Comisiynydd Pobl Hŷn Cymru
Older People's Commissioner for Wales

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Nick Ramsay AM
Chair, Public Accounts Committee
National Assembly for Wales
Ty Hywel
Cardiff
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22 January 2019

Dear Nick,

Inquiry into Mental Health Services for Older People in Betsi Cadwaladr University Health Board

I'm writing to provide an overview of my ongoing concerns in relation to the progress being made by Betsi Cadwaladr University Health Board in relation to improving mental health services for older people.

As you will be aware, for a number of years my office has been actively involved in supporting older people and their families that have received unacceptable care in north Wales and I am still providing ongoing support to an individual affected by older people's mental health services in Betsi Cadwaladr UHB.

The report compiled by Donna Ockenden in 2015 concluded that patients on the Tawel Fan ward had been subjected to a lack of professional, dignified and compassionate care in an environment that led to them being restrained and possibly breeched their individual human rights. It was encouraging that Betsi Cadwaladr UHB accepted

the report's findings and committed to taking further action to achieve a full picture of the events that happened on the ward.

I am aware of the work that the Health Board has started, including appointing an Older Person's Programme Manager, to review and redesign service models and clinical pathways for older people and develop an older people's strategy. However, given the seriousness of the issues faced and the length of time it has taken to start this work, I still have concerns about the experiences of older people accessing these services.

Whilst the HASCAS report, published in 2018, concluded that 'there is no evidence to support prior allegations that patients suffered from deliberate abuse or wilful neglect, or that the system failed to deliver care and treatment in a manner that could be determined to meet the threshold for institutional abuse', it does clearly point to significant system and organisational failures as having contributed to 'suboptimal care' for individuals on Tawel Fan ward. The impact on individuals from such 'suboptimal care' includes:

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

Through my case work, I am aware of the devastating impact that this 'suboptimal care' can have on individuals.

The report is clear that these issues arose as a result of a catalogue of fundamental system failures in relation to oversight and governance. In particular, concerns were raised in relation to patient care pathways and service design, patient acuity and restrictions to service provision, evidence-based practice and the care and treatment of the older adult. The report is clear that the impact of these issues was not restricted to Tawel Fan ward but had implications across a range of services used by older people.

Of particular concern is the report's conclusion that these system failures are still unresolved or in a relatively early stage of improvement and development. Furthermore, the report states that there is insufficient evidence to suggest that, in practical terms, the experience of a patient today would be significantly different from the experience of patients from the investigation cohort, and that this is an area which requires urgent action.

I also find it highly concerning that, a number of years on from the closure of the ward, these issues still effectively remain unaddressed across a range of services and that some of our most vulnerable older people may be exposed to unnecessary risk and poor care as a result.

Correspondence between Donna Ockenden and the Cabinet Secretary for Health and Social Services, recently published via a Freedom of Information request, reflects this situation. A letter from Donna Ockenden noted that she and her team continue to be contacted by service users, representatives and Betsi Cadwaladr UHB staff with concerns about how little progress is being made. Furthermore, she has shared concerns that the Betsi Cadwaladr UHB Board and senior management team within mental health do not have the capability and capacity to deliver the root and branch systemic review that is needed to improve older people's mental health services.

Betsi Cadwaladr UHB staff have told Donna Ockenden that they feel staffing is "worse now" and that they are "exhausted" and "on their knees". Staff do not feel listened to and do not believe positive change has happened or will happen in the foreseeable future. They have also shared doubts about the ability of the Board and senior management team to understand and deliver the safe and effective care that older people have a right to.

I will be meeting with the Chair of the Health Board, Mark Polin, and Director of Nursing, Gill Harris, at the end of January to discuss my ongoing concerns and the progress made in supporting an individual through my casework team. Following this meeting, I will decide what further action I may wish to take, and my office will continue to support the families and relatives of those affected.

I hope the Committee will find this useful as part of your Inquiry and if I can support the Committee's work in any other way, please do not hesitate to contact my office.

Yours sincerely,

Heléna Herklots.

Heléna Herklots CBE
Older People's Commissioner for Wales