Public Accounts Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
Tuesday, 14 July 2015

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:
Michael Kay
Committee Clerk
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Agenda

Private

The Committee agreed on 7 July 2015, a motion under Standing Order 17.42 to resolve to exclude the public from this meeting.

1 Introductions, apologies and substitutions (09:00)

2 Papers to note (09:00-09:10) (Pages 1 - 3)

Governance Arrangements at Betsi Cadwaladr University Health Board: Letter from Andrew Goodall (30 June 2015)

Regional Education Consortia: Welsh Government response to the Auditor General for Wales Report

Work Programme: Letter from Deputy Andrew Lewis, Chair, PAC, States of Jersey (2

July 2015)

3 Regeneration Investment Fund for Wales: Briefing from the Auditor General for Wales (09:10–10:10)

4 Welfare Reform: Consideration of the draft report (10:10–10:40)

PAC(4)-21-15 Paper 1

Public Accounts Committee

Meeting Venue:	**Committee Room 3 – Senedd**
Meeting date:	**Tuesday, 7 July 2015**
Meeting time:	**09.02 – 10.47**

This meeting can be viewed on Senedd TV at:
http://senedd.tv/en/2927

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Concise Minutes:

Assembly Members:	**Darren Millar AM (Chair)** **Mohammad Asghar (Oscar) AM** **Jocelyn Davies AM** **Mike Hedges AM** **Ann Jones AM (In place of Sandy Mewies AM)** **Julie Morgan AM** **Jenny Rathbone AM** **Aled Roberts AM**
Witnesses:	**Simon Jones, Welsh Government** **James Price, Welsh Government**
Committee Staff:	**Michael Kay (Clerk)** **Claire Griffiths (Deputy Clerk)** **Joanest Varney-Jackson (Legal Adviser)** **Sophie Knott (Wales Audit Office)** **Jeremy Morgan (Wales Audit Office)** **Matthew Mortlock (Wales Audit Office)** **Mike Usher (Wales Audit Office)**

TRANSCRIPT

View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 The Chair welcomed the Members to the meeting.

1.2 Apologies were received from Sandy Mewies. Ann Jones substituted.

2 Welsh Government Investment in Next Generation Broadband Infrastructure: Evidence Session 2

2.1 The Committee took evidence from James Price, Deputy Permanent Secretary, Economy, Skills and Natural Resources Group, Welsh Government and Simon Jones, Director, Finance and Performance, Economy, Skills and Natural Resources Group, Welsh Government as part of its inquiry into Welsh Government Investment in Next Generation Broadband Infrastructure.

2.2 James Price agreed to send a note on:

- A list of locations where issues of access have been difficult for Openreach
- What the Welsh Government expects to be delivered as part of the £1.7m marketing budget and how it is used on a geographical basis
- On permitted development rights
- The roll out of Fibre-on-Demand
- Location of where additional contracts will be required following the anticipated announcement on 'Infill Stage 2'

3 Papers to note

3.1 The papers were noted.

3.1 Covering Teachers' Absence: Letter from Owen Evans, Director General for Education and Skills (29 June 2015)

3.2 Welfare Reform: Pan-Wales Discretionary Housing Payments Policy Document

4 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

4.1 The motion was agreed.

5 Welsh Government Investment in Next Generation Broadband Infrastructure: Consideration of Evidence Received

5.1 The Committee considered the evidence received.

6 Meeting the Financial Challenges Facing Local Government in Wales: Consideration of correspondence

6.1 Members noted the letter from the Auditor General for Wales and agreed that the Chair should copy the exchange of recent correspondence to Owen Evans, the newly appointed Deputy Permanent Secretary with responsibility for this area, asking for his reflections on the questions asked. The Committee will return to this issue in September.

7 Forward Work Programme

7.1 Members noted the paper. However, the Clerks were asked to re-schedule the meeting suggested for Monday 28 September to an alternative Monday as a number of Members will be away.

7.2 Members agreed with the suggested list of bodies for account scrutiny and also agreed to prepare a legacy paper.

7.3 Members noted the Chair's request for a valedictory Director General session with the recent departures from the Welsh Government. The Chair was advised that a valedictory session for the outgoing Directors General would not be appropriate as the circumstances of their exit from the organisation was quite different from a previous Director General departure.

Agenda Item 2.1

Yr Athro Mark Drakeford AC
Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol a Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General and Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Darren Millar AM
Chair, Public Accounts Committee

Our Ref: AG/SA

30 June 2015

Dear Darren,

Public Accounts Committee, 16 June 2015

I write in response to the series of questions you sent me following the above session.

Confirm the timing of the Capita report on financial planning, when the Board considered its provisional response

The Capita report was commissioned by Betsi Cadwaladr UHB and it was considered by its Executive Board in January of this year. In March the report was considered by the Board's Finance and Performance Committee and in April, a paper was taken to the public session of the Committee setting out the main findings of the report and the actions being taken to address the recommendations made.

As part of the work being led by the Board's interim Chief Executive, Simon Dean, action on the Capita report and its recommendations will be included within the Governance 100 Day Plan given this was one of the extant areas for improvement under the earlier targeted intervention arrangements. In support of this, there will be a Board session on 1 July facilitated by Ann Lloyd CBE which will focus on the pace and urgency required to deal with the governance issues highlighted under escalation, including capital.

A note of all the serious incidents emanating from nurse/ward level within the last twelve months across Wales

As I indicated to the Committee, there is an open reporting approach to incidents in Wales which underpins a culture of patient safety and the need to respond and learn from incidents. This includes a mechanism for the most serious incidents to be reported through to Welsh Government. The total number of serious incidents (SIs) reported to the Welsh Government for this period was 1,056; all of these are also reported to Boards through their own local process and quality and patient safety committees. 680 of these relate to hospitals/wards. These would have occurred at a number of hospital sites and wards across the NHS estate. The subject type of hospital/ward SIs include: delay

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in treatment, pressure ulcers, infection control, infant death, patient falls, radiation errors, mental health underage admissions and IT related issues.

The remaining 376 SIs relate to community settings such as in a public place; patient's home; nursing or care home; primary care setting or in an ambulance and the subject type of these SIs would include suicides, pressure ulcers, delays in treatment and breach of Data Protection legislation.

Positive reporting of incidents needs to be consistently supported and features in local Health Boards Annual Quality Statements.

A note of the current independent BCUHB Board members and their skill sets and the experience of recruiting people from financial/commercial backgrounds

As I outlined to the Committee, independent members are appointed through a public appointments process. The process is led by Chairs of Health Boards and Trusts but is overseen by officials to ensure compliance with the Commissioner for Public Appointments' code of practice for ministerial appointments to public bodies. In the case of a Chair appointment, the process is led by a Public Appointments Assessor appointed by the Commission.

The Board is currently engaged in a review of its effectiveness and as part of that programme of work will be undertaking a skills audit facilitated by Ann Lloyd CBE. This is a component of the Special Measures arrangements.

When vacancies arise for independent Board members, organisations work with Welsh Government Officials to make sure that they recruit board members with relevant and complementary skills and experience so that the Boards are fully fit for purpose. Ceri Stradling who was appointed in April 2015 has a financial background and extensive skills and experience within audit. In the next nine months three existing independent Board members' current terms of office will come to an end and the opportunity will be taken further to strengthen financial and commercial skills as part of that process.

A note outlining the skills and experiences of the BCUHB Board members is attached.

A note on compliance with the All Wales Disciplinary Policy (and a copy of the policy)

The All Wales Disciplinary Policy and Procedure was reviewed in July 2014 and is due for renewal again in July 2016. The policy and procedure was agreed in partnership with Employers and Trade Unions and ratified by the Welsh Partnership Forum. NHS Employers Wales have confirmed that all Local Health Boards and NHS Trusts are fully compliant with the policy and procedure and that they are not aware of any issues regarding non compliance from staff side representatives.

Officials and NHS Employers Wales have been working on an addendum to the process for Chief Executives within the context of the overall All Wales policy and procedure, recognising that there are unique factors in Chief Executive cases, such as line management; the issue of trust and confidence; and the role of the accountable officer. It is anticipated that the addendum will be issued to the Chairs of health boards and trust for final comments in the coming weeks, prior to implementation.

A new disciplinary procedure for medical and dental practitioners is due to be implemented from September 2015 following a successful ballot outcome from BMA Cymru and pre-implementation training.

A copy of the policy is attached.

Send a copy of the report by the Royal Society of Psychiatrists and action taken

A copy of the report prepared by the Royal College of Psychiatrists in relation to the Hergest Mental Health Unit is available at this link: www.wales.nhs.uk/sitesplus/861/opendoc/229806

At the instigation of the Welsh Government, the NHS Delivery Unit and HIW made a joint visit to the Unit to review compliance with the Mental Health (Wales) Measure, Royal College of Psychiatrists Standards, referral management and practice on the Unit in 2013. As a series of issues were raised, the Welsh Government asked the Board to invite the Royal College of Psychiatrists to undertake an independent review of the Unit and recommend remedial action. The Royal College report together with other ongoing concerns resulted in the Welsh Government's decision to escalate the Board to enhanced monitoring in respect of its mental health services in November 2013. The Board was asked to provide written assurances of the safety of their mental health services and details of the action they would take on the findings of the Royal College and HIW reports.

Since 2013, the Welsh Government has continued to press the Health Board for action in relation to the findings in the reports. Updates have been published as part of the Board papers in March 2014 http://www.wales.nhs.uk/sitesplus/861/page/72656, July 2014 (this followed a further visit from HIW in May 2014), http://www.wales.nhs.uk/sitesplus/861/page/74462 and March 2015 http://www.wales.nhs.uk/sitesplus/861/page/79257

As the Committee is aware, continuing concerns with mental health services (including their responsiveness to Royal College report, formed a key element of the decision to further escalate health board to enhanced monitoring in October 2014 and subsequently special measures last month.

A note on the operational aspects of the out of hours service

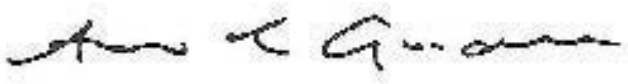
In response to this question, I have reviewed the transcript and refer to Aled Roberts question on this issue which was: *Do you have any observations as well on the situation in Wrexham, where people were being triaged into either out-of-hours services, or accident and emergency, and, when they were nearing the four-hour cut-off, they were being transferred to the other side of the department?*

The independent out of hours report identified that patients often have long waits in the OOHS. The specific points raised in the report were: Emergency Department (ED) staff sometimes treat patients who are more appropriate to OOHS when the ED wait is less; alternatively, a patient can sometimes have waited some considerable time in the ED before they are referred to the OOHS. I am pleased to note there was no suggestion in the report that patients were being referred inappropriately to OOHS.

The Health Board has provided me with absolute assurance that patients are not triaged to OOHS to avoid a breach of the four hour target. They have confirmed that when a patient arrives in ED, they are triaged by the triage nurse who will make a decision at that point as to whether the patient fits the criteria for being seen by the OOHS as an appropriate alternative service that can meet the patients' needs. If the patient meets the criteria they are discharged to the OOHS. As this is done at the triage stage it will generally be well within the four hour target. The exceptions to this will be if the patient arrived at the ED outside of the OOHS operating hours and would have met the criteria for discharge to the OOHS had it been open. If there is a long delay in ED for patients to be seen at this stage, once OOHS opens (in the evening) the triage nurse will review any patients in the waiting room who meet the criteria for referral to OOHS and they will then be triaged to the OOHS to be seen. This is intended to help patients access an appropriate service quickly, based on the local circumstances. In every case, the decision to discharge to OOHS is clinical and not time related.

I trust these responses provide the Committee with the information it requested.

Yours sincerely,



Dr Andrew Goodall

Betsi Cadwaladr University Health Board

Board Paper *23.1.14* **Item 14/011**

Subject:	**Mental Health Services** **Update reports on Hergest Unit Ysbyty Gwynedd and Tawel Fan Ward, Ysbyty Glan Clwyd**
Summary or **Issues of Significance**	Enclosed is a paper regarding the Hergest Unit, Ysbyty Gwynedd and Tawel Fan Ward, Ysbyty Glan Clwyd. The Hergest Unit has been subject to various reviews and improvement processes and the Health Board is updated on the latest review by Healthcare Inspectorate Wales (HIW) and action plan plus the recent review by the Royal College of Psychiatrists (RCP). Tawel Fan is a ward in the Ablett Unit, Ysbyty Glan Clwyd. The Health Board is updated on the recent temporary closure of the ward on the 19th December 2013 and associated investigations related to this closure.
Strategic Theme / Priority / Values Francis Report recommendations addressed by this paper	Making it safe
Relevant legislation or Standard for Health Services	Standard 7 Safe and Clinical Effective Practice Standard 11 Safeguarding
This section is mandatory due to legal requirements	***The Board and its Committees may reject papers/proposals that do not appear to satisfy the equality duty. See http://howis.wales.nhs.uk/sitesplus/861/page/47193***
Equality Impact Assessment (EqIA)	**1.**Has EqIA screening been undertaken? N *(If yes, please supply a copy)* **2.**Has a full EqIA been undertaken? N *(If yes, please supply a copy)* **3.**Please state how this paper supports the Strategic Equality Plan Objectives: http://howis.wales.nhs.uk/sitesplus/documents/861/sep_0412_e.pdf **4.**Please include a justification if no EqIA has been carried out: Service change and policy development is subject to EqIA and monitored through the MHLD CPG Risk Management sub-

	committee.

Recommendations: (e.g for Committee approval or for noting)	The Health Board are asked to consider the recommendations

Author(s)	Dr Giles Harborne, Chief of Staff, Adrian Jones, Associate Chief of Staff Nursing, Simon Pyke, Associate Chief of Staff Operations

Presented by	Mr Geoff Lang, Acting Chief Executive Officer & Mrs Angela Hopkins, Executive Director of Nursing

Date of report	14th January 2014

Date of meeting	23.1.14

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

Mental Health & Learning Disability Clinical Programme Group.
Mental Health Services in North Wales.

Introduction

The briefing provides an update for the Health Board on mental health services, including the recent Royal College of Psychiatrists (RCP) review and the Healthcare Inspectorate Wales (HIW) inspection of the Hergest Unit. Information is also included in respect of Tawel Fan Ward.

Hergest Unit

The Hergest Unit is a 42 bed psychiatric unit at Ysbyty Gwynedd, Bangor. Hergest Unit has been the subject of a range of reviews, with the Quality & Safety Committee and the Board being appraised on the implementation of the Hergest Improvement Plan (HIP) which commenced in February 2012 as a result of a number of concerns raised in the Autumn of 2012.. The focus for the HIP has been to improve care experience, systems and processes, staff training and to improve relations between staff, service users and the Clinical Programme Group (CPG) management team. The HIP has resulted in modest improvements.

In May 2013, the Health Board arranged for the Delivery Unit, Welsh Government, to undertake a review of the Hergest Unit and to assess compliance in relation to the Mental Health Measure. A full report from the Delivery Unit was received by the Health Board in September 2013. The actions from the report were prioritised in the HIP for implementation.

Recent reports

The Health Board commissioned a Review by the Royal College of Psychiatrists which took place during October 2013, with a report received by the Health Board in December 2013 (Appendix 1). The Royal College review outlined recommendations including:

- A review of the management structure to reflect locality based senior managers and development of ward team managers.
- A review of the HIP to reduce the number of work streams.
- Development of training programmes for nurses involved in urgent assessment
- Engagement by staff in quality improvement initiatives.
- Revision of the nursing establishment.
- Urgent consideration to the provision of care for high physical dependency needs and for Electro Convulsive Therapy (ECT) to be provided in a neighbouring approved unit (Glan Clwyd Hospital).
- A nursing development forum to be established.

Healthcare Inspectorate Wales (HIW) commenced an unannounced inspection on the 2nd December 2013. Following the 3 day inspection, HIW

provided a report to the Health Board on the 17th December 2013 enclosing 21 recommendations, concerns identified by the inspection team included:

- Poor professional relationships.
- Lack of staff engagement with the change process.
- Low staff morale.
- Concerns regarding availability of staff to meet a variable patient groups.
- Dignity of care issues with the mix of frail elderly patients with other mental health patients.
- Estates issues impacting on the provision of care for different clinical conditions and for single sex accommodation.

A letter was received from HIW summarising their concerns and seeking assurance in a number of key areas (Appendix 2). The Health Board has accepted the need to respond to all of the areas of concern. A response with an action plan to address the issues has been provided to HIW for consideration. (Appendix 3)

In addition, the Health Board is shortly expecting the report from the external reviewer commissioned to conduct a whistle blowing investigation into concerns raised by a number of staff.

Actions taken.

The leadership of the Assistant Medical Director and Deputy Director of Nursing is facilitating regular multi-disciplinary meetings, monitoring of activities and a focus on actions and improvements led by the team working within the unit.

Additional management support is being provided to the unit with a clear focus on closer liaison with other clinical services provided in Ysbyty Gwynedd to support the physical well-being of patients in Hergest.

A nursing development programme is now in place and weekly senior nurse meetings are supporting engagement of the clinical nurse leaders in a productive change process. Ward briefings are established to improve communication with a date set for a monthly Hergest leader's away day where priority areas to bring about effective change and improvement will be agreed.

Since January 2014, the Clinical Programme Group has also commenced matron led reviews of ward quality metrics. The Hergest quality ward data is now a weekly agenda item on the senior nurse leaders meeting to improve ownership, engagement and support improvements to standards and quality of care to patients.

The ECT service no longer operates in the Hergest Unit. It is now being provided in the accredited ECT unit at Glan Clwyd Hospital.

Admissions across North Wales are now focussed on a locality approach to reduce out of area admissions, which had previously contributed to increased capacity pressures at Hergest.

The CPG is seeking Board approval to effect temporary staged bed reductions and changes to the configurations of wards within the unit. This will ensure that the recommendations contained within the HIW and RCP reports can be more rapidly achieved with improved single sex accommodation and to ensure frail elderly patients with mental health conditions are cared for in a designated area separate from patients with other mental health conditions. This will result in improvements for all inpatients admitted to the Hergest Unit. In addition, this will support development of nursing staff with skills more aligned to the clinical conditions of patients and support the effective staffing establishment review required by RCP. In the medium term, consideration of the broader review of older people's mental health services across the locality should be a consideration to ensure effective utilisation of the total staffing resource to provide a sustainable model of care.

Tawel Fan Ward.

The Ablett Unit at Glan Clwyd Hospital provides inpatient mental health facilities for adult and older people predominantly from the Conwy and Denbighshire area. Tawel Fan is a 17 bed ward in the Ablett Unit providing assessment and treatment for patients with dementia.

During a concerns meeting held on the 12th December 2013 information was presented which gave rise to concerns regarding the care provided to patients on the ward. The Protection of Vulnerable Adult (POVA) policy was invoked, involving police, local authority, Healthcare Inspectorate Wales and the Health Board. The immediate concerns regarding a small number of nursing staff in the team have been addressed with individuals taken out of clinical practice and direct patient care.

The Executive team considered the immediate patient safety issues and required the Clinical Programme Group to develop a contingency plan which would provide assurance regarding safe provision of care to the inpatients on Tawel Fan Ward at the time. A Serious Untoward Incident (SUI) was reported to Welsh Government in relation to concerns raised, with further updates provided on the resulting actions. The Community Health Council has been kept fully updated at all stages.

Following the Health Board In Committee meeting on the 19th December 2013 a decision was taken to implement a temporary closure of Tawel Fan ward with the majority of patients safely transferring to Bryn Hesketh Unit in Colwyn Bay, with other transfers supported for patients to move closer to home and family. Bryn Hesketh Unit is a purpose built dementia inpatient and community unit with 16 beds located 10 miles from the Ablett Unit. The Bryn Hesketh team has achieved a number of Queens' medals and received the Royal College of Psychiatrist Team of the Year award in 2013.

All patients are being treated by their usual consultant psychiatrists and Bryn Hesketh Unit is also receiving regular input from the Older People's Mental Health (OPMH) Head of Programme, Dementia Nurse Consultant and OPMH

Programme Manager. Carers were notified individually by Ablett staff and are receiving on-going support.

The CPG is closely monitoring patient flow and bed capacity for both dementia and functional older age patient groups for Conwy & Denbighshire area to ensure that service user and carer needs are being appropriately met..

Investigations relating to the POVA are on going. Establishment of quality and safety criteria for reopening of the ward is under way, these plans will be considered by the Executive Team as the investigation progresses. There is a clear focus on achieving this as soon as safely possible, as agreed by all the agencies involved in the POVA process.

Recommendations

1. The Board receive the RCP report, the HIW report and action plan.
2. The Board resolve to establish clear assurance processes through to the Quality & Safety Committee to ensure compliance and delivery of improvement across the range of recommendations contained within the reports.
3. The Board approves the temporary reduction of beds in Hergest Unit to support improved nurse to patient ratios, to facilitate more appropriate separation of males and females, and also provide for separation of frail older mental health patients and adult mental health patients.
4. The Board appoint external expert advice to review the systems in place within Older People's Mental Health Services across North Wales to provide assurance regarding quality of care, safety, compassion, dignity, and governance of the service across the Health Board.
5. The Board support the appointment of an interim Director of Mental Health Services to provide executive capacity and leadership to mental health services. The appointee will lead a strategic programme of work to review mental health services across North Wales and bring forward recommendations to improve service provision.
6. The Board receive a full update at its meeting in March, supported by a detailed plan to address, in a sustainable manner, the issues raised by the Royal College of Psychiatrists review.

January 2014.

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE INVITED REVIEW SERVICE

of the

ROYAL COLLEGE OF PSYCHIATRISTS

REPORT OF A REVIEW OF ISSUES RAISED

AT THE HERGEST UNIT, YSBYTY GWYNEDD, BANGOR

Prepared by on behalf of the review team

Dr Janet Parrott
Consultant Forensic Psychiatrist
Oxleas NHS Foundation Trust

Dr Frank Holloway
Emeritus Consultant Psychiatrist
South London Maudsley NHS Foundation Trust

Ms Alison Pearsall
Lead for Mentally Disordered Offenders
Lancashire NHS Foundation Trust

CONTENTS

1. Introduction

The College was asked to conduct a review by the Acting Medical Director (Dr. Martin Duerdin) addressing complex organisational matters relating to clinical management and service delivery at the Hergest Unit. The context of the request was that a number of clinical and management concerns have been raised through different mechanisms and interfaces. In an effort to address these concerns the Health Board had arranged a review process led by Mr. Malcolm Rae but this review was discontinued as it was considered the limited confidence staff and service users had in the process jeopardised its usefulness. More recently a formal WP4 investigation was commissioned from Robyn Holden after staff had raised concerns with the Executive Director of Nursing and Patient Services relating to the management of the unit. An interim report (15th October 2013) has been made available.

The overall remit of the R.C. Psych. Review was to provide an external reference point for the service's own strategy in addressing concerns and to give consideration to ways that the service could improve the quality of care.

Name of Service Visited

Hergest Unit, Ysbyty Gwynedd, Bangor

Dates of Review Visit

21 - 23 October 2013

The Review Team

Dr. Janet Parrott, Consultant Forensic Psychiatrist, Lead Reviewer for the College Invited Review Service

Dr. Frank Holloway, Consultant Psychiatrist, Invited Reviewer for the Royal College of Psychiatrists with expertise in general adult and rehabilitation services.

Ms. Alison Pearsall, Research Fellow, Invited Reviewer for the Royal College of Psychiatrists with nursing and management expertise.

2. The Review

2.1 This review is an independent critique against agreed terms of reference based on information provided to the reviewers and evidence taken through interviews with key personnel at the site visit.

2.2 The quality of service and management concerns were considered against standards documentation if relevant and in the light of the clinical and management experience of two senior R.C.Psych members and a senior nurse representing the views of the College.

2.3 The report will become the property of the Betsi Cadwaladr University Health Board through the Acting Medical Director and will remain

confidential between them and the Invited Review Service of the Royal College of Psychiatrists.

2.4 Subject to maintaining confidentiality the R.C.Psych encourages wider dissemination of the report amongst those involved in the service but this is the responsibility of the report owners and the R.C.Psych does not itself publish or comment on review reports without the express permission and agreement of the review client.

2.5 All staff involved agreed to the Review which was conducted in an open and informal manner. All requests for background information were met and the visit was ably supported in a generous and efficient manner.

3. Terms of Reference

i) The review will evaluate whether recent management changes have compromised patient safety or standards of clinical care and treatment at the Hergest Unit, Ysbyty Gwynedd, Bangor. It will take into account relevant standards and guidance published by the Royal College of Nursing, the Nursing and Midwifery Council, the Royal College of Psychiatrists and the General Medical Council. The review will consider the issues raised by the Rae review on the Hergest Unit and pay due attention to the views of service user and carers groups.

ii) The review will examine the relationship between managers and clinicians (consultants, medical academics and senior nurses) with a focus on concerns raised by four senior clinicians in the West of North Wales.

iii) The review will advise on whether the implementation of the Mental Health Measure at the Hergest Unit has been conducted appropriately.

iv) The review will advise whether the Hergest Unit is safe out of hours. It will examine the management of emergency admissions at the Hergest Unit, particularly outside normal working hours.

v) The review will determine whether untoward incidents involving patient safety incidents are appropriately reported.

vi) The review will seek to identify measures that might improve clinical care at the Hergest Unit.

4. Methodology

The review was based on consideration of information provided and a series of interviews with key personnel, service user and carer groups. The Review Team were given a tour of the ward areas of the Hergest Unit and took the opportunity to join a weekly ward round and the Acute Care meeting. The following personnel were interviewed by the visiting team:

Mr. Geoff Lang, Acting Chief Executive and Lead Executive for Mental Health
Hergest Unit Acting Medical Director

Mr. Malcolm Rae and Ms. Claire Carson, Rae Review Team
Dr. Giles Harborne, Chief of Staff
Dr. Adrian Jones, Associate Chief of Staff Nursing
Mr. Simon Pyke, Associate Chief of Staff Operations
Mr. Andy Bell, Interim Deputy Associate Chief of Staff
Dr. Alberto Salmoiraghi, Consultant Psychiatrist East Area and Head of Programme - Acute Care
Dr. Marie Savage, Consultant Psychiatrist West Area and Head of Programme - Adult Community
Professor David Healy, Consultant Psychiatrist West Area
Dr. Catherine Baker, Consultant Psychiatrist, West Area PICU and Home Treatment Team
Dr. Tony Roberts, Consultant Psychiatrist, West Area
Dr. Sumit Chandran, Consultant Psychiatrist, West Area
Dr. Q. Ijaz, Consultant Psychiatrist, West Area
Professor Robert Poole, Consultant Psychiatrist and Senior Academic
Ms. Alison Parry, Acting Matron, Hergest Unit
Mr. Keith Saycell, Acting Matron, Hergest Unit

Group of Trainee Doctors
Nursing Staff Team, Hergest Unit
Ward Managers/Team Managers Hergest Unit
LAS/Career Grade Medical Team
Out of Hours Nurses
Therapies Team

Service User and Carer Liaison

The Review Team met with Tina Foulkes, Director Unllais, Joan Doyle, Deputy Director Unllais and a group of service users and carers who form part of the Hergest Reference Group.

Review and Discussion

The Review Team met with Dr. Paul Birch, Acting Medical Director, Dr. Giles Harborne, Chief of Staff, Ms. Anne Marie Rowlands, Deputy Nurse Director, Dr. Adrian Jones, Associate Chief of Staff Nursing for preliminary feedback at the end of the Review Visit.

5. Documentary Information

i) Mental Health (Wales) Measure
Implementation guidance for staff on the use of the Mental Health Measure (MHM) and the process of transition from the Care Programme Approach to Care and Treatment Plan (CTP). MHM clinical documents including Assessment of Risk; Summary of Identified Needs, Strengths and Risk; Appraisal of Assessment of Needs, Risks and Strengths, Unmet Need, Care and Treatment Plan.

ii) Letters of 1st September 2009, 26 November 2010, 27 June 2011 giving feedback to the Hergest Unit, on Mental Health Act visits, Healthcare Inspectorate Wales.

iii) Interim report relating to an investigation of concerns raised by staff about the management of the Mental Health Clinical Programme Group in their dealings with the Hergest Unit prepared by Dr. Robin Holden, Investigating Officer 15 October 2015.

iv) Letters raising concerns from four consultant psychiatrists; (1 July 2013) and additional letters from one consultant psychiatrist.

v) Letters from service user representative.

vi) Hergest Service User Feedback 6 month report March - August 2013

vii) Out of Hours Psychiatry, Dr. Harborne (briefing paper)

viii) Mental Health and Learning Disabilities CPG Acute Care Operating Framewoprk, 2013

ix) Concerns Policy, 2012

x) Draft Peer Review Report, Accreditation for Inpatient Mental Health Services - Psychiatric Intensive Care Units (AIMS - PICU).

xi) Confidential Reports on SUIs, BCU 57-11
BCU 73-12
BCU 20-12
BCU 74-12

xii) Hergest Improvement Group - Terms of Reference and Action Plan.

xiii) Letter of concern, Mr. M. Rae.

xiv) Delivery and Support Unit, NHS Wales Hergest Inpatient Review Briefing for BCUHB and feedback presentation.

xv) Report for Quality and Safety Committee.

xvi) Investigation of Serious Untoward Incidents, May 2012 report of Professor R. Poole.

xvii) Weekly Datix Incident Report printouts, 1 September 2012 to 30 September 2013.

xviii) Mental Health and Learning Disabilities CPG: process for the reporting and investigation of serious untoward incidents (draft).

xix) Mental Health and Learning Disability CPG Reporting Structures (January 2013).

xx) DSU, a diagnostic report on the application and implementation of the Care Programme Approach in Arfan Community Health Service, Bangor January 2009.

6. Background Information

Mental health services in North Wales have been subject to extensive management changes in recent years with three providers of inpatient services being brought together with several community providers. Alongside these local changes there have been changes in service configuration and legal requirements relating to mental health particularly associated with the implementation of the Mental Health (Wales) Measure.

Concerns about some aspects of the quality of service at the inpatient site had been raised by the Healthcare Inspectorate Wales in the on several visits in the past and by service user and carer representatives.

The Hergest Unit

The Unit is situated in the grounds of the general hospital and serves a population of around 240,000. The inpatient areas comprise two 18 bed wards, Aneurin and Cyan and a six bed intensive care facility, Taliesin. All the areas are mixed in relation to gender and acute wards provide care for over 65's with functional mental illness.

Earlier this year the Acting Chief Executive and Lead Executive for Mental Health requested a review from the Delivery and Support Unity (DSU), NHS Wales following concerns raised by patient and carer groups and relating to the findings of four investigations of serious untoward incidents. The DSU identified the following areas for attention (briefing, 29th May 2013).

- *Compliance with the Mental Health (Wales) Measure*
  Training records and interviews indicated that the organisation had not adequately prepared their staff for the introduction of the Measure. There was not considered to be a standardised process for co-ordinating care arrangements spanning community and inpatient services.

- *Referral Management*
  Attention focussed on out of hour's referrals and the complex medical on-call arrangements. Frequent difficulties were reported in providing core trainee cover between 5 p.m. and 9 p.m. at that point.

- *The Unit as a Therapeutic Environment*
  Concerns were raised about engagement with staff, psychological treatment and activities. The service was asked to give further consideration to mixed use of the wards for frail older people and those with learning disabilities.

- *Environment*
  Key issues included ligature points which were still considered to present risks and the layout of the wards with poor sight lines, lack of privacy and gender mix.

- *Culture and Relationships*

Attention was drawn to what were considered to be polarised views about the delivery of acute care and staff feeling their opinions were not included in wider BCUHB decisions.

- *Escalation and Feedback*

Patients, carers, staff and advocates expressed a view that concerns are not dealt with in a timely way. Carers, advocates and service users viewed their involvement in the Hergest Improvement Programme as tokenistic.

- *Training*

Other than for therapy staff there was less than 50% compliance for statutory and mandatory training and appraisal and PDRs were not routinely completed.

The appointment of the two new acting matrons and the intentions within the Hergest Improvement Plan were commended.

At the beginning of July 2013 the ward managers of Aneurin and Cyan wards were moved to other duties for the duration of a POVA investigation. They subsequently returned but this event has had a huge impact on confidence in management within nursing and medical disciplines. The substantive Matron had been on leave on health grounds for a long period and subsequently redeployed. This may have contributed to the impact although these duties had been reassigned to acting post holders.

Letters to NHS Wales and Assembly members from medical staff appear to have raised the public profile of concerns.

There has been positive feedback on the service from the AIMS – P.I.C.U. peer review of Taliesin, intensive care unit the report of which was shared with the Review Team by the Taliesin multidisciplinary team. This peer review group included a service user and carer representative. The clinical leadership of the ward manager, multidisciplinary engagement in the care pathway and the improvements in appraisal and training compliance were commended. Action points included the ward environment requiring attention and the need for therapeutic training opportunities for staff. Patients and carers gave feedback that generally the staff were caring and approachable.

This review from the R.C. Psych. was requested in this context with the expectation that it would complement the investigation by Robyn Holden. We were mindful of revisiting issues that had been reviewed before but staff were unfailingly courteous and engaged in the review process with a majority concerned to find a way to secure improvement.

7. <u>The Issues under Review</u>

i) Whether recent management changes have compromised patient safety or standards of clinical care or treatment.

The provision of acute care in this facility is difficult both because of deficiencies in the physical environment and the wide range of patient needs. In these circumstances the service needs to be underpinned both by a redevelopment strategy and a supportive management structure. The Review Team considered that the adult service in Bangor had not been developed optimally prior to the merger as evidenced by the training records and the failure to make improvements to the ward environment and develop alternatives to acute inpatient care during the years of growth. It was widely acknowledged that there has been under investment and limited strategic development in the West prior to the merger although this sits alongside much dedicated work by individual members of staff.

The development of a home treatment team has been welcomed but current funding constraints have meant that this was at the expense of closing one of the three acute wards at Hergest. The fact that the community and inpatient staff have been able to maintain a responsive service and work through the ramifications of this particular change is commendable. However it would seem that this would also have been a timely opportunity to review the functioning of the two remaining wards, particularly their mixed use by elderly patients with high dependency needs and arrangements for consultant input to the wards. There have been numerous management changes in recent years at all levels of the organisation. The wider merger of service providers for the East, West and Central areas has been accompanied by the perception of a 'takeover' by the East. This is linked to a majority of management post holders having more connection with other areas served by the health board.

In relation to broader aspects of clinical care or treatment the review team observed one of the consultant's ward round and the Acute Care Meeting which both functioned as satisfactory clinical decision making forums with appropriate consideration of patients' views. This was against a background of significant pressure on the nursing team through needing to attend both the Acute Care meeting and a large number of ward rounds.

Service user and carer feedback to our meeting was that care on the wards has been improving with more engagement of service users in their care. We were also informed by the group of trainee psychiatrists and non consultant career grades that their clinical work and professional development was well supported through supervision.

The Review team were aware of the considerable local disruption in middle management support. There was however positive feedback from service users and carers on improvement initiatives such as the service user satisfaction feedback on discharge and the responsiveness of the Acting Modern Matron in addressing their concerns. The Review Team were not therefore of the view that recent management changes per se either as a result of the merger or at other levels of the organisation had compromised patient safety or standards of clinical

care or treatment. We agreed however that the management structure since the merger does not provide clear leadership of the service based in Bangor. The absence of a dedicated management team on site means that management can be misconceived as concerned with assurance and reporting in a stereotyped manner rather as than their involvement being a visible presence in driving up quality for patients and valuing staff. A more locality based approach is likely to make it easier to address priority issues and to support the leadership roles of clinical disciplines.

ii) Relationship between managers and clinicians (consultants, medical academics and senior nurses) with a focus on concerns raised by four senior clinicians in the West of North Wales.

There are poor relationships and communication throughout the unit both at ward level and up and down the organisation. This is having a serious effect on morale, commitment and motivation and needs to be addressed within the organisation. Problems in relationships and communication were presented to the Review team by the medical, nursing and management groups.

Staff based at the Hergest Unit reported feeling scrutinised but unsupported. We considered there to be a particular difficulty relating to ward managers being developed and supported to be accountable for and exercise their management responsibilities and consultants working with lead clinicians to achieve shared goals. There was some evidence that consultants did not work on modifications to proposals in a strategic manner e.g. providing a briefing paper on what would work well. Concerns raised by four senior clinicians include the manner in which the acute care model has been developed, urgent care arrangements and on call medical cover. The urgent care arrangements will be discussed later in the report.

Model of Care

A central and appropriate priority of the Hergest Unit has been to agree a model of care that meets both the needs of the inpatient areas and integrates care planning and risk management with community teams. The consultant staff have played a key role in achieving this continuity in the past and a majority would like to retain the benefits of this approach. The model of care debate has been linked with the difficulties experienced by the two admission wards working with a large number of consultants with both inpatient and community responsibilities. Taliesin, the intensive care unit has one consultant who also takes responsibility for admissions not known to a community team and also works within the Home Treatment Team. The Review was given a copy of a consultation survey led by the Acute Care lead on the "acute collaborative model".

It was not clear to the Review Team exactly how the formal proposals had been discussed and agreed. One of the consultants was part of the Acute Workstream within the Hergest Improvement Programme but it

seemed that this consultant's work in the area was not supported and developed into an agreed position by the Consultant group.

Overall the consultants favour the pre-existing model of care with sector consultants maintaining clinical responsibility for patients during an episode of inpatient care. The Review team notes that the evidence base does not favour one particular model of care and it is reasonable for local services to develop any variation of the acute care models that best meet patient needs for the particular area. Whatever model is adopted, there need to be robust interfaces between care co-ordinators in the inpatient and community settings and clear guidance for gatekeeping, home treatment options and intensive care.

Manifestly poor relationships between managers (including medical managers) and local clinicians had impaired work in this area. The Review Team considered the whole group of consultants needed to exercise their own clinical leadership roles in this area in a solution focussed manner, engaging with colleagues of other disciplines to ensure staff understand an agreed way of working and lines of communication within it. Exploring options that have worked in other areas of the U.K. with rural and semi rural populations would be seen valuable. We did not receive feedback as to whether the organisation of services in the central area of North Wales provides a model that could be adapted to fit local needs would also fit the priorities of the West and it may be that this could be further explored. We understand that acute inpatient services at the Heddfan Unit, Wrexham and the Ablett Unit, both participate in the quality network of the R.C.Psych and this could also provide valuable peer group support and learning for staff at the Hergest Unit.

The number of ward reviews timetabled was said to be linked with the current pattern of consultant working within the acute unit. The Review Team considered that tight scheduling of ward reviews would be essential in order for the inpatient ward staff to have time for other aspects of patient care and for patients to know when their reviews would occur. It seemed most appropriate for ward managers to address this matter. Planning also needs to ensure Occupational Therapy activities are not interrupted by clinical reviews.

iii) Advice on whether the implementation of the Mental Health Measure at the Hergest Unit has been conducted appropriately.

Although it was acknowledged that staff training in the use of the Measure had not been facilitated optimally prior to the arrangements being implemented by the time of our visit there had been a focus on this priority and 74% of the staff had completed basic training. Skills improvement on developing Care and Treatment Plans is ongoing. There seemed to be limited knowledge of how to make the documentation 'work' in a positive sense to support patient care while maintaining efficient time management. One example given related to repetitive entry of the same information. While it is likely that a proscriptive format will have some deficiencies it was felt linking with

other professionals to discuss how other acute teams have been using the structure was necessary. We were also advised that there will be an opportunity to review some aspects of the documentation in the future. There is also a proposal for Champions on each ward which should be expedited.

Service users and carers were optimistic that the framework would be beneficial in planning care and meeting needs. They did not express any dissatisfaction with how the service is implementing the new procedures suggesting that the way staff use the tools in a clinical situation is acceptable. The lack of I.T. equipment and support has made implementation of the Mental Health Measure more onerous. Support such as adequate printing arrangements on the wards should be put in place immediately.

The Delivery Support Unit considered that at the time of their review there did not appear to be a standardised process for co-ordinating care arrangements spanning community and inpatient services. We were advised that initially inpatient staff had seen the role of care co-ordinator as linked with community work but that this had now evolved to a better understanding of different team's responsibilities. The Measure formalises these responsibilities in terms of timescale. We were mindful however that staffing on the inpatient wards would need to be reviewed with better support in order to facilitate comprehensive use of the Care and Treatment planning process.

iv) Whether the Hergest Unit is safe out of hours and management of Emergency Admissions at the Hergest Unit particularly outside normal hours.

Reductions in trainee numbers in psychiatry, limitations on the duties of foundation stage doctors and recruitment difficulties in some areas have led to a change to a 24 hour nurse-led assessment and liaison service. This has been successfully introduced within the East and Central areas. Implementation of a similar strategy at the Hergest Unit has led to some concerns. These focus on the competencies of the Band 6 nurses and the way the arrangements were implemented. The local consultant group did not seem to have had the involvement we would expect and the roll-out of the new system occurred during the time the medical on call had become less locally focussed. There was no suggestion that the tier 3 and 4 rotas of more senior medical staff did not provide good support or were unresponsive in any way. The problems were associated with the more limited specific knowledge of those covering who did not work locally and the potentially arduous travel times when a member of the medical staff needed to attend the Unit. Training for the assessment and liaison role for Band 6 nursing staff is available with the University of Bangor which is being taken up.

The situation has settled in that there is now 24 hour Band 6 availability with resident junior doctor. It is agreed that a consultant rota will provide direct support to the acute site. Consultants will visit the Unit over the weekend period to provide a 24 hour review of all new

admissions and urgent clinical issues and carry out all 136 and other complex assessments. The evening period 5pm to 9pm is still problematic in relation to medical cover but it is now supported. Liaison should occur with the hospital at night team in the event of urgent on-site medical intervention being required if exceptionally the rotational arrangement fails.

Availability of Section 12/2 approved doctors for Mental Health Act assessments is monitored by the Mental Health Act Committee of the Health Board. The modernised Section 136 suite is satisfactory and the waiting time for assessment will be reduced through the revised on call rota. The Review Team did not consider the model unsafe provided regular review of assessments occurs and the medical support is robust. One consultant holds a regular teaching session for trainees and this is available to the Band 6 nurses if attendance can be facilitated.

Concerns about 'overflow' patients from other areas being admitted to the Hergest Unit have been raised. It would seem appropriate for the clinical leads to review with the other acute services how often this happens and the nature of the admissions. The goal of this being wholly exceptional is not unreasonable given its undesirability both for patients and the staff team. When it is unavoidable there should be enhanced liaison between medical as well as nursing staff so that there is clarity about the treatment plan.

v) Whether untoward incidents involving patient safety are appropriately reported.

The Review team were given the draft policy document, 'Process for the Reporting and Investigation of Serious Untoward Incidents' for the Mental Health and Learning Disabilities CPG. We were given to understand that it was this process that was in use. We were advised that the services did not have a robust system of incident reporting with regular team feedback prior to the merger. A modern system with datix monitoring across the range of levels is now in place. We requested and were given the datix recording of incidents over a year from September 2012 which included a range of low level incident indicating that the system was used regularly by staff in an appropriate manner.

A number of incidents have been recorded highlighting dignity issues for female patients particularly in relation to using bathroom and toilet areas in close proximity to males. The Review considered that further work was required in this area to optimise safety and welfare.

The Clinical Programme Group had asked Professor Robert Poole to formally review serious untoward incidents in 2012 and he is also offering some ongoing support to improve the system. This analysis indicated that trends in the serious incidents in the Mental Health and Learning Disabilities CPG compared with other CPGs were unlikely to reflect local factors or a systemic problem with one part of the service. This analysis did however highlight improvements required in the SUI reporting system in general and the Review supports the recommendation for further work on the surveillance system. The risk factor of co-morbid substance misuse was highlighted. The Review Team considered that this area requires ongoing attention but is clearly being prioritised by senior management. Individual staff interviewed appeared to be engaged with the process of reporting. We note however that organisations throughout the NHS experience challenges in embedding such systems and in supporting staff to have confidence in reporting and learning from incidents.

vi) Identification of measures that might improve clinical care at the Hergest Unit.

In our view the day to day running of the Hergest Unit does not appear to be posing immediate concerns in relation to patient safety. However a key issue is that staff including consultant staff need to acknowledge that there is room for improvement at the Hergest Unit as in all services. All staff and senior staff in particular need to commit to work collaboratively to identify areas where things could be improved and how improvements could be brought about.

We did have significant concerns about the difficult relationships between front line staff and management which all parties were already aware of. The layout and physical environment does pose risks of

which the service are aware. In order to enhance the ward environment and improve care provision it is essential for the service to improve relationships, communication and clinical leadership.

We considered that the following areas should be addressed to improve the quality of clinical care:

1) Management

- Review of the management structure to develop a locality based senior management team.

- Development of the management competencies of ward team managers and ensuring that their budgets allow them to maintain an appropriate complement of staff. Efforts should be made to ensure an early transition from the numerous acting roles to substantive post holders so that they develop solutions themselves in consultation with the multidisciplinary teams. Some day to day management initiatives such as the change to the room configuration and relocation of the medical records have been implemented in a manner that has not taken practicalities into account and indicates that change has been pushed through at an inappropriate level. The ward managers themselves must be supported in this area.

- Review of the Hergest Improvement Programme to reduce the number of workstreams and consider whether all the workstreams have appropriate representation from clinicians. The scope of work of the Improvement Programme is such that a number of consultants should have time within their job plans to contribute to it and undertake the consultation necessary with colleagues to progress initiatives. Nursing staff of various grades should also participate. Prioritisation within the Improvement Programme should focus on significant service delivery issues. The choice of uniform as a priority given the variety of opinions on this issue in mental health does not seem to be sensitive in the circumstances. The acting Modern Matron does management 'walkabouts' which is positive and this could be extended by general managers considering possibilities for more contact. Reciprocal shadowing between managers and clinicians may facilitate future problem solving.

2) Training and Peer Support

Training remains a priority for inpatient teams and Band 6 nurses involved in urgent assessments. Participation in structured means of improving the quality of inpatient wards such as 'The Productive Ward' or the AIMS accreditation process would be helpful for inpatient teams. Participation in the AIMS liaison service network would also be useful.

Mentoring could be used more often as a clinical management development tool for all disciplines. Staff should be matched to a mentor who has specific skills or experience that they need or wish to develop. Professional development should also be provided in a structured manner for healthcare assistants.

3) Appraisal and Job Planning

The delivery unit had raised the issue of appraisal and personal development plans for nursing staff and the earlier WP4 investigation addresses nursing professional development. All the consultants were broadly up to date with appraisal but we were given to understand that the arrangements did not lend themselves to feedback on clinical leadership roles. A 360 degree appraisal does link with the system but specific feedback from the clinical managers to the appraisers and appraises linking with job planning is required. Appraisal should also provide a review as to whether medical staff consider they have had sufficient support to further clinical management responsibilities. Where staff hold an academic appointment it is important for all parties to conduct appraisal and job planning jointly between the clinical service and the University and for all medical staff the job plan should be reviewed annually informed by feedback from appraisal.

4) Mixed use of the Acute Service

Systems must be in place to support ward managers to raise concerns about inpatient mix. The issue of mixed use for older patients who may have high physical dependency needs should be urgently reviewed. The issue of gender mix and whether it would be preferable for the wards to be single sex should also be evaluated. Mixed used also occasionally involves the admission of patients between the ages of 16 and 18 and the service should review whether best practice guidance is adhered to on each occasion. The AIMS inpatient standards (R.C.Psych) provides such guidance.

If a more radical review is not possible for some time staffing should reflect the need for increased support, adjusting in line with specific patient needs.

5) ECT

The ECT service is not accredited by ECTAS. There is no dedicated ECT nurse and the number of treatments/year falls well below the number required to meet the ECTAS standards without additional training occurring on a regular basis. In these circumstances the Review Team advises that arrangements for ECT should be made with the accredited service at the Ablett Unit. This advice does not imply any adverse criticism of the nursing and medical staff currently involved but reflects best practice opinion on use of accredited services for ECT. The geographical location of the

Hergest Unit does not provide an exceptional reason to deviate from the College position on this issue.

Protocols for transport and where appropriate transfer will need to be in place and if this has not already been done the current medical and nursing lead should liaise with their colleagues at the neighbouring Unit to implement this promptly. If this occurs the operational management should expedite use of the space released so that it benefits patient care and supports staff in a tangible manner.

6) Nursing Development Programme

A Nursing Development Forum could be considered for the Hergest Unit to harness ideas, and identify gaps in knowledge and identify site visits or e discussion forums with other areas. NDF is useful for case presentation of difficult to manage patients, reflection on clinical situations and to recognise and celebrate good practice. It would need to be supported by some flexibility in the staff rota and most forums have a rolling programme to promote best practice e.g. nursing patients with co-morbid substance misuse, involving carers.

8. Conclusion

This independent review was carried out by the Hergest Unit, Bangor by Janet Parrott, Dr Frank Holloway and Ms Alison Pearsall.

It satisfies the terms of reference as set out in section 3 herein and it is hoped that it will provide useful information that could be utilised to improve the clinical management and service delivery at the Hergest Unit.

Mr Geoff Lang
Health Board Headquarters
Ysbyty Gwynedd
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LL57 2PW

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17 December 2013

Dear Mr Lang,

Re: Visit undertaken to the Hergest Unit on the 2, 3 and 4 December 2013

As you are aware Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Hergest Unit, Glan Clywd hospital on the evening of the 2nd December and all day on the 3rd and 4th December 2013. Our visit highlighted areas that are noteworthy and include:

- The way staff co-operated with the inspection process.
- The quality, variety and choice of food for patients.
- The decoration and refurbishment of the unit.
- The pro-active activities co-ordinator that resulted in a diverse range of recreational activities available for some patients.
- The psychiatric intensive care unit (PICU), Taliesin ward, seemed to be operating with far fewer issues than both Cynan and Aneurin wards.
- On the whole patients felt that they have had a positive experience and commented positively about staff.

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Our visit also highlighted a number of issues. It is of concern that several of these were highlighted in our previous report, following our visit in August 2012. For ease of reference we have identified the outstanding issues, from our August 2012 visit, within the table below.

All of the issues detailed must be addressed as a matter of urgency. We provided a verbal overview of our concerns to your senior management team at the end of our visit on 4 December 2013. A summary of these is set out below:

Issue of concern
1. Relationships between some responsible clinicians (RC) and some nursing staff was very poor with staff not talking to each other. In addition, some nursing staff were not talking to other nursing staff. The lack of communication and behaviour amongst professionals is unacceptable and must be resolved. 2. A lack of engagement in the change process of medical, nursing and occupational therapy (OT) staff was having a detrimental effect on the operation of the unit. Staff must engage in the change process to ensure the best possible outcomes for the patient group. 3. A number of staff interviewed during our visit stated that the morale at the unit was low. Strategies for improving staff morale must be identified and implemented. 4. There was a lack of training in some key areas across all wards, specifically fire safety and basic life support. The percentage of staff having received fire safety training was Aneurin 4%; Cynan 8% and Taliesin 0%. The figures for staff receiving basic life support was Aneurin 52%; Cynan 28% and Taliesin 52%. All staff must receive regular and relevant training. 5. A lack of regular staff supervision was identified, specifically on Cynan ward. The figure of staff having received supervision on this ward was 0%. An effective supervision system must be implemented for all staff. 6. Managers do not feel empowered to initiate change and bring leadership to the unit. The reasons behind this must be fully explored and strategies to resolve this must be implemented. (Identified in August 2012) 7. There were 2.5 equivalent full time OTs available on the Hergest unit, however, a substantial amount of this time appeared to be taken up with the assessment process. The reality of this was that only 5 hours of direct contact with patients per week was taking place. More face to face sessions with patients must be facilitated. (Identified in August 2102) 8. A distinct lack of recreational and occupational activities provided by the OT service was observed and this was also confirmed by patient and staff

feedback. A range of meaningful recreational and occupational activities must be made available for all patients. A clear exception to this was the work undertaken by the activities co-ordinator that was having a positive impact upon the social and recreational activities available for patients.

9. All patients on Taliesin ward (PICU) have an OT assessment between 4-7 days after arrival on the ward. At the time of our visit, everyone assessed on Taliesin ward by OT was recommended as not requiring OT and therefore patients on Taliesin ward were not having any OT input. We identified at least patient who it appeared may have benefited from some OT input. This area must be reviewed. (Identified in August 2102)

10. Some patient admissions may be inappropriate and some admissions appear to have complex physical needs. During our visit a number of patients were admitted to the unit and discharged within a very short space of time A review of admissions to the ward is required to ensure they are appropriate. (Identified in August 2102)

11. The range of conditions that patients were experiencing was very diverse including; drug and alcohol dependency and elderly patients suffering from anxiety and depression. A review of the admission criteria to the ward needs to be urgently undertaken. (Identified in August 2102)

12. There was a lack of robust governance and clinical audit processes in place. A robust process of governance and clinical audit processes must be implemented.

13. There was confusion regarding the on-call rota for senior staff when we arrived on Monday 2 December 2013. A clear and robust system of on-call to be implemented.

14. A review of the seclusion room on Taliesin ward is urgently required. The room had a WC and wash hand basin within it and there is a lack of privacy and dignity as windows in the nurse's station look directly onto the WC within the room. In addition, the room has areas, that a patient could potentially not be visible to staff, and this is a significant risk to both patients and staff. (Identified in August 2102)

15. The environment does not promote privacy and dignity for the patient group. There are multi occupancy rooms and the bathrooms are shared between the patients on that ward. There were limited designated male and female facilities. An urgent review of the environment is required. (Identified in August 2102)

16. Significant issues with care documentation were identified and included:
    a. Risks had been identified, but no care plan was in place to address the risk.

b. Evaluation of section 17 leave not always documented.
c. Issues with a lack of care plans for non compliance of medication.

17. Patient information was displayed on whiteboards in the nurses station's and was clearly visible for fellow patients and visitors to see. Patient information must be protected.

18. The electroconvulsive therapy (ECT) suite was last used to provide treatment in August 2013 and following confirmation from staff it became evident that this is only used 2 or 3 times each year. With the ECT suite used so infrequently, we asked the board members, during the feedback meeting, how they can ensure and confirm that staff demonstrate an acceptable level of competence and knowledge to undertake ECT treatment. Therefore the use of the ECT suite must be evaluated.

19. A review of the staffing must be undertaken. Section 17 leave has been affected because of staff shortages. Staffing numbers must be adequate for the patient group and the facilitating of Section 17 leave. (Identified in August 2102)

20. A number of issues were identified in the clinic room on Aneurin ward. These included:
    a. Issues with the controlled drug register. Specifically, wrong dates entered on the charts.
    b. Staff had signed the medication charts prior to any medication given/received by the patient.
    c. There were no signatures for some medication administration.
    d. There were drugs in the cupboard for patients who had been discharged from the hospital.

    (Identified in August 2102)

21. There was no hand/alcohol sanitizer on the wards and/or on the entrance to the wards.

HIW require immediate assurance on the patient safety issues identified within this letter particularly on points, 4, 10, 11, 12, 13, 14, 16, 18, 19, 20 and 21. In addition, the Health Board are required to submit a detailed action plan by Friday 3 January 2014 setting out the action you intend to take to address each of the above issues. The action plan should set out timescales and details of who will be responsible for taking the action forward. When the plan has been agreed by HIW as being appropriate you will be required to provide monthly progress updates.

On receipt of this letter the Health Board are required to comment on the factual accuracy of the issues detailed and on receipt of your action plan, a copy of this management letter, accompanied by your action plan will be published on our website.

We may undertake a further visit to ensure that the above issues have been properly addressed and we will undertake more frequent visits if we have concerns that necessary action is not being taken forward in a timely manner.

Please do not hesitate to contact me should you wish to discuss the content of this letter.

A copy of this letter is being sent to Dr Peter Higson, Chair, Dr Paul Birch, the Acting Medical Director, Mrs Angela Hopkins, Director of Nursing, Midwifery and Patient Services and Mrs Anne-Marie Rowlands the Assistant Director of Nursing

Yours sincerely

Mr John Powell
Head of Regulation

cc – Dr Peter Higson, Chair, Betsi Cadwalader Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Dr Paul Birch, Acting Medical Director, Betsi Cadwalader Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Mrs Angela Hopkins, Director of Nursing, Midwifery and Patient Services, Betsi Cadwalader Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Mrs Anne-Marie Rowlands, Assistant Director of Nursing, Betsi Cadwalader Healthboard, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

Ms Janet Davies, Patient Safety Adviser & Head of CGSDU, Welsh Government, Cathays Park, Cardiff, CF10 3NQ

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Dyddiad / Date: 10 January 2013

Mr John Powell
Head of Regulation
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Welsh Government
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Dear Mr Powell

Re: Healthcare Inspectorate Wales Visit to the Hergest Unit, BCU Health Board

The Health Board would like to thank Healthcare Inspectorate Wales and the team for their visit on 2 December 2013 and for providing verbal and written feedback following the visit to the Acting Medical Director, Clinical Programme Group Senior Management Team and members of the corporate Health Board team.

The Health Board accepts the concerns identified by HIW and has identified the following themes from the letter dated 17 December 2013 and has commenced the following improvements:

Engagement

Recommendations 1, 2, 3, 6 and 12 identify a lack of engagement in the change process by members of the multidisciplinary team. The Health Board has commissioned an external consultant to advise and facilitate engagement with the nursing staff. This process is underway with weekly Hergest senior nurse meetings and a date has been set for the first monthly nursing leadership away day, this being 30 January 2014. A monthly nursing development away day will be focusing on ways to empower nursing, introduce nursing innovation and best practice and engagement in the change process. It is anticipated this will improve morale amongst the nursing staff.

The Health Board has put in place support from the Assistant Medical Director to engage with the Hergest Consultant Medical Group and established a local operational management team supported by site management expertise. This has already started to improve links between the clinical teams on the District General Hospital site and supports a greater sharing of expertise into and from the Hergest Unit. This is particularly beneficial, given the health co-morbidities of mental health patients

The Health Board has moved to a local consultant and trainee on call rota with a local co-ordinator which will give clarity to the on call arrangements.

Staffing

Recommendations 4, 5, 7, 8, 9 relate to the availability of staffing and acuity and the impact on service provision and training.

The Health Board is pleased to confirm that the immediate assurance relating to training for Basic Life Support and Fire Safety has taken place (please refer to action plan). The ongoing implementation of the action plan will further address the present rate of supervision and personal development plans. The Health Board has also introduced an assurance framework to monitor training and a range of quality metrics, which is being monitored by the Matron and reported into the Clinical Programme Group (CPG) Integrated Governance reporting arrangements.

The Health Board is presently recruiting for both registered nurses and health care support workers and short listing of candidates is underway. The establishment review and staffing requirements have been raised and clear escalation procedures for staffing availability have been clarified and communicated with Ward Managers and Matrons. In the short term, the CPG has increased the number of available nursing staff to the required staffing template by use of bank staff and a number of bank staff being given temporary contracts of employment in the Hergest Unit.

The Health Board can confirm that the availability of Occupational Therapy and recreational activity is now being overseen by a senior Occupational Therapist. Occupational Therapy participation in daily clinical decision making will ensure access for all patients including those on Taliesin Ward.

Bed Usage and Dignity of Care

Recommendations 10, 11, 15 relate to bed capacity, demand and dignified care. The Health Board acknowledges the need to respond to the appropriate use of beds for gender, frailty and physical health problems. Proposals have been put forward for a frailty area of a ward to be established alongside a reduction of the beds in each of the wards. The proposed reconfiguration of beds would result in improvement of the mixed sex arrangements and ensure that mixed clinical conditions would also be more appropriately separated, ensuring the frail older patients have accommodation more suited to their needs. The bed reduction would also result in a higher ratio of nursing staff, improve the skill mix and support the availability of nursing staff to undertake further training and personal professional development. The Health Board is currently undertaking an evaluation of the usage of Electroconvulsive Therapy and confirms it is not currently being undertaken at the Hergest Unit.

Estate

A number of the recommendations, notably 14, 15, 17, 21 relate to the estate. The Health Board will take further guidance regarding the changes required for the Seclusion Room on Taliesin ward. Changes have been made to the protection of confidential patient information and hand hygiene dispensers are in place. The Health Board will undertake a review of the environment with the aim of developing plans which maximize safety for frail patients and promote dignity and privacy within the existing infrastructure.

The Health Board is undertaking a review of wider mental health services across North Wales and longer term improvement plans for the Hergest Unit will form part of that review.

Yours sincerely

GEOFF LANG
ACTING CHIEF EXECUTIVE

Enc

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Hergest Unit Healthcare Inspectorate Wales Action Plan 2014

Introduction

This Action Plan has been developed to respond to the specific areas of concern identified by Heathcare Inspectorate Wales following the unannounced visit to the Hergest Unit between 2nd and 4th December 2014

Actions have been recorded against each issue of concern to indicate how they will be addressed. The resulting actions will be aligned with the actions required following the invited review of the Hergest Unit which was undertaken by the Royal College of Psychiatrists, to form an overall plan for improvement.

To facilitate the actions set out in this plan the Board has provided additional clinical and managerial leadership capacity for the Unit, and has enhanced monitoring arrangements to ensure that progress is maintained.

The Action Plan will be implemented by the team in Hergest Unit, actions will be reported through the Clinical Programme Group Integrated Governance arrangements and assurances on progress will be provided to the Board via quarterly reporting, or by exception reporting.

Action Plan					
Issue of concern		**Action Required**	**Progress to Date**	**By Whom**	**By When**
1	Relationships between some responsible clinicians (RC) and some nursing staff was very poor with staff not talking to each other. In addition, some nursing staff were not talking to other nursing staff. The lack of communication and behaviour amongst professionals is unacceptable and must be resolved.	An operational management group will be established within the Hergest Unit to address communication and enhance effective teamworking.	First meeting date set. Membership invited.	Head of Programme Community & YG site manager	January 2014
2	A lack of engagement in the change process of medical, nursing and occupational therapy (OT) staff was having a detrimental effect on the operation of the unit. Staff must engage in the change process to ensure the best possible outcomes	The operational management group above will facilitate further engagement. Senior nursing staff will meet regularly to ensure enhanced engagement in the change process	First meeting planned for January A Hergest senior nurse meeting has met weekly since December 2013	Head of Programme Community & YG site manager ACOS Nursing supported by External Consultant	January 14 December 13

	for the patient group.	The Executive Director of Nursing has commissioned an external consultant to provide support and facilitation to a Hergest nursing development plan. This will include direct support and mentoring to the nursing leadership in the Hergest Unit. The Assistant Medical Director will initiate regular meetings with Consultant staff to develop effective engagement	A date has been set for the monthly nurse leadership team to meet at the end of January 2014 and a programme of activity planned. Meetings commenced in December		January 14 December 13
3	A number of staff interviewed during HIW visit stated that the morale at the unit was low. Strategies for improving staff morale must be identified and implemented.	The Hergest Nursing Development Plan referred to above will address ways to improve morale. Regular team meetings will be established to review progress and address local issues of concern	As above	ACOS Nursing supported by External Consultant	January 14

4	There was a lack of training in some key areas across all wards, specifically fire safety and basic life support. The percentage of staff having received fire safety training was Aneurin 4%, Cynan 8% and Taliesin 0%. The figures for staff receiving basic life support was Aneurin 52%, Cynan 28% and Taliesin 52%.	The CPG has put in place immediate training in basic life support and fire training following the HIW visit A system of regular monitoring and reporting of access to key aspects of training will be implemented	Attendance rates for basic life support is now 96.3% and for fire training is now 96.1% (of available staff) A weekly assurance template has been developed for the Matron to maintain checking of training	Matron Matron	December 13 January 14
5	Improve regular staff supervision, specifically on Cynan ward. The figure of staff having received supervision on this ward was 0%.	Immediate attention is required to supervision practice to ensure compliance with the Board's supervision policy. Matrons to be updated on the requirements of supervision and their role in delivery.	The CPG has redistributed the supervision policy to all matrons The supervision compliance for the nursing team in the Hergest unit is: Taliesin 58% Cynan 42% Aneurin 37% at	ACOS Nursing Matron & Ward Managers	January 14 January 14

	[redacted]	Personal development plans are to be in place for all staff.	December 2013 A weekly assurance template has been developed for the Matron to maintain checking of supervision The number of nursing staff with a personal development plan in the Hergest unit is: Taliesin 15 staff Cynan 15 staff Aneurin 17 staff. Outstanding staff are booked into Ward Diary for next 3 months at	Matron Matron & Ward Managers	March 14

6	Managers must be empowered to initiate change and bring leadership to the unit.	Review local management arrangements to enhance local ownership of issues and influence to make change happen. • Identify a local lead clinician for the Unit • Establish the local Operational Management Team • Support the weekly Hergest senior nurse meeting • Review the management support required for services in the west.	Job plan for Adult Community HoP See above (1) See above (2) Acute Care Manager post has been advertised and awaiting interview process	Chief of Staff ACOS Operations / Nursing	January 14
7	There were 2.5 equivalent full time OTs available on the Hergest unit, however, a substantial amount of this time appeared to be taken up with the assessment process. The reality of this was that only 5 hours of direct contact with patients per week was taking place. More face to face sessions with patients must	Additional senior OT capability to be deployed to enhance assurance and delivery OT action plan including revised operational process and senior local leadership to be in place covering the following • All service user related duties which includes face to face and non face to face duties related to the delivery of effective	Band 7 OT seconded to the OT team in December 2013 to support the development of the OT service on the unit and support the OT team with daily clinical decision making.	Head of OT	December 13 January 14

	be facilitated. (Identified in August 2102)	clinical care. • Direct and indirect contact activity data will be monitored through the implementation of the therapy manager system. • Staff to be supported with implementation of the therapy manager system. • OT acute care services are being developed through a BCUHB OT acute care development meeting. Band 7 OT to periodically audit OT care plans to ensure they represent all clinical activities undertaken with and on behalf of the service user.	Therapy Manager system has been uploaded to computers Training for staff in usage to commence in next 2 weeks		February 14 onwards
8	A distinct lack of recreational and occupational activities provided by the OT service was observed and this was also confirmed by patient and staff feedback. A range	As above • OT now supporting the activity co-coordinator role through directing service users to the		Head of OT	January 14

	of meaningful recreational and occupational activities must be made available for all patients. A clear exception to this was the work undertaken by the activities co-coordinator that was having a positive impact upon the social and recreational activities available for patients.	sessions. • Recreational and Occupational activities can be delivered through a range of staff and agencies on the unit. OT to review and update the current action plan which supports this. OT staff can provide education and training to others on the unit.			
9	All patients on Taliesin ward (PICU) have an OT assessment between 4-7 days after arrival on the ward. At the time of our visit, everyone assessed on Taliesin ward by OT was recommended as not requiring OT and therefore patients on Taliesin ward were not having any OT input. We identified at least patient who it appeared may have benefited from some OT input.	Band 7 OT to audit the assessment and service delivery on Taliesin .		Head of OT	January 14

10	Some patient admissions may be inappropriate and some admissions appear to have complex physical needs. During our visit a number of patients were admitted to the unit and discharged within a very short space of time.	Establish a frail elderly nursing team with allocated beds on one of the open wards. Mitigate environment issues and ensure that nursing staff are trained in identifying and meeting these needs. (See also point 15 below)	Options for provision identified	ACOS Nursing	January 14
		Improve the availability of inpatient performance and clinical audit measures to facilitate regular review by clinicians and managers.	Analysis of available information underway	Improvement and Business Support	February 14
		Develop an improvement plan for Home Treatment and acute liaison, to include; • Improved medical input with a lead consultant for HTT. • Development of alternatives to admission. • Parallel improvements to services in the Ablett including a second HTT consultant.		Acute Care Manager	March 14
		Review the provision of an age appropriate response for the functional elderly patient in West Conwy, Gwynedd and Angelsey		ACOS Operations	March 14

11	The range of conditions that patients were experiencing was very diverse including; drug and alcohol dependency and elderly patients suffering from anxiety and depression.	See above for plans for frail patients Training will be arranged to support nursing staff in managing patients with Co-occurring mental health and substance misuse problems.	The CPG has produced training on substance misuse and this will be put in place for February 2014	Head of Programme SMS	February 14
12	There was a lack of robust governance and clinical audit processes in place. A robust process of governance and clinical audit processes must be implemented.	Weekly quality and safety metrics tool to be completed for all Hergest wards Local clinical governance group to be established including medical and nursing senior staff. The CPG governance team will ensure that local processes for CPG quality and safety activity, including all SUIs, incidents and complaints are in place. Quality and safety lead post to be put in place	The Matron led quality and safety tool in place from January 2014 Local Chair to be identified West quality and safety lead advertised for appointment	Matron Chief of Staff Business Manager Governance Business Manager Governance	January 14 January 14 January 14 March 14

13	There was confusion regarding the on-call rota for senior staff when we arrived on Monday 2 December 2013. A clear and robust system of oncall to be implemented.	A local on call rota will be established for the Hergest Unit A local coordinator and clinical lead will be identified to manage the trainee and consultant rota at each site.	The CPG has reviewed on call arrangements for senior medical staff across North Wales to ensure clarity of out of hours arrangements. New rota to commence on 6th January 2014.	Chief of Staff	December 13
14	A review of the seclusion room on Taliesin ward is urgently required. The room had a WC and wash hand basin within it and there is a lack of privacy and dignity as windows in the nurse's station look directly onto the WC within the room. In addition, the room has areas that a patient could potentially not be visible to staff, and this is a significant risk to both patients and	Full risk assessment to be carried out on the continued use of seclusion facility and arrange estates plan to undertake any programme of works required	Risk assessment regarding short term options for improvement to be undertaken Advice has been sought from the National Association of Psychiatric Intensive Care Units regarding the latest standards. New advice is	ACOS Operations supported by Matron	January 14 February 14

	staff. (Identified in August 2012).		imminent (2 weeks) and the facility will be reviewed urgently as soon as the advice is published . If it is not published within this timeframe expert opinion will be sought regarding best practise		
15	The environment does not promote privacy and dignity for the patient group. There are multi occupancy rooms and the bathrooms are shared between the patients on that ward. There were limited designated male and female facilities. An urgent review of the environment is required. (Identified in August 2012).	A temporary reduction of beds will be implemented in order to support staff to maintain a safe service, reduce the level of multi occupancy and pressure on bathroom facilities. Bed reduction will be supported by: HTT improvement plan as above. OPMH improvement plan as above. PICU step down to the IRU (Cynnydd ward). Full review of the environment to be commissioned to maximise safety for frail patients and promote dignity and	Options for bed reductions identified and currently being evaluated Some refurbishment has already taken place	Chief of Staff ACOS Operations	January 14 March 14

		privacy, within the existing infrastructure.	and work is on-going to facilitate improvement within the existing infrastructure		
16	Significant issues with care documentation were identified and included: a) Risks had been identified, but no care plan was in place to address the risk. b) Evaluation of section 17 leave not always documented. c) Issues with a lack of care plans for non compliance of medication.	Audit mechanisms will be established to regularly check the compliance of care plans and risk assessments, including medication compliance Further training will be offered in relation to the requirements of the mental health measure The CPG has a risk assessment strategy document that has advocated WARRN training with ongoing training in place. Training compliance will be subject to performance management	 Current compliance with MHM foundation training is 76% and further training on the 2 day MHM training is planned for 2014 Current compliance with Asking Difficult Questions (ADQ) (risk training) is Taliesin 50% Cynan 40% Aneurin 50% This training is only	ACOS Nursing Matron to ensure staff are allocated time to attend training on MHM & ADQ MHM training coordinator	January 14 January 14 onwards

			for qualified staff – all Band 6 and 7 are completed		
			Further ADQ training is planned for 2014	MHM training coordinator	
			Registers maintained on MHM and ADQ training	MHM training coordinator	
		Section 17 leave arrangements will be subject to audit		ACOS Nursing	February 14 onwards
17	Patient information was displayed on whiteboards in the nurses station's and was clearly visible for fellow patients and visitors to see. Patient information must be protected.	Ensure notice board is moved and not visible to patients / visitors.	Arrangements have been put in place to preserve patient confidentiality on the information boards	Matron	December 13
		Information boards to be re-sited	New information boards to be ordered	Matron	February 14

18	The electroconvulsive therapy (ECT) suite was last used to provide treatment in August 2013 and following confirmation from staff it became evident that this is only used 2 or 3 times each year. With the ECT suite used so infrequently, we asked the board members, during their feedback meeting, how they can ensure and confirm that staff demonstrate an acceptable level of competence and knowledge to undertake ECT treatment.	All ECT activity to be suspended in Hergest Unit The future provision of the ECT service in North Wales must be evaluated and options considered.	ECT is not currently being undertaken at Hergest Patients who require ECT to be transferred to the Ablet Unit	Chief of Staff ACOS Nursing supported by Matron Chief of Staff	December 13 December 13 March 14
19	A review of the staffing must be undertaken. Section 17 leave has been affected because of staff shortages. Staffing numbers must be adequate for the patient group and the facilitating of Section 17 leave. (Identified in August 2012)	Temporary reduction in beds to be implemented in order to support staff to maintain a safe establishment and release staff for Section 17 escort duties. The staffing ratio for Cynan and Aneurin wards to be increased	Recruitment ongoing for both temporary and permanent staff to increase ratios to required levels. Staff ratios have been increased on Cynan and Aneurin	ACOS Nursing supported by Matron	January 14

		Ward Managers to escalate to Matron if unable to maintain a safe roster on a daily basis Additional nursing staff recruited on a temporary basis to ensure sufficient staffing.	Escalation procedures in place		
20	A number of issues were identified in the clinic room on Aneurin ward. These included: a. Issues with the controlled drug register. Specifically, wrong dates entered on the charts. b. Staff had signed the controlled medication charts prior to any medication given/received by the patient. c. There were no signatures for some medication administration. d. There were drugs in the cupboard for patients who had been discharged from	Immediate review of practice and adherence to policy required. All staff are to be made aware of and are required to adhere to current BCU HB medicines management procedures	The issues raised by HIW have been reviewed by BCU HB medicines management nurse on 5th and 9th December 2013 Recommendations have been made by the Specialist Nurse Medicines Management in relation to controlled drugs and a memo has been distributed to matrons to this effect	Medicines Management Nurse Specialist ACOS Nursing	December 13 January 14

	the hospital (Identified in August 2102)	Periodic audits of medicines administration and controlled drugs to be implemented		ACOS Nursing	February 14 onwards
21	There was no hand/alcohol sanitizer on the wards and/or on the entrance to the wards	Ensure hand sanitizers are in place either at ward entrance or for personal use	Hand sanitizers now in place New dispensers to be fitted in ward entrances	Matron Matron	January 14 February 14

Betsi Cadwaladr University Health Board

AGENDA

Meeting to be held in Public on Thursday 27th March 2014 9.30am-3.00pm in the Boardroom, Ysbyty Gwynedd, Bangor

Item	Topic
14/047	Chairman's Introductory Remarks
14/048	Apologies for Absence
14/049	Declarations of Interest
14/050 **14/050.1** **14/050.2**	Draft Minutes of the Health Board Meeting held in Public on 23rd January 2014: Accuracy Matters Arising and Review of Actions
Strategy & Leadership	
For decision / ratification	
14/051	The Health Board's Three Year Plan 2014-17 – Summary Update *(Mr N Bradshaw)*
14/052 **14/052.1** **14/052.2**	Partnership Working Final Statement of Intent – for approval (*Mr G Lang)* Intermediate Care Fund (Regional Proposal) - for endorsement (*Mr G Lang)*
For discussion	
14/053	Draft Recruitment & Retention Strategy *(Mr G Lang / Mr J M Jones)*
Quality and Safety	
For decision	
14/054	Patient Safety Issue Antibiotics : Avoiding Harm in Patients With Allergies – for adoption (*Mrs A Hopkins / Prof M Makin*)
14/055	Update of Register (All Wales) *(Mr G Lang)*

14/055.1 **14/055.2**	Section 12(2) Approved Doctors Approved Clinicians
For discussion	
14/056	Quality & Safety Reports
14/056.1	Integrated Quality & Safety Report *(Mrs A Hopkins / Mr T Lynch)*
14/056.2	Infection Prevention & Control Update (*Mrs A Hopkins)*
14/056.3	Putting Things Right - Complaints, Concerns and Incidents (*Mrs A Hopkins)*
14/057	Health & Safety Report *(Mrs G Lewis-Parry)*
14/058	Mental Health Services Update – Hergest Unit & Tawel Fan (*Mr G Lang / Mrs A Hopkins)*
Financial Stewardship	
For decision	
14/059	Blaenau Ffestiniog Business Case *(Mr N Bradshaw)*
14/060	Proposed Free Nursing Care and Continuing Health Care Fees 2014-15 (*Mr G Lang)*
Lunch Break	
14/061	Budget Strategy (*Mr B Evans)* **Supporting narrative paper*
For discussion	
14/062	Finance Report *(Mr B Evans)*
Performance and Assurance	
For decision	
14/063	Standing Orders and Standing Financial Instruction Amendments *(Mrs G Lewis-Parry)*

14/064	Strengthening Governance Arrangements: *(Mrs G Lewis-Parry)*
14/064.1	The Role of the Board Champions
14/064.2	Committee Advisers
For discussion	
14/065	Annual Audit Report 2013 (*Wales Audit Office*)
14/066	Performance Report *(Mr T Lynch)*
14/067	Corporate Risk Register *(Mrs G Lewis-Parry)*
For Information	
14/068	*Item Deferred*
14/069	Workforce Dashboard *(Mr JM Jones)*
14/070	Board Cycle of Business and Schedule of Meetings (*Mrs G Lewis-Parry)*
14/071	Register of Seals *(Mrs G Lewis-Parry)*
14/072	Issues of Significance and draft minutes of Committee meetings and Advisory Groups:
14/072.1	Finance Committee – approved minutes 21.1.14 and draft minutes 25.2.14
14/072.2	Quality & Safety Committee – approved minutes 30.1.14 and 6.2.14 and draft minutes 6.3.14
14/072.3	
14/072.4	Workforce & Organisational Development Committee – approved minutes 9.1.14
14/072.5	Charitable Funds Committee – draft minutes 20.2.14
14/072.6	Mental Health Act Committee – approved minutes 31.1.14 Stakeholder Reference Group – approved minutes 20.1.14
14/072.7	Healthcare Professionals Forum – approved minutes 24.1.14

14/072.8 **14/072.9**	Local Partnership Forum – draft minutes 11.2.14 Information Governance Committee – draft minutes 13.1.14
14/073	Date of next meeting to be held in public : Tuesday 6th May @ 10am in Wrexham

Health Board Agenda and Papers 29.7.14

Betsi Cadwaladr University Health Board

AGENDA

Meeting to be held in Public on Tuesday 29th July 2014 @ 9.30am
in the Boardroom, Corporate Offices, Wrexham Maelor Hospital

14/139 Chairman's Introductory Remarks

14/140 Apologies for Absence

14/141 Declarations of Interest

14/142 Draft Minutes of the Health Board Meeting held in Public on 3rd June 2014:

14/142.1 Accuracy
14/142.2 Matters Arising and Review of Actions

14/143 Corporate Risk Register *(Mrs G Lewis-Parry)*

Quality and Safety
For discussion

14/144 No item

14/145 Trusted to Care Report : BCUHB Response (*Mrs A Hopkins*)

14/146 Integrated Quality, Performance and Workforce Report *(Mr T Lynch / Mr JM Jones)*

14/147 Infection Control - Revisiting the Review of Governance Arrangements, Structures and Systems for the Control of Healthcare Associated Infections *(Mrs A Hopkins)*

14/148 Hergest Unit Update *(Mr G Lang)*

14/149 Serious Untoward Incident Review - Deeside Community Hospital (*Mrs A Hopkins)*

Comfort Break

For decision / ratification

14/150 Third Sector Mental Health Commissioning Plans 2015-16 (*Mr G Lang)*

14/151 Health & Safety Annual Reports 2013-14 and Policy (*Mrs G Lewis-Parry)*

14/152 Update of Register (All Wales) *(Mr G Lang)*

14/152.1 Section 12(2) Approved Doctors
14/152.2 Approved Clinicians

Strategy & Leadership
For discussion

14/153 Public Health *(Mr A Jones)*

14/153.1 Public Health Update Report
14/153.2 Major Infrastructure Developments – Update Report

14/154 Seasonal Plan Update 2014-15 *(Mr T Lynch)*

14/155 Sustainable Services Update Report (*Mrs S Baxter*)

14/156 An Overview of Governance Arrangements Betsi Cadwaladr University Health Board – a Summary of Progress Against Recommendations Made in June 2013 (July 2014) (*Professor T Purt*)

Lunch Break

Financial Stewardship
For discussion

14/157 Finance Report (*Mr B Evans)*

For decision / ratification
14/158 Alaw Unit Development Project Business Case

14/159 Funded Nursing Care (*Mr G Lang)*

Performance and Assurance
For decision / ratification

14/160 Standards for Health Services in Wales (*Mrs A Hopkins*)

14/160.1 Position Statement

14/160.2 Assurance to the Board

14/161 Healthcare Standards for Wales – Governance & Accountability Module (*Mrs G Lewis-Parry)*

14/162 Together for Health Delivery Plans (*Mr T Lynch)*

For Information

14/163 Annual Report: Implementation of Carers Strategies (Wales) Measure 2010 at BCUHB *(Mrs A Hopkins)*

14/164 NHS Reconfiguration and Older People: Correspondence from the Older People's Commissioner for Wales *(Mrs S Baxter)*

14/165 Public Service Ombudsman for Wales (PSOW) S16 Report 1st July 2014 (*Mrs A Hopkins)*

14/166 Public Services Ombudsman for Wales Annual Report 2013-14 *(Mrs A Hopkins)*

14/167 All Wales Standards for Accessible Communication and Information for People with Sensory Loss (*Mrs A Hopkins)*

14/168 Issues of Significance and draft minutes of Committees, Advisory Groups and Joint meetings:

14/168.1 Mental Health Act Committee 14.3.14

14/168.2 Welsh Health Specialised Services Committee – Joint Committee 25.3.14

14/168.3 Emergency Ambulance Services Committee – Joint Committee 11.4.14

14/168.4 Local Partnership Forum

- Draft Minutes 10.6.14
- Approved Minutes 8.4.14

14/168.5 Workforce & Organisational Development Committee

- Draft Minutes 16.6.14

- Approved Minutes 14.4.14

14/168.6 Approved Minutes Stakeholder Reference Group 12.5.14

14/168.7 Draft Minutes Board to Board meeting with Community Health Council 13.5.14

14/168.8 Approved Minutes Healthcare Professionals Forum 16.5.14

14/168.9 Information Governance Committee Approved minutes 19.5.14

14/168.10 Finance Committee

- Draft Minutes 24.6.14
- Approved Minutes 27.5.14

14/168.11 Quality & Safety Committee

- Draft minutes 5.6.14
- Draft Minutes 3.7.14

14/168.12 Audit Committee

- Approved Minutes 3.6.14
- Issues of Significance 10.7.14

14/168.13 Draft Minutes Charitable Funds Committee 13.6.14

14/169 Date of next meeting to be held in public

Tuesday 2nd September 2014 commencing at 9.30am with the Annual General Meeting (Ysbyty Gwynedd, Bangor)

PART B IN COMMITTEE MEETING – CONFIDENTIAL

Health Board Agenda and Papers 10.3.15

Betsi Cadwaladr University Health Board

AGENDA

Meeting to be held in public on 10.3.15 at 10.30am – 2.30pm
in the Boardroom, Preswylfa, Mold

Opening Business:

15/46 Chairman's Introductory Remarks

15/47 Apologies for Absence

15/48 Declarations of Interest

15/49 Draft Minutes of the Health Board Meeting held on 10.2.15

15/49.1 Accuracy

15/49.2 Matters Arising and Review of Actions

Financial Stewardship:

For Decision:

15/50 Investment Manager Tender – Update (Mr R Favager)

For Discussion:

15/51 Finance Report (Mr R Favager)

For Information:

15/52 Funded Nursing Care and Continuing Healthcare Rates (Mr G Lang)

Quality & Safety:

For Discussion**:**

15/53 Integrated Quality & Performance Report (Ms M Olsen)

15/54 Public Health – Health 2020 : Investing in Prevention (Mr A Jones)

15/55 Update on the Interim Service Changes Obstetrics and Gynaecology (Ms M Olsen)

For Decision**:**

15/56 Update of Register (All Wales) (Mr G Lang)

15/56.1 Section 12(2) Approved Doctors

15/56.2 Approved Clinicians

Lunch Break

Strategy & Leadership:

For Discussion:

15/57 Item removed

15/58 Improving Mental Health – the Forward Plan (Mr G Lang)

For Information:

15/59 Operational Management Structure (Prof T Purt)

Performance & Assurance:

For Approval**:**

15/60 Board Cycle of Business & Work Plan and Schedule of Meetings (Mrs G Lewis-Parry)

For Information:

15/61 Minutes and Summaries:

15/61.1 Welsh Health Specialised Services Committee confirmed minutes 25.11.14 and summary 27.1.15

15/61.2 Healthcare Professionals Forum draft minutes14.11.14

15/61.3 Stakeholder Reference Group approved minutes 10.11.14 and draft 12.1.15

15/61.4 Emergency Ambulance Services Committee confirmed minutes 25.11.14 and summary 27.1.15

15/62 In committee Board business to be reported in public

- Finance Report

15/63 Information circulated to the Board since the last meeting:

- Mid Wales Healthcare Study Response
- Response to Dolgellau & Barmouth League of Friends petition regarding elderly & mentally infirm (EMI) service provision

15/64 Date of next meeting : 30.3.15, at 1.30pm in the Boardroom, Wrexham

BOARD MEMBERS

Peter Higson OBE
Peter grew up in the Conwy Valley in North Wales. After attending school locally he studied psychology at Bangor University. He then went on to do a PhD in Psychology at Bangor.

Peter then started working in the NHS in 1977 at the former North Wales Psychiatric Hospital in Denbigh. His first role was in carrying out post doctoral research for three years, after which he trained as a Clinical Psychologist.

In the mid 1980s Peter began a change in career direction into health service management. In the late 1980s he was the manager of all mental health services in the former county of Clwyd and was closely involved in the planning and re-provision of services at the North Wales Hospital through to its closure in 1995.

In 1993 Peter became the Deputy Chief Executive of the former Clwydian Community Care NHS Trust where he remained until moving in 1998 to become a Director of the former North Wales Health Authority. In 2002 Peter secured a secondment to ELWa and was its interim Chief Executive in 2003-4 during a very difficult period for the organisation.

Peter was then appointed as the first Chief Executive of Healthcare Inspectorate Wales in 2004 and remained in this post until he retired at Christmas 2012.

Following retirement Peter worked part time with the Older People's Commissioner before being appointed in September 2013 as the Chairman of Betsi Cadwaladr University Local Health Board. Peter was awarded the OBE in the 2013 New Year's Honours list for services to health, education and support for veterans

Margaret Hanson
Margaret Hanson has started her role as Vice Chair and is based at Preswylfa, Mold. Margaret has lived in Flint for over 20 years and was a town, borough and county councillor for 19 years.

She was formerly Chief Executive Officer for Age Concern North East Wales and has a particular interest in promoting meaningful ageing, especially for the most frail older people.

Margaret holds a Diploma in Public Health from the University of Wales and is soon to receive her Master's Degree in Public Health.

Jenie Dean
Jenie has been appointed as an Independent Member with Trade Union background to the Board. She lives in Bethesda with her partner and twin daughters.

Jenie joined the NHS in 1977, working in Gwynedd as a nurse and then as a midwife. A member of the Royal College of Midwives, she has been a trade union representative since 1993. She brings a wealth of experience to the Board having held several elected officer roles for the North West Wales NHS Trust joint trades

unions committee including that of Trust Board representative. Passionate about the quality of health care and believing that staff are key to the achievement of high standards, Jenie will bring a trade union and staff perspective to the Board

Bobby Feeley
Councillor Feeley is a County Councillor for Denbighshire and has lived in Llanfair DC for 38 years. She is a member of the Ruthin and District Civic Association and on the Editorial Group of the Ruthin & District Town and Around.

Keith McDonogh
Mr Keith McDonogh lives in Wrexham. He retired from the post of Director of Education and Children's Services and Deputy Chief Executive at Flintshire County Council in 2002.

His public service involvements have covered membership of the Wales Advisory Committee on Drugs and Alcohol Misuse and Deputy Chair of Education and Learning Wales (ELWa). Mr McDonogh is currently the Safeguarding Co-ordinator for the Roman Catholic Diocese of Wrexham and Chair of the Diocesan Trustees. Mr McDonogh was a Non-executive Director of the North Wales NHS Trust and chaired its Finance and Performance Committee. He is one of the Non Officer Member with a specialist interest in Finance

Jo Rycroft-Malone, PhD, MSc, BSc(Hons), RN
Jo is a Professor of Health Services and Implementation Research, Head of School for Healthcare Sciences and Bangor University's academic lead for impact. She trained as a nurse in the mid 1980's in London and in later graduated with degrees in psychology and occupational psychology, before being awarded her PhD from the University of Southampton in 2002.

Internationally, she is known for her research into how health services might close the gap between what is known and what is practiced so that the care patients receive is more evidence-based. Over the past 5 years with colleagues she has developed an internationally recognised Implementation Research programme at Bangor University including the development of the first Professional Doctorate in Implementation.

Jo is also the current Chair of the National Institute for Health and Care Excellence's (NICE) Implementation Strategy Group. She sits on a number of other international and national strategy, funding and 'think tank' groups including Chief Medical Officer's (England) 'Clinical Effectiveness Research Agenda Group,' the National Institutes for Health Research (NIHR) Health Services and Delivery Research Programme commissioning board, Knowledge Mobilisation Fellowship Scheme, and the Canadian Institute for Health's Research Knowledge Exchange and Translation Committee. Jo was the inaugural editor of the international peer reviewed journal *Worldviews on Evidence-Based Nursing*, and currently sits on the editorial board of BioMed Central Implementation Science.

Dr Chris Tillson
Chris Tillson studied medicine in London and has practiced as a GP in Bangor since 1981. He has a keen interest in medical education and has held the positions of GP trainer, Course organiser and GP tutor with Cardiff University.

In a medical advisory role he was previously Chairman of the North Wales Medical Advisory Committee and is currently a member of the Welsh Medical Committee. Service innovation and redesign are his particular interests.

He was involved in setting up Meddygon Menai, the out of hours cooperative and he was the GP lead in the TEAMS project that improved patient access to appropriate musculo-skeletal services in North West Wales.

He was the Chairman of the Gwynedd Local Health Group for four years and following this has been the GP lead for Primary and Community Services within the Gwynedd Local Health Board. He strongly supports the current emphasis on Primary and Community Care and the closer integration between health and social services.

Through regular personal contact with patients and their families he is aware of the various health issues and needs of the local community and he looks forward to helping to improve the quality of services across North Wales

Marian Wyn Jones
Marian is the former Head of Centre for the BBC in North Wales, a role which she carried out for fifteen years. An award winning journalist and documentary maker, she has worked on a wide variety of Radio and TV programmes in Wales and on the Network in a hugely successful broadcasting career which spanned three decades.

A fluent Welsh speaker, she was brought up at Tywyn, Gwynedd. She graduated at Aberystwyth University and began her Journalistic career as a Graduate News Trainee with the BBC in London.

Marian is currently working as a Media Consultant and is involved with a number of charities and public organisations. She is a member of the Snowdonia National Park Authority, a Director of the renowned William Mathias Music Centre, a Council member of Bangor University and has recently been appointed Chair of Governors at Ysgol Uwchradd Syr Hugh Owen.

Ceri Stradling
Following graduation Ceri trained and qualified as a Chartered Accountant in Cardiff. He later left practice to work in the electricity distribution sector before moving to the Audit Commission to undertake both financial and value for money assignments. Over the next decade he occupied a range of senior manager posts in both Wales and England with the Commission. In 1996 he was appointed as the Statutory Auditor responsible for all NHS bodies, Local Authorities and Home Office organisations in North Wales. He has been a member of the Management Boards of the Audit Commission in Wales and the Wales Audit Office. He is currently the Deputy Chair of the Local Democracy and Boundary Commission for Wales and Chairs its Audit and Risk Committee, a member of Snowdonia National Park Authority and a member of the BBC Audience Council in Wales

Lyn Meadows
Lyn Meadows has been the HR Director at Bangor University since March 2008. She has responsibility for the strategic direction of both the operational side of HR and staff development.

Lyn has extensive experience in the public sector specifically managing change and fostering good employment relations. Between 2008 and 2014 Lyn was a Non-Executive Director at Wirral University Teaching Hospital. She took a lead Non-Executive role with the Quality and Safety agenda and Chaired the Partnership Forum. Lyn has a Masters in Business Administration, a law degree and is a fellow of the Chartered Institute of Personnel Development.

Bethan Russell Williams
Bethan originates from Llanbedrog on the Llŷn Peninsula. She attended the University of Wales, Aberystwyth between 1984 and 1989 where she graduated twice during that period, firstly gaining an honours BA in Welsh language in 1987, and two years later an honours LL.B in Law. She later attended The College of Law and worked briefly in the private sector. She spent some time working as a Law Lecturer in the Further Education sector before embarking on a career in the Third Sector.

In 1997 she joined the Workers Educational Association (WEA) where she became Deputy Director for North Wales. For the past ten years she has worked as Chief Executive Officer of Mantell Gwynedd County Voluntary Council. Bethan is passionate about the Third Sector and particularly about the future role of the Third Sector in the delivery of public services in Wales.

"NHS Organisation"

Disciplinary Policy and Procedure

Approved by: Welsh Partnership Forum: 8 July 2014

Issue Date: July 2014

Review Date: July 2016

C O N T E N T S

1. Policy Statement

1.1 The "*NHS Organisation*" recognises the need to maintain the highest standards of conduct amongst its employees encouraging self-discipline from all staff and for them to accept responsibility for their own conduct and behaviour.

1.2 The policy ensures that fair and effective arrangements exist for dealing with disciplinary issues and to ensure that expected standards of conduct and behaviour are observed. The policy should be regarded as a valuable tool to promote good employee relations and to correct standards of behaviour, and not as a punitive measure against employees.

1.3 The "*NHS Organisation*" is also committed to promoting good employee relations and allows all employees access to impartial advice consistent with employment law, equality and human rights legislation, good practice, and includes the right to defend themselves and present their case.

1.4 The disciplinary process is based on a series of escalating and linked responses to disciplinary matters. The appropriate levels of response will be determined by the circumstances of the case and the seriousness of the alleged offence(s). It is a fundamental principle that all cases are examined on their merits and no prejudgement is made at any stage of the process. Equally the principle of the policy and the manner in which it is applied must be consistent and show no differential for grade/ band or position.

1.5 This document has been designed to observe current employment, equality and human rights law and the Advisory, Conciliation and Arbitration Service (ACAS) Code of Practice. This policy is to be used alongside related local policies and procedures.

1.6 The "*NHS Organisation"* is committed to implementing the policy in a way which promotes the fair and equal treatment of all employees and eliminates discrimination on the grounds of race, disability, gender, gender reassignment, age, sexual orientation, pregnancy and maternity religion and belief, language, human rights, trade union membership and whistleblowing. It is the responsibility of managers and employees to ensure that they implement this policy/procedure in a manner that recognises and respects the diversity of the workforce and the different needs of all employees.

The "*NHS Organisation*" also recognises it has a legal duty to make any reasonable adjustments to the workplace, or to the way work is done, to ensure that a disabled employee is not substantially disadvantaged.

1.7 It is in the interests of both employees and the *"NHS Organisation*" that, where allegations of misconduct have been made, every effort is made to expedite the investigation and any subsequent action as swiftly as possible.

1.8 Disciplinary warnings cannot be issued to an employee outside of this policy and procedure.

2. Aims and Objectives

The principal aims of this policy are to:

2.1 Improve and protect standards of care by providing an orderly means of correcting inadequate standards of conduct, attendance or behaviour at work.

2.2 Provide a mechanism for dealing with any disciplinary issues that arise in a way that is fair, consistent, without discrimination and as quickly as possible.

2.3 Ensure that managers, employees and their representatives are aware of their rights, responsibilities and obligations within the disciplinary process.

2.4 Maintain the relationship between the employee and their manager.

2.5 Ensure that no disciplinary action against an employee is taken until the case has been appropriately investigated.

2.6 Ensure that all cases of suspected fraud or corruption are reported at the earliest opportunity to the "*NHS Organisation*" Local Counter Fraud Specialist (LCFS) or to the NHS Counter Fraud Service Team (CFS Wales).

2.7 Ensure that where an issue is identified that relates to the protection of vulnerable adults (POVA) or the protection of children (POCA) it will be dealt with in accordance with inter-agency protocols and any relevant external and/or regulatory bodies as appropriate.

3. Scope

3.1. This is the disciplinary policy and procedure to be used for all employees within NHS Wales unless specific alternative contractual arrangements are in place.

3.2. All staff, students, trainees, volunteers and other employees who work on "*NHS Organisation"* premises but are not directly employed by the organisation will be subject to the "*NHS Organisation"* standards of conduct and behaviour at work but will be dealt with under the scope of their own employer's Disciplinary Policy.

3.3. Where disciplinary action is being contemplated against a Trade Union Official, the appropriate full time officer or senior lay official will be notified, prior to any action being taken.

3.4. The policy does not apply in cases of absence attributed to sickness which will be addressed through the relevant Sickness Policy or in cases of poor performance which can be attributed to capability and which will be addressed through different mechanisms, except where there is evidence of a wilful breach of the relevant procedures.

3.5. In accordance with the principles of clinical governance, disciplinary action would not normally result from reporting incidents, mistakes or near misses, but other procedures may apply. However, issues which may lead to disciplinary action would include criminal or malicious activities (including malicious reporting), acts of

gross misconduct or gross negligence, and repeated unreported errors or violations of procedure.

3.6 All disciplinary matters relating to the protection of vulnerable adults (POVA) and the protection of children (POCA) are covered by this policy, but will be dealt with in accordance with inter-agency protocols and any relevant external and/or regulatory bodies as appropriate.

4. General Principles

The following principles will be taken into account in the application of this policy:

- The right of all employees subject to this policy to be treated fairly and with dignity and respect.
- No disciplinary action will be taken against an employee until the case has been appropriately investigated.
- Each step of the disciplinary process will be taken as quickly as possible on the part of the *"NHS Organisation".*
- The timing and location of meetings will be reasonable and accessible.
- All parties will be given the opportunity to explain their position during meetings arranged as part of the investigation process.
- When a disabled employee is involved in this process, the *"NHS Organisation"* and the employee will work together to identify any reasonable adjustments that may be put in place to ensure the employee is not disadvantaged in any way.
- Other access issues, such as the need for linguistic support will be addressed to ensure that all employees are able to fully participate in the process.
- At every stage in the process the employee will be advised of the nature of the allegations made against them and will be given the opportunity to state their case before any decision is made.
- No employee will be dismissed for a first breach of discipline except in the case of gross misconduct, where the penalty could be dismissal without notice or payment in lieu of notice.

5. <u>Awareness</u>

Employees will be made aware of the disciplinary rules and of the expected standards of conduct and behaviour when they join the organisation. They will be made aware of how they may access information on any subsequent changes. Every employee is encouraged to familiarise themselves with the detailed content of the policy and to ensure that they understand their responsibilities under it.

6. Right to be Accompanied

6.1 This policy allows all employees to be accompanied at formal investigation meetings. However, as long as a suitable alternative representative is available, unavailability of a preferred representative or workplace colleague should not delay the hearing taking place.

6.2 All employees have the right to be accompanied by a Trade Union representative or a *NHS Organisation* workplace colleague, at all formal hearing stages of the procedure. However, as long as a suitable alternative representative is available, unavailability of a preferred representative or workplace colleague should not delay the hearing taking place.

Where reference is made in this policy to the employee's "representative", this will refer to the Trade Union representative or work place colleague.

6.3 At the disciplinary or appeal hearing the representative will be allowed to:

- address the hearing
- put or sum up the employee's case
- respond on behalf of the employee to any views expressed at the meeting
- confer with the employee during the hearing
- question witnesses called by the Disciplining Officer
- request an adjournment
- seek clarification of the panel

The representative does not, however, have the right to:

- answer questions on behalf of the employee,
- address the hearing if the employee does not wish it, or
- prevent the employee from explaining their case.

7. Informal Discussions

7.1 The immediate manager should deal with minor conduct/standards of behaviour issues on an informal basis as appropriate. This may involve advising the employee as to expected standards of behaviour or conduct.

7.2 This is not part of the disciplinary process, but may be used to improve performance and prevent the need for future disciplinary action. It should be a two-way discussion, undertaken in a constructive manner, clarifying the standard of future conduct/behaviour expected of the employee, together with the way in which improvement will be monitored.

7.3 The employee should be advised that failure to improve may lead to action being taken under the Disciplinary Policy. A note of the discussion should be placed on the employee's personal file and a copy given to the employee for their records.

7.4 Where more serious or continued concerns arise on conduct/standards of behaviour the appropriate manager must consider, having taken advice from HR, whether the Disciplinary Policy should be invoked.

7.5 If, at any stage during the informal discussion process, additional information comes to light and the manager believes it is no longer appropriate to deal with the matter by informal discussion, the meeting must be adjourned and the formal disciplinary process must be instigated.

8. Potential Criminal Offences including Fraud, Corruption and Bribery

8.1 Where there is a reasonable suspicion that fraud or corruption may have occurred, the Local Counter Fraud Specialist (LCFS) or the NHS Counter Fraud Service Team (CFS Wales) must be notified immediately.

8.2 Where the initial assessment indicates that other criminal offences may have been committed, these matters should be discussed with the appropriate senior manager and reported to the Police.

8.3 In such circumstances, the "*NHS Organisation"* shall not be precluded from taking disciplinary action in accordance with this policy so long as it is not prejudicial to any potential criminal investigation.

8.4 The "*NHS Organisation*" is not required to wait until after a criminal trial to proceed with its own investigation, though on occasion it may be prudent to do so. Where a criminal offence has been allegedly committed by an employee inside or outside work, an investigation of the facts and circumstances surrounding the case as it relates to their employment will be conducted, unless a request from the Police or LCFS/CFS Wales has been made that to do so may be detrimental to a criminal investigation. The investigation will seek to establish whether, on the balance of probability, the incident/misconduct occurred. There is a need for close co-operation with the person taking forward the parallel criminal investigation.

8.5 Where an investigation appears to indicate that an incident or misconduct has occurred, the suitability of the employee for continued employment must be considered. Disciplinary action may be appropriate, but will depend on a number of factors. These include:

8.5.1 The relevance of the offence to the job for which the employee is employed, whether or not it impinges upon the contract of employment.

8.5.2 Whether there is the potential of risk to patients, public, and other employees or to the employee themselves.

8.5.3 The risk of serious damage to the reputation of/or public confidence in the organisation.

8.5.4 Whether the alleged offence will be required to be reported to a professional and/or regulatory body.

8.6 Following the outcome of any criminal investigations and prosecutions, and subsequent criminal proceedings, an employee, subsequently found not guilty, has no further right of appeal in respect of any internal disciplinary action.

9. Procedure for Dealing with Alleged Misconduct

9.1 Where the manager becomes aware that an incident or misconduct has apparently occurred, the following procedure should be followed. It is expected that the employee will be afforded due courtesy and sensitivity at all stages, and that the procedure will be followed with appropriate promptness.

9.2 Initial Assessment

The purpose of the initial assessment is for the manager to determine, on the information available at that time, what the next appropriate course of action might be. This fact finding assessment will involve discussing the alleged incident/misconduct with the employee as well as obtaining other preliminary pieces of information as necessary. A request for representation will not normally be refused. Following the assessment, the manager may decide that:

- No further action is necessary because there is no evidence to support the allegation that an incident or misconduct occurred.
- Given the minor nature of the misconduct, informal discussion is a more appropriate measure than formal disciplinary action. (Paras 7.1 to 7.5 refer).
- The fast track Disciplinary process may be appropriate because the employee has admitted misconduct or where prima facie evidence exists. Fast tracking can only occur in incidents where it appears that the nature of the misconduct would only warrant a verbal or first written warning as a maximum. A letter will be issued to advise the employee of this decision and outline the allegation.
- A formal investigation will be required, with due consideration given to the need to suspend the employee without prejudice or deploy him/her whilst the investigation is ongoing. A letter will be issued to advise the employee of this decision and outline the allegations (see appendix 3).
- Application of a different policy may be more appropriate, e.g. capability.

9.3 Fast Track Disciplinary Process

9.3.1 The fast track disciplinary process allows for cases to be dealt with in a timely manner, within one month of the initial assessment, unless there are exceptional circumstances. There will not be any need for a formal investigation report although a thorough examination of the known facts will take place. An investigating officer will not, therefore need to be appointed.

9.3.2 Those situations where fast track may be suitable are as follows:-

- Incidents that are regarded as 'Misconduct' which would normally result in either a verbal or first written warning.

- The employee against whom the allegations are made has admitted to them in full.
- Where the employee does not admit to the allegation but there is factual evidence which the employee cannot refute, i.e. there is indisputable prima facie evidence, fast tracking may take place.

9.3.3 If the manager feels that the fast track approach is appropriate, they must, in the first instance, discuss this with an HR adviser. A review of the information will be undertaken in conjunction with the manager, the employee and his/her representative and a decision taken as to whether the fast track process should be adopted. **This must be agreed by all parties in writing.**

9.3.4 If the decision has been made to fast track then the following process should be followed:

- The Disciplining Officer will ensure (if not done already) that there is a written statement from the individual who reported the incident and also from the employee involved, together with any supporting information gathered.

- The Disciplining Officer will write to the employee involved asking them to attend the fast track disciplinary hearing, and will provide a copy of all information gathered plus the date, time and venue of the hearing (this should be sent no less than 7 calendar days before the hearing). The employee will be given the right to be accompanied if they so wish.

- The Disciplining Officer will be supported by a Workforce & OD (HR) Advisor and professional adviser, where appropriate (The Hearing Panel). The employee and their representative will also be present. No witnesses will be called.

9.4 The procedure for the fast track hearing is as follows:

- Introductions are made.
- The Disciplining Officer outlines the nature of the allegation(s) and advises that it (they) may result in disciplinary action up to and including a written warning.
- The Disciplining Officer confirms with the employee that they admit to the allegations previously stated or confirms the evidence available.
- The employee or their representative will have the right to put forward any comments or statements relating to the incident (including any mitigation).
- The Hearing Panel may wish to question the employee.
- The Hearing Panel will adjourn briefly to give full consideration to the case.
- After reaching a decision the Hearing Panel will reconvene.
- The Disciplining Officer will then communicate their decision to the employee and their representative. The penalty, if any, will not exceed a verbal or first written warning.
- The Disciplining Officer will send a letter confirming the decision of the Hearing to the employee, advising them of their right of appeal. The record of any warning will be kept on the employee's personal file.

9.5 If an issue arises as part of the fast track process, which warrants a full investigation, a full investigation will be instigated.

10. Formal Investigation (see flowchart at appendix 4)

10.1 Where the case is not suitable for a fast track hearing, an Investigating Officer should be appointed to undertake a full investigation.

The Manager must ensure that the Investigating Officer is provided with sufficient support in terms of time, administrative facilities and reallocation of their work responsibilities, and adequately trained to be able to demonstrate the necessary competencies to be able to carry out a careful and thorough investigation in a timely manner.

Regular verbal or written updates on progress will be provided by the Investigating Officer to the manager and the employee and his/ her representative.

10.2 The investigation is commissioned by and conducted on behalf of the employee's manager.

10.3 The Investigating Officer will produce a factual report containing all the evidence gathered. It is not the role of the Investigating Officer to make any judgement about the case.

10.4 The report will be considered by the Disciplining Officer who will make a decision about the appropriate course of action. Once the report is accepted by the Disciplining Officer this decision will be made within 10 days. Any delay should be communicated to the employee with reasons.

10.5 The Investigating Officer should normally be appointed from a different department to that in which the employee works. The Investigating Officer should have the specialist skills and/or knowledge relevant to the case being investigated. This may be an individual from another NHS Organisation.

10.6 The employee must be made aware of all the allegations made against them and be interviewed as part of the investigation process. They may be accompanied by their representative at this meeting**,** the aim of which is to establish, impartially, all the key points pertinent to the investigation that can be provided by the employee. The employee should be allowed to offer any information that they feel is relevant during this interview as it may affect the decision about whether to proceed with a disciplinary hearing. A written record of the interview should be made and signed by the employee as an accurate record.

The investigation will also make enquiries of relevant witnesses and collect documentary evidence as necessary. Such evidence must be copied to the employee and their representative, as part of the investigation report.

Should the Investigating Officer establish evidence which would suggest that the terms of reference for investigation and/or the allegations against the employee need to be

widened, they should draw this to the attention of the Disciplining Officer. If the Disciplining Officer concludes that further allegations need to be investigated, the terms of reference issued to the Investigating Officer will be re-issued and the employee will be formally notified that additional/amended allegations are to be considered.

10.7 If an employee becomes unwell during the disciplinary process, the investigation may continue, albeit in a sensitive and considerate manner. Advice from the occupational health department may be sought, if appropriate.

10.8 The Investigating Officer will be given advice on the process by a Workforce & OD (HR) Advisor who would not then be part of a disciplinary panel. Where the Investigating Officer requires secretarial support, then the Manager must take this into account when instigating the investigation. However, disciplinary matters require high standards of confidentiality and the number of staff involved must be the absolute minimum to deliver a comprehensive report within a reasonable timescale.

10.9 Once the investigation is complete the Investigating Officer will prepare a report of their findings, providing documentary evidence of the facts, and any witness statements.

On receiving the Investigating Officer's report, the Disciplining Officer will determine, within 10 calendar days what further action should be taken. i.e.

- no case to answer
- to proceed via informal discussion as outlined in 7.1 to 7.5
- to proceed to a disciplinary hearing
- to proceed through an alternative procedure (e.g. capability)

Where a decision is made to proceed to a disciplinary hearing, this should take place as soon as possible after the decision is made.

10.10 The Investigating Officer will attend the disciplinary hearing to present an overview of their report and to answer any points of clarification required.

10.11 Where the allegation is of a potentially serious nature, in the interests of minimising unnecessary delay it may be advantageous to arrange, a provisional date for a disciplinary hearing at the outset of an investigation. This is a practical measure that does not, in any way, attempt to prejudge whether such a disciplinary hearing will be deemed necessary.

10.12 Witnesses

10.12.1 All employees of the "*NHS Organisation*" have a duty to co-operate with management in disciplinary proceedings. Witnesses who have provided statements should be advised of the fact that a hearing may take place and of their being required to attend, that their statement will form part of the investigation report, and that if a hearing is necessary, the panel and the employee will have sight of them.

10.12.2 The employee or their representative must make the Disciplining Officer aware of those staff they wish to call as witnesses.

10.12.3 The Disciplining Officer will arrange to call all witnesses required after having discussed and agreed these with the employee and his/her representative.

10.12.4 Witnesses who are employees of "*NHS Organisation"* are obliged to attend if requested to do so by the Disciplining Officer.

10.12.5 Arrangements will be made for witnesses to be released from their duties to enable them to attend the hearing. They may bring a representative or workplace colleague with them for personal support if desired.

10.12.6 People not directly employed by "*NHS Organisation*" may be invited to attend the hearing as a witness but cannot be compelled to do so.

11. Alternatives to Suspension / Temporary Deployment During Period of Investigation

11.1 In some circumstances it may be appropriate to suspend the employee or to deploy the employee to another post/work pattern or to another work place on a temporary basis. Where alternatives to suspension are being considered, this would only be done following a discussion with the employee and their Representative and would take into account its reasonableness in all the circumstances. LCFS / CFS Wales should always be advised of any decision to suspend or deploy an employee when the employee is under investigation by the LCFS/ CFS Wales.

11.2 If an employee, as an alternative to suspension, is deployed to another post / work pattern or to another workplace there should be no loss of earnings i.e. night allowance, weekend allowance and regular overtime.

11.3 If suitable temporary deployment is offered, the employee will be expected to accept.

12. Suspension from the Workplace

12.1 Suspension is not a disciplinary penalty and is without prejudice. Suspension from the workplace will be with pay, in accordance with Paragraph 12.3.2 of this Policy. Suspension may be considered appropriate where keeping the employee in the workplace after the incident/ misconduct may:

- Compound the offence.
- Interfere with or prejudice the investigation.
- Jeopardise the safety or well being of patients and / or employees.

12.2 If the decision to suspend is taken by the manager (in consultation with a senior Workforce & OD (HR) Advisor or, where not available, another manager of equivalent seniority) the employee should be told of this decision immediately. The employee should be asked about any other organisation that they are engaged by,

paid or voluntary, and these organisations will be advised of the suspension accordingly. Where possible the employee should be given the opportunity to be accompanied at the meeting when they are informed of their suspension if they so wish.

12.2.1 Unavailability of a preferred representative or workplace colleague will not, however, delay the meeting from taking place.

12.2.2 The employee should be given information regarding the support available to them e.g. Occupational Health.

12.3 During suspension the employee must not (unless as a patient or to access sources of help e.g. to meet with their Representative) enter *"NHS Organisation*" premises or their normal place of work without the express permission of their manager. Details of the suspension will be confirmed in writing giving the reason(s) for this course of action by the manager.

12.3.1 An employee who is suspended from duty should not undertake any other work, within or outside the NHS, without consulting their line manager beforehand and receiving authorisation to do so. It is the responsibility of NHS organisations to advise other employers (where known) of the suspension.

12.3.2 Pay during suspension will be calculated according to the normal duty roster worked by the employee and during this period the employee will be recorded as on authorised paid leave in order to maintain confidentiality.

12.3.3 Employees who are suspended must make themselves available to attend meetings and interviews as part of the disciplinary process.

12.4 If an incident occurs, or is reported out of hours and an employee's manager or an appropriate member of the Workforce & OD (HR) Department is not available, an appropriate senior member of staff can make a decision to send an employee home on the basis that there is a risk to themselves and/or others if they were to stay in work. The employee will be asked to report to their manager on a specified day. This decision will not constitute suspension but is required in order that the facts of the case are reviewed as soon as reasonably possible. The employee will be recorded as on authorised paid leave and paid as per their normal shift.

12.5 The manager must ensure that the period of suspension is kept to a minimum and that the investigation takes place as swiftly as possible. The manager should review the suspension regularly but at least monthly, this should be recorded and any cases that continue beyond four months should be reported to the Board of the "*NHS Organisation*", together with information on the expected completion of the investigation. Regular summary reports should be made to Board meetings or an appropriate Board committee detailing the number of current suspensions and their duration. Information identifying individual employees should not, however, be presented in open Board meetings.

12.6 If an employee wishes to book annual leave during the period of their suspension they must apply to the manager giving due notice. Such applications will be

considered sympathetically but may reasonably be refused if the leave would delay the resolution of the disciplinary matter. Annual leave booked prior to the suspension will be honoured and will be deducted from the employees total annual leave entitlement.

12.7 If the employee is on sick leave this does not preclude the Investigating Officer from continuing with the investigation. However, advice may need to be sought from Occupational Health if there are concerns about the employee's ability to continue to participate in the process.

13. Procedure for Reporting to Disclosure and Barring Service (DBS)

13.1 All organisations have a legal duty to refer any information about employees who could pose a risk of harm to children and vulnerable adults to the DBS who will assess the information and make a barring decision. Such referrals will include when an incident comes to light, when a member of staff has been dismissed, or resigned before dismissal.

A referral should not be made when an allegation is first made. An investigation and evidence gathering should be first undertaken by the person or organisation that would normally refer to the DBS. This is in order to establish if the allegation has foundation, for example as part of an internal disciplinary process. Without evidence or substance to the claims many allegations will quickly be identified as unjust as there will be no foundation on which the DBS can proceed.

13.2 'Harm' is stated as being physical, sexual, emotional, neglect or financial. Neglect could include a failure to act or an omission.

13.3 Where a person / organisation has a legal duty to refer, there are two main conditions which should be met for a referral to be made, these are;

1) They have permanently removed a person from 'regulated activity' through dismissal or permanent transfer from 'regulated activity' (or would have if the person had not left, resigned, retired or been made redundant); and
2) They believe the person has
   a. Engaged in 'relevant conduct', or
   b. Satisfied the 'harm test' (i.e. no action or inaction occurred but the present risk that it could was significant), or
   c. Received a caution or conviction for a 'relevant offence' (a list of these offences is available on the DBS website, or from calling the helpline for advice).

14. <u>Procedure for Reporting to Professional Regulatory Bodies</u>

14.1 It will be the responsibility of the Head of Profession to contact the appropriate professional regulatory body at the point at which it is decided that there is evidence of a concern relating to fitness to practice. The decision on when this occurs should be taken in discussion with the appropriate body.

15. Arrangements for the Disciplinary Hearing

15.1 Once the investigation has been completed and the report with all the appendices is submitted, the Disciplining Officer will then decide if the investigation has established that there is sufficient evidence to support the allegations.

15.2 The Disciplining Officer will determine within 10 days of accepting the report what further action should be taken. Where a hearing is being convened the employee must be informed in writing that they have the right to be accompanied to the hearing and will have the right to state their case; where the allegation(s) are considered gross misconduct the letter must also outline that disciplinary action may include dismissal.

15.3 The Disciplining Officer conducts the hearing and makes the decision as to whether the allegations are proven. The Disciplinary Panel will comprise:

15.3.1 The Disciplining Officer

It is important that the Disciplining Officer is of sufficient seniority to make the decision on the appropriate penalty. This is critical in those cases where dismissal is a possible outcome.

15.3.2 Workforce & OD (HR) Advisor

An appropriate member of the Workforce & OD (HR) Department, (with no previous involvement in the case), who advises the hearing on procedure and employment issues and can assist the Disciplining Officer in establishing the facts of the case.

15.3.3 Panel Member

When appropriate, the Disciplining Officer may also be supported by a senior manager from outside the line management chain of the employee who is able to provide specialist, professional or technical expertise.

15.4 Practical arrangements for holding the Disciplinary Hearing will be made as soon as possible.

15.5 The employee must attend a disciplinary hearing when requested to do so. Where he/she is unable to attend for any reason they must notify the manager in order that the meeting can be rearranged.

Where an employee has a justifiable reason for failing to attend a disciplinary hearing, such as an accident or personal emergency, the hearing should be adjourned in the first instance and rearranged as soon as possible. The employee must be warned if they fail to attend for a second time, the hearing will be held in their absence and a decision may therefore be made on the information available to the panel at that time.

15.6 All documentation supporting the allegation/s will be passed to the employee as soon as possible but no later than 21 calendar days prior to a disciplinary hearing. This will include the investigation report which will contain interview notes, any witness statements and all other documentary evidence that is to be considered. Any additional information which the employee wishes to rely upon should be

submitted to the Disciplining Officer as soon as possible but no later than 10 calendar days prior to the hearing. In exceptional circumstances, the employee may request to make a submission which has not been made available within the above timescale.

15.7 At the same time, the list of agreed witnesses will be provided no later than 14 calendar days before the hearing date.

15.8 The Disciplining Officer will make arrangements for the attendance of all appropriate witnesses required at the hearing.

16. The Disciplinary Hearing

16.1 The Hearing is an opportunity to examine the evidence and allows the employee concerned the proper opportunity to comment on the evidence and make any representations or offer their views concerning the allegations. The Hearing must consider all the evidence and give the employee a fair opportunity to make their views known whilst at the same time ensuring that all evidence is examined thoroughly so that an appropriate decision can be reached. No new written evidence may be produced by either party after the exchange of case papers without the agreement of all parties.

16.2 The Disciplinary Hearing itself should normally follow the sequence described below, requiring the designated Disciplining Officer to:

16.2.1 Introduce those present

16.2.2 Explain the purpose of the Hearing, i.e. indicate that it is a disciplinary hearing convened in accordance with the "*NHS Organisation's*" Disciplinary Policy to address the allegation(s) as detailed and (where applicable and appropriate) to consider a report concerning the issue(s), together with all other documentation to be relied upon as evidence.

16.2.3 Outline the nature of the Hearing, i.e. that the allegation(s) is/are viewed most seriously and may result in disciplinary action, including dismissal, where appropriate.

16.2.4 Refer to the principles which govern the hearing:

- that full and fair consideration will be given to all issues pertinent to the case.
- that all evidence will be considered, and
- that the employee or their representative will have the opportunity to deny, or to defend themselves/the employee against the allegation(s).

16.2.5 Describe the procedure to be followed at the Hearing (and ensure this is understood by the employee).

16.2.6 A Workforce & OD (HR) Advisor is available to attend the panel meeting to support and advise the investigating officer but will not answer questions directly on their behalf.

16.3 Order of proceedings

- In the first instance, the Investigating Officer will present an overview of their report and clarify any points raised.

- Witnesses shall be asked by the panel to clarify any issues as appropriate. The witness(es) will then answer questions from the employee or his representative.

- The employee or his representative will then be invited to make statements and present evidence, whether oral and/or written, to explain, deny, and offer mitigating circumstances or otherwise comment upon the allegations made against them.

- The employee will then answer questions from members of the disciplinary panel.

- Witnesses called by the employee or his representative shall first be questioned by the employee or their representative and thereafter may be questioned by members of the disciplinary panel.

- An opportunity will then be given to the Investigating Officer to restate the key points if the panel deems it necessary, and the employee or their representative to sum up their case and make any final comments or ask any final questions. The employee and/or their representative will speak last. No new information may be introduced at this stage.

16.4 General Principles

- The Disciplinary Panel members shall have the right to ask questions of anyone present, at any time during the proceedings.

- The employee or their representative shall have the right to ask questions of any witness.

- The Investigating Officer shall remain in attendance throughout the hearing. Their role will be to present an overview of their report and to clarify points as required by the Disciplining Officer, the employee, or their representative. They will not have the right to ask questions.

- No witnesses called either by the Disciplining Officer or the employee may be present at the hearing before giving evidence. After giving evidence witnesses may be asked to remain available for clarification purposes, but shall not remain in attendance.

16.5 Once the hearing has examined all the evidence provided for in the report or presented at the hearing the panel will adjourn, to give full consideration to the case.

16.6 At this stage, further information may be requested if appropriate, in which case the hearing will reconvene once the additional investigations have been completed.

16.7 The Disciplining Officer with the advice of the panel then reaches a conclusion as to whether the evidence supports the allegation based on the balance of probabilities. They must be satisfied that the investigation and hearing have been conducted in accordance with this policy, that the disciplinary rules have been appropriately considered and applied and that the penalty is reasonable, and reflects the seriousness of the offence.

16.8 After reaching a decision the Hearing will reconvene and the employee will be advised of the Disciplining Officer's decision as to whether the allegations have been proven, on the balance of probability, and the nature of the penalty imposed, if any.

16.9 The decision should be conveyed to the employee verbally on the same day; or, if a decision cannot be made on the day of the hearing, the employee should be informed of the decision within 7 calendar days. If the decision is likely to take longer for some reason, then the employee must be contacted by the Disciplining Officer and informed of this fact, along with the reasons for the delay.

16.10 The letter to the employee confirming the outcome of the case and any disciplinary action should be sent to the employee no later than 7 calendar days after the notification of the outcome of the hearing. The letter should confirm the date, time, and place of the disciplinary meeting and of those present. If the employee declined to be accompanied this should be noted in the letter.

16.11 The letter should also:

- Confirm the allegations that were considered and specify those found unproven and, on the balance of probability, those that were found proven.
- State clearly the nature of misconduct or failure to reach the required standards.
- State the rationale for the decision.
- Specify the disciplinary action being taken and, if a warning is being imposed, state how long the warning will remain "live".
- Outline any recommendations, training or support that must be actioned to improve conduct or behaviours in future or any management recommendations as appropriate.
- Where a warning is imposed, confirm that committing any further related offences or, failing to improve performance, could result in more serious disciplinary action, up to and including dismissal.
- Remind the employee that they have the right of appeal within 14 calendar days of notification of the disciplinary action and state to whom the appeal should be made.
- Reference that the appeal should be directed to the manager one level above the manager taking the disciplinary action.

All such letters should be sent out by a recorded method of delivery.

16.12 Where the investigation arises from a recent series of different incidents or a recent series of minor incidents of the same nature, they may be accumulated and taken into account at the same disciplinary hearing and dealt with by the same disciplinary action. The employee must have been informed of this in the original letter confirming the disciplinary hearing date.

16.13 Where the incident that leads to disciplinary action being taken occurs during a period when a warning is already in operation, this warning may be taken into consideration in deciding the appropriate action, so long as the most recent incident is of a similar nature to that for which the warning was imposed.

16.14 Where appropriate, the Disciplining Officer shall, in discussion with the Professional Advisor on the Panel inform the employee's professional body and/or the DBS of the outcome of the hearing.

17. Notification of Disciplinary Action

Below is a summary of the possible penalties resulting from a disciplinary hearing. They are not necessarily sequential and their application will depend on the particular circumstances of the case.

Formal Disciplinary Process Begins	
Verbal Warning	Minor Misconduct
First Written Warning	Misconduct or further offence
Final Written Warning	Serious misconduct or further offence
Dismissal*	Gross misconduct or further offence
Other formal action, short of dismissal	There may be a situation where dismissal is justified, but where the disciplining officer believes the circumstances are such that he/she wishes to offer alternative employment, in conjunction with a final written warning, as an alternative to dismissal. This may be to a lower pay band (to the top of the band provided this does not lead to an increase in salary) and/or to another area and would not attract protection of salary or excess travel. The employee would have the opportunity to consider this option and respond in writing

	within 7 calendar days accepting this variation in their terms and conditions as an alternative to dismissal. Accepting alternative employment does not remove the employee's right of appeal against the original decision to dismiss.

17.1 Verbal Warning

17.1.1 If conduct or performance does not meet acceptable standards, the employee can be issued with a verbal warning. The employee will be told of the reason for the warning and that it is the first stage of the formal procedure.

17.1.2 Where, a verbal warning is considered necessary, this will be active for 6 months. The record of the hearing (as provided to the employee) will be placed on the employee's personal file, and confirmation that a warning has been issued will be forwarded to the employee (and their representative if requested by the employee).

17.1.3 Provided that no further verbal warnings have been issued during the specified period, the verbal warning is considered to be spent and cannot be used in order to warrant an escalation in the penalty. All subsequent offences whether or not they are identical to the 'spent' offence are considered entirely on their own merits and the process starts from the beginning again.

17.2 First Written Warning

17.2.1 If the offence is of a more serious nature, or if conduct has not improved as a result of a verbal warning, the Disciplining Officer may decide that a formal written warning is appropriate.

17.2.2 The written warning will be active for a period of 12 months. The record of the hearing (as provided to the employee) will be placed on the employee's personal file, and confirmation that a warning has been issued will be forwarded to the employee (and their representative if requested by the employee).

17.2.3 Provided that no further written warnings have been issued during the warning period, the written warning will then be considered to be spent and cannot be used in order to warrant an escalation in the penalty. All subsequent offences whether or not they are identical to the 'spent' offence are considered entirely on their own merits and the process starts from the beginning again.

17.3 Final Written Warning

17.3.1 A final written warning will be issued where:

- There is a failure to reach the required standards, which normally will have been set out in previous warnings.
- Serious misconduct has taken place.

17.3.2 Written notification will be as outlined above, but in addition, the letter to the employee confirming the final written warning should also indicate:

- Reference to previous relevant disciplinary action, where appropriate.
- Confirmation that further misconduct of a similar nature will lead to dismissal. The written warning is considered active for 24 months.

17.3.3 If the misconduct or failure to meet standards is of a serious nature then a final written warning may be implemented without previous warnings having been issued.

17.3.4 The record of the hearing (as provided to the employee) will be placed on the employee's personal file, and confirmation that a warning has been issued will be forwarded to the employee (and their representative if requested).

17.4 Dismissal

17.4.1 Dismissal is normally considered to be the appropriate action:-

- Following an act of gross misconduct or a serious continued failure to meet required standards.
- Where there is a failure to reach the required standards which have been specified in previous warning(s).

17.4.2 Where an employee is dismissed for continued failure to reach the required standard the appropriate period of notice or pay in lieu of notice along with other entitlements should be made. In cases of gross misconduct, the employee will be summarily dismissed without payment in lieu of notice and without notice (right of appeal and reinstatement if found to be justified still apply).

17.4.3 A letter must be given to the employee in person or sent by a method of recorded delivery within 7 calendar days confirming the dismissal and should also state:

- Date, time, place of disciplinary meeting and those present
- The reason(s) for dismissal and effective date of termination
- The appropriate period of notice or pay in lieu of notice or in cases of summary dismissal, that no notice will be paid. Any other rights, for example, annual leave due should be included in the final pay arrangements
- Where appropriate, that the relevant professional body and/or the DBS will be informed
- The right of appeal, including time limits, and that the appeal should be made to the manager one level above the manager taking the disciplinary action.

Dismissal where there has been no previous warning regarding conduct is a penalty only applicable in cases of gross misconduct or breach of contract as outlined in the Disciplinary Rules. No employee will be dismissed for a first offence outside those categorised as gross misconduct or breach of contract.

18. Expiry of Warnings

18.1 The warning becomes "spent" following the specified period of the warning. The NHS Organisation will put in place a system to ensure the employee is informed when the warning is "spent". There may be occasions, however, when an employee's conduct is satisfactory throughout the period the warning is in force only to lapse soon thereafter. In these circumstances, where a pattern of behaviour emerges, the Disciplining Officer can take the employee's full disciplinary record into account when deciding the length of any new warning that is to be imposed.

18.2 Periods for which warnings will be active may be extended if an employee is absent from work for an extended period, whereby performance/conduct cannot be monitored, to cover the length of the absence.

19. Debrief/Lessons Learnt

19.1 Following the completion of the internal disciplinary process, a formal debriefing session may be convened by the Disciplining Officer to review the case, any lessons learnt and any further agreed action required. Present at the discussion should be the Investigating Officer, other panel members as appropriate and staff side representatives.

20. Employment Monitoring

An accurate record of all disciplinary events should be maintained on the Electronic Staff Record (ESR), to enable the organisation to consider whether there are any issues that may be contributing to unintended discrimination. This information must be capable of being disaggregated by each of the protected characteristics and routinely collected, analysed and reported on to ensure that disciplinary processes are fair and equitable for all employees and groups, and to demonstrate that the *"NHS Organisation"* is meeting its employment equality monitoring duties.

21. Appeals

21.1 All employees have the right to appeal against disciplinary action or dismissal.

21.2 The person to whom an appeal is made must be specified in the letter informing the employee of the outcome of the disciplinary hearing and/or the disciplinary action to be taken.

21.2.1 An employee who wishes to appeal (appellant) against disciplinary action or dismissal must lodge their intention to appeal within 14 calendar days of receiving written notification of the disciplinary action taken.

21.2.2 This notification of intention to appeal should indicate the grounds on which this appeal is based. The employee should be explicit as to whether this is an appeal against the judgement of the disciplining officer, against the disciplinary penalty imposed, or against the process of the disciplinary investigation and hearing itself.

21.3 An Appeal Officer will be appointed and the appeal heard within 28 calendar days of the notification of appeal being received. The appeal panel will consist of an Appeal Officer and Workforce & OD (HR) Advisor and where appropriate a further panel member. In exceptional circumstances it may be necessary to extend this deadline with the agreement of both parties but every effort should be made to hear the appeal promptly.

21.4 At least 7 calendar days before the Appeal Hearing the Appeal Officer must receive the nature of the appeal and all documentary evidence in support of it. Failure to comply may result in either the appeal being postponed or the appeal going ahead without this information.

21.5 There will be two levels of constitution of appeal hearings.

21.5.1 For appeals against disciplinary warnings short of dismissal, the appeal will normally be heard by a manager one level above the manager who imposed the penalty. If organisational structures allow, the Appeal Officer should be from a separate directorate/locality in line with best practice.

21.5.2 The Workforce & OD (HR) Advisor will be in attendance in order to give advice and to support the Appeal Officer in ensuring that all aspects of the appeal are fully explored. The Appeal Officer must ensure they have access to appropriate professional advice, where necessary.

21.5.3 In cases of appeals against dismissal, the Appeal Officer will be a senior officer nominated (by the Director of Workforce and Organisational Development), in line with the organisation's scheme of delegated authority. Where appropriate, the Appeals Officer may be supported by a second senior manager who will provide any necessary professional advice.

21.6 The officers nominated to hear an appeal must not have been involved in the disciplinary process at any earlier point.

21.7 The purpose of the appeal is to establish if the decision taken at the disciplinary hearing was reasonable in light of the grounds raised by the employee. The appeal is not a re-hearing of the original evidence.

21.8 The appeal hearing must restrict itself to looking at the grounds of appeal made by the employee and ensuring that these grounds are adequately examined in order to reach a proper judgement on whether the appeal should be upheld.

21.9 The appeal hearing will consider specifically whether the disciplinary action decided upon by the disciplining officer was fair and reasonable at the time that the action was taken. The appeal hearing may look at whether the procedure was applied correctly when deciding on the disciplinary action.

21.10 The appeal will take account of any substantial new information cited in the grounds for appeal.

21.11 The decision reached by any level of appeal hearing is considered final. No further appeal mechanism will operate within the *"NHS Organisation."*

21.12 Conduct of the appeal

The Appeal Officer will act as Chair of the appeal hearing and will introduce those present and state the order of proceedings which is as follows:

21.12.1 Both the disciplining officer and the appellant and his/her representative will remain present throughout the proceedings until the panel adjourn to deliberate in private.

21.12.2 The appellant or his/her representative shall confirm their grounds of appeal and provide information supporting their case.

21.12.3 The disciplining officer will have the opportunity to ask questions of the appellant.

21.12.4 The members of the appeal panel shall have the opportunity to ask questions of the appellant.

21.12.5 The disciplining officer will present the justification for the decision that they took at the disciplinary hearing.

21.12.6 The appellant or representative shall have the opportunity to ask questions of the disciplining officer.

21.12.7 The members of the appeals panel shall have the opportunity to ask questions of the disciplining officer.

21.12.8 The disciplining officer will have the opportunity to sum up. New information must not be introduced at this stage.

21.12.9 The appellant or representative will have opportunity to sum up. New information must not be introduced at this stage.

21.12.10 The appeal panel may, at its discretion, adjourn the appeal hearing in order that further information may be sought and reviewed.

21.12.11 The appeal panel shall deliberate in private only, recalling both parties to clarify any points of uncertainty on evidence already given. If a recall is necessary both parties shall return.

21.12.12 When a decision is reached by the Appeal Officer they should inform the appellant and disciplining officer of the outcome immediately or within 7

calendar days. In either case, the decision will be notified to all parties in writing within 7 calendar days of the appeal.

The decision of the Appeal Officer is final.

22. Authority to Dismiss

The level of manager with the authority to dismiss will be determined by the "*NHS Organisation"* in its scheme of delegation.

23. Equality

The NHS Organisation recognises the diversity of its workforce. Our aim is to provide a safe environment where all employees are treated fairly and equally and with dignity and respect. The NHS Organisation recognises that the promotion of equality and human rights is central to its work both as a provider of healthcare and as an employer. This policy has been impact assessed to ensure that it promotes equality and human rights.

24. Policy Review

All policies are subject to ongoing review to ensure they are entirely compliant with all aspects of equalities and human rights legislation, best practice and the ACAS Code. This policy will be subject to full review at intervals to be determined by the Welsh Partnership Forum.

25. Help and Advice

Help and advice on the application of this policy and procedure can be obtained from the Workforce & OD (HR) Department.

26. Agreement

The policy and procedure has been agreed in partnership and has been ratified by the Welsh Partnership Forum.

Appendix 1 - Disciplinary Rules

Introduction

The aim of the *"NHS Organisation*" is to provide first class healthcare to the general public. In order to maintain high standards it is essential that all employees conform to the standards set by the *"NHS Organisation*" to ensure an efficient and safe environment for staff, patients and visitors and to maintain good relations within the workplace.

Whilst it is acknowledged that the vast majority of staff conform to these required standards, it is important that all employees are made aware of the standards expected of them and the consequence of failing to adhere to them and clearly understand their rights and obligations.

The Disciplinary Policy is written in accordance with the principles set out in the policy which include:

- The employee is treated consistently and fairly
- The organisation, other employees, patients and members of the public are protected
- The employee understands the standards/behaviour expected of them

The lists provided below should not be regarded as exhaustive or comprehensive and can only serve as a guide as it is impossible to cover every eventuality. In addition many departments /directorates have specific rules and failure to observe these could result in disciplinary action.

Every case will be considered on its own merit, including the particular circumstances of the case and its seriousness but will also have full regard for the principle of consistent treatment of every employee. Due consideration will therefore be given to any mitigating circumstances in each case.

Repeated minor misconduct or misconduct offences can accumulate and employees may be dismissed if it is clear that warnings have had no effect on the employee's behaviour. In these cases, it is not the nature of the offences that is held to be of primary concern, rather that the employee has shown themselves to be incapable of responding appropriately to the warnings and to have failed to improve their behaviour accordingly.

Examples of Misconduct

Misconduct (including minor misconduct)

This list is not exhaustive, but examples of offences which might lead to recorded verbal or first written warning warnings, would include:

- Lateness for duty without reasonable explanation.
- Failure to report for duty without reasonable explanation.

- Minor instances of discourtesy/rudeness to patients, visitors or other members of staff.
- Failure to wear correct uniform or protective clothing where provided or unsatisfactory condition or appearance related to personal hygiene.
- Poor attendance record/capabilities, but only where the use of the NHS Organisation's staff performance policy is inappropriate.
- Failure to meet required standards of performance and behaviour as expected within the employee's role and responsibilities.
- Minor insubordination and /or failure to carry out a reasonable instruction.
- Failure to comply with local or department rules relating to performance, safety or conduct.
- Smoking in areas designated as 'No Smoking'.
- Outside employment- employees engaging in employment in off duty hours must ensure that such employment does not adversely affect their work in the "*NHS Organisation*". The disciplinary procedure may be used if the "*NHS Organisation*" feels that the employee's performance is thereby affected.

Serious Misconduct

Failure to respond to previous warnings could result in a final warning, but additionally certain types of conduct could lead directly to this form of disciplinary action. Included in this category might be:

- Failure to respond to minor misconduct warnings.
- Unauthorised absence without reasonable cause whilst purporting to be on duty.
- Failure to comply with conditions of service or working procedures.
- Refusal to carry out reasonable instructions given by an authorised person.
- Failure to maintain registration with relevant mandatory professional body.
- Serious instances of professional misconduct.
- Personal behaviour conducted either inside or outside of work or working hours that, results in bringing the NHS Organisation or any of its employees into disrepute.
- Serious failure to meet required standards of performance and behaviour as expected within the employee's role and responsibilities.

Gross Misconduct

Gross misconduct is misconduct that is so serious that the "*NHS Organisation"* is justified in no longer tolerating the employee's continued presence at work. It is misconduct that strikes at the root of the employment relationship with "*NHS Organisation"* and confidence that must exist for the contract of employment to be effective. In most cases the result will normally be summary dismissal without notice or payment in lieu of notice.

An employee who commits such an offence will therefore be regarded as having fundamentally breached his or her contract of employment and can expect to be summarily dismissed in accordance with the "*NHS Organisation*" Disciplinary policy. Summary dismissal, will be the normal action taken against an employee on the first occasion on which any of these offences is committed.

The action taken will reflect the seriousness of the offence. The seriousness of the offence (and therefore the culpability of the employee) will depend on the individual circumstances and consequences of each case, but particular consideration will be given to the implications or resultant consequences of the offence; whether the offence is persistent; or whether a previous warning has been issued for the same or related offence(s), for example negligent performance in respect of safety as a first offence may result in a final written warning but where this jeopardises patient care or places others at risk, dismissal may result.

Examples of what might lead to summary dismissal for gross misconduct are as follows:

1. **Disclosure Of Confidential Information** - to unauthorised persons particularly in relation to a member of staff or patient.

2. **Assault** – any assault, fighting or threatening behaviour directed at a patient, member of the public or fellow employee.

3. **Theft** – unauthorised or unlawful possession of property of "*NHS Organisation*" (including patient related documents), fellow employees or members of the public.

4. **Fraud** – any deliberate attempt to defraud the employer, fellow employees or members of the public.

5. **Corruption** – this refers to any receipt of money, goods, favours in respect of services rendered.

6. **Wilful Or Malicious Damage** – the intentional causing of damage to the *"NHS Organisations"* property or property of fellow employees, patients or members of the public.

7. **Unfit For Duty** – this could result from being under the influence of alcohol or drugs which have been self inflicted and not prescribed by a person qualified to do so.

8. **Gross Negligence** – any action or failure to act which could result in serious damage to property or equipment, or endanger the health and safety of others. Failure to give appropriate care and protection to patients within the "*NHS Organisations"* care.

9. **Gross Insubordination** - including wilful refusal to carry out a reasonable instruction or behaviour or other display of attitude which seriously undermines management's authority.

10. **Misrepresentation** - falsification or failure to declare relevant information on medical questionnaires, application or enrolment forms that is fundamental to the contract. This may also constitute a criminal offence.

11. **Sexual, Racial Or Other Forms Of Harassment** - serious cases of racial or sexual harassment or bullying against other employees, patients or visitors either as an offender, or manager failing to take appropriate action after an incident is brought to his/her attention. N.B. Issues of this nature will be dealt with in accordance with the "*NHS Organisation's*" Dignity at Work policy.

12. **Unacceptable Behaviour** - towards, staff, patients, visitors or public in the course of work or on Trust premises.

13. **Misuse Of Information Technology** - unauthorised and improper use "*NHS Organisation"* information technology systems.

14. **Destroying/Concealing Evidence Of Malpractice –** the intentional destruction or concealment of evidence of malpractice**.**

15. **Victimisation Of Whistleblowers** - where employees raising concerns under the Whistle blowing Policy (Public Interest Disclosure Act 1998) are subject to victimisation by managers, colleagues or other "*NHS Organisation"* staff.

16. **Non Compliance With The Declaration Of Interest** - Unauthorised possession of property belonging to the NHS Organisation (or its contractors), patients, members of the public or staff.

17**. Unauthorised Use or Misuse of NHS Organisation Facilities or Property**- Use of NHS Organisation vehicles, plant machinery, tools facilities, or property. Misuse of telephones or internal / external post.

18**. Serious Acts Of Insubordination Or Personal Behaviour That Results In Bringing The "*NHS Organisation*" Into Disrepute** - Wilful acts which seriously undermine the "*NHS Organisation's*" professional standing or that of its employees.

19. **Failure to Meet Required Standards** - Gross failure to meet required standards of performance and behaviour as expected within the employee's role and responsibilities.

20. **Gross Areas of Professional Misconduct**

21. **Withdrawal of DBS registration –** withdrawal of an individual's DBS registration can be considered gross misconduct

22. **Breach of Contract of Employment -** Any fundamental breach of the Contract of Employment which makes continuation of employment impossible. This category may include:

- Failure to meet statutes concerning Professional Registration**.**
- It may also apply to the removal of a driving licence from staff for whom driving is an essential part of their work, or wilful failure to obtain a DBS check, or work permit.
- Withholding information which has a serious bearing on the offer of or continuation of employment, e.g. a conviction or dismissal from a previous employer that the employee fails to disclose
- Conviction for a criminal offence committed in or out of work which renders the employee inappropriate or unavailable for continued employment
- Where information comes to light that would render the employee inappropriate for the post they occupy

Appendix 2 – Equality Act 2010

The Equality Act 2010 came into force on 1 October 2010. The Act brings together a number of existing anti discrimination laws and introduces changes that give employees greater protection from unfair discrimination. It sets out the characteristics that are protected by law and the behaviour that is unlawful. The protected characteristics under the Act are (in alphabetical order):

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

Under the Act people are not allowed to discriminate, harass or victimise another person because they have any of the protected characteristics. There is also protection against discrimination where someone is perceived to have one of the protected characteristics or where they are associated with someone who has a protected characteristic. The Act recognises 6 forms of discrimination: direct; indirect, discrimination by perception; discrimination by association; harassment and victimisation. The Act changes and extends certain concepts and definitions and introduces new forms of unlawful discrimination including:

Association Discrimination

This means that employers cannot directly discriminate against someone because they are associated with another person who possesses a protected characteristic.
Employers need to be mindful of this extension to the law when dealing with employees who are carers of elderly relatives or disabled children as they will be protected against discrimination or harassment in relation to the person they care for.
Consideration is particularly relevant when dealing with flexible working applications from carers, or when subjecting an employee to a disciplinary procedure because of their persistent lateness where the employee may have a caring responsibility.

The Equality and Human Rights Commission has prepared Codes of Practice on employment, services, public functions and associations and equal pay. The purpose of these Codes is to explain the new statutory provisions of the Act. The Codes were laid before Parliament on 12 October 2010 and will remain in draft form until the Government makes the Order bringing them into force. The Codes will be available to download from the Equality and Human Rights Commission at www.equalityhumanrights.com

2. The Duty to Make Reasonable Adjustments

Equality law recognises that bringing about equality for disabled people may mean changing the way in which employment is structured; the removal of physical barriers and/or providing additional support for a disabled employee. This is the duty to make reasonable adjustments. The duty aims to make sure that a disabled person has the same access to everything that is involved in getting and doing a job as a non-disabled person, as far as is reasonable.

When the duty arises, employers are under a positive and proactive duty to take steps to remove or reduce or prevent the obstacles a disabled worker or job applicant faces. In particular the need to make reasonable adjustments for an individual employee or job applicant must:

- not be a reason not to appoint someone to a job or promote them if they are the best person for the job with the adjustments in place
- be considered in relation to every aspect of a person's job
- not be a reason to dismiss an employee.

Less favourable treatment of a disabled person for a reason related to their disability cannot be justified where the reason for the treatment can be removed or made less than substantial by a reasonable adjustment.

Where a disabled employee is subject to the disciplinary policy, advice on the duty to consider reasonable adjustments may be sought at any stage of the process from a human resources advisor, the Occupational Health Department or from trade union or professional organisation representatives.

The Disability Advisory Service (Access to Work) can advise on work place adjustments and where necessary possible alternative employment options and in certain cases will contribute to the purchase of specific equipment or other workplace adjustments, which will enable the person to continue in employment. The employee will be involved in all of the above processes.

Only equality law is referenced above. There are other laws which you need to comply with to ensure that the disciplinary process is fair. You can find out more from the ACAS Code of Practice on Disciplinary Procedures at www.acas.org.uk

Appendix 3 – Allegations letter template

Private & Confidential

Date

Name
Address
Address
Address

Dear <Name>

DISCIPLINARY INVESTIGATION

Further to our discussions today/on <date>, in the presence of <name, title>, I confirm that a formal disciplinary investigation will be undertaken, in accordance with the "*NHS Organisation"*'s Disciplinary Policy, into the allegation(s) that:

Allegation…discuss with Workforce & OD team

These allegations are serious and if proven, could be considered gross misconduct.

<Name> has been appointed to act as the investigating officer in this case and to undertake an impartial investigation in line with "*NHS Organisation"'s* Disciplinary policy.

He/she has arranged an interview with you on <date> at <time> in the <venue> to establish the facts. At this interview you are entitled to be accompanied by a trade union representative or a workplace colleague not acting in a legal capacity. I would be grateful if you could let <name> know in advance of the arranged meeting if you are to be accompanied. He/She can be contacted via <telephone number>.

It is important that you attend this interview as this is your opportunity to respond to the allegation that has been made against you. If you have any difficulty in doing so, please contact <name> as soon as possible to see if alternative arrangements can be made.

*****In view of the seriousness of the allegation consideration has been given to suspending you from the workplace. However, instead a decision has been made that you will continue to work at <Department name/venue>. This is a measure to protect the interest of all parties involved and to allow the investigation to be conducted as quickly as possible.

You will continue to be paid your normal salary and will not be financially disadvantaged during this period. If you have any difficulties regarding this arrangement, please do not hesitate to contact me.

***In view of the serious nature of the allegation you have been informed that you have been suspended from the workplace with immediate effect. This has been considered to ensure that**

you cannot compound the offence, interfere with or prejudice the investigation or jeopardise the safety or well being of patients or employees. This is a measure taken to protect the interest of all parties involved and to allow the investigation to be conducted as quickly as possible.

During your suspension, you must not work in any other capacity within "*NHS Organisation*" until further notice. However, you must make yourself available to attend investigatory interviews or medical / Occupational Health appointments (if appropriate) as reasonably requested. You will continue to be paid your normal salary, as if you were still in work, and you will not be financially disadvantaged.

If you wish to take annual leave during this period you must put your request in writing to me for consideration and authorisation. You must not take any leave without it being authorised.

You must not enter any "*NHS Organisation*" premises without permission from me or the investigating officer, unless attending as a patient or a visitor of a patient. You will be able to attend "*NHS Organisation*" premises to meet with your representative also however, you will need to notify me prior to this taking place.

It is likely that the decision to suspend you will remain in place until the conclusion of the investigation. However, this decision will be reviewed on a regular basis to consider whether it remains necessary and you will be informed of any changes to this arrangement.
* delete as appropriate

I appreciate that this is difficult time for you so please contact me if you require any further support or your trade union representative. Additionally, "*NHS Organisation*"'s Employee Wellbeing Service (<insert telephone number>) offers a confidential support service for staff undergoing this type of formal process which can be accessed on a self referral basis and/or Occupational Health are also available on <insert telephone number> should you require their services.

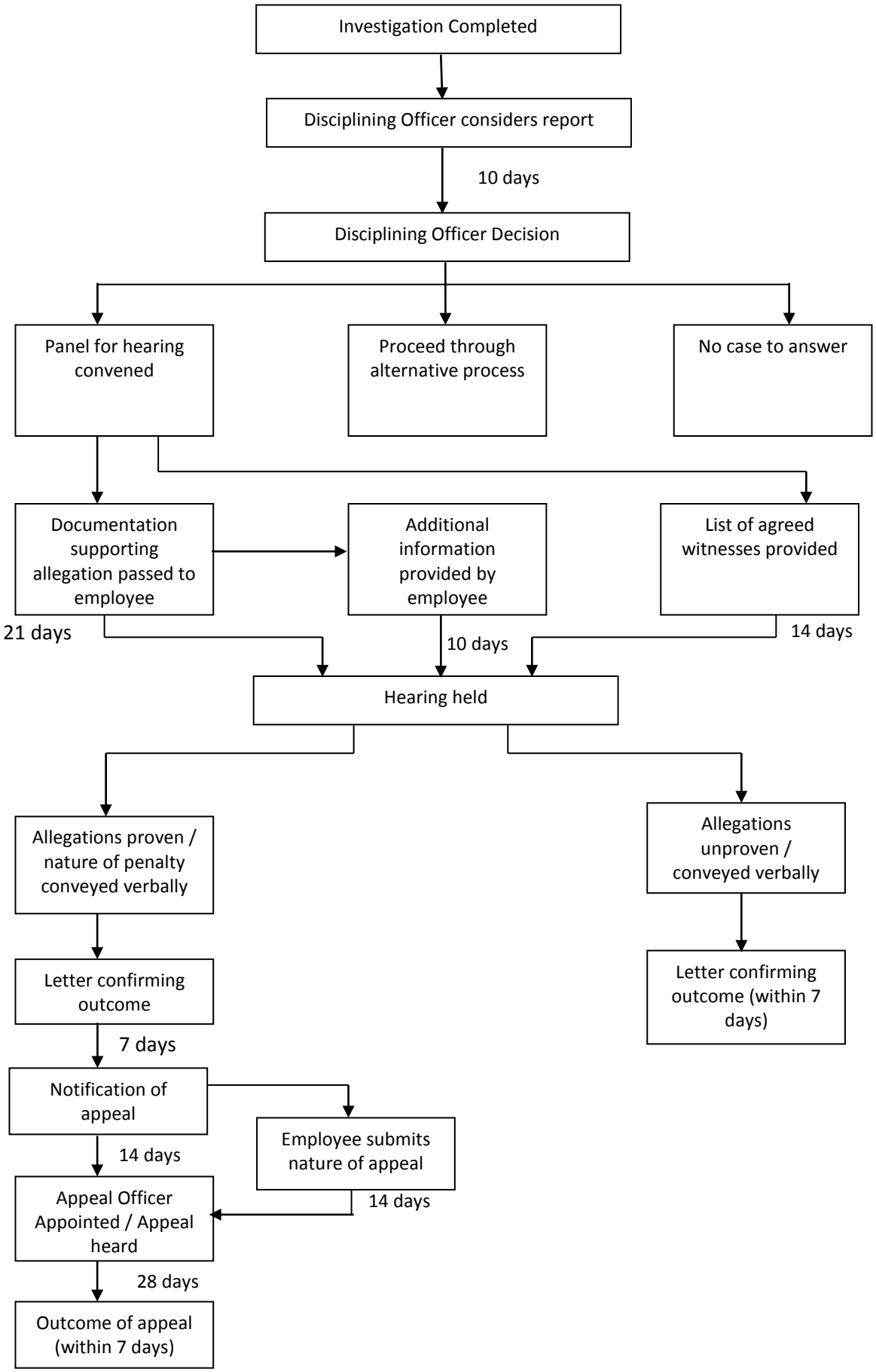
You are advised not to discuss the investigation or the content of this letter with anyone other than the Investigating Officer, your trade union representative or the Workforce and OD Department. Please find enclosed a copy of "*NHS Organisation*"'s Disciplinary Policy for your information.

<name> (investigating officer) will endeavour to conclude the investigation as soon as is practically possible and will keep you informed of the progress of the investigation at regular intervals.

Yours sincerely

Name
Title
(Disciplining Officer)

Appendix 4 – Disciplinary and Appeals Process Flowchart



Owen Evans
Dirprwy Ysgrifennydd Parhaol • Deputy Permanent Secretary

Grwp Addysg a Gwasanaethau Cyhoeddus
Education and Public Services Group

Llywodraeth Cymru
Welsh Government

Y Pwyllgor Cyfrifon Cyhoeddus / The Public Accounts Committee
PAC(4)-21-15 PTN2

Mr Darren Millar AM
Chair to the Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

7 July, 2015

Dear Darren

Auditor General's report: *"Achieving improvement in support to schools through regional education consortia – an early view"*

In response to your letter of 3 June, please find attached at annex A, a Welsh Government response to the Auditor General's report: "Achieving improvement in support to schools though regional education consortia – an early view."

You will be aware that the Auditor General asked for the study at this early stage in the development of the consortia in order to provide assurance of progress and to identify areas where additional work may be required. The report has been helpful in clarifying our approach to consortia working and our response to the recommendations reflects this.

Yours sincerely

O. Evans

Owen Evans
Deputy Permanent Secretary – Education and Public Services

Annex A

Auditor General's report: *Achieving improvement in support to schools through regional education consortia – an early view*

Welsh Government's response to the recommendations

Introduction

The Auditor General for Wales asked the Wales Audit Office (WAO) to carry out a study on the Welsh Government's approach to improving schools through regional consortia.

The WAO and Estyn carried out joint fieldwork visits to each regional consortium and evidence was shared between the two organisations. The WAO and Estyn reports were jointly published on 3 June 2015.

The fieldwork visits took place between November 2014 and January 2015. The review involved the scrutiny of a wide range of evidence from schools, local authorities, diocesan authorities, regional consortia and the Welsh Government. In addition the WAO and Estyn attended, in an observer capacity, the Ministerial review and challenge sessions undertaken in October and November 2014.

The report focuses on progress in the delivery of school improvement through regional consortia. In particular it concentrates on the development of regional consortia governance structures which are carried out by means of either joint committees or, in the case of the South East Wales Consortium, through a company structure. The WAO felt that this approach was new and the effectiveness of governance arrangements would be essential for the achievement of improved outcomes for learners in Wales.

The study was intended to provide assurance on progress and to identify areas where further work may be required to ensure that suitable governance and financial structures for the system are set in place.

With the field work having been completed less than a year in to the implementation of the National Model for Regional Working (1 April 2014), the report provides an early indication of the progress being made by the consortia.

Verbal feedback was provided by the WAO and Estyn to each consortium at the end of the fieldwork exercise; as a result, each consortium is already progressing specific recommendations. A further progress check was undertaken by officials as part of the pre-planned summer review and challenge sessions. These sessions were held across Wales between 25 June and 3 July 2015 and have contributed to the collective all Wales response to the WAO recommendations provided below.

Recommendation One - To clarify the nature and operation of the consortia.

WAO found there to be continuing uncertainty about some aspects of the nature of regional consortia and their present and future scope. WAO therefore recommend:

- The Welsh Government should take full account of the statutory responsibilities of local authorities, and take appropriate legal advice, when considering changes to the roles it expects of local authorities and the regional consortia.

- The Welsh Government should update the National Model to be less prescriptive on the structure under joint committees or boards whilst maintaining a focus on outcomes.

- The Welsh Government and local authorities should develop and agree a consistent approach to the role of regional consortia and the Welsh Government in school improvement interventions so that all parties are clear what they should be involved in and responsible for.

- Local authorities should clarify whether consortia services are jointly provided or are commissioned services (services provided under a joint committee arrangements are jointly provided services and are not commissioned services).

Accept points one to three

The National Model for Regional Working was co-constructed with key stakeholders (local authority leaders and chief officers, consortia, Estyn and head teachers) and sets out the parameters for regional consortia operation. It was always the intention to review the model and to refine it as regional consortia developed. The intention was that the National Model for Regional Working would act as a flexible framework within which consortia would operate and not a prescriptive set of instructions. It was signed-off by all 22 council leaders and their respective cabinets.

A review of the model is already underway with key stakeholders. This will provide further clarity on structures, roles and responsibilities. Robert Hill, who led on the development of the National Model for Regional Working, has been commissioned to lead this exercise which will result in some refinements to the model, in order to ensure clarity for all stakeholders. Our intention is that a refreshed model will be published by September 2015. It is also proposed that after the refinements have been agreed, a communications plan will be put in place so that all stakeholders are fully aware of the division of responsibilities.

Partly accept point four

We think that this this needs further exploring with the WAO as there may be misinterpretation of the arrangements that are in place.

Whilst retaining the statutory responsibility for education improvement, local authorities no longer directly provide school improvement services as single authorities. This is in line with the National Model and underpinned by the Department's overarching strategy "Qualified for Life". Three regions have decided to deliver school improvement services jointly through a consortium arrangement and one has decided to commission directly from a company (the Education Achievement Service). We are content with this approach and believe that local authorities are best placed to determine their own delivery arrangements. However we do agree that these arrangements need to be clarified and this will be reflected in the redrafted National Model for Regional Working.

Recommendation Two - To focus on outcomes through medium term planning.

WAO found that the development of effective regional consortia was hindered by a focus on short-term actions and uncertainty about the future of consortia. WAO therefore recommend:

- As any possible local authority re-organisation will not be fully implemented until 2020, the Welsh Government and regional consortia should develop three-year plans for the further development, scope, and funding of regional consortia linked to appropriate strategic objectives

Accept

Working with local authorities, consortia and the Welsh Local Government Association (WLGA) we have this year streamlined consortia business plans into headline business plans which address specified key priorities. These high level plans are underpinned by more detailed plans used by each region to inform performance management and work-streams. This year's headline plans for discussion with Welsh Government officials included 3 year milestones, so that the direction of travel for each work-stream could be shown.

We intend to move to a three year planning cycle and discussions have already taken place with key stakeholders. This approach will support the development of longer term outcome based targets and improved planning. In addition we intend to continue with our programme of rationalising grants so as to ensure that the Education Improvement Grant is firmly focused on strategic outcomes. The intention is to reduce the administrative burden and move to more outcome focussed targets. We will agree the detail by October 2015 and ensure it is fully operational for start of the 2016 financial year. The introduction of a three year planning cycle will follow the same timescale.

Recommendation three - To develop more collaborative relationships for the school improvement system.

The development of the National Model for Regional Working involved many school improvement partners but we found that this had not led to the development of sufficiently collaborative relationships. WAO therefore recommend:

- The Welsh Government should develop the present 'Review and Challenge' approach (where the Welsh Government hold regional consortia to account) to a more collaborative but robust comprehensive 'system review' approach in which all partners in the system share progress, challenges and issues openly.

- Regional consortia should develop improved arrangements for sharing practice and supporting efficiency (for example, one consortium could take the lead on tackling an issue or have functional responsibility for the development of a policy).

- The Welsh Government, local authorities and regional consortia should recognise the interdependency of all partners fulfilling their school improvement roles and agree an approach to:

- information sharing and consultation about developments related to school improvement;
- developing collaborative relationships of shared accountability;
- undertaking system wide reviews, and an alignment of the understanding and position of regional consortia across all Welsh Government relevant strategies

Accept

Since the WAO and Estyn commenced their fieldwork, the termly review and challenge sessions between Welsh Government and consortia have been reformed into an integrated cycle of reviews with clearly set aims and objectives. This has strengthened the focus of each session. We will undertake a fundamental review of the current process following the Autumn Ministerial sessions in October.

A number of joint good practice seminars have been delivered across Wales, the most recent being in North Wales coordinated by GwE but supported by and actively involving representatives from all four consortia.

The four consortia have jointly committed to facilitate a two day sharing good practice workshop to be held in September 2015. Attendance will include the full senior leadership team and second tier leaders from all four consortia. This will generate an opportunity not only to share good practice but to jointly highlight and tackle 'All Wales' issues with each consortium agreeing to lead nationally on named issues and priorities, thus avoiding unnecessary duplication across the other three. Increasingly the strategic leads for different aspects of work in each region are liaising with each other to share plans and ensure greater consistency.

The four consortia successfully submitted a joint bid to Welsh Government to provide the lead on the moderation of Key Stage assessment in Wales. That work is underway and has deepened the level of collaboration across Wales, and will grow over the coming year.

In addition, as part of the New Deal for the Education Workforce, Welsh Government is working in collaboration with the second tier leaders from each region to ensure that there is high quality provision for professional learning across Wales. This will include facilitating partnership working between the regions to share and develop provision; and agreeing the professional learning areas that each region will lead on.

Welsh Government Officials will ensure that policy teams develop their policies in a collaborative manner, engaging with consortia, ADEW and the diocesan authorities, starting in September 2015.

Welsh Government officials will support the regional consortia to develop a peer review system to encourage cross consortia working at all levels and expect this to be in place by April 2016. The teacher assessment moderation programme currently being led by the consortia is providing a firm foundation for this.

We will continue to work with Estyn as they develop their framework for consortia inspection to ensure that there is a clear focus on collaborative working amongst the four consortia

We will continue to develop with consortia school-to-school working and explore ways on how we can accelerate the federation of schools.

Recommendation four - To build effective leadership and attract top talent.

Regional consortia, local authorities and the Welsh Government have all found difficulties in recruiting to senior leadership for education and we found there had been limited action to address this. WAO therefore recommend:

- The Welsh Government should work with local authority leaders to improve capacity and capability in the system to support strategic development and effective governance.

- The Welsh Government and local authorities should collaborate to improve the attractiveness of education leadership roles to attract the most talented leaders for the school improvement system.

- Local authorities should collaborate to support the professional development of senior leaders and to ensure appropriate performance management arrangements are in place for senior leaders.

Accept

The WLGA, working with the Virtual Staff College, has developed a leadership programme for education directors in Wales. The programme is aimed initially at current serving directors with a view to further develop this for future and aspiring education directors.

The first programme takes place in Autumn 2015 and will cover theoretical leadership thinking with practical examples from Wales and England. All 22 Directors of Education will be in attendance

Through the New Deal for the Education Workforce, the Welsh Government is developing a new leadership development strategy for Wales. This will include early identification of potential leaders and strategies for development from early career in schools, up to and through headship and into wider system leadership. It will also include strands on attracting, sharing and retaining talented individuals to work in Wales.

Developing leaders for the entire system in Wales is a clear priority. The strategy will be co-designed and implemented in collaboration with leading practitioners, Consortia, local authorities and WLGA to ensure shared ownership and commitment. Additionally, the four regions will explore ways to ensure that the top talent in the school, and local authority workforce, is attracted to the most senior posts in the regions.

Recommendation five - To improve the effectiveness of governance and management of regional consortia.

Whilst continuing progress is being made, WAO found that regional consortia have not yet developed fully effective governance and financial management arrangements. WAO therefore recommend that local authorities and their regional consortia should:

- improve their use of self-evaluation of their performance and governance arrangements and use this to support business planning and their annual reviews of governance to inform their annual governance statements;

- improve performance management including better business planning, use of clear and measurable performance measures, and the assessment of value for money;

- make strategic risk management an integral part of their management arrangements and report regularly at joint committee or board level;

- develop their financial management arrangements to ensure that budgeting, financial monitoring and reporting cover all relevant income and expenditure, including grants funding spent through local authorities;

- develop joint scrutiny arrangements of the overall consortia as well as scrutiny of performance by individual authorities, which may involve establishment of a joint scrutiny committee or coordinated work by local authority scrutiny committees;

- ensure the openness and transparency of consortia decision making and arrangements;

- recognise and address any potential conflicts of interest; and where staff have more than one employer, regional consortia should ensure lines of accountability are clear and all staff are aware of the roles undertaken; and develop robust communications strategies for engagement with all key stakeholders.

Accept

Whilst refining the National Model for Regional Working, we will work with and support consortia and local authorities to further strengthen their governance arrangements. Welsh Government officials are undertaking some additional scoping work in relation to the scrutiny function. We believe that each local authority is accountable for providing assurance to its elected members and will therefore have its own scrutiny arrangements. We will however work with WLGA to support consortia and local authorities to further strengthen this area and ensure that mechanisms are developed to share innovative and best practice. Regions are already ensuring that each authority's lead members for the scrutiny function are liaising with each other to ensure best practice, and further work is already underway to share scrutiny information. All consortia are in the process of strengthening scrutiny arrangements and we expect this to be embedded by December 2015. This work will also include a consistent approach in relation to value for money for the services being delivered and the outcomes being achieved. This has been a feature of the recently completed challenge and review sessions.

Welsh Government officials are encouraging and supporting consortia and local authorities to share good practice in relation to self-evaluation processes, target setting, performance management and to further develop clear and robust financial management arrangements. An all Wales good practice event and work-shop will be facilitated by Welsh Government with the intention that strengthened arrangements will be adopted by all 22 local authorities and the consortia in preparation for the start of the financial year in 2016.

Increasingly there are specialists working across more than one consortium, and in some cases those individuals also provide support for local authorities. Clear lines of

accountability have been developed, and the strong emphasis on the performance management of Challenge Advisers together with a consistent national approach to the moderation of their work, should ensure that conflicts of interests, such as those identified in the WAO report, are more effectively managed in future.

Monitoring Progress and Impact

Our challenge and review sessions with each consortium will continue to monitor the progress of these recommendations along with the impact on educational outcomes across the system. This will also be embedded within the consortia new three-year business planning cycle

Agenda Item 2.3

RECEIVED
6 JUL 2015

States of Jersey
States Assembly

États de Jersey
Assemblée des États

Public Accounts Committee

Darren Millar AM
Chair, Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

2nd July 2015

Dear Darren,

Re: PAC Visit 23rd - 24th June 2015

I write to thank you, your committee and the staff assigned to support you most sincerely, both for the invaluable learning opportunities you laid on for us last week and for your most generous hospitality.

From a procedural perspective, observing your working practices and discussing your work programme with our colleagues from the Northern Ireland Assembly has given us real food for thought. We anticipate pursuing a number of changes to our own working practices – and potentially even to our terms of reference – as a consequence of our visit. On a more general note, the tour of your Senedd was one of several highlights. Your pride in the building is justified and we admit to being a little jealous of the quality of the facilities you enjoy within it.

It may interest you to know that I have spoken briefly to our Chief Minister, Senator Ian Gorst, about our visit. Senator Gorst is, I believe, interested in discussing further the possibility of creating a pool of directors across the devolved assemblies, which might help mitigate the issue of conflicts and shortage of quality directors required by quangos and other arms-length state entities. If it would be helpful, I should be delighted to recommend that he contact you or your colleagues in the National Assembly to discuss the above and perhaps to share our experience of having established and reviewed the operation of the States of Jersey Appointments Commission.

Enclosed with this letter is a small token of our gratitude. We hope you and your PAC colleagues find it interesting.

Public Accounts Committee, States Greffe, Morier House, St Helier JY1 1DD
Tel: (+44)1534 441026 E-mail: i.clarkson@gov.je

Yours sincerely,

Deputy A.D. Lewis
Chairman

Public Accounts Committee, States Greffe, Morier House, St Helier JY1 1DD
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By virtue of paragraph(s) vi of Standing Order 17.42

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