Health and Learning Disability Committee with the findings and recommendations for Betsi Cadwaladr University Health Board made in the Independent Report and to consider the implications of these recommendations for the care and services provided by Aneurin Board University Health Board.			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	✓		
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Martine Price – Interim Executive Director of Nursing			
Report Author: Lin Slater – Deputy Director of Nursing			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board**	**Mental Health and Learning Disabilities**
Date of the Report: 22nd March 2019			
Supplementary Papers Attached:	Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: A lesson for learning. HASCAS.		

Introduction

An independent investigation by the Health and Social Care Advisory Service (HASCAS) into the care and treatment provided on Tawel Fan Ward in BCUHB: A Lessons for Learning, was published on 3rd May 2018. The report was commissioned by BCUHB in August 2015 to examine specific concerns raised by 23 families about the care and treatment of their relatives between January 2007 and December 2013. As well as investigating the specific concerns raised by the 23 families the investigation team was asked to examine the archives developed during prior investigations and reports including - The Ockendon external investigation (conducted in 2014 and published in May 2015); The North Wales Police Investigation (2014-2015) and the Betsi Cadwaladr mortality review (2015). Consequently an additional 85 patients were added to the investigation. The HASCAS panel examined the care pathways and the care and treatment received by the patients in the investigation cohort in order to identify the lessons for learning.

This paper outlines Aneurin Bevan University Health Board's (ABUHB) self-assessment against the key findings of the investigation and the actions required to provide assurance

to the Board and the Gwent population that the lessons from the Tawel Fan investigation have and will be used to improve the services delivered now and in the future.
The findings and recommendations identified in the Tawel Fan investigation report have been discussed at a number of fora across the Health Board. Actions, interventions and proposed additional work to be undertaken have been discussed at the Board's Cross Divisional Nursing Group meeting on 4th July 2018, the Executive Team meeting on Monday 9th July 2018, a special joint briefing meeting of members of the Health Board's Quality & Patient Safety (QPSC) Committee and Mental Health & Learning Disabilities (MHLD) Committee on 12th July 2018, the Health Board's Safeguarding Committee on 17th July 2018 and the Quality and patient Safety Committee on 25 July 2018. At this latter meeting it was agreed that, for the future, the MH&LD Committee will provide overview and assurance that the lessons learned are being reviewed and appropriate actions implemented. Subsequently an update was provided to the MH&LD Committee in relation to MH&LD services in February 2019. The report was also considered at a meeting of the Gwent wide Adult Safeguarding Board on September 4th 2018 in order to seek assurances with regard to the multiagency arrangements for safeguarding.

ABUHB welcomes the report, the lessons identified and the recommendations made to BCUHB and will use them to guide and evaluate care and services in ABUHB.

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

The Greater Gwent Health and Social Care and Well-being Partnership Board is a key partnership body; established to lead and guide on the implementation of the Social services and Wellbeing (Wales) Act 2014 in the greater Gwent area. The provision of coordinated, person centred care, treatment and support is a key long term priority for the Board. Significant work has been undertaken to establish a robust governance framework to direct work and translate it into effective operational delivery at a locality level. The governance model provides shared leadership and ensures that the Area Plan is appropriately aligned with both local authority and Health Board corporate planning and the well-being objectives of the Public Service Board Plans. Five strategic hubs include a Mental Health and Learning Disability Strategic Partnership and the Adult Strategic Partnership, with a regional Dementia Board.

Aneurin Bevan University Health Board hosts and Chairs the regional Dementia Board. This provides opportunities for the statutory partners, the third sector, service users and carers to work together to improve services across the region of Gwent. A regional Dementia Strategy was launched in May 2018, to support the implementation of the Welsh Government's Strategy for Dementia. A detailed action plan is in development and this includes the requirement for a clear dementia care pathway with consistency in provision of services across the region. As part of this ongoing work, via ICF Dementia Funding, the Gwent Regional Partnership Board commissioned an independent review to map existing Dementia service provision on a regional footprint across all sectors. This work has highlighted best practice examples and provided a whole system view of dementia care services. This was completed in March 2019 and considered at the Dementia Board on 19th March 2019. This is now being used to co-ordinate, plan and develop services across the region.

Recommendation Two:	**Dementia Strategy**

BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with Recommendation One. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the Mental Health Directorate) in all care and treatment settings (community, primary and secondary care).The action plan should take into account all of the clinical and practice deficits that have been highlighted by this Investigation and will require independent clinical input and oversight.

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

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

As previously noted, the Gwent Regional Dementia Strategy was launched in May 2018. Further development of the Action Plan is taking place following the completion of an independent review and mapping of dementia service provision across the region.
ABUHB as a key partner in delivering the strategy reporting on progress to the Dementia Board. Work includes the following areas:

ABUHB Hospitals Dementia Group

This group, originally established to focus on improving care of patients with dementia in general hospitals has been expanded to support care and services throughout all areas. The programme of work includes:

- Improvement in delirium intervention in General Hospitals
- Improvement in the collection of personal patient Information for people with dementia and use to provide care and care conversations across the dementia pathway.
- Ensuring person centred decision making and discharge planning
- Implementation of workforce training strategy and development of skilled practice
- Ensuring environments in care settings are dementia friendly environments.
- Improvement in individual and organisational understanding of clinical outcomes following admission for hospital care

MHLD Division

From a MHLD perspective, the older adult re-design has considered the needs of older adults with mental health needs and their carers and the re-investment in community provision is intended to address the gaps in service provision across Gwent.

The Memory Assessment Team Pathway review is nearly complete with the outcome being one common pathway across all boroughs. This includes mechanisms for measuring the outcomes of interventions provided from this service within the value based health care remit.

Dementia Assessment Wards and Older Adult Functional Wards have completed self-assessment against standards detailed in the QNOAMHS (RPSYCH 2017). This will be repeated annually. A revised Standard Operating Procedure has been implemented.

OAPL (Older Adult Psychiatric Liaison, Formerly RAID) Services are in place with the recent addition of the Flexible Hospital Response Team as part of OAPL to provide a modelling approach to providing personal care, clear communication and engagement and occupation to older adults who demonstrate challenging behaviour due to cognitive issues. This service is currently under review with cross divisional consultation to identify the best use of this resource.

Cross Divisional Pathway Development

A Primary Care and Community Division/MHLD Division workshop identified mechanisms for improved cross divisional working and has established the following workstreams to progress:

- A more integrated approach to In Reach to Care Homes
- Further embedding Older Adult Mental Health expertise and Memory Assessment Services within primary care/integrated community hubs

- Meeting the holistic physical and mental health needs of those in community hospitals and older adults mental health wards via enhanced MDT working
- Enabling the Road to Well-being programme to more accessible for older people

Primary Care and Community Division

The training currently being delivered by the Professional Development teams (PDT) in care homes will promote inclusivity for older adults within the independent sector. Previous work was confined to nursing homes, however since April 2017, residential homes have been afforded equal access to training.

It is recognised that some older people living with dementia in care homes may have limited or fluctuating capacity, therefore the training currently being delivered by the PDT is encouraging the care home workforce to urgently facilitate advance care plans (ACP) for their residents to promote choice and dignity regarding current and future care needs, especially at end of life.

For those adults living with dementia who no longer have capacity, the team are advocating that the homes convene MDT meetings to prepare a record of best interest decision.

Raising awareness with stakeholders such as Local authorities, Social services, Neighbourhood Care Networks and District Nursing Teams will ensure that the older adult living with dementia in the care homes have additional support with regards to Advance Care Planning (ACP).

In addition in meeting the regional plans the MHLD Division's re-design of OAMH services has enabled re-investment in therapy and non-medical interventions.

This has allowed for funding to be released for re-investment in therapy and non-medical interventions. A therapies review is underway with MHLD and Therapies Division mapping current therapy provision against best practice guidelines. The expected outcome will be the development of a new model for provision of therapies.

Development and implementation of Dementia Care Mapping (DCM) Strategy is underway. 27 additional mappers were trained in June 2018. A strategy is being developed to steer the implementation of DCM into care pathways.

Person Centred Care in Dementia Training has been developed and established as mandatory for all staff working in on OAMH Inpatient Dementia Assessment Wards. The target is that 85% of staff will have received this by April 2019. This training is to the informed level of the good work framework.

Dementia, Delirium and Depression training is being provided across Acute and Community Hospitals. This is an ongoing proves and a responsibility of OAPL Services.

The Dementia Co-ordinator role is being reviewed and reinvigorated to further focus on training and development of staff within OAMH, across the wider Health Board and with partner organisations.

Roles within all OAMH Teams are to be mapped against the good work framework. This will make clear the expectation in terms of level of training in dementia across all teams.

Review of clinical environments takes places quarterly for all wards as part of the HEB process. This identifies deficits with fixtures and fittings.

QNOAMHS Self-Assessment has identified deficits in environmental standards which are being addressed. This is through rearrangement of wards where possible and capital funds where necessary. Inability to provide single sex accommodation on one of our wards has been identified but mitigations are in place to manage patient privacy and dignity.

A MH and LD estates strategy is under development to ensure that future decisions are aligned to a vision of fit for purpose OAMH inpatient wards.

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

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

In nursing homes across the ABUHB footprint where NHS Continuing HealthCare is commissioned, the development of services is included within the Dementia Strategy.

A common contract has been developed for commissioned NHS care as requirement of Social Services Well Being Act (2104) Part 9. This will lead to the development of integrating contract monitoring between statutory organisations overtime.

In addition to the established communication mechanisms with individual and collective care homes, a Care Home Governance Group is in place within the Health Board which brings together service integration from Complex Care, Mental Health and Primary Care. This supports a programme of work that includes:

- The development of in reach service.
- A care home collaborative to reduce pressure damage.
- The development of person centred care alternatives to the prescribing of anti-psychotics in care homes. This involves developing evidenced based research and funding opportunities as alternatives to prescribing anti-psychotic medication. This work stream includes partners from OAMH, Complex Care and Allied health professionals, therapies and supported by research partners Cardiff University. This bid was successful against the Dementia Action plan and will commence in a home in Newport from 1st April 2019 with completion November 2019.
- Work is ongoing in providing support to Care Homes (Nursing), in developing the skills, knowledge and competencies of their carer workforce through schemes of delegation by the Registered Nurses in the homes.

In addition to the above work, in 2011 the Divisional Nurse set up a "Matron's Forum" where nursing home managers could network and discuss any learning and good practice. Over the years this forum has gone from strength to strength and is used to provide CPD and important updates for Nursing home mangers. The Divisional Nurse/Associate Director of Nursing for Primary care & Community Division, The Deputy Divisional nurse for Complex Care, and the Senior Nurse for Integration and Professional Development work together to co-produce a forum that is supportive and informative. Within recent months the forum has been re-named as the care Home professional development Forum,

Residential Home managers are now invited to sessions that may provide information or updates relevant to their practice.
The Professional development Team are providing training and support to residential home staff as well as Nursing home staff and work with the Complex care team to ensure care homes receive the most appropriate support and development to ensure that their staff have the knowledge and skills to care for the older adults in their care.

Recommendation Four:	**Safeguarding Training**

BCUHB will revise its safeguarding training programme to ensure it is up-to date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance.

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

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

The Health Board safeguarding committee provides oversight in respect of safeguarding training. A multi-media programme of training is available to staff and the ABUHB safeguarding team continues to support the delivery of face-to-face training through the Safeguarding Boards. The overall training rate for adult safeguarding, reported in January 2019 was 64% and the Health Board therefore recognises that the numbers of staff accessing training requires improvement. The monthly workforce dashboards will be revised to include the disaggregated reporting of compliance with safeguarding training and this is now a standing agenda item for the Safeguarding Committee.

The Intercollegiate Competency Document (ICD) for Safeguarding (Adults & Children) has recently been agreed and the Health Boards Safeguarding Training Strategy will be updated to reflect this new guidance.

Recommendation Five:	**Safeguarding Informatics and Documentation**

BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 are implemented – namely:

- The use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity.
- Process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance.
- Team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.

In addition BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided.

This to include specific guidance on:

- The content of protection plans.
- The recording of strategy meetings and all decisions taken (guidance should require a standardised approach across all BCUHB clinical divisions).
- Formal monitoring and review templates should be developed and audited to ensure safeguarding timescales are met and those with key responsibilities in this regard held to account.
- BCUHB will repeat the audit within 12 months of the publication of this report to ensure that all clinical areas are compliant.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

Within ABUHB DATIX is used to record all safeguarding matters including referrals. This has been updated to ensure that the fields available support recording. The Safeguarding Team has access to all safeguarding referrals and provide some monitoring of use.

Monthly reports of open safeguarding concerns are provided to each of the Divisions by the Safeguarding Team to support their management and to trigger timely updates. To support staff in managing historical allegations the Head of Safeguarding meets with service leads to review open cases.

MHLD have taken part in an All Wales audit of the Safeguarding Children Standards for Adult Mental Health. Positive findings have been reported at the Safeguarding Committee. Safeguarding referrals are agendered at the bi-weekly Safeguarding Panel within Mental Health and Learning Disabilities Division.

Divisional Designated Lead Managers (DLMs) responsible for investigation safeguarding referrals receive training on management. The corporate safeguarding team will ensure that training is available at least twice a year with sessions planned for May and October 2019.

Safeguarding Committee has recently approved the use of 7 minute briefings to share learning and good practice.

Recommendation Six:	Safeguarding Policy and Procedure

The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This Investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report.

The actions are:

- "To identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners;
- Agree a priority list and activity timeframe to review documents within the parameters of Corporate Safeguarding;
- Provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy and legislative safeguarding frameworks;
- Agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;
- Update and maintain the Safeguarding Policy webpage;
- Continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards".

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned
The national safeguarding procedures are currently being revised through a national task group of which the ABUHB Head of Safeguarding is a member. Publication is expected for the end of 2019. Within Gwent consideration is being given to the adoption of a threshold criteria to support a more consistent approach. The Head of Safeguarding for ABUHB is also a member of the Gwent Safeguarding Boards Policy and Protocol sub group. An internal audit of safeguarding practice undertaken by NHS Wales Shared Service Partnership in 2017 provided reasonable assurance in safeguarding policies within ABUHB.

Recommendation Seven:	The Tracking of Adults at Risk across North Wales
BCUHB will work with multi-agency partners, through the North Wales Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
The Independent Investigation of Tawel Fan and the recommendations made have been considered at a meeting of the Gwent Wide Adult Safeguarding Board. The Corporate Safeguarding Team hold a database of all Duty to Reports made concerning the Health Board. They can report prevalence by Division and ward. The Continuing Health Care Team also hold a database of all safeguarding referrals made in regard to individual nursing care homes. The individual Leads within the Divisions are expected to scrutinise safeguarding data to determine whether or not there are any patterns in referrals or concerns.	

Recommendation Eight:	Evaluation of Revised BCUHB Safeguarding Structures
BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
An internal audit of safeguarding practice undertaken by NHS Wales Shared Service Partnership in 2017 provided assurance in safeguarding structures within ABUHB.	

Recommendation Nine:	Clinical Records
• BCUHB needs to undertake a detailed check of the clinical records in the investigation cohort to evaluate and re-order all commingled casenotes. • BCUHB needs to ensure that none of the commingling involving living patients could have led to any inappropriate acts or omissions on the part of clinical treatment teams during any episode of care (past and present).	

• BCUHB needs to restructure and redesign its hard copy clinical records archiving and retrieval systems. This redesign needs to provide assurance in relation to the tracking of individual casenotes across north Wales together with a set of service level agreements pinpointing the timeframes required for clinical record retrieval and access.
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned
The Health Board will be transferring its MH & LD records to WCCIS in 2019-20. As part of the readiness for this the records will be reviewed to ensure their integrity. Any instances of discrepancies in clinical records integrity and tracking are reported as incidents and investigated and records are amended as part of any review. The Health Board has mandatory Information Governance training for **all staff;** this includes records management and tracking; above that which is required in the Core Skills Training Framework (CSTF).

Recommendation Ten:	**The Prescribing and Monitoring of Antipsychotic Medication**
• The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report. • BCUHB will continue to work with care homes across north Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of antipsychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit detailed in the bullet point directly above.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
Antipsychotic medication prescribing for people with dementia and alternative suitable person centred care, environmental development approaches, knowledge and skills development and governance procedures is an integrated and cross cutting issue. Work is underway to address prescribing governance, roles and protocols against CG42. Evidence was provided for the Welsh Government All Party review on antipsychotic use and prescribing across ABUHB both verbal and written. This integrated task and finish activity is supported by best practice, the expertise of OAMH, evidenced based alternative non pharmacological approaches and research partners in Cardiff University. This bid was successful against the Dementia Action plan and will commence with a multi-disciplinary/therapy approach in a home in Newport from 1st April 2019 with completion November 2019. Further examples of activity in this area include: • A workshop convened for the MHLD and Primary, Community Divisions considered areas of work that overlaps and led to the development of key priorities; anti-psychotic prescribing in care homes is one of those priorities. A task and finish group is convening to work on this. • A snapshot database of antipsychotic medication reviews for CHC patients in nursing homes is maintained by the Complex Care Team's pharmacist and has led to the creation of an antipsychotic medication data base for residents under the care of ABUHB by the OAMH directorate, this will be populated over the next year with exploration of smarter ways to import data so it is timelier and a 'living' document.	

- The re-design of OAMH services has enable the MHLD division to increase the access to specialist Mental Health care home in-reach provision. A Behavioural Support Team has been introduced aimed at supporting care home staff to develop more holistic, psychologically based care plans which reduce the reliance on pharmacological intervention to manage behaviour that challenges.

- A proposal for enhanced Pharmacy provision working across inpatient and community services has been developed by Mental Health Pharmacy Lead. A key focus of this role will be reviewing of antipsychotic medication. Bids to fund this enhanced Pharmacy provision have been submitted.

- A task and finish group is developing proposal for 'perfect world' wrap around service to care homes. The proposal is that this service will be provided to one/two care homes with measurement of impact including the use of antipsychotic medication.

- The Divisional Nurse for the Primary Care & Community Division and the Lead Nurse for Patient Engagement and Education are leading on a national piece of work to reduce loneliness and isolation. They have put together a team of dedicated ABUHB staff who are known as Ffrind i Mi. Along with many stakeholders and partner organisations and led by the Ffrind i Mi team several initiatives to support isolated and lonely individuals in our communities have been very successful. One such initiative has been intergenerational work between primary schools and care homes. One Residential home has reported that as a result of this work anti-psychotic prescribing within the home has been reduced by 100%. The aim is to share this excellent work and encourage intergenerational work in care homes on a national scale.

Recommendation Eleven:	**Evidence-Based Practice**

BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet. As part of this work:

- A risk assessment should be conducted to prioritise the work that needs to be undertaken and to establish whether there are any urgent policy revisions and alerts required to ensure patient safety is maintained.

- Work should be undertaken to review the extant clinical policies across the three BCUHB geographical regions to determine corporate ratification and fitness for purpose.

- All clinical policies should be reviewed with the specific needs of the older adult in mind. Policies should either be re-written to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified in detail, or separate clinical policies and procedures should be developed for this particular patient cohort. This work should be conducted with expert multidisciplinary inputs.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

The Corporate Team holds a comprehensive database of ABUHB policy documents including Mental Health and clinical policies. There is a flagging system which highlights any policies overdue or any due for review within the next six months. The relevant Division/Directorate is then provided with a list of policy documents which need to be reviewed in the upcoming months. The Corporate Services Manager – Policies and Procedures has close links with the Quality & Patient Safety Manager and Clinical Lead - Mental Health Act Administration regarding the review and ratification of Mental Health Policy Documents. Once documents have been ratified via the correct process (MH&LD QPS or Clinical Standards & Policy Group) these are then securely saved on the ABUHB shared drive and made accessible to all staff via the intranet. Staff throughout the organisation are notified of any new policy documents or updates via the weekly Nye's News and quarterly Policy Digest which are issued and circulated to all staff across the organisation.

MHLD division has a programme of policy review – there is an action plan and policies are ratified via divisional quality and patient safety meeting. This work plan will be assigned to the Dementia Board Divisional Action Plans for ABUHB. For example, revisions to the EQUIA in line with the Good Work dementia framework are required and scoping of policies which require adjustments related to the protected characteristics of dementia and disability.

The Head of Service/Divisional Nurse for Complex Care is a member of the National Care Home Steering Group and provides notifications and timely sharing of information relating to changes in practice or practice developments.

Recommendation Twelve:	**DoLS**
BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018 – 2019.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
Recommendation specific to BCUHB. The Health Board has undertaken an audit of patients who have the potential to be subject to Court of Protection and actions taken to support practice.	

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

Within ABUHB, MHLD clinicians are engaged in the national OAMH community of practice and MHLD restrictive practice training lead is engaged in national work to re-design Module 4 of Violence and Aggression Passport for Wales.

MHLD training has been re-designed to focus on de-escalation and is entirely consistent with current guidelines.

Use of restrictive practice is recorded as an incident on DATIX. A 6-monthly report on the use of restrictive practice is considered at MHLD QPS meeting. Use of restrictive practice is monitored on the divisional quality dashboard.

The development of Person Centred Care training and Dementia Care Mapping, as well as the development of the Behavioural Support Team to provide psychological intervention support to care homes and the Flexible Hospital Response Team to model better ways to engage those with cognitive issues on General wards also enhance the ethos of primary prevention.

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

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

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

In ABUHB Advanced Care Planning (ACP) is undertaken with patients who have life limiting diseases. This addresses important points such as preferred place of care (PPC) and preferred place of death (PPD) and makes these choices known to the clinical teams delivering care to patients. ACP also incorporates thresholds of care and DNACPR ensuring that no treatment is planned for a dying patient against their wishes.

The ACP facilitators within the Health Board have had 4000 contacts to date with Gwent residents about ACP to raise awareness of the issue and encourage the formulation of ACPs for all citizens across the Health Board area.

The Primary Care & Community Division Professional Development Team are offering Training on Advance Care Planning to all Nursing and Residential homes within the ABUHB geographical area.

Currently >70% of residents in general nursing home beds and > 37% of residents in general residential home beds have an active ACP and work is still ongoing.

However ACP is only appropriate for those adults who have capacity to make the decisions and choices regarding their current and future care including end of Life Care. For care home residents who no longer have capacity to articulate those choices and decisions, the PDT are recommending that the care homes organise an MDT meeting (including carers and family/friends) and a record of best interest (RBID) is recorded that will indicate what choices and decisions they think the individual would have made regarding their care if they were able. This should include preferred place of care and preferred place of death, setting ceilings of treatment and resus status. This should then be used to support the clinical decision maker when needed.

All care homes are being encouraged to share any ACPs and RBID with the GP Out of Hours service to ensure continuity of care and adherence to patient preferences.

Recommendation Fifteen:	End of Life Care Environments

All older adults and people with dementia have the right to the same access to quality end of life care as any other individual (of any age) with any other condition. If a person is to receive end of life care on an older person's mental health ward (and in particular an acute admission ward) the following should always be undertaken:

- A clinical risk assessment to determine the appropriateness of end of life care being provided in an older people's mental health facility – the risk assessment should take into account the levels of patient acuity and any potential conflicts that could be present;
- An assurance that out of hours medical cover can be provided if the patient's physical condition requires it;
- An assurance that equipment can be resourced with the minimum of delay and that patients are never nursed on mattresses on the floor due to a shortage of hi/low beds;
- An assurance that patients can be supervised appropriately and not left unattended due to other challenges that ward might face;
- An assessment to confirm patients can be nursed in quiet and peaceful environments and that the ward layout can accommodate this;
- An incident form should be completed if a patient receives end of life care due to a lack of appropriate alternative placements and difficulties with transport;
- Consultation with relatives who should be able to request the transfer of their loved one to a different clinical setting if they feel a mental health facility is in any way unsafe or inappropriate;

The training of all registered nursing staff (including night staff) in end of life and palliative care.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

ABUHB's Fast Track End of Life process does not discriminate in relation to adults with physical deterioration and those with mental health deterioration such as dementia who are entering their End of Life. This process enables the preferred environment of care to be commissioned and care provided by staff with the relevant skills and often supported by our local hospices.

Using ACP – The PPC/PPD is identified prior to the point of a patient becoming EoL in most cases – especially if a patient is receiving palliative care. To achieve PPC/PPD if this is home, CHC fastrack is completed to allow discharge home with a package of care (PoC). If home is not suitable, a hospice bed may be offered if available. If neither are achievable or safe and place of death is a hospital, care follows the '*Care Decisions for the Last Days of Life*' guidance in conjunction with 2015 NICE guidance '*Care of the Dying Adult'* to ensure that the wishes of the patient and those important to them are accounted for. This incorporates all of the points raised in relation to delivering clinical care in Recommendation 15.

In addition there is a rolling programme of Sage & Thyme communication training run by the Lead Nurse for Palliative Care which trains staff in communication about difficult issues at the point of EoL.

The OAMH directorate are also working collaboratively with the Alzheimer's society and Cruise in providing pre and post bereavement counselling to those with dementia and their carers.

Conclusion

Aneurin Bevan University Health Board has welcomed the opportunity to undertake this benchmarking activity against the recommendations made to Betsi Cadwaladr University Health Board. It is recognised that there has been significant activity to support improvement to care and services for this vulnerable group of patients. There is also acknowledgement that much of the improvement work requires further development to ensure that this is embedded and sustained.

This will continue to be overseen through the appropriate governance arrangements.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Reputational and quality of care risk to the Health Board in failing to address the specific needs of older people in care home settings.
Financial Assessment, including Value for Money	*Not identified in this report.*
Quality, Safety and Patient Experience Assessment	Impacts on the quality of life and care experience of older people living in care homes.
Equality and Diversity Impact Assessment (including child impact assessment)	Addresses potential inequalities of care to older people in care settings.
Health and Care Standards	Contributes to Health and Care Standards concerning: 1.1 Health promotion, protection and improvement 2.1 Managing risk and promoting Health & Safety 2.2 Falls prevention 2.5 Nutrition and hydration 2.6 Medicines management 3.1 Safe and clinically effective care 4.1 Dignified care 5.1 Timely access to care 6.1 Planning care to promote independence 6.2 Peoples rights; individual care 6.3 Listening, learning and feedback
Link to Integrated Medium Term Plan/Corporate Objectives	Particularly steps 2, 3, 5 and 6 of Dementia road map.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	This work contributes to the 5 ways of working in terms of longer term planning, integration of services, involvement of patients and public, collaboration between partners and the prevention of ill health and promotion of well-being.
Glossary of New Terms	Terms explained
Public Interest	Paper can be shared.

2.1

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

Executive Summary

This report was commissioned by
Betsi Cadwaladr University Health Board

May 2018

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

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Contents

1 Preface

1.1 The Independent Investigation into the care and treatment provided on Tawel Fan ward was commissioned formally by Betsi Cadwaladr University Health Board (BCUHB/the Health Board) in August 2015 pursuant to the Welsh Government (Version 3 – November 2013) *Putting Things Right: Guidance on Dealing with Concerns about the NHS from 1 April 2013.* The Investigation was commissioned initially to examine specific concerns raised by some 23 families about the care and treatment received by their loved ones between January 2007 and December 2013. At this time the 23 families were held on the BCUHB open concerns register. In order to identify any other patients whose care and treatment might have fallen below an acceptable standard the Investigation was also asked to examine the archives developed during the following prior processes:

1 The Ockenden external investigation (conducted in 2014 and published in May 2015).

2 The North Wales Police investigation (2014-2015).

3 The Betsi Cadwaladr Mortality Review (2015).

1.2 Consequently additional patients were added to the Investigation Cohort which rose to 108 in number. Separate confidential reports have been prepared detailing the findings in relation to each case.

1.3 The Investigation was also commissioned to provide human resource management reports for any person employed by the Health Board identified with either conduct or competency issues in relation to any established untoward events or substandard practice on Tawel Fan ward.

1.4 The care pathways followed, and care and treatment received, by the patients in the Investigation Cohort have been examined closely in order to identify the lessons for learning. It is a matter of public interest to understand exactly what occurred on Tawel Fan ward, how expressed concerns were escalated and managed, and to establish the lessons for learning relevant to both local and national service provision.

1.5 Investigations of this kind should aim to increase public confidence in statutory health service providers and to promote organisational competence. It is the duty of any Independent Investigation Panel to conduct its work in an impartial and objective manner. This Investigation has endeavoured to maintain an independent and evidence-based stance throughout the course of its work with the aim of providing as accurate account of events as the available evidence allows.

2 Acknowledgements

Patients, Families and Friends

2.1 The Investigation Panel would like to extend its sincere thanks to the patients, families and friends who have contributed to this work. For some individuals the process has been a demanding one whereby challenging and difficult experiences have had to be relived.

2.2 The Investigation Panel has heard, and taken into account, a wide variety of views and concerns. There has been no unified set of experiences put forward; family accounts differ greatly. For example: some families stated that in their view Tawel Fan ward was an abusive environment where their loved ones were mistreated, neglected and came to harm. Other families offered the view that the care and treatment their loved ones received was of a very good standard with staff showing kindness and compassion throughout their relative's entire episode of care.

2.3 The Investigation Panel acknowledges the lived experience of every person who has come forward and has endeavoured to provide a fair and balanced view based on an independent analysis of events.

2.4 It should be recognised that each individual who came forward to the Investigation, either in writing or in person, gave a significant amount of their time to the process. We are grateful to them for this.

Witnesses

2.5 Independent Investigations commissioned via NHS frameworks do not have the statutory powers to compel witnesses to take part in proceedings. Whilst individuals who were either employed by the NHS (or who were still active on a professional register) had a requirement to take part in the Investigation, those to whom these conditions did not apply could not be compelled to take part against their wishes. The Investigation would therefore like to thank all of those participating individuals who are currently retired or who no longer work in health related activities for coming forward voluntarily to assist with the inquiry process.

2.6 Those current NHS employees who were called to give evidence were asked to provide information about clinical and managerial practice. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Health Board's senior management team who have granted access to facilities and individuals throughout this process.

Support

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

Multi-Agency Partners and External Stakeholders

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

3 Investigation Terms of Reference

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

Terms of Reference

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

Remit

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

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

Purpose

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

(1) Complaints Management

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

(2) Professional Regulation and Employment policies and procedures

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

Escalation

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

Timescales

The Investigation will complete the work program which has been set out in 5 stages.
First Stage: August/September 2015
Second Stage: September/October 2015
Third Stage: October/November 2015
Fourth Stage: December/January 2016
Fifth Stage: January/February 2016

Reporting

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

Team and Resources

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

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

4 Summary of General Findings and Key Lessons for Learning

Investigation Context

4.1 There always have been, and probably always will be, occasions when NHS services fail to deliver against the standards that it strives to achieve. The pressures that NHS services face are reported frequently in the media together with the recognition that patient care is sometimes compromised. It is important to recognise that this state of affairs, whilst regrettable, occurs for a number of reasons as part of the ebb and flow of daily service provision within the NHS.

4.2 The Investigation Panel does not seek to be an apologist for the NHS in general, or for BCUHB or Tawel Fan ward in particular, however it would be both unrealistic and unreasonable to visit harsher tests than those deemed to be acceptable for any other NHS service currently delivering patient care under the normal day-to-day pressures that are encountered throughout the United Kingdom. It has therefore been essential for the Investigation Panel to work in a manner proportionate to the circumstances and the available evidence base.

4.3 The Investigation Panel concludes that the care and treatment provided on Tawel Fan ward was of a good overall general standard even though there were key areas identified where clinical practice and process required development and modernisation.

4.4 Nevertheless it was also identified that, on occasions, the experience of some patients and their families was compromised due to a combination of systemic failures exacerbated by significant financial restrictions, poor service design and ineffective governance arrangements. However it should be understood that these issues were not as a result of any failings in relation to Tawel Fan ward *per se* but were encountered by patients and their families across a wide range of services on the care pathway that they travelled.

4.5 These issues encompassed problems from the point of first diagnosis through to (and often past) the point of discharge from Tawel Fan ward and/or the eventual death of a patient. These issues also included the lack of dementia friendly Accident and Emergency Department inputs and the difficulties patients and families encountered on medical wards and with other BCUHB services.

4.6 Tawel Fan was the common denominator in that of the 108 patients in the Investigation Cohort 105 were admitted onto the ward for a period of time. However it is evident that many of the concerns and complaints raised by families did not relate to the ward and that a significant number of families had nothing but praise for the care and treatment their loved ones received on Tawel Fan and for the kind and compassionate care provided by members of the treating team.

4.7 This view was not shared by all of the families in the Investigation Cohort; the Investigation Panel encountered significant dissonance between the accounts provided by family members. It has been a key responsibility of the Investigation Panel to ensure that no single view or family stance took precedence over any other and that all findings and conclusions were made after extensive examination and triangulation of the evidence available. It was also the responsibility of the Investigation Panel to ensure that the focus remained upon lessons for learning rather than calls for punishment and retribution which were entirely disproportionate to the actual findings and conclusions of the multidisciplinary expert Investigation Panel.

4.8 Whilst the Investigation Panel found the care and treatment provided on Tawel Fan ward to be of a good overall general standard, there were nine key factors that served on occasions to compromise the quality of the patient and family experience during the period of time under investigation. These factors are set out below and apply to the experience of the older adult (and their families) across the whole care pathway encountered including Accident and Emergency Departments, medical wards, old age psychiatry and community-based care.

Summary of General Findings

Factors Impacting upon Patient Care

4.9 **Governance.** During the period of time under investigation governance processes (both corporate and clinical) were weak across the whole of the BCUHB provision; this served to disrupt strategy development and implementation. This also served to prevent a robust approach from being taken in relation to patient safety in that evidenced-based practice and organisational learning were under-developed and could not always be relied upon to provide the levels of protection that were required.

4.10 Clinical governance provides the means to ensure patient safety and quality improvement; its effectiveness (or lack of it) has a direct impact on service delivery. In the most basic of terms the care and treatment delivered by BCUHB services was often compromised by:

- poor quality clinical policies and guidelines that did not always provide an appropriate and evidence-based set of standards for practice (particularly in relation to the older adult);
- limited training and education opportunities for staff;
- an ineffective approach to patient safety alerts such as those raised by complaints, incidents and safeguarding referrals;
- inadequate levels of capacity and capability in relation to the workforce in general and medical and nurse staffing in particular;
- ineffective clinical information systems which compromised access to individual patient information in a timely manner.

4.11 **The Care Pathway.** Most of the patients in the Investigation Cohort experienced problems with the care pathway that they encountered. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.22 **Carer and Family Support.** During the period under investigation the levels of advice, supportive coordination, counselling and education provided to patients and their families were of an inconsistent standard at the point of first diagnosis. For many patients and their families this served to create confusion throughout the dementia journey that they embarked upon.

4.23 Consequently patients and their families were not always able to plan for the future in an informed manner and on occasions this compromised the levels of trust and confidence they had in NHS services and also compromised their ability to make decisions and be effective co-partners in care and treatment planning.

4.24 **The Clinical Record and Professional Communication.** During the period of time under investigation BCUHB operated (and operates still) a hard-copy clinical records system. Recording templates were inconsistent and were not subject to audit. This meant that the quality of the clinical records varied enormously.

4.25 Of particular concern was the archiving and retrieval system which meant that clinical records could not always be accessed with ease by members of treating teams. This created problems with continuity and, at times, compromised the efficacy of patient care.

Key Lessons for Learning

Patient and Family Support

1 **Counselling.** There is a need for a more comprehensive and specialist range of pre and post diagnostic counselling opportunities for patients and their families. Regardless of how well members of the treating team try to communicate diagnostic information they are to some extent boundaried by their primary clinical roles and functions. It is naïve to expect individual clinicians, no matter how caring and compassionate they are, to be able to provide a consultation in a memory clinic, or a ward-based family meeting context, in *lieu* of formal counselling.

2 **Dementia Coordination and Signposting.** There is a need for the better coordination of patients and their families from the point of first diagnosis; this is in keeping with Welsh Government strategy. Continuity of care and relationship building are essential factors when working with patients and their families over a long period of time, especially as the dementia process is both challenging and progressive.

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

3 **Clarification at the Point of Admission.** When admissions take place during times of crisis it is difficult for families to understand what is happening and what they are being asked to agree to. It is important to clarify events and revisit the decisions made and the subsequent consequences once the admission is complete and the patient has been made safe. It is not good practice for misunderstandings to arise; however on occasions these will be inevitable. To minimise the likelihood of this it is important that families are provided with a clear account of events as soon as is possible and that plans for the immediate future are discussed with them moving forward.

4 **Operational Policy Synchronisation.** In order to provide a streamlined service that can meet expectations it is necessary for there to be a consistent set of criteria in place to guide the care pathway. Operational policies should be developed from an 'integrated' service perspective so that patients and their families can be signposted correctly and reliably.

5 **Living Well with Dementia.** Over recent years a more positive and community-based approach to living with Dementia has grown. Clinical services need to ensure that they are in step with this ethos and assessment and care and treatment planning needs to focus on holistic need with the aim of providing meaningful person-centred care which does not focus on disease processes alone.

6 **Education, Information and Support to Patients and their Families.** People need access to education, information and support throughout their journey with dementia. 'Frontloaded' inputs at the point of diagnosis are not enough, and neither are meetings and consultations with members of treating teams once a person has reached a point of crisis. Consideration needs to be given as to how information can be provided and tailored to each stage of the journey, particularly at key points of transition such as admission to acute inpatient wards or eventual placement in care homes. It should also be understood that family support needs will be ongoing and they should be re-assessed and provided for in a dynamic manner.

7 **Communication Practice across all NHS Services.** Patient and family communication issues were identified in relation to Accident and Emergency, medical and surgical services. There is an obvious need for all NHS services to communicate well; however a key lesson for learning is that all services should (in addition) be dementia aware and appreciate the fact that family members often have to give consent for their loved ones who are no longer able to do this for themselves.

8 **Placing the Patient at the Centre of Decision Making.** The best interests of the patient should always be at the centre of any decisions made. When there are ongoing disputes between families and treating teams these disputes should be recorded and independent advice sought. It is essential that delays to important decisions are avoided (such as admission or discharge) as these can have a negative impact on the safety and welfare of the patient.

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

Clinical Governance

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

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

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

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

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

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

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

14 **Policy Development.** Policy guidance should be tailor made to the needs of the older adult. It is poor practice to subsume them into policies produced for adults of working age whereby the evidence-base in relation to older adults is ignored and care and treatment guidance compromised as a result.

15 **Professional Leadership and Escalation.** When wards are under pressure it is essential that managers and senior clinical practitioners are available to provide advice, leadership and support. During 2013 when Tawel Fan ward was under its most significant period of pressure it was evident that the ward team were able to rely increasingly upon the Modern Matron, the Dementia Nurse Consultant and senior CPG managers. This ensured that (whilst care and treatment and service management issues arose) overarching safety was maintained whenever possible.

Legislative Frameworks

16 **Mental Capacity, Best Interests and Advocacy.** Legislative frameworks must be deployed for patients deemed to have a loss of capacity when making specific treatment decisions. This is of particular importance for those patients who are not detained under the Mental Health Act (1983). The use of independent advocates should be an integral part of any service provided.

17 **Patient-Centred Care.** It is important that care giving is flexible and sensitive enough to ensure dignity, health, wellbeing and safety whilst at the same time allowing the patient sufficient autonomy wherever possible. This applies to all patients, but is particularly relevant for those deemed to no longer have the capacity to make decisions on their own behalf. There should be no 'one size fits all approach' and care plans should take into account the needs and preferences of each individual patient which always take preference over those of families and services alike whenever appropriate to do so.

18 **Family Communications, Engagement and Support.** Legal frameworks are complicated to understand and often associated with preconceptions and stigma. It is important to ensure that each family member is acknowledged in accordance with their particular roles (Lasting Power of Attorney, nearest relative and/or next of kin) and their rights are both explained to them and supported. Strategies need to be agreed and put in place so that communication is effective (and bears in mind the needs of large families) without contravening due process in relation to decision making and confidentiality.

19 **The Need for Clarity Regarding Legal Frameworks.** NHS organisations must provide clear guidance to services about the use of the Mental Health Act (1983) and the Mental Capacity Act (2005); the guidance should clarify how they must work together and which takes precedence over the other and in what circumstances. These guidelines should be kept under review and audited where necessary on a patient-by-patient basis.

20 **The Protections that Legal Frameworks Afford to the Patient.** The Mental Health Act (1983) should not be seen as a punitive and restrictive option for the older adult with advanced dementia. Instead it should be seen as the framework under which individuals are protected and their rights upheld.

21 **The Importance of the Independent Mental Capacity Advocate (IMCA).** Under the Mental Capacity Act (2005) all patients have the right to access an IMCA. This is important when complex and difficult decisions have to be made in the patient's best interests as an independent advocate should always be accessed to ensure they are maintained and protected. When there are disputes between family members and the treating team the input from an IMCA is essential to ensure the patient's needs are paramount and that they are addressed in the best manner possible.

22 **The use of Legislative Frameworks.** Even if families are engaged in full, when difficult decisions have to be made in relation to care and treatment risk versus benefit analyses, Do Not Attempt Resuscitation (DNAR), end of life care and any planned changes to a clinical placement an Independent Mental Capacity Advocate should be involved where the patient is deemed not to have the capacity to make decisions on their own behalf.

23 **Accident and Emergency Departments and Medical Wards.** When elderly confused people are admitted to these kinds of NHS facilities the requirements of the MHA (1983) and MCA (2005) cannot be 'suspended'. They apply equally to all care and treatment environments where a patient meets the threshold for assessment and intervention under the Acts. All treatment decisions need to be recorded clearly and any issues in relation to capacity, consent and DoLS should be made explicit and managed in keeping with Acts. The failure to do so could result in illegal detention and the potential for improper care and treatment interventions.

Medication and Treatment

24 **Psychotropic Medications – Documentation and Standardised Evaluation Processes.** Psychotropic medications carry an inherent degree of risk. It is always good practice to adhere to National Institute for Health and Care Excellence (NICE) guidance and to ensure that documentation is completed in a systematic manner. This will ensure a comprehensive record is made of all decisions taken and will assist with a logical and evidence-based evaluation process. Where there are no pre-set organisational standards or clear levels of expectation clinical practice is determined by individual practitioners and might not always be optimal.

25 **Risk Assessment.** Risk assessment is a key cornerstone of clinical practice. As such it should be prioritised and conducted as a core multidisciplinary function. All aspects of clinical risk should be recorded and subsequent care plans documented clearly so that explicit rationales for clinical decision taking are set out and patients are protected.

Efficacy of the Care Pathway

26 **Resourcing.** Patients who are acutely unwell and in crisis require the highest levels of expertise and resource. It is poor practice for financial pressures to remove essential services from wards like Tawel Fan (such as occupational therapy and routine physiotherapy). The quality of the patient experience is reduced, the quality of the care and treatment compromised and the length of stay potentially lengthened. This kind of cost saving is both counter productive and ineffective. Care and treatment approaches should be multidisciplinary in nature. The older adult suffering from dementia often has a range of comorbidities and needs. It is naïve to assume these can be met by a 'traditional' doctor and nurse treating team.

27 **Transitions between Secondary and Primary Care.** The transition point between secondary care and primary care ought to be examined. Arrangements need to be agreed in relation to specialist assessment, monitoring and review once a person has been discharged back to the care of their General Practitioner. This is to ensure that antipsychotic medication is not used as a 'maintenance medication' and that all benefits and risk are kept under regular review.

28 **Access to Medical Assessment.** Psychiatric inpatients should not experience lower levels of medical assessment access than those to be expected in a community setting.

29 **Management of the Elderly Confused Patient in Acute Secondary Care.** Accident and Emergency Departments and Medical Wards must ensure that the care and treatment provided to elderly confused patients is person-centred, dignified and safe. It is not acceptable for them to be left for hours without food and drink, nursed in corridors, or left unsupervised encountering numerous falls that could be prevented with better assessment and management plans.

30 **Strategic Planning and Multiple Moves.** Service provision should be as integrated and person-centred as possible so that patients can experience smooth transitions of care which ensure optimal clinical outcomes and inspire trust and confidence. It is not acceptable for patient care to be compromised by rigid boundaries between services. It has long been recognised that multiple inpatient moves have been associated with raised rates of morbidity and mortality. It is never acceptable for multiple moves to be conducted to meet the needs of the service as opposed to the needs of the patient.

31 **Risk Assessment and Service Modernisation.** Service improvement and modernisation requires financial and service re-modelling. Improvements that require the concurrent running down of one service whilst another is built up carries inherent risks over the period required to enact the change; wards like Tawel Fan can be expected to absorb the pressures. The risks to the system and its ability to manage extant patient services should be understood and compensated for, particularly when specific groups of patients can be readily identified to be placed at additional risk during change management processes.

Safeguarding

32 **Connectivity between Multi-agency Partners.** Safeguarding frameworks require a consistent and unified approach. Despite the challenges posed by geographies (such as county and statutory agency boundaries) systems and processes have to be robust enough to provide person-centred safety measures. The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (first version 2010 and second version 2013) required small Unitary and Local Authorities to work together to ensure consistency and safety across geographical areas; it also required full cooperation between the NHS and Social Services. It is an essential lesson for learning that safeguarding systems and processes have to be managed across boundaries if they are to achieve their primary goal to safeguard adults at risk.

33 **Prioritisation and Adequate Resourcing.** Safeguarding adults at risk cannot be compromised by an organisation's perceived inability to adequately resource the systems and processes required. All NHS and Local Authority bodies are required to conduct themselves in accordance with policy guidance and any capacity and/or capability shortfalls should be addressed and managed so that their statutory duties can be fulfilled.

5 Overview of Conclusions and Recommendations

Overview of Conclusions

General Conclusions

5.1 The findings and conclusions in relation to BCUHB governance and systems failures have been identified previously by multiple review processes which have already been placed in the public domain. If an organisation operates with inadequate governance arrangements then the likelihood of poor service provision is heightened together with an increased inability to identify and remedy failings and patient safety problems. The findings and conclusions of this particular Investigation concur with those previous findings but also makes a separate and distinct contribution in relation to the following:

- the patient care pathway and service design;
- patient acuity and restrictions to service provision;
- evidence-based practice and the care and treatment of the older adult.

5.2 Any investigation process that undertakes an examination of care and treatment that took place a number of years ago has to differentiate between findings and conclusions that are 'historic' in nature and where practice has moved on and improved, and those where practice remains of a suboptimal nature and where urgent remedial action is required in the here and now.

5.3 The three points listed above have been identified by the Investigation Panel as being the basic underlying factors that made a distinct contribution to suboptimal care and treatment provision in the past and which the available evidence suggests are either still unresolved or in a relatively embryonic stage of service improvement and implementation.

The Patient Care Pathway and Service Design

5.4 One of the most significant findings of this Investigation is in relation to the fragmented care pathway followed by the majority of the patients in the Investigation Cohort; most of the patients in the Investigation Cohort experienced problems with the care pathway that they were placed on. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as those for medicine and psychiatry, often served to create significant boundaries which had a negative impact upon patients and the timely access to the care and treatment that they required.

5.5 Older adults are placed at significant risk when care pathways are not managed well. Disruptions to care pathways are known to increase the likelihood of hospital acquired infections and injuries and, on occasions, death. The poor management of the older person's care pathway across north Wales is a key finding of this Investigation. The lack of strategic direction and oversight,

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

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

Patient Acuity and Restrictions to Service Provision

5.7 The Investigation Panel established that patient acuity rose on Tawel Fan in the years prior to its closure due to:

- the reduction of care home beds;
- a relatively embryonic community-based Home Treatment Team that could not manage patients in their own homes once they had reached crisis;
- reductions to the numbers of older adult inpatient beds across the Mental Health and Learning Disability CPG.

5.8 This situation was exacerbated by additional pressures placed on mental health services by Emergency Departments, inadequate Out of Hours provision and restricted access to medical and hospice services.

5.9 It is recognised widely in Wales that the number of people with dementia is rising steadily and will continue to rise. Pressures on nursing home beds remain and there is evidence to suggest that community-based services remain under-developed and that older people with dementia still experience compromises in relation to the kinds of service they can be offered in community, primary and secondary care settings.

5.10 The challenges for BCUHB and its multi-agency partners in 2018 is to provide a range of services that do not discriminate against those individuals with dementia and to ensure that a diagnosis of dementia is not one of exclusion or compromise.

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

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

5.12 Of particular concern was the fact that clinical practice was not subject to audit in the manner prescribed within the United Kingdom for the past twenty years. This meant that clinicians were left largely to 'their own devices' and that there were no structured clinical governance structures in place to ensure patient safety.

5.13 The Investigation Panel heard evidence from many senior clinicians during the course of its work. From the testimonies provided by those witnesses it would appear that the custom and practice around the development and auditing of clinical practice guidance within BCUHB is still in a somewhat embryonic stage. Witnesses described the work as 'being part of a journey', or 'not yet having reached its destination'. This is not acceptable for a modern NHS service and will require urgent and priority actions to take place.

5.14 Part of the challenge that BCUHB needs to face is the underlying culture of resistance to clinical policy uniformity and regulation. The Investigation Panel established that a key barrier to progress being made is predominantly one of custom and practice and that there are views still retained by some senior clinicians within the organisation that the clinical decision-making process should not be overseen by formal governance and management structures. This is exacerbated by a lack of organisational confidence and ethos in relation to formal oversight and performance management as a legacy of the highly devolved and medically-led service model that prevailed for many years within BCUHB.

The Issue of Wilful and Institutional Abuse and Neglect

5.15 The nature and scale of any failures in relation to patient care on Tawel Fan ward cannot be compared to those of the Stafford Public Inquiry or the Trusted to Care Independent Investigation (conducted in Wales), on either a macro (system) or micro (individual patient) level.

5.16 Neither of those robust and universally accepted reports set their findings within the context of institutional abuse or concluded that care and treatment deficits occurred within the context of an abusive system (even though care and treatment fell well below those standards commonly accepted by the general public and statutory services alike). The Investigation Panel concludes that this approach has to be maintained in relation to the circumstances encountered by patients and their families on Tawel Fan ward, especially as the standards of care on the ward have been found to be of a good overall general standard, even though on occasions care and treatment practice across the pathway was compromised.

5.17 The Investigation Panel could not replicate the specific findings of abuse from any of the earlier investigations and reviews that did. This does not mean that the Investigation Panel can categorically state that abuse on an individual patient basis *never* took place on Tawel Fan ward; no investigation of this kind could ever make such a bold statement. However the Investigation Panel can, and does, conclude that the evidence relied upon previously was:

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

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

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

Safeguarding

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

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

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

5.23 These arrangements made it very difficult for clinical staff in the ward areas to navigate the adult safeguarding system easily. There were delays in the process of safeguarding, which often moved outside of the timescales in the policy, and ward staff who were responsible for the protection of the individual whilst they were in their care, often did not receive feedback in terms of what had been decided within the safeguarding meetings rendering ongoing protection and decisions regarding discharge, difficult.

5.24 During the period of time under Investigation there were poor safeguarding record storage and retrieval processes. This resulted in staff being unclear about what protection processes they were supposed to be putting in place and how to best deal with relatives when they were considered to be a risk to the individual in their care. As a result, information to individuals, families and carers was not conveyed clearly which led to confused expectations and understanding of what was happening.

5.25 In relation to BCUHB processes, the Investigation Panel found that adult safeguarding had not been well resourced and each CPG had been allowed to develop its own processes and structures. In addition, Board oversight was not strong and the Executive and Independent Members were not advised clearly of the problems relating to adult safeguarding in either the multi-agency partnership or specific clinical areas. Audit systems during this period of time were rudimentary, so opportunities for BCUHB to triangulate data about safeguarding referrals were lost.

5.26 At the time of writing this report there was evidence to suggest that good foundation work is taking place in relation to the restructuring and resourcing of the internal BCUHB safeguarding frameworks and processes. However a substantial amount of service development is still required in order to ensure safeguarding works to protect adults at risk across north Wales as many of the issues identified by the Investigation Panel are still a problem within current service provision. The Investigation Panel concludes that this constitutes essential and priority work for the organisation and those responsible for its performance management moving forward.

Summary of General Conclusions Specific to Clinical Care and Treatment

5.27 Many of the findings and conclusions made specifically in relation to Tawel Fan are to a large extent redundant as the ward is now closed. However there are key issues that have been identified in relation to clinical practice that need to be highlighted as they are relevant to the care and treatment of the older adult and/or those with dementia regardless of clinical setting.

5.28 Many of the findings of the 2014 *Trusted to Care* report dovetail into those of this Investigation. Basically the needs of the older adult and those with dementia require specialist nursing and medical care and treatment. Older adult services should not be seen as ‘Cinderella’ services but should be recognised as priority services that require clinical staff with expert skills and access to specialist

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

5.29 During the period under investigation older adult and dementia services were neither planned nor coordinated with the degree of organisational strategic oversight that was required. This not only made an impact upon the quality of the care pathway patients and their families encountered, but also made a direct impact upon the effectiveness of the care and treatment that they received.

5.30 It is of significance that during the period of time under investigation there were no older adult or mental health clinical specialists at Board level or within the senior corporate team. Inspections, strategy and assurance processes were overseen by those with limited expertise and a limited understanding of what evidence-based service provision and care and treatment should look like.

5.31 At the present time significant work has taken place to make services more aware of the needs of the older adult and those with dementia. However the approach taken remains rather *ad hoc* with separate clinical divisions approaching these issues differently. The work currently being undertaken is primarily being led by the mental health division and BCUHB needs to move away from the stance that dementia is primarily the concern of mental health services and embrace a different ethos where the Health Board accepts the care and treatment challenges of old age and of dementia embrace all health and social care provision in all care and treatment settings. However one very positive step has been the decision to appoint a dedicated dementia specialist into the corporate nursing team to ensure that in future a more integrated approach is taken; in this manner resources are beginning to be aligned to support pace and consistency.

5.32 Moving forward BCUHB needs to ensure all aspects of clinical governance come together to ensure the particular needs of the older adult and those with dementia are met. This needs to include workforce capacity and capability, education and training, clinical audit and evidence-based practice guidance, patient safety and safeguarding. Alongside this costed and timed strategic plans need to be developed spanning the entire of breadth of service provision to ensure the needs of the older adult and those with dementia are inbuilt into every service and care and treatment context. The work that needs to be undertaken *must* be built across all executive teams and clinical divisions to ensure full integration and a unified strategic ethos.

Recommendations

Overview

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

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

5.34 The Investigation Panel has not been privy to all of the outstanding issues or the levels of progress made by BCUHB to-date. To this end the recommendations fall into two distinct categories – the first requiring a concerted degree of oversight (and possible further development) from Welsh Government in relation to ongoing high-level performance issues, and the second requiring practical, operational service change within BCUHB requiring a less intensive level of oversight from external bodies.

5.35 In addition BCUHB will soon be in receipt of the Ockenden Governance Review. This review will provide a significant number of recommendations in relation to governance systems, structures and processes. Consequently this Investigation has limited the setting of its recommendations to strategic and specific clinical practice issues. Following the publication of the Ockenden Governance Review further work will need to be undertaken to provide synergy in relation to action planning and the recommendations from both of the separate investigative and review processes.

5.36 On reviewing the progress made by BCUHB in relation to many of the current recommendations it is working to, it is evident that moving forward *all* future recommendations need to be overseen with the support of a structured action plan that sets:

- clear milestones, aims and objectives;
- clear performance targets and indicators;
- clear methods of audit and evidence collection, progress review and assurance;
- clear costings and resource implications;
- clear indications of where multi-agency inputs are required;
- clear timeframes and completion dates;
- clear methods of accountability and oversight.

5.37 With this in mind the Investigation Panel has reviewed the progress made by BCUHB in relation to the findings and conclusions of this Investigation. The recommendations have been set with the intention of supporting the work that BCUHB has already embarked upon and to also ensure that future strategic planning incorporates inputs from Welsh Government particularly where multi-agency partners also need to make significant contributions to planning, process and service provision.

5.38 The Investigation Panel has identified that during the period of time under investigation, and into the present day, many BCUHB initiatives have either been confounded or rendered ineffective by a lack of integrated, strategic thinking and planning. The recommendations set out below place emphasis on the importance of joined-up thinking and integrated service planning. The expectation is that all recommendations will be completed within 12 months of the publication of this report.

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

The Dementia Care Pathway and Service Design

Progress Made

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

Progress Required

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

Recommendation One: Care Pathway and Service Design

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

- The review outcomes and options should underpin all current and future health and social care strategies across north Wales and be overseen by the appropriate performance management and inspection bodies.

Implementation of the National Wales Dementia Strategy

Progress Made

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

1 The Health Board has a designated Consultant Nurse in Dementia care who provides input at a strategic and clinical level into services.

2 There are currently a wide range of opportunities for patients and families to obtain support through memory services and the third sector (such as the Alzheimer's Society). In addition BCUHB dementia training is now open for

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

3 There is a Delirium and Dementia Specialist Nurse available to provide expertise to individuals and services. There has also been a strong focus on the recruitment of Dementia Support Workers who are working across the organisation together with ten Dementia Activity Workers who are further supporting patients when accessing mental health services.

4 The Flynn and Eley Review highlighted the importance of support for those affected by or living with dementia at or around the point of diagnosis. They recommended that BCUHB develop a standard offer of post diagnostic support for people living with dementia and their families as part of a wider network of support.

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

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

Progress Required

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

Recommendation Two: Dementia Strategy

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

- The action plan should take into account all of the clinical and practice deficits that have been highlighted by this Investigation and will require independent clinical input and oversight.

- Access to therapy and non-medical interventions and treatments should be an integral part of any costed Dementia Strategy plan which takes into account NICE (and all other) best practice guidance in this regard. The capacity and capability of the workforce should be reviewed to ensure that fit for purpose services can be provided. Implementation should be managed and audited in tandem with Recommendation Ten (see below) as the reduction of the use of antipsychotic medication will to a large extent be predicated upon alternative therapeutic interventions being made available.

- Formal audit and performance management arrangements should be agreed and built into the action plan.

Care Home Provision in North Wales

Progress Made

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

1 **Practice Development Team**. This team is responsible for ensuring the delivery of quality, evidence-based and personalised care within the homes. They undertake annual quality monitoring audits utilising an electronic tool that scores the delivery of care associated with Healthcare Standards and the Fundamentals of Care. The team facilitates and delivers training in-house and can arrange for specialist nurse support to provide clinical leadership.

2 **Quality Assurance Framework**. This has been developed to describe and set out quality assurance processes to ensure safe care. This includes holding a monthly clinical management group to proactively discuss each care home with all relevant stakeholders. This helps to gain and collate key intelligence and provides a robust and proactive response in order to support homes as required.

3 **Contracts and Fees**. The Health Board has employed a contracts team. This team works to explicit performance indicators and can work with the Practice Development Team to raise quality and provide practical support directly into any care home experiencing difficulties.

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

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

Progress Required

5.44 The Investigation Panel acknowledges the progress that is being made in this area. Moving forward this progress needs to be audited and any ongoing work programmes need to form part of an integrated process that brings together the BCUHB Mental Health Strategy, the Dementia Strategy and all ongoing service re-design initiatives; particularly those changes and improvements to community support provision.

5.45 A fragile care-home market can impact greatly upon NHS community, primary and secondary care services. Care home provision and quality monitoring needs to be unified into wider strategic action planning as part of an integrated approach to providing timely access to appropriate and good quality services.

Recommendation Three: Care Homes and Service Integration

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

Safeguarding

Progress Made

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

Progress Required

5.47 At the time of writing this report there were significant areas that still required improvement. However the Investigation Panel acknowledges the fact that BCUHB is aware of the areas that require improvement and is reassured by the levels of increased insight and understanding of its safeguarding responsibilities. BCUHB have identified ongoing issues:

- the current safeguarding training programme is not fit for purpose and requires updating;
- staff are not attending safeguarding training in the numbers required;

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

Recommendation Four: Safeguarding Training

- BCUHB will revise its safeguarding training programme to ensure it is up-to-date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance.

- BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation.

- BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.

Recommendation Five: Safeguarding Informatics and Documentation

- BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 are implemented – namely:

  - the use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;
  - process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;
  - team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.

- In addition BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided. This to include specific guidance on:

  - the content of protection plans;
  - the recording of strategy meetings and all decisions taken (guidance should require a standardised approach across all BCUHB clinical divisions);
  - formal monitoring and review templates should be developed and audited to ensure safeguarding timescales are met and those with key responsibilities in this regard held to account.

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

Recommendation Six: Safeguarding Policy and Procedure

- The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This Investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are:

  - *"to identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners;*
  - *agree a priority list and activity timeframe to review documents within the parameters of Corporate Safeguarding;*
  - *provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy and legislative safeguarding frameworks;*
  - *agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;*
  - *update and maintain the Safeguarding Policy webpage;*
  - *continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards".*

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

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

Recommendation Eight: Evaluation of Revised BCUHB Safeguarding Structures

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

Category Two: Recommendations Concerning Localised Operational Service Change

Informatics and Clinical Records

Progress Made

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

Progress Required

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

Recommendation Nine: Clinical Records

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

Medications Management and the Use and Monitoring of Antipsychotic Medications

Progress Made

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

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

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

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

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

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

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

Current Situation

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

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

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

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

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

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

Progress Required

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

Recommendation Ten: The Prescribing and Monitoring of Antipsychotic Medication

- The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.

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

Evidence-Based Practice and Clinical Guidelines

Progress Made and Still Required

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

Recommendation Eleven: Evidence-Based Practice

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

Legislative Frameworks: Deprivation of Liberty Safeguards (DoLS)

Progress Made

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

Progress Required

5.54 The BCUHB Annual Report sets out a work plan which at the time of writing this report was close to completion. The work plan includes:

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

Recommendation Twelve: DoLS

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

The Management of Aggression in the Elderly

Progress Made

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

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

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

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

Progress Required

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

Recommendation Thirteen: Restrictive Practice Guidance

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

End of Life Care

Progress Made

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

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

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

Progress Required

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

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

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

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

Recommendation Fifteen: End of Life Care Environments

- All older adults and people with dementia have the right to the same access to quality end of life care as any other individual (of any age) with any other condition. If a person is to receive end of life care on an older person's mental health ward (and in particular an acute admission ward) the following should always be undertaken:

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

2.1

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GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Mental Health and Learning Disabilities Committee 11th April 2019 Agenda Item: 3.2

3.1

Aneurin Bevan University Health Board

Mental Health and Learning Disabilities Performance Report

Executive Summary

This report provides the Committee with an update of performance against key Mental Health and Learning Disabilities Performance Targets.

The report highlights:

- Good progress in sustaining all national Mental Health Measure performance targets at the end of January 2018 with confidence in achieving end of year targets across all indicators.
- Good performance in maintaining urgent and routine referral specialist CAMHS waiting times targets throughout the year.
- Major challenges in maintaining the Primary Care Intervention target in April and May 2019 due to reduced service capacity.
- Major transformational and operational changes being undertaken to sustainably improve performance in Children and Young Persons Primary Care Mental Health Services
- Progress in reporting psychological therapy waiting times with around a third of patients currently waiting over 26 weeks for therapy, with the new measure expected to go live in April 2019.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Executive Sponsor: Nick Wood, Director of Primary, Community Care and Mental Health Services

Report Authors: Ian Thomas, General Manager; Virginia Morgan, PCMHSS Strategic Lead; Liz Andrews, Head of Adult Psychology

Report Received consideration and supported by :

Executive Team		**Committee of the Board**	Mental Health & LD

Date of the Report:20.02.19

Supplementary Papers Attached: No

Purpose of the Report

To provide a report on the current performance against the Welsh Government performance measures for Mental Health and Learning Disabilities Services.

Background and Context

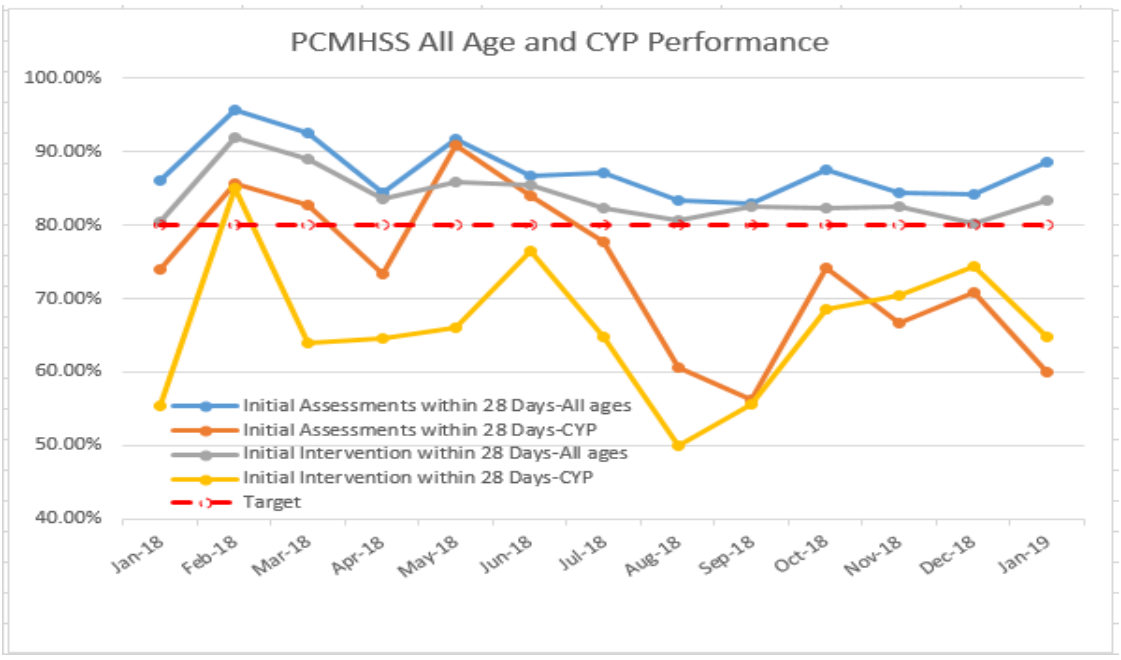
The Divisions remain on track to deliver against all Welsh Government Mental Health Measure performance framework targets in 2018/19. The key target measures are highlighted in the table below.

Performance Framework Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
PCMHSS initial assessment in 28 days (80%)	84.4%	91.7%	86.6%	87.1%	83.2%	82.9%	91.0%	84.5%	84.0%	88.6%
PCMHSS initial intervention in 28 days (80%)	83.5%	85.8%	85.2%	82.5%	80.3%	80.9%	82.3%	82.4%	80.4%	83.3%
MH Measure Part 2 : CTP completed (90%)	90.1%	90.9%	91.2%	87.4%	90.9%	90.3%	90.6%	90.6%	90.2%	91.1%
MH Measure Part 3 : Assessment outcome in 10 days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

1. Performance against MH Measure Targets

- **Part 1 MH Measure PCMHSS**

Performance has been sustained over the Christmas and New Year period for both assessment and intervention targets and early indications are that the targets will be met at the end of February. There is confidence that performance targets will also be sustained for year end.



There are a number of key challenges for PCMHSS moving forward and these are set within the context of the priorities for the service outlined in the IMTP.

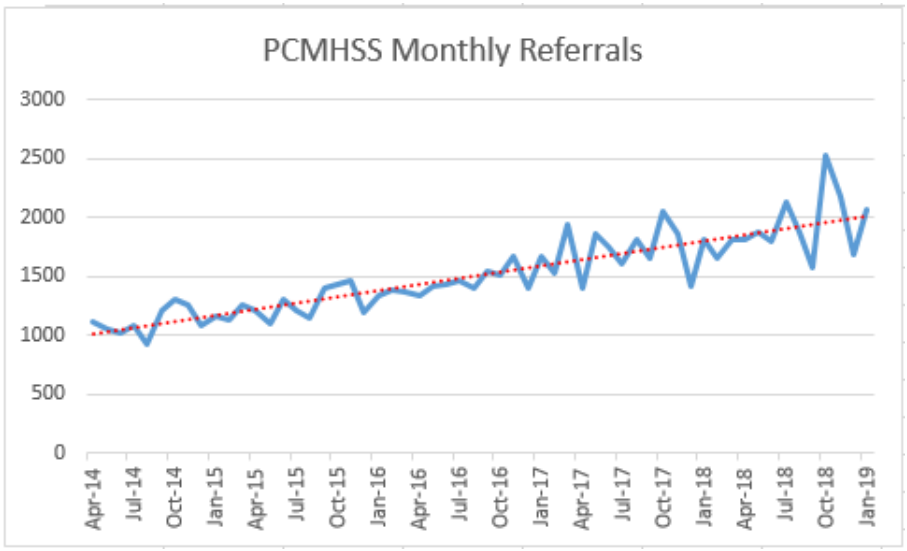
- For CYP provision – the standardisation of therapeutic intervention and the development of group based intervention
- Engagement with stakeholders to develop a more sustainable service model in light of increasing demand

- For adult service provision - ensuring the PCMHSS follow the prudent healthcare principles when providing interventions
    - Strengthen provision of low intensity and group based interventions where appropriate
    - Increase the intensity of interventions provided where appropriate (in line with Matrics Cymru) in partnership with secondary mental health services

As the graph above illustrates, there has continued to be a significant difference in performance in access times into Primary Care Mental Health Support Services (PCMHSS) for Adults and for Children and Young Persons (CYP). Performance in the latter has consistently been significantly below that of adults, particularly for interventions.

A number of initiatives and developments are being undertaken to improve this position although the impact will not be evidenced before June 2019.

- Successful recruitment of 3.4 wte CYP practitioners, although starting dates are unlikely to be before the end of May 2019. Previous recruitment attempts had resulted in no appointments being made.
- SPACE wellbeing (development of single point of access, multi-agency panels) should be operational in all five boroughs by the end of March 2019. It is anticipated that this will eventually reduce the number of CYP referrals made into PCMHSS, based on initial pilot work in two boroughs
- Significant training resources have been provided to increase the range of therapeutic interventions in line with Matrics Cymru. This will initially have an adverse impact on performance as staff are released to undertake training, with significant capacity reductions in April and May 2019.
- Additional counselling capacity has been commissioned from an external provider with high volumes of CYP being seen in April and May. Although this is positive, as it will enable CYP to access the right interventions, as this backlog is tackled there will be an adverse impact on performance targets initially in month.



There are significant operational challenges on a daily basis that are being tackled by the operational managers across the boroughs in matching demand and capacity in a GP practice based service model. As can be seen in the graph above, referrals into the service

have been growing steadily over the last few years. A key IMTP priority over the next year will be to review the sustainability of the current service model in light of increasing demand.

Recent positive discussions have been held with Primary Care to look at the development of alternative service models, building on the strength of the current practice based model, but recognising the need to deliver some services at an NCN or borough based model to ensure equity, sustainability and resilience. The training in more group based interventions will help to inform this service model going forward.

The adult PCMHSS service will also lose significant capacity in April and May due to the need to train staff to increase the range of therapeutic interventions and to develop group based approaches to service delivery in order to be in a better position to meet demand. Additional counselling resources have been commissioned to mitigate the impact of some of the loss of capacity due to training. Where staffing allows, weekend assessment clinics will be run, telephone assessment appointments offered and temporary adjustments to job plans made.

The reductions in capacity highlighted above are likely to have an overall short term negative impact on performance in April and May. In addition the Easter and May bank holidays and school holiday periods will also impact on staffing and capacity over the period. While all efforts will be made to minimise the impact, it is unlikely that the intervention targets will be met over this period. While this is disappointing, this will put the service into a more sustainable position in adult and CYP services moving forward, with a fully staffed CYP service, a new programme of group based interventions running and a more appropriately skilled and trained workforce. It is anticipated that target compliance will be regained by the end of June 2019 and beyond.

- **Part 2 and Part 3 MH Measures**

As noted above the target is being consistently met and is forecast to continue to be compliant to year end.

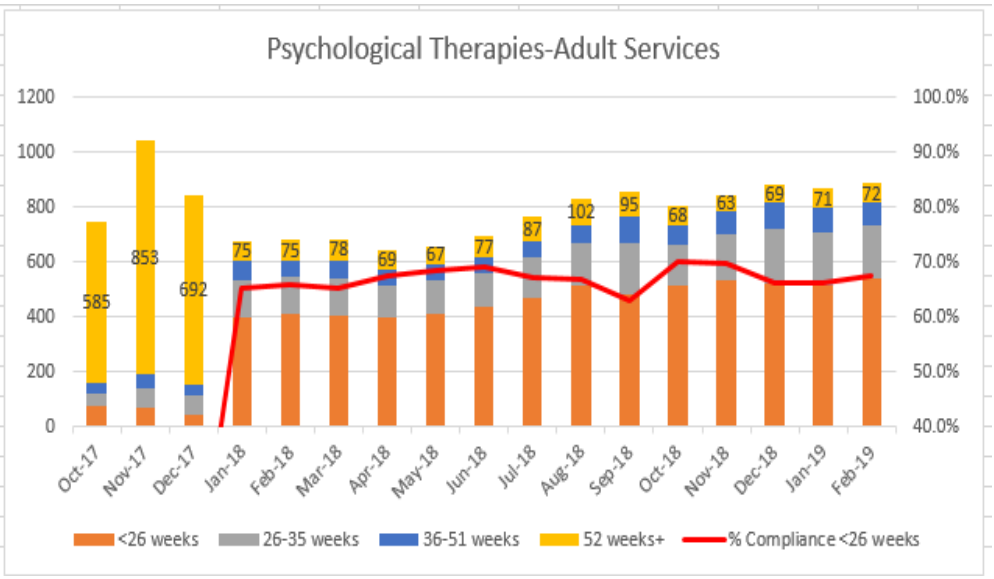
2. Specialist CAMHS Assessment Target

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
ABUHB S-CAMHS Monthly routine referral compliance %	81.4	83.3	87.7	94.3	89	95.6	96	98	97	94.5	88
ABUHB S-CAMHS Emergency/Urgent referral compliance %	100	100	100	100	100	100	100	100	100	100	100

All Health Boards across Wales have a target to see 80% of patients for routine assessments by specialist CAMHS within 28 days referral and urgent cases within 48 hours. There has been significant improvement in access waiting times in specialist CAMHS services and the routine target has been consistently met by ABUHB specialist CAMHS this year. 100% compliance has been maintained against the urgent referral target.

3. Access to Psychological Therapies

The 26 week RTT target will be applied to Psychological Therapies for the first time from April 2019/20. During this year shadow data submission reporting has been established, although performance figures are not currently officially published externally. The target is for 80% of patients referred to be seen within 26 weeks. Currently the Health Board only reports adult psychology data, while data validation and improvements are being made to enable reporting across other areas. It is expected that Older Adult Psychology will be the next area to be included in reporting from April 2019.



An additional three quarters of a million pounds has been provided through WG funding to improve access to psychological therapies in the Health Board. The Division has been working hard to implement the proposals included in the successful funding bid. However the recruitment into all posts is unlikely to be fully complete until around August 2019 due to the effect of recruiting into top banded psychology grades initially. There has been some marginal improvement in waiting times over the last quarter of this year. However in order to utilise non-recurring expenditure to extend the scope and delivery of interventions, there has also been a push for significant additional training which has impacted on overall service capacity in the last quarter. This training will support the strategic direction of offering more group based interventions while continuing to target longer waiting patients whose needs are often more complex and long term.

Some positive developments in the adult psychological therapies include:

- All therapies listed in Matrics Cymru are now available in all boroughs
- The Division is continuing to develop a robust trauma pathway. 85% of the people referred to adult psychology have complex trauma. Typically, an episode of care for someone with complex trauma can last over 3 years. The Health Board is focussing on developing a trauma pathway in order to ensure equitable access to evidence based psychological therapies, delivered by the right people with the right skill at the right time and also to ensure that there is flow through the system with patients being offered episodes of care, rather than one long episode.
- All raw data has been collected to undertake mathematical modelling of demand and capacity.

- Waiting List initiatives are being run in Caerphilly and Monmouthshire to focus on the longest waiters through individual and group interventions

Currently there has been a 24% increase in the adult psychology workforce, going from 16.3 qualified WTE in August 2018 to 20.3 qualified WTE in February 2019 with a further 2.2 wte planned. The 24% increase in workforce to date has resulted in a 36% increase in productivity and given that there has been a significant amount of training in that period for new and existing staff, it is expected that productivity will increase further.

The service continues to look to develop a robust improvement trajectory. However nationally there do not appear to be any successfully used demand and capacity modelling tools for psychological therapies. Consequently, the Division is working with corporate performance and information and mathematical modellers from ABCi from April 2019 to try to develop a local modelling tool. An improvement profile will need to be developed in conjunction with directorates and signed off and monitored through the Executive Divisional Assurance process and performance will be reported at future Committee meetings.

Assessment and Conclusion

Compliance has been maintained across all targets as at the end of January 2018 with confidence that these will be maintained at the end of this financial year in line with submitted IMTP trajectories for 2018/19.

There is expected to be dip in performance of the PCMHSS Intervention target below the national target during the first two months of the next financial year but action is being taken to try and mitigate this. However the work being undertaken will make the service more sustainable moving forward with improvements anticipated in CYP services.

Recommendation

The Committee is asked:

- To note the good performance against the range of current performance targets and note the actions being taken to prepare for the anticipated formal reporting of psychological therapy waiting times from April 2019.
- To consider the anticipated reduction in performance in PCMHSS in April and May in light of the longer term sustainability benefits and improvements in CYP waiting times.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Reputational risks in not meeting core performance targets and delivering MH Measure statutory targets for the local population.
Financial Assessment, including Value for Money	Additional funding made available through transformation and psychological therapies funding to deliver improvements in access targets.
Quality, Safety and Patient Experience Assessment	Reduction in waiting times is a key quality/patient experience indicator

Equality and Diversity Impact Assessment (including child impact assessment)	The report shows longer access times for children and young persons than for adults accessing the Primary Care Mental Health Support Services and actions being taken to reduce inequality in service.
Health and Care Standards	Standard 2: Safe Care standards 2.1 Standard 3: Effective Care standards 3.1, 3.2, 3.5 Standard 4: Dignified Care standards 4.1,4.2 Standard 5: Timely Care standard 5.1 Standard 6: Individual Care standards 6.1,6.2,6.3 Standard 7:Staff and Resources standard 7.1
Link to Integrated Medium Term Plan/Corporate Objectives	Maintenance of core targets are a key component of the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	
	Long Term – Improving mental health remains a key long term priority
	Integration – Mental Health & LD are delivered on a multi-agency basis through established partnership boards
	Involvement – There continues to be significant service engagement and involvement with users and carers in the delivery and planning of services
	Collaboration – Primary Care MH services and Children's services remain areas of close cooperation across Divisions and agencies
	Prevention – Improving access to primary care MH services, sCAMHS and psychological therapies promote improved mental health and better outcomes for individuals
Glossary of New Terms	N/A
Public Interest	This paper is written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Mental Health and Learning Disabilities Committee 11th April 2019 Agenda Item: 3.4

3.3

Aneurin Bevan University Health Board

Mental Health and Learning Disabilities Risk and Issues Report

Executive Summary

This report provides an overview of the current highest level risks and issues identified by the Mental Health and Learning Disabilities and Family and Therapies Divisions (for CAMHS service). The risk profile for mental health services continues to be reviewed and revised regularly within the services.

The report provides a summary of the top rated risks, concerns and issues that have emerged since the last reporting period.

The Committee is asked to note the current risks and actions being taken to manage those risks.

The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			X
Note the Report for Information Only			
Executive Sponsor: Nick Wood, Director of Primary Care and Mental Health			
Report Author: Ian Thomas, General Manager			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board**	Mental Health and LD
Date of the Report: 18 March 2019			
Supplementary Papers Attached:			

MAIN REPORT:

Purpose of the Report

This report provides the Mental Health and Learning Disabilities Committee with a summary of the key risks and issues identified through the Divisional Risk Assessment process and recorded on the relevant directorate/divisional risk registers. The report is provided for assurance purposes to highlight the service risks to the successful delivery of safe, quality and effective care.

Background and Context

Risk management is a process used to ensure the Health Board is focused on the identification and management of current issues and future risks.

Active management of clinical risk is part of daily activity for the mental health and learning disabilities services across all of its sites and services. The Division has developed risk management processes to ensure that the management teams are aware, engaged and assured about the ways in which risks are identified and managed across their relevant services.

Within the Division a Risk Register is compiled and updated through continuous engagement with relevant clinicians and managers. In addition there are more detailed project based risk registers that support specific work-streams or programmes. (Eg Implementation of WCCIS system, ligature reduction programme, Whole Person, Whole System Adult MH Crisis Transformation Programme.)

This report provides the current dashboard of the top risks within mental health and learning disability services across the Division of Mental Health, Learning Disabilities and the CAMHS service (Family and Therapies Division). This is the third report in the style of the new dashboard recently adopted by the Health Board to receive the Risk Report.

While the risks are summarised to make them accessible to the MH & LD Committee, more detailed risk assessment, controls and mitigating actions are contained within the Divisional Risk Register.

The risk registers are compiled using the risk assessment matrix approach outlined in the Health Board's Risk Management Strategy (2017). This report highlights the current top rated risks in mental health and learning disabilities services and seeks to provide an overview of:

- The key risks identified across services and current level of risk
- Mitigating actions and the actual or proposed impact on risk level
- Other current or emerging priority risks, issues or concerns and how they are being managed

Assessment and Conclusion

Since the last meeting the Divisional representatives have been participating in a series of corporate workshops looking at the risk management process to highlight areas of good practice with the aim of getting a more consistent approach to risk and issue management. It is expected that this will lead to changes in the way future risks are reported to reflect the concept of organisational risk appetite going forward.

From reviewing the top risks within mental health services there are currently 33 assessed risks on the registers. A breakdown of the top rated risks collated by risk score is shown in the table below.

Score range	Mental Health	sCAMHS	Risk Rating
20-25	14	1	
12-16	18		
6-10			
1-5			

The main changes over the last period include:

- Removal of a number of estates risks following scheme completion
- Addition of new risks and issues linked to IMTP strategic priorities

A summarised selection of the top rated risks in mental health, learning disabilities and CAMHS is considered below. These have been categorised into three areas, namely risks associated with capital, MH & LD service risks and CAMHS specific risks. In addition a number of service issue and concerns have been flagged up and are currently being assessed and will be added to future versions of the risk register.

- **Capital and Estates Risks**

The current prioritisation of the Health Board's discretionary capital is linked to the risk rating. A significant number of risks on the current risk register are related to the capital and estate and these are highlighted below. It should be noted that the risk register is updated monthly and the specific risk scores may change, once the information on progress has been updated.

Since the last meeting:

- Re-flooring work has been completed on Annwylfan ward and nearing completion on Sycamore Ward to reduce the risk of falls on dementia wards.
- Fencing work around garden areas of Ty Siriol and Ysbyty'r Tri Chwm undertaken to make areas more secure.
- Significant progress in completing anti-ligature priority works, with around 85% of all work completed as at the start of March 2019. New anti-ligature policy guidance adopted and new annual audit process developed to improve consistency of audit outcomes to inform the prioritised programme of works.

- A range of environmental improvements taken forward to implement recommendations from HIW inspections and local Environmental inspection visits

However, since the last meeting works and estates has confirmed that they would been unable to complete the works on upgrading shower facilities on Adferiad ward due to the structural issues which would necessitate the closure of shower areas. It has therefore been agreed to defer this work until early in the next financial year to enable the bathroom area to be completed on Kemys adjacent to Adferiad ward to provide alternative bathing facilities while this work is undertaken.

The top capital and estates risks are currently assessed as:

Current Score **20**	**Risk: MH/LD** **Owner:** Lead Nurses/QPS lead	**Ligature points on Acute Inpatient Units** **Oversight:** Ligature Group through to QPS Committee
	Impact:	Inpatient units are not as free from ligature risk as they could be, with risk of possible harm or death.
No change since Oct 18	**Action:**	Re-audit completed and identified risks have been scored and prioritised at a ligature meeting on 24 Aug 18. Programme of tackling highest rated risks nearing completion in 18/19 with around 85% of work completed at start of March 2019. Risk assessed prioritised programme put forward for funding in 19/20 with £200k in outline capital programme.
	Score after action:	**10**

Current Score **20**	**Risk: MH/LD** **Owner: GM**	**Wentwood Suite Uneven Driveway, SCH** **Oversight:** Accommodation Group to DMT
	Impact:	Uneven road surface with risk of falling, slipping for older adults attending clinics
No Change since Oct 18	**Action:**	Funding approved through slippage in capital programme. Work has commenced and due for completion by end March 2019.
	Score after action:	**5**

Current Score **20**	**Risk: MH/LD** **Owner: DM**	**Variation of staff alarms and processes on inpatient units** **Oversight:** QPS Committee
	Impact:	Staff unable to summon help when working alone
No change since Oct 18	**Action:**	Installation work on Talygarn completed in October 2018. Limited allocation currently in 19/20 capital programme to continue improvement programme.
	Score after action:	**10**

Current Score 20	**Risk: MH/LD** **Owner: GM**	**Lack of clinical space to see patients leading to longer waiting times or under use of staff resource** **Oversight:** Accommodation Group through to DMT
	Impact:	Patients waiting longer than required. Challenge to meet waiting times targets as unable to increase clinical capacity
No Change since Oct 18	**Action:**	Accommodation Group considering internal options. Further capital options being explored. Ongoing dialogue with other Divisions/Stakeholders to identify additional areas.
	Score after action:	**4**

Current Score 20	**Risk: MH/LD** **Owner: LN**	**Sycamore Ward bedroom cubicle flooring unsuitable for dementia patients, increasing risk of falls** **Oversight:** Accommodation Group and QPS Committee
	Impact:	Risk of falls on dementia ward bedrooms with potential harm to patients
No change Oct 18	**Action:**	Revised costings obtained to undertake work and will require capital bid through discretionary capital programme. Cost estimated at £30k. Capital funding approved for 18/19. Work to be completed by March 2019
	Score after action:	**5**

Current Score 20	**Risk: MH/LD** **Owner: LN**	**Fencing inadequate around Cedar Park Ward gardens with risk of dementia patients absconding.** **Oversight:** Accommodation group and QPS Committee
	Impact:	Garden area restricted for access with only supervised patients allowed in garden area.
No Change since Oct 18	**Action:**	Costings received and funding obtained through discretionary capital to undertake work by end of March 2019.
	Score after action:	**5**

Current Score 20	**Risk: MH/LD** **Owner: GM**	**Ty Skirrid Ward environment extremely poor and requires refurbishment/updating** **Oversight:** Accommodation Group
	Impact:	Poor patient experience. Reputational risk if externally inspected.
New Risk	**Action:**	Capital refurbishment bid to be put forward in 19/20 capital programme to improve environment. Immediate maintenance issues being addressed. New furniture ordered.
	Score after action:	**10**

Current Score **16**	**Risk: MH/LD** **Owner: GM**	**Current Mental Health Estate is not fit for purpose** **Oversight:** Accommodation Group to DMT
	Impact:	Services are provided from premises that are not fit for purpose
No Change since Oct 18	**Action:**	MH & LD Estates Strategy being developed. Capital Priorities for discretionary capital for 19/20 to be submitted in Feb 19. Regular meetings held with senior Divisional Mgrs in Facilities to address ongoing Minor Works and maintenance issues.
	Score after action:	**10**

Current Score **12**	**Risk: MH/LD** **Owner: LN**	**Shared Dormitory accommodation still in use in some adult mental health facilities** **Oversight:** Adult Assurance meeting and QPS
	Impact:	Privacy and dignity issues, poor patient experience. Reputational issue as consistently raised through HIW visits
New Risk	**Action:**	SBar report has been undertaken for discussion at next Assurance meeting in March (Feb meeting cancelled). Solutions likely to have significant impact on bed numbers.
	Score after action:	TBC

Current Score **16**	**Risk:MH/LD** **Owner: GM**	**Delays in completing Minor Works and Estates costings and jobs** **Oversight:** Accommodation Group
	Impact:	Negative impact on patient and staff experience and reputational risk in delaying completion of agreed actions following HIW inspections
New Risk	**Action:**	New Minor works system established to vet new requests weekly. Fortnightly meetings in place with SIMs and Works and Estates to monitor progress in dealing with backlog.
	Score after action:	**6**

Current Score **12**	**Risk: MH/LD** **Owner: LN**	**Poor quality of shower facilities and lack of bath facility on Adferiad Ward** **Oversight:** Adult Assurance meeting and QPS
	Impact:	Poor patient experience. Reputational issue as raised through HIW visit.
New Risk	**Action:**	Urgent maintenance undertaken to clean shower room and repair. Capital funding bid submitted to refurbish shower rooms and create additional bath area on Kemys ward. PPD submitted and funding agreed. Shower work delayed due to need to do destructive asbestos survey. Bath area progressing as planned and shower work to commence once commissioned.
	Score after action:	**6**

- **Service Risks**

The risks highlighted below are related to service challenges. Changes to the risk scores/register include:

Current Score **20**	**Risk: MH/LD** **Owner: DN**	**Staffing of current 136 (Place of Safety) Suite is having negative impact on ward staffing and being on Adferiad** **Oversight:** QPS committee
	Impact:	High sickness levels and significant staff well-being issues experienced on Adferiad Ward, compromising patient care.
No change since Jan 19	**Action:**	Directorate action plan being developed. Increased senior nurse support and supervision provided for ward. Ward staffing out of hours temporarily increased pending development and sign off of action plan. Option Appraisal to be undertaken on alternative service model to manage 136 service through Crisis/HTT service.
	Score after action:	**5**

Current Score **20**	**Risk: MH/LD** **Owner: DD**	**Inpatient and CRHTT Services for Adults in Acute Crisis are not fit for purpose** **Oversight:** Programme Board reporting through Partnership Board
	Impact:	Patients admitted due to lack of alternatives. High readmission rates.
No Change since Oct 18	**Action:**	Component of 'whole system, whole person' service transformation programme. PDSA Tests for change being made. Communities of practice event to redesign inpatient/CRHTT services held in June 2018. Extension of PDSA in HTT service. Additional capacity funded in HTT through Transformation funding. Host families funding obtained to pilot in one borough. Crisis House funding not possible through ICF. Other commissioning alternatives being pursued.
	Score after action:	**15**

Current Score **20**	**Risk: MH/LD** **Owner: GM**	**Lack of Medical Cover due to recruitment difficulties** **Oversight:** Medical Workforce Group
	Impact:	Patient safety may be compromised
No change since Oct 18	**Action:**	Medical workforce plan in place but under review. Increased recruitment of Fixed Term Appointments and MTIs successful to cover junior posts. Agency usage static but being used to cover essential posts. Ongoing recruitment campaign. Review of current plans being undertaken.
	Score after action:	**16**

Current Score **20**	**Risk: MH/LD** **Owner: DD**	**CHC increasing costs threatens Financial Sustainability of Core Services** **Oversight:** Complex Care Programme Board
	Impact:	Potential £6m impact in 2018/19 if growth maintained at 17/18 level
No Change since Oct 18	**Action:**	LSU SOC submitted to WG. Meeting with WG on 27 March. PICU extension completed. Transformation bid successful and programme of work being developed and progressed. SCM service recruited into. Commissioning of community support under development.
	Score after action:	**16**

Current Score **16**	**Risk: MH/LD** **Owner: DD**	**Lack of management and clinical capacity to deliver significant transformational change agenda** **Oversight:** DMT
	Impact:	Full benefits of transformational change will not be delivered on time or at all.
New Risk	**Action:**	Increased Divisional Mgt Team resource approved. Review of Directorate management capacity and support undertaken to enable delivery of change programme undertaken. Additional interim support approved to provide additional project management and senior management capacity.
	Score after action:	8

Current Score **10**	**Risk: MH/LD** **Owner: GM**	**No deal Brexit destabilising staffing and supply chain** **Oversight:** DMT and corporate Brexit Group
	Impact:	Largely unknown as still being quantified on a Regional basis inc pharmacy, procurement, ICT, Estates maintenance
No change since Jan 19	**Action:**	High level assessment undertaken and no immediate concerns identified. UK settled status scheme publicised. ESR status of staff being updated. Daily reporting in place.
	Score after action:	6

- **sCAMHS Risks**

The main CAMHS risk identified by the directorate is outlined below.

Current Score **20**	**Risk: sCAMHS** **Owner: DN**	**Challenges in caring for 16 to 18 year olds on acute wards.** **Oversight:** sCAMHS Mgt Team
	Impact:	Unclear care pathway as 16 to 18 year olds will not be admitted to GUH
No change **Since Jan 19**	**Action:**	Care pathway in development. Datix of incidents. Negotiating on individual cases. Clear agreement between AMH/Paediatrics and SCAMHS to ensure immediate action.
	Score after action:	**6**

- **Other Emerging Risks and Issues**

A number of service and estates issues have been flagged up and work is ongoing as part of the risk management process to assess these and put appropriate actions in place to manage the risks accordingly. These will be risk rated as part of the monthly review cycle and added to the risk register.

- Approval in principle given to increase management support in Adult directorate to help support transformation programme.
- Daily reporting is now in place for 'No deal' Brexit although no impact currently identified or anticipated
- The availability of capital to take forward Divisional priorities is extremely limited in 2019/20 and the outline capital allocation for priorities through the draft discretionary capital programme will need to be reviewed and risks reflected in the divisional risk register accordingly.

Current Score **16**	**Risk: MH/LD** **Owner: DD**	**Poor access to physical healthcare for individuals with MH problems or a learning disability** **Oversight: DMT**
	Impact:	Poor access to physical health checks leading to increased risk of morbidity and mortality compared to general population.
New Issue	**Action:**	Programme of work to be developed to improve access to physical health care on inpatient units during 2019/20 and to improve access to physical health checks for individuals within the community.
	Score after action:	TBC

Current Score 12	**Risk: MH/LD Owner: GM**	**Cross border funding disputes increasing due to different guidance operating in NHS England and NHS Wales**
	Impact:	Increasing potential for disagreement over funding responsibilities, leading to more disputes and legal challenges
New Issue	**Action:**	Legal Advice being sought on individual cases. Review of current guidance being undertaken for WG by Collaborative Commissioning Team
	Score after action:	6

Current Score 16	**Risk: MH/LD Owner: DD**	**Lack of an agreed pathway for individuals with Neurodevelopmental disorders**
	Impact:	Variation in access for assessment, diagnosis and treatment of ASD and ADHD
New Risk	**Action:**	Learning day from recent admitted patient episode held in February 2019. Action plan being developed from learning day to take forward pathway development. Bid submitted to expand current IAS service.
	Score after action:	6

Recommendation

The Committee is asked:

- To receive the report outlining current high level risks within mental health services and current concerns and issues.
- To note the actions being taken to eliminate, reduce and manage the risks.
- To note the intention to take the learning from the recent Risk Management Workshop to enable improvements in the risk register over the first quarter of 2019/20.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report provides key information on how mental health services identifies and manages key risks and issues in accordance with the Risk Management Policy
Financial Assessment, including Value for Money	Risk management is an important aspect of financial management and a key component in reducing future risk of financial liability and sustainability
Quality, Safety and Patient Experience Assessment	Risk Management is integral to the delivery of safe, quality services to patients
Equality and Diversity Impact Assessment	Robust risk assessment processes inform the Health Board's approach to understanding equality issues

(including child impact assessment)	
Health and Care Standards	Relevant to Care Standards 2,3,4,5 and 6
Link to Integrated Medium Term Plan/Corporate Objectives	All Divisional IMTP priorities are risk assessed and rated with a number of strategic priorities highlighted in the report. The correct assessment of risk is a key component of the IMTP assurance and delivery process.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The delivery of safe and effective risk management supports Health Board Well-Being Objective 9. WBFGA considerations are included within consideration of individual risks.
Glossary of New Terms	None
Public Interest	This report has bene written for the public domain.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Arolygiaeth Gofal **Cymru**
Care Inspectorate **Wales**

4.2

Joint Thematic Review of Community Mental Health Teams

Thematic Report

Review date: 2017-2018

Publiction date: 7 February 2019

Contents

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality care.

Our values

We place patients at the heart of what we do. We are:

Independent
Objective
Collaborative
Authoritative
Caring

Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice

Influence policy and standards:
Use what we find to influence policy, standards and practice

Care Inspectorate Wales (CIW)

Our purpose

To regulate, inspect and improve adult care, childcare and social services for people in Wales.

Our values

Our Core values ensure people are at the heart of everything we do and aspire to be as an organisation:

Integrity: We are honest and trustworthy.

Respect: We listen, value and support others.

Caring: We are compassionate and approachable.

Fair: We are consistent, impartial and inclusive.

Our strategic priorities

We have identified four strategic priorities to provide us with our organisational direction and focus over the next three years. These are:

To consistently deliver a high quality service

To be highly skilled, capable and responsive

To be an expert voice to influence and drive improvement

To effectively implement legislation.

Foreword

This report brings together HIW and CIW's joint work over the last two years and aims to highlight key themes and issues arising from our inspections of Community Mental Health Teams (CMHT) across Wales.

Over the course of this review we frequently found disparity and variability in the standards, consistency and availability of treatment, care and support provided by Community Mental Health Teams across Wales. Welsh Government, Health Boards and Local Authorities need to carefully consider and examine the areas we have highlighted and act on our recommendations so that people living with mental illness will receive equitable care wherever they live in Wales.

We believe the findings and recommendations are of interest to service users, their relatives and carers who are accessing or have accessed community mental health services and we would like to take this opportunity to thank the people and staff across Wales who participated in this review and shared their experiences with us openly and honestly. We hope they will recognise their input and realise how their experiences have helped guide our findings and recommendations.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Arolygiaeth Gofal **Cymru**
Care Inspectorate **Wales**

Key Findings

In this section we outline the key issues found over the course of our review. Further information about how we approached the review, and our detailed findings and recommendations follow in subsequent sections of the report.

Access to Services

We found that initial access to services is an area which requires improvement within most Community Mental Health Teams (CMHTs) across Wales. In particular, the linkages between CMHTs and General Practice (GPs) need strengthening. It appears there is often a lack of clarity regarding the referral criteria into CMHTs, as well as a lack of knowledge of the range of services available for people to be referred to. This needs attention and new ways of working are required to simplify referral and assessment processes, and reduce waiting times. Some areas are moving towards a more integrated single point of contact for mental health services, which will improve the situation, however the picture across Wales is variable. More work needs to be done to improve consistency in relation to referrals, assessments and service provision across Wales. Improved understanding of service provision within and between the GPs and CMHTs will improve timely access to the most appropriate care.

We found variability across Wales in the response to people experiencing mental health crisis or in urgent need. We found that some service users receive immediate intervention and support but others experience a delayed response, for example having to attend A&E departments on more than one occasion or having difficulty contacting services out of hours. We also found that a significant number of people did not know who to contact out of hours and were not satisfied with the help offered. This means that people accessing services in a crisis cannot be assured that their needs are always responded to appropriately and in a timely manner.

Better listening and learning, especially from service users' experiences of access and their journey through the systems, will ensure improvements are designed around their needs and that service users are, and remain, at the centre of service provision.

Care Planning

We found that because of the diligence and hard work of staff, care planning and legislative documentation is, in most CMHTs, being completed in a timely manner. However, we are not assured that service users and their families/carers are always as involved in developing the care and treatment plan as they would like to be. This may be a training issue or a lack of communication between care co-ordinators and service users. Nevertheless, it is an area that needs attention. Similarly, we are not assured that all CMHTs routinely offer advocacy services on assessment or at significant points during a service user's care. Additionally, carers' assessments are not undertaken routinely to identify if and what information, advice, assistance or support they may need to care for the service user.

Whilst Welsh Government figures[1] indicate that most services are meeting the required timescales for assessments and care planning, we found that this did not always equate to good quality care plans. Not all CMHTs are focusing on the quality of, and detail within, records and documentation.

1 www.statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Mental-Health-Measure

We are satisfied that individually, health boards and local authorities carry out sufficient audit of documentation including care and treatment planning. However, there is less evidence of the joint audit and analysis of documentation and outcomes for service users. Improvement is required in this aspect.

Whilst all health boards scrutinise Mental Health Act (MHA) documentation, the quality and expertise of this differs from health board to health board. There needs to be more standardisation across Wales.

Delivery

We found that the working environments within most CMHTs needs improvement with some clinical areas not fit for purpose. Whilst staff attempt to work effectively and efficiently both clinically and collaboratively, their working environment does not always facilitate this. More needs to be done to resolve these problems.

Whilst we are assured that health boards and local authorities have clear oversight of the quality of care provided within their relevant CMHTs, many health boards are in a time of transformation. We heard of many significant areas of strategic service development, however, there remains a duty to ensure service users receive the appropriate care from the appropriate person at the appropriate time, whilst wider transformation of services takes place.

We are concerned regarding the arrangements for medicine management, with the need to develop better audit, guidance and support from dedicated mental health community pharmacists.

We found that there are a range of different support services being offered across Wales, many tailored for particular regions. However, in some areas there are issues regarding the ability to access some third sector and other support services. This is because eligibility for some third sector (voluntary) and other support services is dependent upon eligibility to receive CMHT support. This can be a barrier to proactive preventative care. The third sector can offer invaluable support in addressing the needs of people experiencing poor mental health and that this is a resource that should be embraced and used more frequently where available.

Nationally, we have found that access to psychology or therapeutic services within secondary, primary and third sector is very limited and there are long waiting times in Wales; up to 24 months in some areas. This requires urgent action to address the shortfall in service provision. This involves not only increased recruitment in these disciplines, but looking at more innovative ways of meeting this need. Health boards and local authorities must consider identified unmet needs to inform future commissioning and operational plans.

We are not assured that there is robust scrutiny of discharge planning and consequently, service users may not always be discharged from CMHTs in a safe and timely way, with the appropriate support or information to access primary care or third sector (voluntary) services if required. More consideration needs to be given to ongoing community support to ensure that the risks associated with discharge from services are minimised.

Governance

In most areas we heard about new strategies and approaches for mental health services that include plans to develop new models of service delivery to more effectively meet the needs of the population. Whilst this is encouraging to see, the current needs of people in receipt of services must continue to be met and all efforts made to ensure safe, good quality services are being provided.

Information technology and universal access to patient/service user records remains a considerable problem in health and social care services. This is particularly challenging for integrated services such as CMHTs. There is a role for Welsh Government in developing systems that allow for this and to enable safer, more efficient and effective collaborative record keeping.

We found in some areas, people are supported to provide feedback on services via third sector organisations, however, this is an area for further development. In general there are a lack of opportunities available for people to provide feedback on treatment, care and support services and limited information given on how to raise a concern. More work needs to be done to ensure that the voice of those in receipt of services is heard, listened to and acted upon.

We noted challenges relating to resources amongst CMHTs with issues in relation to staff recruitment and retention, although most CMHTs are considering different ways of addressing this. We are satisfied that whilst staff training is improving in most teams, more work is required to ensure that staff are up to date with mandatory training topics. We found that staff supervision systems were robust in health and in social care, with supervision and support on a day to day basis from both organisations clearly evident. There is a need for local authority staff to receive formal, recorded, one-to-one supervision to ensure that they have an opportunity to discuss on-going training, development and well being.

Recommendations

No.	Recommendation
1.	Health boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.
2.	CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern.
3.	Health boards need to ensure that information relating to the ‘Putting Things Right’ process is available at all CMHT locations.
4.	CMHTs need to improve the way that they oversee the handling, monitoring, and lessons learned aspects of concerns/complaints.
5.	Health boards and local authorities need to look at ways to improve awareness of advocacy provision amongst their staff and develop local monitoring of CMHT engagement with advocacy services, to ensure service users have access to the support they require on assessment at significant points within their care.

No.	Recommendation
6.	Significant work is required from health boards to improve the provision and maintenance of safe and clinically appropriate facilities for CMHT service users and staff.
7.	CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.
8.	CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve.
9.	CMHTs must ensure copies of CTPs are given to service users and their relatives, where consent has been provided for this to happen.
10.	Health boards ensure regular audits are performed to ensure that service users are not detained under section 4 of the MHA for longer than 72 hours.
11.	Health boards and Local Authorities need to ensure there is joint access to relevant CMHT records. This has a clear potential adverse impact upon the standard of care being provided and needs to be addressed as a matter of priority.
12.	Health boards need to ensure there are clear lines of accountability, staff training, dedicated pharmacy support and robust auditing processes to oversee and implement medicines management within community services, especially within CMHTs.
13.	CMHTs need to ensure that all staff complete mandatory adult and child safeguarding training.
14.	CMHTs need to ensure that carers' assessment of needs are routinely offered.
15.	CMHTs need to undertake an audit of discharges to measure the quality and timeliness of discharge planning in order to help improve services and outcomes for service users.
16.	CMHTs need to review the role of the care co-ordinator and establish whether the service users are receiving the correct input from the most appropriate professional.
17.	CMHTs and care co-ordinators in particular, need to ensure discharge planning is robust and meets with legislative requirements.
18.	CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users.
19.	Health boards need to explore and utilise the support that may be offered by third sector services across Wales, with a need to take advantage of the range of community groups and mental health support services available to patients in their local communities.

No.	Recommendation
20.	Much more work is needed to increase the availability and timely access to psychological therapies across Wales. Health boards need to improve resources in this area and look at different ways of making sure sufficient psychological services were being provided.
21.	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection.
22.	Welsh Government needs to ensure that the implementation of the Welsh Community Care Information System (WCCIS) progresses with pace.
23.	All CMHT staff should receive training in the following: • Mental Health Act; • Social Services and Well Being Act; • First Aid and the use of defibrillators.

What we did

In its 2016-17 Operational Plan, Healthcare Inspectorate Wales (HIW) proposed to undertake a thematic review relating to mental health services in the community. This decision was primarily a response to a report published by HIW in March 2016: *Independent External Reviews of Homicides – An Evaluation of Reviews Undertaken by HIW since 2007*[2]. This review collated common themes which emerged and assessed the impact that the reviews had on the provision of mental health services across Wales.

The broad issues highlighted within the evaluation report included:

- Care planning, assessment and engagement with families/carers
- Risk management
- Diagnosis
- Discharge and aftercare planning
- Integrated and co-ordinated services
- Communication and information sharing.

Given the integrated nature of community mental health services, it was agreed that the review would be carried out jointly with Care Inspectorate Wales (CIW), and that CIW's 2017-19 adult services' engagement programme would include a focus on community mental health services.

Scope

The review was conducted in two phases. Phase one of the review consisted of seven joint inspection visits to selected CMHTs within each of the seven health boards[3]. Our inspections comprised of:

- A self assessment completed by each health board and local authority
- Interviews with selected CMHT staff
- Review of patient documentation including care plans and assessments
- Review of systems in place to plan and coordinate the provision of care and treatment to patients
- Interviews with service users and carers.

2 See: www.hiw.org.uk/reports/natthem/2016/homicideevaluation/?lang=en

3 ABUHB – South Caerphilly CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180216caerphillycmhten.pdf
ABMUHB – Swansea (Area 2) CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180131swanseacentralcmhten.pdf
BCUHB – Deeside CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180131deesidecmhten.pdf
C&VUHB – The Links CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180329thelinksen.pdf
CTUHB – Cynon CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180219cynoncmhten.pdf
HDUHB – South Pembrokeshire CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180326southpembrokeshireen.pdf
PTHB – Welshpool CMHT www.hiw.org.uk/docs/hiw/inspectionreports/180131welshpoolcmhten.pdf

Phase two built upon phase one findings and sought, through engagement with strategic and clinical leads across Wales, views on the issues previously identified and plans for improvements issued during phase one inspections. Engagement activity was undertaken by HIW and CIW with people who use services, carers, third sector and regulated service providers. A Community Mental Health survey was also undertaken to receive responses from people who used community mental health services. The second phase of this review set out to refine our understanding and assess:

Access to Services

- Effectiveness of arrangements, including referral processes and criteria to CMHTs.

- **Care Planning**
  - Quality and quantity of information collated to assist with care planning and assessments.
  - Compliance with the Mental Health (Wales) Measure 2010 and Social Services and Well Being (Wales) Act 2014, in relation to care planning and assessments, including clinical care and crisis intervention.
  - Compliance with the Mental Health Act (MHA) 1983, including community treatment orders.

- **Delivery**
  - Infrastructure, integration and co-ordination of services within CMHT teams, including effectiveness of Multi-Disciplinary Teams (MDTs), resources, case loads and information sharing arrangements.
  - Understanding the mechanisms used for communication/information sharing with patients, their families and carers.
  - Timeliness and accuracy of discharge arrangements and the robustness of aftercare planning for patients.
  - Links to and availability of other support services.

- **Governance**
  - Leadership and governance.
  - Quality Assurance of services.

Methodology

The joint thematic review focused on community adult mental health services (people between the ages of 18-65). Primarily we looked at Community Mental Health Teams (CMHTs)[4] and made inspection visits to CMHTs based in each health board[5]. The inspections included interviews with selected CMHT staff (NHS and local authority) responsible for providing and co-ordinating the care and treatment, service users and family or carers. We also undertook documentation and systems reviews to help form our findings. Relevant policies and guidance were utilised as a baseline for the review, and included:

4 Community Mental Health Teams (CMHTs) support people living in the community who have complex or serious mental health problems. Mental health staff from both the local authority and health work in a CMHT.

5 These inspection visits totalled seven, one per health board.

- Mental Health (Wales) Measure 2010 [referred to as the Measure in the report]
- Mental Health Act 1983 [referred to as the Act in the report]
- The Social Services and Wellbeing Act (SSWBA) 2014
- Health and Care Standards 2015
- Together for Mental Health A Strategy for Mental Health and Wellbeing in Wales 2016.

Community Mental Health Survey

Service users, their relatives and carers are at the centre of HIW and CIW's approach to inspection and review. Therefore, as part of this thematic review, HIW and CIW sought to capture the views of service users and their relatives/carers. Along with face to face interviews we undertook a confidential survey to ascertain what the service users and their families/carers felt about the quality of the services provided. We had 280 responses made up as follows:

Family member or carer:	127 responses
Previous service user:	51 responses
Current service user:	102 responses.

Some of the findings have been incorporated into the text of the report. Further detailed results can be found in Appendix B.

Stakeholder Reference Group

HIW's Mental Health Stakeholder Group acted as the thematic review stakeholder group. Membership included: Hafal, Advocacy Support Cymru, Mental Health Foundation, Mental Health Alliance, Gofal, Mental Health Matters in Wales, Unllais, Hafan Cymru, Diverse Cymru, Bipolar UK, HUTS, Gwalia, Small Steps Project, Ponthafren Association. The group was used to ensure that relevant organisations were kept suitably informed with the plans and progress for the review, as well as to provide guidance and scrutiny for our review where necessary. In addition, CIW liaised with the Association of Directors of Social Services (ADSS) Cymru.

The Review Team

To support our work we utilised expertise comprising of Mental Health Nurses and Social Workers as well as Mental Health Act administrators.

What we found

Quality of Service User Experience

Our review found that in general the service experienced by people in most CMHTs requires improvement. Although progress is being made in improving some aspects of services such as access, there continues to be improvement required with regard to:

- Including service users and their carers/relatives in enhancing service provision.
- Reducing referral and assessment times.
- Simplifying the referral and assessment process.
- Access to advocacy services.

Timely Access

The principle of timely care is that people have access to appropriate services as quickly as possible based on the persons' clinical need. We found that CMHTs across Wales are aware of and are addressing issues in relation to referral pathways and some are moving towards a more integrated single point of contact to ensure prompt referrals to the most appropriate team.

Health and Care Standard 5.1 Timely Access:
All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

Quality Standards for Local Authorities 1c:
Work with people as partners to undertake an assessment of personal well-being outcomes in a timely manner.

Quality standards for local authorities issued under section 145 of the Social Services and Well-being (Wales) Act 2014.or a more detailed paragraph version. The code of practice in relation to measuring social services performance is issued under section 145 of the Social Services and Well-being (Wales) Act 2014. This code of practice contains the performance measurement framework for local authorities in relation to the exercise of their social services functions. The performance framework is made up of quality standards and performance measures.

We would expect to see evidence that referrals, assessments and treatments are undertaken in a timely way consistent with national timescales, care pathways and best practice. Additionally, the NHS Outcomes and Delivery framework 2017-18 requires that people in Wales have timely access to services based on clinical need and are actively involved in the decisions about their care.

What we found:

We found that overall people's experience of accessing services was variable with some expressing satisfaction with the timeliness of response and others experiencing delays.

We found the processes for accessing mental health care cumbersome and difficult to navigate across Wales. For instance, difficulty in understanding the different referral criteria for the various community support teams and the appropriateness of each team in relation to the service users' identified need meant that many referrals to CMHTs, especially from GPs, were submitted with limited or incorrect information. This resulted in referrals often being sent back to the GP for further detail, delaying access to assessment and support for people. We saw response times vary from the same day (within 4 hours) to the Welsh Government target of within 28 days. Over a half of service users in our survey told us they waited 4 weeks or longer to be seen by a CMHTs following referral (54%).

Welsh Government figures and our survey (73%) show that GPs are the main source of referral, however analysis of GP referrals undertaken by one Welsh health board showed that 68% were not accepted into CMHT's for ongoing care. This highlights the need for further work to be undertaken specifically to raise awareness and understanding about the mental health referral process across GP practices.

The problems created by the complexity of referral processes are compounded by the variety of access points for services across Wales. For example, some community services have different access points for individual services, where others have a single point of access where referrals are triaged[6] and the service user is signposted to the most appropriate service. There are no processes in place to check whether this signposting is successful in meeting the service users' needs and organisations cannot be assured that people's needs are always being met. There is with a risk that people's mental health may deteriorate or relapse due to untimely or inappropriate care.

We also looked at access to services for people experiencing mental health crisis or urgent need and again found variability across Wales. Some, service users received immediate intervention and support, whilst others experienced a delayed response, for example having to attend A&E departments on more than one occasion or having difficulty contacting services out of hours.

Most CMHTs provide an out of hours service (after 5 pm and on weekends), albeit delivered in different ways. Importantly, our survey told us that only half of people who had accessed mental health services knew how to contact the CMHT out of hours service (49%) and only around two fifths of people who had contacted a CMHTs out of hours service said they received the help they needed (43%). A significant number of service users did not know who to contact and were not satisfied with the help offered. This means people who need to access services in a crisis cannot be confident their needs will be responded to appropriately and in a timely manner.

The majority of family members or carers told us that they had concerns about the safety or wellbeing of their family member or the person they care for, themselves or other people (83%). However, less than two thirds of family members or carers said that they would know who to contact in the event of a crisis or serious concern (60%). Additionally, only just under a half of family members or carers that contacted the CMHT in a crisis or with a serious concern, told us that they got the help they needed (45%).

6 Triage generally is a process of sifting and prioritizing both in terms of urgency and relevance.

Nevertheless, Welsh Government told us that over the last 12 months, there has been a decrease in the number of adverse incidents reported due to service users experiencing delays in accessing urgent support. We were told this is a result of improved processes and engagement between referrers and crisis teams, more appropriate escalation to secondary care when required and the tightening of processes between all community services.

No.	Recommendation
1.	Health boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.
2.	CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern.

Individual Care

We found that people are not being routinely offered the opportunity to feedback their views on the services provided, nor given information on how to raise a concern. Whilst in some areas CMHTs are obtaining service user feedback via third sector surveys, this is not consistent throughout Wales and we did not see any evidence of improvements made to services as a direct result of people's feedback. We did however hear of some innovative practice with service users involved with service development boards and recruitment panels.

Health and Care Standard 6.3 Listening and Learning from Feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

SSWBA Code of practice in relation to measuring social services performance 3.1 and 3.2: Measuring well-being

Focussing on people's individual outcomes means that local authorities **must** look beyond formal service provision and work with people and communities to identify and plan for support and opportunities that can help people achieve what matters to them.

Local authorities **must** ensure that the range and level of services provided support the delivery of the outcomes that matter to people.

We expect to see evidence that individual service users, their family and/or carers' voices are listened to and that health boards and local authorities use these experiences to shape future services, as required in the Together for Mental Health Delivery Plan 2016-19, the NHS Outcomes and Delivery Framework 2017-18, and the Social Services and Well-being (Wales) Act 2014 Code of practice in relation to measuring social services performance. We would also expect to see evidence of compliance with legislation and guidance to deal with concerns, incidents, near misses and claims as set out within the NHS Concerns, Complaints and Redress arrangements (Wales) 'Putting Things Right' and Local Authority arrangements as set out in *A guide to handling complaints and representations by local authority social services (2014)* guidance.

Additionally, we expect to find regular monitoring and audit of these arrangements, and examples of lessons learned and honest and open engagement with all who access the services.

What we found:

There were not always systems in place that enabled service users and relatives to provide written or verbal feedback and there was a lack of clear information on how to raise a concern.

We did find evidence of developing practice by involving service users in service change. For instance, in some CMHTs arrangements are in place for service users to be included on staff interview panels, at service development events and also to provide feedback on services. Additionally, some health boards are linking with third sector organisations to explore ways to engage and learn from service users' experiences. However, these initiatives are not consistently seen across Wales and very few are jointly developed between health boards and local authorities specifically for CMHTs.

We were told patient feedback forms/questionnaires and 'Putting Things Right' guidance are available for in-patients but not always available in community services. During the course of our fieldwork it was widely acknowledged that this information needs to be in waiting rooms, treatment rooms and could also be discussed as part of the discharge plan.

Many areas told us they use complaints as one means of measuring patient satisfaction. Whilst we saw, from minutes of meetings, that there are quality assurance and health and safety reporting processes, with evidence of senior representation on each other's boards (health and local authority), it remains unclear how lessons are learned and shared in a meaningful way. This is because we identified inconsistencies in how complaints about CMHT services are handled. Although there is some alignment between NHS and Local Authority concern reporting processes since the local authority complaints arrangements were introduced in 2014, there are still distinct differences between procedures. This sometimes results in lengthy and inconsistent responses to complaints, duplication of effort, and in some complaints not being handled at all. We also found within health boards, concerns were not always being recorded and logged in accordance with 'Putting Things Right'. Therefore, it was unclear whether they were being monitored, investigated, themes highlighted and lessons learnt. It was also unclear how improvements were being measured and monitored and whether this was undertaken via action plans, sharing of information with relevant teams, or through monitoring by senior managers.

Overall, we found improvement was needed to ensure systems and organisational structures effectively support service users and carers to contribute to the review/evaluation of services and to service development.

No.	Recommendation
3.	Health boards need to ensure that information relating to the 'Putting Things Right' process is available at all CMHT locations.
4.	CMHTs need to improve the way that they oversee the handling, monitoring, and lessons learned aspects of concerns/complaints.

Advocacy

Service users are not routinely offered advocacy services at significant points of their care pathway.

Health and Care Standard 6.2 Peoples Rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirements recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

Social Services and Well-being (Wales) Act 2014
Code of practice in relation to measuring social services performance:
Quality standards for local authorities.
Social services and Well-being (Wales) Act 2014 – Part 10 Code of Practice (Advocacy)

This code sets out the requirements for local authorities to:

a. ensure that access to advocacy services and support is available to enable individuals to engage and participate when local authorities are exercising statutory duties in relation to them; and
b. to arrange an independent professional advocate to facilitate the involvement of individuals in certain circumstances. Paragraph 45 of the code states local authorities **must** arrange for the provision of an independent professional advocate[7] when a person can only overcome the barrier(s) to **participate fully** in **the assessment, care and support planning, review and safeguarding processes** with assistance from an appropriate individual, but there is no appropriate individual available.

We expect to see evidence that service users' individual needs are recognised, and when required, advocacy services are offered in a timely and responsive manner. This would enable service users who are most vulnerable, to receive support to explore choices and options before making decisions about their lives.

7 **Independent professional advocacy** – involves a one-to-one partnership between an independent professional advocate who is trained and paid to undertake their professional role as an advocate. This might be for a single issue or multiple issues. Independent professional advocates must ensure individuals' views are accurately conveyed irrespective of the view of the advocate or others as to what is in the best interests of the individuals.

What we found:

Under Part 4 of the Measure, the provision of advocacy covers any service user who is subject to a CTO[8] where the hospital responsible for them is situated in Wales. The over-arching duties under section 6 of the SSWBA require that any person exercising functions under the Act must in so far as reasonably practicable, ascertain and have regard to people's views, wishes and feelings. We could not be assured that service users were routinely being offered advocacy services at assessment or at significant points throughout their care.

Our survey found that less than a quarter of service users and previous service users were offered the support of an advocate (22%), especially for assistance with initial assessments, mental health review tribunals, hospital manager hearings or CTP reviews. Advocacy support ensures services users can participate fully in assessment and care planning and making decisions about their future. Due to the lack of record keeping regarding an active offer of advocacy support, we did not see evidence that this was consistently and routinely happening.

In addition, it is not clear joint commissioning arrangements ensure sufficient and appropriate advocacy resource is available consistently across Wales. Senior CMHT managers could not assure us that advocacy services were routinely and consistently being offered to service users because current quality assurance reporting systems do not provide evidence that advocacy has been offered. It was acknowledged not all staff recognised the importance of making this offer at an early stage. We saw that most health boards had links with statutory advocacy organisations, and some had a contract to provide advocacy services, but this was usually for inpatients and not always for people in the care of CMHTs. In order to ensure compliance with the Measure, the Mental Health Act Code of Practice, and the SS&WBA a more systematic/routine offer of advocacy to service users is required.

Throughout Wales we found that advocacy representatives do not come regularly to the CMHT services to meet patients, or attend Mental Health Review tribunals, case reviews or CTP reviews.

No.	Recommendation
5.	Health boards and local authorities need to look at ways to improve awareness of advocacy provision amongst their staff and develop local monitoring of CMHT engagement with advocacy services, to ensure service users have access to the support they require on assessment at significant points within their care.

8 A Community Treatment Order (CTO) is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

Delivery of Safe and Effective Care

We are assured that health boards and local authorities have oversight of the quality of care provided within their CMHTs. However, in the context of significant service transformation it is important for senior managers to maintain focus on ensuring service users continue to receive the appropriate care from the appropriate person at the appropriate time whilst the wider organisational changes are being introduced.

Safe Care

We were not assured that due care and attention was being given to CMHT environments which directly impacted on service users' dignity and privacy as well as staff safety.

Health and Care Standard 2.1 Managing Risk and Promoting Health and Safety

People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced and prevented.

Quality standards for local authorities: Code of practice in relation to measuring social services performance.

Local authorities must work with people who need care and support and carers who need support and relevant partners to protect and promote people's physical and mental health and emotional well-being.

We would expect to see evidence that risk management and health and safety are embedded within services and that all possible measures are taken to prevent serious harm or death. We would want to see safety notices, alerts and up to date information available to help identify and manage any potential risks or emerging issues.

What we found:

We found environmental concerns at most of the CMHT areas we visited. Many involved unsuitable premises which impacted on the privacy and dignity of service users such as the absence of clinical rooms for administration of medication. Additionally, many of these had environmental risk assessments which indicated that there was outstanding work directly relating to staff safety and infection control, for example, no hand wash basin or safety alarms in individual rooms.

All health boards and local authorities described similar processes for ensuring appropriate actions were undertaken to address any environmental shortcomings, for example, through Health & Safety (H&S) audits and infection control audits which are discussed in operational groups. However, our work indicated that these arrangements were predominantly for inpatient or residential facilities. Further exploration showed that most health boards and local authorities have very few routine environmental audits or H&S audits of CMHT premises.

The importance of providing an inviting reception area was acknowledged by CMHTs and some service users reported experiencing sensitive, caring and professional response from reception staff.

No.	Recommendation
6.	Significant work is required from health boards to improve the provision and maintenance of safe and clinically appropriate facilities for CMHT service users and staff.

Care and Treatment Plans

We found that health boards and local authorities have individual programmes of audit to ensure compliance with national standards. However, there are areas for improvement specifically:

- the quality of collaborative audits between both services;
- the quality of Care and Treatment Plans (CTP);
- the involvement of service users and their relatives/carers in developing the plans.

Health and Care Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Quality standards for local authorities: Code of practice in relation to measuring social services performance

Local authorities must work with people who need care and support and carers who need support and relevant partners to protect and promote people's physical and mental health and emotional well-being.

Part 2 of the Measure and the Mental Health (Care Co-ordination and Care and Treatment Planning) (Wales) Regulations 2011 place duties on care-co-ordinators in relation to the preparation, content, consultation and review of care and treatment plans. Service users should be involved in planning their care and treatment, where practicable. All SSWBA Codes of Practice reinforce that local authorities must work with people who need care and support and carers who need support to define and co-produce personal well-being outcomes that people wish to achieve.

This means that mental health professionals must engage with service users to identify and plan the delivery of a range of services to meet their needs. Engagement should include the co-production of a care and treatment plan between the service user, mental health service providers and the care coordinator, as well as the setting of goals to achieve the agreed outcomes within the plan. It should also include the monitoring of the delivery of services, with any amendment of the plans undertaken through a planned and systematic review process. Engagement should also apply to the families and/or other significant people in the lives of the service user, subject to their ongoing agreement and consent.

We would expect to see that service users are encouraged and supported to participate in planning their care. There should be on going risk assessments and individual care planning involving all those relevant to the person's care. There should be evidence of multi-disciplinary-professional-agency working to support service users to reach their full potential.

What we found:

We found the quality of Care and Treatment Plans (CTPs) was variable across Wales. Whilst some areas reflected aspects of good multi-disciplinary person centred work, most documentation did not provide sufficient evidence of the discussions, assessments, investigations and decisions made by the multi disciplinary team around service users' care, treatment and support in accordance with regulatory requirements. There was also a lack of recorded evidence of carers' assessments being offered.

We found improvement was needed in the recording of risk assessments to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.

Although service users told us that they and their carers had sometimes been involved in the writing of their CTPs and that some recorded the views of service users in their own words, this was not consistently the case. In addition we found CTPs were sometimes not signed and did not evidence that service users (or where appropriate their carers) were provided with a copy. This means that people cannot see for themselves that their CTPs are current and relevant to outcomes they wish to achieve. There is more work to be done to ensure that copies of CTPs are given to service users and their relatives where consent has been provided for this to happen. We found in our survey that under half (48%) of service users were given an opportunity to have a copy of their care plan.

It was clear that within the CMHTs, health board and local authorities have individual routine quality audits of service user care plans in place. However, whilst senior managers attend each organisation's quality assurance meetings, there is less evidence that there are joint quality assurance audits undertaken. It would be beneficial if there were unified audits which looked at the CMHT as a whole integrated team rather than two co-located services. It would also foster closer working relationships and integrated service provision. There were also concerns raised in some areas regarding the quality of the audits, suggesting that there is sometimes a tendency to look at the presence of care plans rather than quality of them. This is an issue that requires action to address.

Our survey findings suggest a number of additional areas which would benefit from closer scrutiny in CTP audits. These include the involvement of service users in the development of their care plan (only 23% feeling involved) and feeling that a member of their family, or someone else close to them, was not involved as much as they would have liked (51%).

We saw some evidence of staff engaging well with people. Positive comments from relatives and carers who were involved in care planning included almost half saying that their CMHTs staff offered sufficient time to express their views and family members or carers confirming that they felt listened to during these discussions. Three quarters of service users felt that their CMHT worker usually listened to them carefully (76%). We found many people in receipt of a service from their local CMHT felt well supported by their mental health workers and were treated with dignity and respect. Some people interviewed expressed satisfaction in their relationship with their worker. Comments included:

"Everyone is so welcoming"

"Staff go out of their way to provide support"

"Without this service I would not be here"

"Staff demonstrate human qualities; respectful and trustworthy practice"

Welsh Government has a 90% achievement target for service users to have a valid CTP within 6 weeks of allocation to a care co-ordinator.

Care and treatment plan (CTP) compliance, by LHB, service and month (March 2018)

	Total number of patients resident in the LHB with a valid CTP at the end of the month	Total number of patients resident in the LHB currently in receipt of secondary Mental Health services at the end of the month	Percentage of patients resident in the LHB, who are in receipt of secondary mental health services, who have a valid CTPs
Wales	21,135	23,753	89.0
BCUHB	4,899	5,736	85.4
PTHB	980	1,033	94.9
HDUHB	2,182	2,371	92.0
ABMHB	2,854	3,213	88.8
CTUHB	2,288	2,657	86.1
ABUHB	2,892	3,183	90.9
C&VUB	5,040	5,560	90.6

Mental Health (Wales) Measure Part 2 – Care and Treatment Plans (Statswales.gov.uk)

In Wales, there were 23,753 service users in receipt of secondary mental health services during June 2018. Of these, 21,135 (89.0%) had a valid Care and Treatment Plan (CTP), with half of the CMHTs meeting the 90% target. This is despite CMHTs reporting that caseloads are high and care co-ordinators are inundated with work. This is a credit to the diligence and conscientiousness of staff.

Part 3 of the Measure provides eligible service users with an entitlement to request an assessment (usually by a member of the CMHT) should they feel that their mental health is deteriorating. Welsh Government has a target of 100% for assessment of service users within 10 working days of their request.

Outcome assessment report compliance, by LHB and month

	Number of outcome assessment reports that were sent up to and including 10 working days after the assessment had taken place	Number of outcome assessment reports that were sent after 10 working days after the assessment had taken place	Total number of outcome of assessment reports sent within the month	Percentage of outcome assessment reports sent less than or equal to 10 days after the assessment had taken place
Wales	84	4	89	95.5
BCUHB	16	2	18	88.9
PTHB	1	0	1	100.0
HDUHB	6	0	6	100.0
ABMUHB	2	0	2	100.0
CTUHB	4	2	6	66.7
ABUHB	12	0	12	100.0
C&VUHB	44	0	44	100.0

Part 3: Assessment of Former Users of Secondary Mental Health Services – Outcome assessment report compliance, by LHB and month (Statswales.gov.wales)

We commend the hard work of front line staff in developing outcome assessment reports for service users in a timely way (95.5%). Our review, however, indicated that less than half (43%) of previous service users knew they could refer themselves to their CMHTs if they felt that they were relapsing.

It is evident that throughout Wales, there needs to be greater emphasis on explaining and engaging service user and service user relatives with the process of developing CTPs.

No.	Recommendation
7.	CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.
8.	CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve.
9.	CMHTs must ensure copies of CTPs are given to service users and their relatives, where consent has been provided for this to happen.

Record Keeping and Mental Health Act Documents

Whilst all health boards have arrangements in place for scrutinising Mental Health Act documentation, the quality of these arrangements, and expertise available to do so, differs from health board to health board. The quality of the documentation needs improvement; this may be due to training needs and the recruitment of appropriate staff to undertake the role of care co-ordinator.

Health and Care Standard 3.5 Record Keeping

Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.

We would expect to see documentation and service user records maintained according to the standards set by individual professional bodies. Entries should be clear and support clinical judgements formed from appropriate risk assessments. There should be clear documentation in line with legal requirements on:

- the administration of the Mental Health Act;
- section expiry dates;
- records in regard to any hospital manager reviews and mental health tribunals; and
- detained service users should be aware of their rights and this is recorded.

What we found:

We found that although each health board has a governance structure to ensure that the legal documentation required by the MHA is reviewed on a regular basis, the overall quality of record keeping in most health boards did not meet the required standards. For instance, because staff were not always aware of the parts of the Mental Health Act which informs their work, aspects of record keeping were not compliant with legislation or guidance.

In one area we found a disproportionate number of service users detained under section 4[9] of the MHA. It appears that there is a direct link between this and the limited availability of section 12[10] doctors[11] in that area. Section 4 is an emergency admission which only allows a doctor to admit a patient for 72 hours therefore, the Act requires that two doctors agree if a service user is to be detained for a longer period. Insufficient staffing is not an acceptable reason to keep service users under section 4. Health boards must ensure, in line with the Code of Practice that there are sufficient section 12 doctors on their register.

We found recording of documentation varied across Wales with the majority of local authority and health boards continuing to use separate electronic systems. In addition some records (mainly medical) continued to be kept in paper format, which means that access and storage of records is a problem. Communication across health and social care was further complicated as staff employed by either health or local authority organisations had different degrees of access to the main databases or intranets of each other's organisations.

Managers also informed us that current electronic systems do not always provide routine reports in relation to some key factors such as the offer of advocacy or carers assessments.

Recently, a great deal of work has been undertaken across Wales to offer more support/training to MHA managers with the development of the All Wales MHA Forum. This provides a network of contact details for MHA administrators and offers support to all health boards. This is a significant move towards supporting consistency in MHA documentation and monitoring throughout Wales and can be a conduit to provide a framework for standard setting.

No.	Recommendation
10.	Health boards must ensure regular audits are performed to ensure that service users are not detained under section 4 of the MHA for longer than 72 hours.
11.	Health boards and Local Authorities need to ensure there is joint access to relevant CMHT records. This has a clear potential adverse impact upon the standard of care being provided and needs to be addressed as a matter of priority.

9 Section 4 of the Mental Health Act 1983 is used in emergencies, where only 1 doctor is available at short notice. Unlike a section 2 or 3, you can be detained with a recommendation from only 1 doctor. You can be kept for up to 72 hours. This gives the hospital time to arrange a full assessment.

10 Section 12(2) of the Mental Health Act 1983 requires that, in those cases where two medical recommendations for the compulsory admission of mental disordered person to hospital, or for reception into guardianship, are required, one of the two must be made by a practitioner approved for the purposes of that section. See: www.rcpsych.ac.uk

11 A section 12 doctor is a doctor trained and qualified in the use of the Mental Health Act 1983, usually a psychiatrist. They may also be a responsible clinician, if the responsible clinician is a doctor.

Medicines Management

There are varied arrangements for medicine management across CMHTs in Wales. Some areas have robust policies and procedures with clear accountability and guidance, while others have more informal arrangements with no dedicated mental health pharmacists, limited external audit and poor facilities.

Health and Care Standard 2.6 Medicines Management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

We would expect to see evidence of compliance with legislation, regulatory and professional guidance and with local guidance for all aspects of medicines management. That there was timely, accessible and appropriate medicines advice and information for service users, carers and staff and that service users understood the purpose and correct use of their medication or alternate treatment options. We would also expect to see robust systems in place to report reactions and adverse incidents and that these are managed appropriately.

What we found:

We found a variety of issues across CMHTs regarding safe administration and storage of medication. For example we found:

- Neither room or fridge temperatures were regularly checked.
- CMHTs need to consider making wider use of the physical monitoring forms in relation to depot[12] injections.
- Medication and medication transport policies/guidelines were not available in the clinical rooms.
- No named pharmacist attached to a CMHT to attend meetings, oversee stock management, and to undertake independent medication chart audits.
- Poor stock checks and recording of medicine administration.
- Poor environmental facilities.

In view of the lack of compliance with legislation, clear regulatory and professional guidelines and an absence of local guidance for medicine management, there is the potential for harm and error. Health boards, specifically regarding CMHTs, need to evaluate their processes for medicines management with a view to aligning with the requirements of in-patient care which includes dedicated pharmacists and regular audit.

No.	Recommendation
12.	Health boards need to ensure there are clear lines of accountability, staff training, dedicated pharmacy support and robust auditing processes to oversee and implement medicines management within community services, especially within CMHTs.

12 A depot injection is a slow-release, slow-acting form of a service users usual medication. It's administered by injection, and it is given in a carrier liquid that releases it slowly so it lasts a lot longer.

Safeguarding

We are satisfied that both health and local authority senior managers have oversight of safeguarding referrals and any on going concerns. CMHTs demonstrated an increasing awareness about safeguarding issues; some are actively incorporating key safeguarding prompts within their assessment documentation.

Health and Care Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

Quality standards for local authorities: Code of practice in relation to measuring social services performance. Local authorities must take appropriate steps to protect and safeguard people who need care and support and carers who need support from abuse and neglect or any other kinds of harm[13].

We would expect to see effective local safeguarding strategies that combine preventative and protective elements with a thorough understanding of safeguarding procedures across all staff working in CMHTs in line with the Social Services and Well-being (Wales) Act 2014. Staff should receive training according to their role to enable an understanding and application of the principles of safeguarding.

What we found:

It was not always clear whether consideration was routinely given to whether people were at risk of harm, abuse or neglect. For example, in one specific case we saw documentation relating to concerns about the safety of a service user's children but there was no evidence of any further consultation with the respective child safeguarding team. This highlights the need for a more robust approach to linking with and recording contact with child and adult safeguarding teams.

Organisational arrangements for dealing with safeguarding referrals varied, with some services having centralised safeguarding teams whilst in other services team managers held the designated lead manager role. The important factor, whatever the organisational arrangements, is to ensure that the roles and responsibilities are understood and they have the capacity and knowledge to carry out these responsibilities. We found some staff did not feel confident in their knowledge of safeguarding policy and procedures and these matters were not routinely discussed at allocation and team meetings. Although training is provided on a routine basis in most CMHTs, we found not all staff had completed the mandatory adult and child safeguarding training.

No.	Recommendation
13.	CMHTs need to ensure that all staff complete mandatory adult and child safeguarding training.

13 Abuse, neglect and harm are defined in the Social Services and Well-being (Wales) Act 2014.

Carer Assessments

We are not assured that all carers are receiving a carer's assessment to identify any support or assistance they may need to care for the service user.

Health and Care Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Part 3 Code of Practice (assessing the needs of individuals)

A local authority must assess whether the carer[14] has needs for support (or is likely to do so in the future) and if they do, what those needs are or are likely to be.

We would expect to see evidence in line with Health and Care Standards 2015, and SSWBA that carers of service users who are unable to manage their own health and well being are supported. The SSWBA requires local authorities to offer carers an assessment of their needs where it appears they may have need for support. The provision of information, advice and assistance is also a core part of what must be provided. Carers must feel they are equal partner in their relationship with professionals.

What we found:

The State of Caring 2018 report reveals that 74% of carers across Wales say they have experienced mental health illness as a result of their caring role. In comparison to the whole of the UK the figures show that Wales ranks slightly above the UK average of 72% on this aspect. 61% of carers in Wales also feel their physical health has declined due to their role.

With care support provided by the UK's unpaid carers being an estimated £132 billion per year it is significantly more than the NHS' annual budget in Wales £6,381 million 2016-17 (Statswales.gov.uk). With 11.2% of the total amount spent on supporting people with mental health problems, it is troubling when our survey shows that only half of family members or carers say they feel valued in their caring role (50%).

We were told by senior managers that staff were sensitive to carers' needs and rights but they acknowledged case records did not always reflect this. Staff and managers report there is generally a low up take of assessment and support services by carers of people with mental health needs. In some services carers' champions have been introduced to try to raise the profile of carers and encourage staff awareness of the issues. However, we are not assured that senior managers are fully aware of the quality or quantity of carers assessments offered by CMHTs. Our survey indicated that only 23% received an offer or an assessment of their own needs. Furthermore when we asked for reassurance that care co-ordinators were reminded about assessments and were ensuring that these were taking place within the team, senior managers were unable to give us conclusive information.

14 A carer is defined in the Act as a person who provides or intends to provide care for an adult or a disabled child. In general, professional carers who receive payment should not be regarded as carers for the purposes of the Act, nor should people who provide care as voluntary work.

> We also found that almost three quarters of family members or carers said that they didn't have sufficient information about the services available to support their family member or the person they care for (70%). A similar proportion said they felt they didn't have sufficient information about their eligibility for those services either.
>
> The lack of awareness and support for carers by CMHTs has an impact on their own mental health and well-being. Nevertheless, some carers spoke warmly about the services provided by third sector organisations in providing support and recognition of the role they undertake.

No.	Recommendation
14.	CMHTs need to ensure that carers' assessment of needs are routinely offered.

Discharge

We are not assured that there is robust scrutiny around whether the legal requirements of discharge planning are being met. Consequently service users may not be receiving safe and timely discharges with the appropriate support or information to access primary care or third sector (voluntary) services if required.

Health and Care Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Quality standards for local authorities: Code of practice in relation to measuring social services performance

Local authorities must work with people who need care and support and carers who need support to define and co-produce personal well-being outcomes that people wish to achieve.

Local authorities must work with people who need care and support and carers who need support and relevant partners to protect and promote people's physical and mental health and emotional well-being.

We would expect to see evidence of an agreed discharge care plan, with on-going support provided, where necessary, by a range of mental health professionals in the community, which can include support from both statutory and voluntary agencies. In addition to a person's GP, this team of professionals could include: Community Psychiatric Nurses (CPNs), Social Workers, Psychologists, Occupational Therapists (OTs) and support workers who can provide a range of services encompassing monitoring and administering medication; providing 'talking therapies' and giving long-term support.

What we found:

We consistently found, across all CMHTs that CTP and risk assessment documentation needed to be updated prior to discharge, especially when there were transitional arrangements between CMHT and other services[15]. We found in most CMHTs that service users were not routinely being advised of their right to re-refer back to services without going through their GP. People who had experience of mental health services indicated variable experience regarding discharge and re-referral arrangements and from the evidence we have seen, we were not assured that CMHTs are consistently delivering quality or timely discharge from care for service users. Furthermore there are no robust systems in place to measure the quality and timeliness of discharge planning and the follow up with relevant services. With this lack of monitoring and audit there is a lost opportunity to learn lessons and improve services.

One area identified as having an impact on untimely discharges was high case loads for care co-ordinators[16], specifically those cases managed by consultants.

Careful planning is required in order for patients to be discharged in a safe manner. All discharges need to include any identified discharge needs, and involve service users. However, this isn't always happening due to workload challenges and service users are being discharged late or with incomplete CTPs. This is an area for improvement to ensure service users are receiving the correct level of care by the most appropriate member of the CMHT.

In our survey almost half of family members or carers said that they weren't involved at all in the discussions leading to the decisions for CMHT support to be discontinued (49%), and less than a third of family members or carers told us that they were provided with information about who to contact if they had further concerns about the health or wellbeing of their family member, or the person they care for, following discharge from the CMHT (32%).

According to the Mental Health Act, and the Mental Health Code of Practice for Wales, there are stipulated areas which need to be discussed prior to discharge. The following examples highlight some of the issues facing care co-ordinators.

Service users should be supported to find suitable accommodation

The availability of specialist support housing is variable and whereas some service users told us they had been given support to access council accommodation, others reported a long wait before appropriate accommodation became available. Additionally, only a quarter of family members or carers told us that the CMHTs provided advice with finding accommodation for their family member and only 34% of service users confirmed that their accommodation needs were met with the help of CMHTs. We asked senior managers what was available in their area in relation to this issue. With the exception of north Wales most could give examples of good engagement with local authority and third sector services and confirmed that there was good partnership working around accommodation.

15 When service users move between other services such as the CMHTs, private hospital sector, Children and Adolescence Mental Health Services (CAMHS) and older persons mental health services.

16 A care coordinator is the main point of contact and support for ongoing mental health care. They keep in close contact while the service user receives mental health care and monitor how that care is delivered – particularly outside of hospital. They are also responsible for carrying out an assessment to identify any health and social care needs. A care coordinator is usually a mental health professional.

However, despite existing policies, strategies, and legislation emphasising the importance of joined up and collaborative working, the experience of many staff on the ground was that this is not happening enough in practice. It is positive to note that some areas have been looking at alternative ways to meet local accommodation needs and Gwent Partnership[17] are exploring the use of some unique services such as a host family scheme, sanctuary provision and short-term crisis house residential support. Additionally, they are looking at the provision of an acute inpatient and crisis resolution home and treatment team to provide care to service users with significant mental health needs delivered by staff with specialist mental health expertise in their own home.

Personal care and well being

In preparation for discharge there should also be discussions to maintain personal care and wellbeing such as attending regular physical health checks with their GP or practice nurse. Our survey indicated that only 26% of family members or carers said that the CMHT provided advice with finding support for any physical health needs their family member or the person they care for had. In addition, only half of service users who needed support for physical health said that their CMHT gave them help or advice with finding support for these needs (48%). When challenged most senior managers told us that letters were sent to GPs to notify of any discharge plans and first appointments were made, where necessary. Additionally, ABMUHB told us that they have purposely developed some of their depot clinics within GP buildings to try and improve working relationships.

Benefits

Another area that should be explored prior to discharge is an assessment for entitlement to benefits and where appropriate support to access these. However, only 10% of family members or carers said that they were provided with information about direct payments to support their needs as a carer and nearly three quarters of service users and previous service users said that the option to receive direct payments to help meet their care and support needs was never discussed with them (73%). This represents a significant number of service users and their carers who believe that they did not have relevant financial support prior to discharge.

Our work has shown that there are variations across Wales regarding the quality of discharge planning and the availability of local services. Attention needs to be given by CMHTs to ensure that discharge reviews take place in a timely and meaningful way.

No.	Recommendation
15.	CMHTs need to undertake an audit of discharges to measure the quality and timeliness of discharge planning in order to help improve services and outcomes for service users.
16.	CMHTs need to review the role of the care co-ordinator and establish whether service users are receiving the correct input from the most appropriate professional.
17.	CMHTs and care co-ordinators in particular, need to ensure discharge planning is robust and meets with legislative requirements.

17 Gwent Strategic Partnership for Mental Health and Learning Disabilities.

Links/Access to other services

We found that there are a range of different support services being offered across Wales, many tailored to particular regions. However, a consistent message was that on a day-to-day basis there is often poor communication and a lack of joined up working across agencies. Psychology services within secondary, primary and third sector are also very limited and waiting times reflect the urgent need for successful recruitment in this discipline. Our overall conclusion is that all CMHTs managers need to use evidence of unmet need to inform planning and service development in partnership with service users and voluntary organisations.

Health and Care Standard 6.1 Planning Care to Promote Independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.

Quality standards for local authorities: Code of practice in relation to measuring social services performance

Local authorities must actively encourage and support people who need care and support and carers who need support to learn and develop and participate in society.

Local authorities must support people who need care and support and carers who need support to safely develop and maintain healthy domestic, family and personal relationships.

Local authorities must work with and support people who need care and support and carers who need support to achieve greater economic well-being, have a social life and live in suitable accommodation that meets their needs.

Part 9 Section 162 of the Social Services and Well-being (Wales) Act 2014

Co-operation and partnership – Arrangements to promote co-operation: adults with needs for care and support and carers.

Together for Mental Health Delivery Plan: 2016-19 states that "Access to services should be based on individual need, recognising individuals may need access to both talking and non-verbal therapies in order to express and explore their mental health problems. Good practice and the knowledge and experiences of delivering to diverse and sometimes complex groups must be shared across Wales."

We would expect to see evidence in the CTP of the outcomes agreed with the service user regarding some or all of the areas set out in section 18 of the Measure and in SSWBA. We would also expect to find that support is provided to develop competence in self-care and promote rehabilitation and re-enablement.

What we found:

We saw very little written evidence of links being established with other agencies to maintain wellbeing. CMHTs across Wales need to review processes and linkages with the crisis intervention teams or alcohol and drug misuse teams to ensure timely referrals. Additionally, there is a need to implement systems to assess the effectiveness of information and signposting to address service user needs. People reported mixed experiences around accessing information about services at an early stage in their involvement with professionals. Some indicated both the timing and method of information provision was something services needed to consider, particularly in relation to the service users' health and ability to retain or process information which can be a factor in mental health problems deteriorating.

We found CMHT reception areas contained a variety of information leaflets, but in some cases there was a lack of information provided in the Welsh language making the organisation non-compliant with Welsh language legislation. Our survey indicated that almost three quarters of family members or carers said that they didn't have sufficient information about the services available to support their family member or the person they care for (70%), whilst a similar proportion of family members or carers also felt that they didn't have sufficient information about their eligibility for those services either.

Generally, people in receipt of a service from the CMHT feel they are supported to engage in community activities. Most senior managers told us that the availability of third sector services can be dependent upon funding and commissioning priorities. They confirmed that in some areas, eligibility for some third sector and other support services is dependent upon eligibility for CMHT involvement and this could be a barrier to proactive preventative care. This is not consistent with the preventative or early intervention agenda.

We found varied levels of engagement with the third sector across Wales, sometimes dependant upon the region and the different needs of the specific population. There was though, a consistent message that on a day-to-day basis there is often poor communication and a lack of joined up working across agencies, and in particular across health, social care and housing services. However, we did hear of examples of good innovative partnership working. For example in a bid to develop services an innovative pilot project, jointly funded by Aneurin Bevan University Health Board and the Police and Crime Commissioner for Gwent, was set up, aimed at reducing demand on police officers where mental health is an underlying factor, managing risk and harm in relation to mental health crisis and to ensure that appropriate care and support is delivered in a timely way. Any emergency calls to Gwent Police are monitored by an Approved Mental Health Professional (AMHP) who works alongside staff in the control room and assists them in managing risk and harm to those with a mental illness or suffering a crisis. The AMHP has access to both the Police Force and the Health Board computer systems, which enables them to build a picture of the incident and the people involved.

There were also examples of services being provided by third sector organisations which ensured that people had access to good quality information at the right time to meet their needs and the requirements of the SSWBA. These included, Community Connector posts[18], sponsored by MIND in Blaenau Gwent, and well-being advocates placed in GP surgeries under an initiative taken by West Wales Action for Mental Health, (WWAMH)[19]. CMHTs in the BCUHB area are involved in the Bringing Agencies Together initiatives led by Unllais[20], which help showcase the range of community groups and mental health support services available to patients in their local communities. It is clear that the third sector has a wealth of experience and expertise that health boards and local authorities need to ensure they utilise in the most effective way.

Within Welsh Government's national strategy *Prosperity for All* there is a commitment to build on the capacity of communities by using approaches such as social prescribing.[21] Social prescribers are staff, mainly linked to GP surgeries who are usually social workers or local authority employees. We spoke to senior managers in areas where this scheme has been implemented and based on referral rates and feedback from GPs it seems to be working well generally. The aim is to link service users to non-clinical resources to support wellbeing and recovery. However, in relation to CMHTs, service users told us they were not aware of this service, suggesting that the CMHTs are either unaware of the resource or are not, where available, highlighting the social prescriber linked to their GP surgery.

CMHTs are aware of the geographical challenges in their areas and recognised the importance of people accessing services closer to home. Despite population needs analysis being completed for each health board, most CMHTs agreed that there has not been a robust review of unmet needs, or a mapping exercise to establish exactly what services are available in their location and determine any gaps in provision.

A noteworthy example of this is the Hafod Community Mental Health Team, a joint service between BCUHB and Denbighshire County Council. It is the first in Wales, and only the fourth in the UK, to receive the Accreditation for Community Mental Health Services from the Royal College of Psychiatrists. The accreditation has been given in recognition of their exemplary practice across 31 key areas identified by mental health professionals, carers and service users. A service user who has regular support from the Hafod Team said:

> **"My experience is very positive because of the people around me who support me. They do their jobs because they believe in it, and when you have the right people around you it's better. Everyone needs something different, I need someone who lets me talk and listens and I have this."**

18 Community Connectors work throughout the area and aim to reconnect people back into their communities. Community Connectors also work with many groups and organisations to help people find activities and groups that can help people improve their well-being.

19 West Wales Action for Mental Health (WWAMH) is an organisation involved in a broad range of activities to promote mental health and helps ensure people have access to independent and impartial information.

20 Unllais is a development, information and training agency that provides support to the voluntary sector, service users and carer organisations working in the field of mental health in North Wales. Through partnerships promote good practice in the planning, provision and monitoring of mental health services.

21 Social prescribing facilitates patients with a range of social, psychological and physical problems to access a wide range of local interventions and services provided by the voluntary sectors and others.

Service users' mental health is likely to worsen when faced with lengthy delays for psychological therapies, making recovery more difficult. These delays can also have a substantial impact on their lives, including their relationships, employment and accommodation. A theme across Wales is the general shortage of psychology services, with severe delays in accessing these services. This situation has been recognised by the Welsh Government which has allocated additional funds to health boards to help address the lack of sufficient resource. Health boards told us they were continually trying to improve resources and look at different ways of making sure sufficient psychological services were being provided.

Welsh Government has set a 28 day achievement target for interventions in primary care to support recovery and prevent unnecessary deterioration in health. This table represents the number of service users waiting for and starting therapeutic interventions for the month of June 2018.

Waiting times for a therapeutic intervention, by LHB and month

	Number of patients who had waited up to and including 28 days from LPMHSS assessment to the start of a therapeutic intervention	Number of patients who had waited over 28 days and up to and including 56 days from LPMHSS assessment to the start of a therapeutic intervention	Number of patients who had waited over 56 days from LPMHSS assessment to the start of a therapeutic intervention	Total number of therapeutic interventions started during the month	Percentage of therapeutic interventions started within 28 days following LPMHSS assessment
Wales	1,200	133	82	1,415	84.8
BCUHB	188	26	24	238	79.0
PTHB	107	29	3	139	77.0
HDUHB	121	6	6	133	91.0
ABMUHB	140	18	5	163	85.9
CTUHB	288	14	13	315	91.4
ABUHB	290	33	6	329	88.1
C&VUHB	66	7	25	98	67.3

Part 1: Local Primary Mental Health Support Services
Waiting times for a therapeutic intervention, by LHB and month
(Statswales.gov.wales)

To meet this target health boards across Wales are being prudent and innovative with many exploring the training of staff within the CMHTs to deliver specific therapies. For instance, ABUHB have recently recruited two extra psychologists and are presenting a bid for additional monies for cognitive behavioural therapists. ABUHB's plan is to train and support a group of mental health nurses to provide specific Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT) groups. The expectation is that the nurses will be predominantly in the community and it is anticipated that this will reduce waiting times for therapies in the community. The health board told us that here are no waiting times for psychological therapies in-inpatient services within this health board.

Service users indicated that where these issues were addressed, through direct service provision such as the involvement of support workers or engagement with third sector organisations, they valued the services received. We heard of examples where statutory and commissioned services are assisting people to maintain links with family members, to attend social community activities and to develop skills and confidence.

No.	Recommendation
18.	CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users.
19.	Health boards need to explore and utilise the support that may be offered by third sector services across Wales, with a need to take advantage of the range of community groups and mental health support services available to patients in their local communities.
20.	Much more work is needed to increase the availability and timely access to psychological therapies across Wales. Health boards need to improve resources in this area and look at different ways of making sure sufficient psychological services were being provided.

Quality of Management and Leadership

Governance Arrangements

We saw a move towards stronger clinical governance and clearer lines of accountability, changing cultures and developing better systems to measure outcomes. We have seen significant changes to divisional structures and heard about different ways of working for the future.

Information technology remains a considerable issue and Welsh Government needs to expedite support for health boards to enable safer, more efficient and effective record keeping.

Health and Care Standards: Part 2

Effective governance, leadership and accountability in keeping with the size and complexity of the organisation are essential for the sustainable delivery of safe, effective person-centred care.

Mike – can you reference CoP 8

Code of Practice on the Role of the Director of Social Services

The director of social services must have regard to the well-being duty and other overarching duties in relation to how the local authority exercises all its social services functions. The director of social services must show strategic leadership in ensuring all care and support services in the local authority area seek to promote the well-being of all people with care and support needs.

The director of social services must similarly seek to develop an effective environment to promote co-operation in relation to people with care and support needs with external partners, including the Local Health Board, the third sector and independent sector. Paragraphs 52 to 56 set out the role of the director in relation to formal partnership arrangements provided for by Part 9 of the Act which can be used for this purpose.

We would expect to see evidence of effective leadership through setting direction, pace and drive, and developing people. The strategies for should be set with a focus on outcomes, and choices based on evidence and people insight. The approach must be through collaboration building on common purpose. Health services should be innovative and improve delivery, plan resource and prioritise, develop clear roles, responsibilities and deliver models, and manage performance and value for money. Health boards should foster a culture of learning and self-awareness, and personal and professional integrity.

The SSWBA provides a legislative framework to support the transformation of the way people's needs for care and support are met and make social services in Wales sustainable. We would expect to see:

- A focus on people – ensuring people have a voice and control over their care and support.
- Measuring success in relation to outcomes for people rather than process.
- Delivery of a preventative and early intervention approach to minimise the escalation of need and dependency on statutory services.
- Effective cooperation and partnership working between all agencies and organisations.
- Improving the information and advice available to people and ensuring that everyone, irrespective of their needs, is able to access that information.
- The development of new and innovative models of service delivery, particularly those that involve service users themselves.

What we found:

Senior managers told us that due to increasing demand and reducing resources, the effectiveness of local senior management joint structures in resolving issues and leading joint service development and improvement is sometimes unclear.

Services have been subject to considerable organisational change in recent years which has disrupted local relationships and working practices. Discussions with senior managers across Wales indicated the Local Mental Health Partnership Boards (LPBs)[22] initiated under the Welsh Government 10 year Strategy Together for Mental Health are developing differently across Wales. In some areas a review of the model of service delivery for mental health services is underway, providing an opportunity to evaluate the present organisational structures and service provision, but not always involving all partners. Although needs analysis work has been undertaken, not all services have up to date commissioning strategies for mental health services in place. It is not clear therefore that commissioning of advocacy, engagement with housing, education and development of employment opportunities in addition to support services provided by the third sector are well targeted and sufficient to meet need.

We heard senior managers from both health boards and local authorities speaking about the need for stronger clinical governance and clear lines of accountability, focussing on changing the culture and improving systems to measure outcomes for service users. Some health boards and local authorities already have improvement plans in place and are actively implementing change by reviewing current governance arrangements, looking at gaps in accountability and for health, improving ward to board reporting and for local authority improved service to council reporting. Others have made significant changes to divisional structures and are proposing very different ways of working for the future.

Operational managers from health and social services were seen to work well together in the CMHT. There was mutual respect and cooperation and staff in general felt well supported by their line managers and other managers on the sites. We were told serious incidents and practice learning was regularly discussed at team and management meetings. This ensures that the CMHTs are learning from previous incidents and looking at improved ways of working for the future.

However, joint governance structures were not so well aligned. Across Wales and within each individual CMHT we found numerous recording systems in place, and not all staff had access to these records because health and social systems were not integrated. A number of CMHTs continue to use paper records and to complicate issues some have different multi-disciplinary paper records within the teams, this makes managing records and collating accurate data on CMHT services almost impossible. Additionally, whilst there are arrangements for audits to be reviewed at individual and joint senior management level, it is not always clear how effective these are in driving improvement. Consequently, interviews with senior managers did not provide assurance that there are effective joint processes in place to ensure appropriate data collection to guide future service delivery.

22 The Local Mental Health Partnership Boards (LPBs) will oversee the delivery and implementation *Together for Mental Health – A Strategy for Mental Health and Wellbeing in Wales* and its Delivery Plan; guiding and monitoring progress, and facilitating co-ordination of the cross-cutting approach required across Welsh Government, Statutory Agencies, the Third and Independent Sectors.

> The new Welsh Community Care Information System (WCCIS) is gradually being rolled out across Wales and is anticipated to address the information sharing interface within health boards and between local authorities and health boards, including CMHTs. It is envisaged that there will be better communication between teams and improved information collation for strategic planning. The implementation of the WCCIS needs to progress with pace in order to improve efficiency of operation in a service that is encountering high levels of demand, and to support the requirements of the H&CS and the SS&WBA.

No.	Recommendation
21.	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection.
22.	Welsh Government needs to ensure that the implementation of the Welsh Community Care Information System (WCCIS) progresses with pace.

CMHT Resources and Capacity

There continues to be a staff recruitment and retention issue across CMHTs, although most CMHTs are looking at different ways of working to address the problems.

Health and Care Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Part 8 Code of Practice on the Role of the Director of Social Services (Social Services Functions)

The director of social services has a strategic leadership role to promote high standards across the care and support workforce, including the private and third sectors.

The director must ensure a whole sector workforce plan is in place which identifies and secures implementation of measures to ensure a sufficiently large, skilled, safe and focused workforce to promote the well-being of people with care and support needs.

We expect to see evidence of effective workforce plans which are integrated with service and financial plans to ensure services are meeting the needs of the population, through an appropriate skill mix with staff having language awareness and the capability to provide services through the Welsh language. We also expect to see evidence of promoting continuous improvement of services, through better ways of working, and conformation that staff are trained, supervised and supported appropriately.

What we found:

We identified issues in relation to the recruitment and retention of all CMHT staff. With staff vacancies and sickness rates within CMHTs[23] increasing and pressure on existing staff to meet demands, it is encouraging to see some health boards actively looking at reasons for and ways to improve retention and recruitment of staff such as, succession planning and strategic mapping of the workforce to address gaps in teams.

A further complication is the volume/remit of psychiatry workloads, such as home treatments, delivering training, assessments, supervision and care co-ordinator role, resulting in increased pressure to meet demands. Whilst the MHA clearly sets out the choice of professionals capable of undertaking the care co-ordinator role, most health boards state that medical staff (psychiatrists) are usually assigned this role, despite concerns raised as part of HIWs mental health homicide reviews. These reviews highlighted the difficulty for service users in accessing the consultant care co-ordinator and the complications that arise with undertaking the co-ordinator role (as intended in the Act), along side a large and complex workload. It also reinforces a mental health service culture that emphasises the need to actively and assertively maintain long term engagement with some service users rather than closing cases when they disengage. However, it is recognised that in some instances service users with short term complex needs may be better off initially allocated to a medical member of staff.

We were consistently told that, at present consultant psychiatrists' case loads are too high and many health boards are looking at different way of working to reduce these. The challenge is to find ways of modifying roles to take on new or shared responsibilities. Although the majority of service users and previous service users told us that a Community Psychiatric Nurse (31%) or a psychiatrist (23%) was in charge of organising their care and services, there is an indication that there is an increase in the appointment of social workers to this role, to the point where they are nearing maximum capacity.

Staff Supervision and Appraisals

Staff supervision systems were robust in health and in social care. However, although supervision and support on a day to day basis is evident, formal recorded one-to-one supervision is not undertaken as routinely as is necessary to ensure staff have an opportunity to discuss on-going training, development and well being.

23 Swansea Central (Area 2), South Caerphilly, Deeside and Welshpool CMHT.

Health and Care Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Part 8 Code of Practice on the Role of the Director of Social Services (Social Services Functions)

The director of social services has a strategic leadership role to promote high standards across the care and support workforce, including the private and third sectors.

The director must ensure a whole sector workforce plan is in place which identifies and secures implementation of measures to ensure a sufficiently large, skilled, safe and focused workforce to promote the well-being of people with care and support needs. This includes in relation to recruitment and retention, pre-employment vetting, registration, reward, addressing poor performance, career pathways, competency and qualification requirements, skill mix, training needs, evidence based practice, compliance with codes of practice and contributions to workforce data.

We expect to see evidence of systems being in place to ensure that annual appraisals and regular supervision are taking place for all CMHT staff. Appraisals need to incorporate issues such as staff well being and other aspects of their work. We would also expect to see other systems of support such as reflective practice groups, debriefs following serious incidents or medication errors.

What we found:

Overall, we found that staff working in social care were receiving the same level of appraisal of their work as their health colleagues. This was encouraging as it is important that staff receive appraisals of their work to ensure good and poor practice is acknowledged, areas of development are identified and an individuals' progress is facilitated.

Whilst we found that staff vacancies and sickness rates within the majority of CMHT[24] is increasing pressure on existing staff to meet demands, the majority of staff told us they felt well supported by managers on a daily basis in relation to ad-hoc incidents and enquiries.

The multidisciplinary nature of CMHT gives the opportunity to provide a comprehensive service to meet the complex needs of individuals. The organisational and management arrangements deployed within CMHT, need to support professional accountability confidence and development. We found that in some teams, pressures were being experienced by some parts of the workforce more than others for example where psychiatrists were undertaking the care coordinator role, where there were difficulties in recruiting Section 12 doctors or social workers to undertake the AMHP role. Senior managers need to ensure that staff have confidence in these issues being addressed through regular, service wide, evaluation of staffing needs in order to support staff performance and morale.

24 Swansea Central (Area 2), South Caerphilly, Deeside and Welshpool CMHT.

Staff Training

We are satisfied that staff training is improving across most CMHTs, although there are areas where specific training needs to be developed.

Health and Care Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Staff should be enabled to learn and develop to their full potential.

Part 8 Code of Practice on the Role of the Director of Social Services (Social Services Functions)

The director of social services has a strategic leadership role to promote high standards across the care and support workforce, including the private and third sectors.

The director must ensure a whole sector workforce plan is in place which identifies and secures implementation of measures to ensure a sufficiently large, skilled, safe and focused workforce to promote the well-being of people with care and support needs. This includes in relation to recruitment and retention, pre-employment vetting, registration, reward, addressing poor performance, career pathways, competency and qualification requirements, skill mix, training needs, evidence based practice, compliance with codes of practice and contributions to workforce data.

We would expect to see evidence that staff are encouraged to maintain and develop competencies in order to develop to their full potential. We would expect to see a robust mandatory training matrix and a system to ensure all staff have received the training according to the grade in which they work.

What we found:

We found that mandatory training topics throughout all health boards are similar and this is also the case for local authority staff. However, compliance rates for mandatory training vary between health and local authority organisations. Local authority staff told us that although there was good access to skills based or specialist training in some teams, in other areas staff found it difficult to undertake training due to staff shortages and workloads not allowing time to attend.

We saw that some health boards have placed major investment in staff training, although we did identify some gaps regarding knowledge of the MHA in CMHTs. ABMUHB told us that their MHA administrators deliver training to CMHTs, providing bespoke training packages where required. Additionally the SS&WBA is not on the training agenda for health staff, with the provision of this training last taking place in 2014, before the Act's implementation. To ensure all staff are fully aware of how aspects of the Mental Health Act and SS&WBA impact on the work they undertake there is need for further investment particularly amongst health staff.

It remains a concern that not all CMHT staff receive First Aid training or training in the use of defibrillators. With staff working in isolation and with a very vulnerable service user group this training should be considered as mandatory.

No.	Recommendation
23.	All CMHT staff should receive training in the following: • Mental Health Act; • Social Services and Well Being Act; • First Aid and the use of defibrillators.

Conclusion

The intention of this review was to identify key themes arising from HIW and CIW's joint inspections of Community Mental Health Teams (CMHT) across Wales. Overall, we found that people receive an acceptable quality of care from hard working and compassionate staff.

With 43% of service users and previous service users telling us that the services provided completely met their needs or met most of their needs, it is important to recognise that staff are delivering a responsive service during challenging times. Significantly, whilst the performance data suggests that compliance with CTP targets is satisfactory, much more work is required across Wales to ensure that these are of a high standard and that service users are fully involved with and engaged in the development of their CTPs.

Whilst it is clear that progress is being made in many areas, there is scope to improve services and to develop a more seamless, integrated approach to community mental health care across Wales. We understand that economic constraints pose significant challenges to ensuring services are designed to meet current and future demands, and acknowledge that these transformations are not achievable or sustainable without partnership working across public, private and third sectors. Therefore, it is encouraging to see increasing collaboration between all sectors. However, there is still more progress to me made.

In 2018 the Welsh Government published its Plan 'A Healthier Wales' which emphasises the need to move services to communities. For there to be a successful transition of mental health services from in-patient to community care there needs to be an investment in new ways of working with clear improvement plans and resources supported by staff development. Whilst we have seen these kind of improvements being made, positive practice is not always shared or adopted across CMHTs. There are opportunities within Wales for greater levels of joint working and making better use of the third sector to support service users. Welsh Government should consider how issues raised in this report can be tackled on an all Wales basis.

The findings of this review indicate that there is still significant improvement required across Community Mental Health services to be in a position to meet the vision set out in Together for Mental Health, the Welsh Government strategy to improve mental health care in Wales.

What Next?

We expect Welsh Government, health boards and local authorities to carefully consider the findings from this review and our recommendations set out in Appendix A.

To service users and their families, and/or carers we hope we have captured the accounts you have shared with us and that this review will help make service provision in your area more accessible and tailored to meet your needs.

Appendix A – Recommendations

As a result of the findings from our review, we have made the following overarching recommendations which Welsh Government, health boards and local authorities should address.

No.	Recommendation	Regulation/Standard
1.	Health boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.	Health and Care Standard 5.1 Timely Access.
2.	CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern.	Health and Care Standard 5.1 Timely Access.
3.	Health boards need to ensure that information relating to the 'Putting Things Right' process is available at all CMHT locations.	Health and Care Standard 6.3 Listening and Learning from Feedback.
4.	CMHTs need to improve the way that they oversee the handling, monitoring, and lessons learned aspects of concerns/complaints.	Health and Care Standard 6.3 Listening and Learning from Feedback.
5.	Health boards and local authorities need to look at ways to improve awareness of advocacy provision amongst their staff and develop local monitoring of CMHT engagement with advocacy services, to ensure service users have access to the support they require on assessment at significant points within their care.	Health and Care Standard 6.2 Peoples Rights.
6.	Significant work is required from health boards to improve the provision and maintenance of safe and clinically appropriate facilities for CMHT service users and staff.	Health and Care Standard 2.1 Managing Risk and Promoting Health and Safety.
7.	CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations.	Health and Care Standard 6.1 Planning Care to Promote Independence.
8.	CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve.	Health and Care Standard 6.1 Planning Care to Promote Independence.

No.	Recommendation	Regulation/Standard
9.	CMHTs must ensure copies of CTPs are given to service users and their relatives, where consent has been provided for this to happen.	Health and Care Standard 6.1 Planning Care to Promote Independence.
10.	Health boards ensure regular audits are performed to ensure that service users are not detained under section 4 of the MHA for longer than 72 hours.	Health and Care Standard 3.5 Record Keeping.
11.	Health boards and Local Authorities need to ensure there is joint access to relevant CMHT records. This has a clear potential adverse impact upon the standard of care being provided and needs to be addressed as a matter of priority.	Health and Care Standard 3.5 Record Keeping.
12.	Health boards need to ensure there are clear lines of accountability, staff training, dedicated pharmacy support and robust auditing processes to oversee and implement medicines management within community services, especially within CMHTs.	Health and Care Standard 2.6 Medicines Management.
13.	CMHTs need to ensure that all staff complete mandatory adult and child safeguarding training.	Health and Care Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk.
14.	CMHTs need to ensure that carers' assessment of needs are routinely offered.	Health and Care Standard 6.1 Planning Care to Promote Independence.
15.	CMHTs need to undertake an audit of discharges to measure the quality and timeliness of discharge planning in order to help improve services and outcomes for service users.	Health and Care Standard 6.1 Planning Care to Promote Independence.
16.	CMHTs need to review the role of the care co-ordinator and establish whether the service users are receiving the correct input from the most appropriate professional.	Health and Care Standard 6.1 Planning Care to Promote Independence.
17.	CMHTs and care co-ordinators in particular, need to ensure discharge planning is robust and meets with legislative requirements.	Health and Care Standard 6.1 Planning Care to Promote Independence.
18.	CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users.	Health and Care Standard 6.1 Planning Care to Promote Independence.

No.	Recommendation	Regulation/Standard
19.	Health boards need to explore and utilise the support that may be offered by third sector services across Wales, with a need to take advantage of the range of community groups and mental health support services available to patients in their local communities.	Health and Care Standard 6.1 Planning Care to Promote Independence.
20.	Much more work is needed to increase the availability and timely access to psychological therapies across Wales. Health boards need to improve resources in this area and look at different ways of making sure sufficient psychological services were being provided.	Health and Care Standard 6.1 Planning Care to Promote Independence.
21.	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection.	Health and Care Standards: Part 2.
22.	Welsh Government needs to ensure that the implementation of the Welsh Community Care Information System (WCCIS) progresses with pace.	Health and Care Standards: Part 2.
23.	All CMHT staff should receive training in the following: • Mental Health Act; • Social Services and Well Being Act; • First Aid and the use of defibrillators.	Health and Care Standard 7.1 Workforce.

Appendix B – HIW Survey Results

Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales' Thematic Review of Community Mental Health Services: Survey. We received responses from almost all regions of Wales, certainly each Health Board was represented. Some Local Authority areas did not have respondents because this was a target population (identified CMHT's) and the respondents were only a sample of the whole population of Wales. The results are therefore only a part of the collective findings of the review.

Survey Information:

Family member or carer:	127 responses
Previous service user:	51 responses
Current service user:	102 responses
Total responses:	**280**

Family member or carer survey results:

Were you provided with contact names and numbers for the Community Mental Health Team?

	%	
Yes	65	53
No	57	47
Total	**122**	**100**

How involved were you in discussions about the care treatment and support options for your family member or the person you care for?

	%	
Very involved	34	27
Quite involved	29	23
Not very involved	34	27
Not at all involved	27	22
Total	**124**	**100**

Did you feel you were given sufficient time in these discussions to express your views?

	%	
Yes	47	47
No	52	53
Total	**99**	**100**

Did you feel you were listened to in these discussions?

	%	
Yes	46	46
No	53	54
Total	**99**	**100**

Did you feel you had sufficient information about the services available to support your family member or the person you cared for?

	%	
Yes	34	30
No	81	70
Total	**115**	**100**

Did you feel you had sufficient information about their eligibility for those services?

	%	
Yes	36	29
No	87	71
Total	**123**	**100**

Did you feel valued in your caring role?

	%	
Yes, completely	17	14
Yes, to some extent	45	36
No	62	50
Total	**124**	**100**

Were you offered an assessment of your own needs as a carer?

	%	
Yes	23	23
No	76	77
Total	**99**	**100**

Were you provided with information about direct payments to support your needs as a carer?

	%	
Yes	11	10
No	101	90
Total	**112**	**100**

Were you supported to apply for direct payments?

	%	
Yes	9	8
No	102	92
Total	**111**	**100**

Did you have concerns about the safety or wellbeing of your family member or the person you care for, yourself or anyone else?

	%	
Yes	103	83
No	21	17
Total	**124**	**100**

Did you know who to contact in the event of a crisis or serious concerns?

	%	
Yes	74	60
No	50	40
Total	**124**	**100**

Was action taken in response to any concerns you made?

	%	
Yes	44	45
No	54	55
Total	**98**	**100**

Did the Community Mental Health Team provide help or advice to you or your family member or the person you care for with finding support for any physical health needs they had?

	%	
Yes	25	26
No	70	74
Total	**95**	**100**

Did the Community Mental Health Team provide help or advice to you or your family member or the person you care for with finding support for any accommodation needs they had?

	%	
Yes	18	25
No	54	75
Total	**72**	**100**

Did the Community Mental Health Team provide help or advice to you or your family member or the person you care for with finding support for any employment or education needs they had?

	%	
Yes	9	12
No	64	88
Total	**73**	**100**

Did the Community Mental Health Team provide help or advice to you or your family member or the person you care for with finding support for any social needs they had (being able to go out when they wanted to)?

	%	
Yes	25	26
No	73	74
Total	**98**	**100**

To what extent were you involved in the discussion leading to the decisions for the service from the Community Mental Health Team to be ended?

	%	
Very involved	10	12
Quite involved	8	10
Not very involved	24	29
Not at all involved	40	49
Total	**82**	**100**

Were you provided with information about who to contact if you had further concerns about the health or wellbeing of your family member or the person you care for after their support from the Community Mental Health Team ended?

	%	
Yes	34	32
No	71	68
Total	**105**	**100**

Service users and previous service users survey results:

How were you referred to your Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
By my GP	37	73	73	73	110	73
I referred myself	3	6	7	7	10	7
Other	11	22	20	20	31	21
Total	**51**	**100**	**100**	**100**	**151**	**100**

How long did it take to get seen by your Community Mental Health Team following your referral?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
About 1 week	7	16	20	28	27	24
About 2 weeks	4	9	10	14	14	12
About 3 weeks	3	7	7	10	10	9
About 4 weeks or longer	29	67	34	48	63	55
Total	**43**	**100**	**71**	**100**	**114**	**100**

When was the last time you saw someone from your Community Mental Health Team?

	Previous service user		Current service user	
	Number	%	Number	%
In the last month	3	7	59	63
1 to 3 months ago	6	13	16	17
4 to 6 months ago	3	7	8	9
7 to 12 months ago	9	20	2	2
More than 12 months ago	24	53	9	10
Total	**45**	**100**	**94**	**100**

How easy or difficult did you find it to access support from your Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Very easy	4	8	18	18	22	15
Quite easy	10	20	37	38	47	32
Quite difficult	14	29	21	21	35	24
Very difficult	21	43	22	22	43	29
Total	**49**	**100**	**98**	**100**	**147**	**100**

Thinking about your needs, what did you feel about how often you were seen by your Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
I was not seen enough when needed	33	67	50	51	83	56
I was seen the right amount of times	15	31	47	47	62	42
I am seen more often than needed	1	2	2	2	3	2
Total	**49**	**100**	**99**	**100**	**148**	**100**

Did you feel that the Community Mental Health Team worker usually gave you enough time to discuss your needs and treatment? (This might be about your care, housing or accommodation, benefits, finances, medication advice, advocacy services, contact numbers, support groups, GP surgery.)

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	24	53	65	73	89	66
No	21	47	24	27	45	34
Total	**45**	**100**	**89**	**100**	**134**	**100**

Do you feel the CMHT worker usually listens to you carefully when you meet?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	30	67	74	80	104	76
No	15	33	18	20	33	24
Total	**45**	**100**	**92**	**100**	**137**	**100**

Were you offered the support of an advocate? (An advocate might help you access information you need, go with you to meetings to support you or speak for you in situations where you don't feel able to speak for yourself.)

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	3	7	28	29	31	22
No	41	93	68	71	109	78
Total	**44**	**100**	**96**	**100**	**140**	**100**

Who was the person in charge of organising your care and services? (This person could have been anyone providing your care, and may have been called a care coordinator or key worker.)

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
A Community Psychiatric Nurse	11	29	26	32	37	31
A GP	8	21	7	9	15	13
A Mental Health Support worker	4	11	5	6	9	8
A Psychiatrist	5	13	22	27	27	23
A Psychotherapist/ Counsellor	7	18	5	6	12	10
A Social Worker	3	8	11	13	14	12
Other	0	0	6	7	6	5
Total	**38**	**100**	**82**	**100**	**120**	**100**

Did you know how to contact this person if you had a concern about your care?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	31	66	83	86	114	80
No	16	34	13	14	29	20
Total	**47**	**100**	**96**	**100**	**143**	**100**

To what extent did the services provided meet your needs?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met my needs	4	9	16	16	20	14
Met most of my needs	11	23	31	32	42	29
Met some of my needs	18	38	37	38	55	38
Did not meet any of my needs	14	30	13	13	27	19
Total	**47**	**100**	**97**	**100**	**144**	**100**

To what extent did you feel involved in the development of your Care plan?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Very involved	5	11	28	29	33	23
Quite involved	11	24	28	29	39	27
Not very involved	15	33	23	24	38	27
Not at all involved	15	33	17	18	32	23
Total	**46**	**100**	**96**	**100**	**142**	**100**

Did you receive or were you given an opportunity to have a copy of your care plan?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	8	20	50	61	58	48
No	32	80	32	39	64	52
Total	**40**	**100**	**82**	**100**	**122**	**100**

Did you have formal meetings or reviews with your care coordinator to discuss how your care was working? (This meeting may have been called a Care Programme Approach (CPA) or Care and Treatment Plan (CTP) meeting or case review.)

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	7	16	46	52	53	40
No	37	84	43	48	80	60
Total	**44**	**100**	**89**	**100**	**133**	**100**

To what extent did you feel involved in the discussions and decisions made about your care and support during your formal meeting or review?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Very involved	4	9	21	23	25	18
Quite involved	11	24	32	35	43	31
Not very involved	21	46	24	26	45	33
Not at all involved	10	22	14	15	24	18
Total	**46**	**100**	**91**	**100**	**137**	**100**

Were you given the opportunity to challenge any aspect of your care and treatment plan that you disagreed with during your formal meeting or review?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	9	24	44	61	53	48
No	29	76	28	39	57	52
Total	**38**	**100**	**72**	**100**	**110**	**100**

To what extent do you feel that your accommodation needs were met by the services provided through the Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met	8	24	22	41	30	34
Partially met	7	21	16	30	23	26
Not met at all	18	55	16	30	34	39
Total	**33**	**100**	**54**	**100**	**87**	**100**

To what extent do you feel that your employment needs were met by the services provided through the Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met	2	8	10	22	12	17
Partially met	3	12	11	24	14	20
Not met at all	20	80	25	54	45	63
Total	**25**	**100**	**46**	**100**	**71**	**100**

To what extent do you feel that your education needs were met by the services provided through the Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met	2	9	11	26	13	20
Partially met	2	9	15	36	17	27
Not met at all	18	82	16	38	34	53
Total	**22**	**100**	**42**	**100**	**64**	**100**

To what extent do you feel that your social needs (being able to go out when you wanted) were met by the services provided through the Community Mental Health Team?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Completely met	1	3	21	31	22	22
Partially met	13	42	21	31	34	34
Not met at all	17	55	26	38	43	43
Total	**31**	**100**	**68**	**100**	**99**	**100**

Did your Community Mental Health Team give you any help or advice with finding support for your physical health needs?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	3	25	19	56	22	48
No, I asked for help but didn't get any	9	75	15	44	24	52
Total	**12**	**100**	**34**	**100**	**46**	**100**

Was the option to receive direct payments to help meet your care and support needs ever discussed with you?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	1	4	21	36	22	27
No	22	96	37	64	59	73
Total	**23**	**100**	**58**	**100**	**81**	**100**

Did you know how to contact the Community Mental Health Team Out of Hours service?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	16	40	51	53	67	49
No	24	60	45	47	69	51
Total	**40**	**100**	**96**	**100**	**136**	**100**

If you have felt the need to contact the Community Mental Health team's Out of Hours Service, did you get the help you needed?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	4	18	25	56	29	43
No	18	82	20	44	38	57
Total	**22**	**100**	**45**	**100**	**67**	**100**

If you have needed to contact the Community Mental Health Team in a crisis in the last 12 months, did you get the help you needed?

	Current service user	
	Number	%
Yes	30	42
No	42	58
Total	**72**	**100**

Do you know how to request a further service from the Community Mental Health Team if you have concerns about your health or care?

	Current service user	
	Number	%
Yes	18	37
No	31	63
Total	**49**	**100**

Did your Community Mental Health Team involve a member of your family, or someone else close to you, as much as you would have liked?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	6	21	30	56	36	43
No	21	72	21	39	42	51
They have involved them too much	2	7	3	6	2	6
Total	**29**	**100**	**54**	**100**	**83**	**100**

Do you know that you can refer yourself to your Community Mental Health Team if you felt that you were relapsing?

	Previous service user	
	Number	%
Yes	22	43
No	29	57
Total	**51**	**100**

Do you know who to contact if you have a crisis or relapse?

	Previous service user		Current service user		Total	
	Number	%	Number	%	Number	%
Yes	19	44	53	56	72	52
No	24	56	42	44	66	48
Total	**43**	**100**	**95**	**100**	**138**	**100**