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Health Board



Service Groups' Highlight Report for Quality and Safety Committee

Meeting Date:	26 th October 2021
Service Group:	Mental Health and Learning Disabilities
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Presenter:	

Summary of Quality and Safety issues since last report to the Committee (Reporting period: October 2020 to October 2021)

Clinical Audit Program

The clinical audit group has achieved the following outcomes in the last 12 months:

- The development and implementation of a structured audit approval process which ensures that audits approved for the Audit register are of an appropriate standard and reference to the risks in the service. This is supported by Clinical Audit 'drop in' sessions to guide and advise potential audit teams.
Please 1. see attached.
- Clinical Audit events where the outcomes of audits are presented to clinical teams. These occurred throughout the year as per below:
 - September 2020
 - February 2021
 - July 2021
 - November 2021 (in planning)
- Clinical audit newsletter
Please 2. see attached.

Care and Treatment Plan Improvement Program

As a consequence of the 2018 Welsh Government Delivery Unit (DU) national review of the quality of Care and Treatment Plans (CTP) the Service Group has undertaken focussed work to improve local standards, reporting to the Mental Health Legislative Committee. In 2020 we agreed an internal annual audit process building on the DU framework, undertaking a fresh audit in the autumn of 2020 across a wider service footprint than that undertaken by the DU. The audit results were fed back to the Divisional Teams at the beginning of 2021 (delayed due to the response to the pandemic) and subsequently new action plans were developed and submitted to the Legislative Committee in August. The results of the internal audit are outlined in the below:

Please 3. see attached.

Listen, Learning and Improvement Sessions

The Service Group has developed a strategy to ensure that staff across each service area has an opportunity to review data collected by their service. This is undertaken through a set of meetings where detail from incidents, complaints, serious incident reviews and patient feedback is shared and reviewed.

Service specific presentations are developed with the respective Divisional Manager and Lead Nurse facilitated by the Quality Improvement Lead, with the detail presented to the relevant staff team in a scheduled event where they are facilitated to review the data and reflect on how the information can be used to improve patient experience and outcomes. Please see below example:

Please 4. see attached.

Lunch and Learn Events

To ensure that learning opportunities are made available across the staff team a series of Lunch and Learn events have been developed with a wide range of topics. Each is around 45 minutes. In each learning is shared on a relevant topic and there is a question and answer session at the end. The range of topics covered can be seen below:

Please 5. see attached.

Challenges, Risks, Mitigation and Action being taken relating to Quality and Safety issues noted above (what, by when, by who and expected impact)

Serious Incident Review Backlog

Welsh Government has identified that the death of a mental health or learning disabilities patient who had contact with the service in the 12 months prior to their death should be reviewed as a serious incident. As a Service Group the volume of cases that fit this criterion has left us in a position for a number of years whereby we have not been able to achieve appropriate timescales in conducting reviews, resulting in a backlog of cases. To manage the backlog and continued volume of reported incidents requiring review, in 2020 the Service Group agreed additional funding to expand the Serious Incident Review Team from 1.00wte to 3.2wte with appointments commencing from March 2021.

Whilst managing newer cases that require a level of urgent review, the Team are working to reduce the historical backlog of cases. The table below outlines the current position:

	August	October
Fully closed Cases	30	79
Remaining backlog	81	32

Working through the cases to complete closures and reviews as well as answer queries returned by Welsh Government the team has made significant progress in the last months. This has been assisted by many of the remaining cases being less complex, however the level of work undertaken has put the Service Group in a good position going forward to respond to the new Delivery Unit led Serious Incident Framework which was implemented in June 2021.

Valproate Prescribing in Females of Childbearing Potential Action Plan PSN/037

Good progress is being made in managing the risk to relevant patients. The current position of the reviews that have been undertaken are outlined in the below table with plans in place to address the outstanding cases – patients not yet engaged for completion of ARAF have been sent a letter; GP's contacted for weekly prescriptions and to stop if no engagement as agreed in Q&S action plan

CMHT	FCBP on valproate	ARAF in date	ARAF expired	No ARAF
Central	21	21	0	0
Ty Einon	12	12	0	0
Tonna	23	15	4	3
Forge	48	29	6	13

Please 6. see attached.

Court of Protection Litigation Cases

The management and coordination of Court of Protection cases including:

- Re x applications for individuals who have their liberty restricted in their best interests in settings other than hospitals and care homes
- Individuals challenging, via their advocate, the restrictions that are in place in the Deprivation of Liberty authorisation.
- Rarely individual challenging their capacity to make decisions or one or more of the areas approved in the Deprivation of Liberty authorisation.

These cases are heard in the Court of Protection and involve complex legal procedures and a significant amount of work for frontline nurses and multi-disciplinary teams in the presentation of witness statements and other evidence.

A work stream is being considered within the Service Group to:

- Identify processes to ensure efficient management of the cases and support teams when cases arise.
- Provide training to staff on the expectations of the court for relevant witness statements and evidence.
- Ensure that staff have the support and resources needed for complex cases

Controlled Drugs Action plan

The Service Group signed up to the controlled drugs assurance scheme and has been working to a controlled drugs action plan with monthly task group meetings reporting to the Quality and Safety group.

Please 7. see attached.

**Progress Against Annual Plan Quality and Safety Priorities 2021/22 (as applicable)
Quality Priorities: reduction in healthcare acquired infections; improving end-of-life care; sepsis; suicide prevention; and reducing injurious falls.**

Health care acquired infections

A review of actions taken during the initial COVID response provided the Service Group with important lesson learnt.

Please 8. see attached.

The Service Group have a plan to support the reduction of episodes of patient harm by reducing the incidence of C. Difficile Infection (CDI). The proposed reduction goal for the number of CDI cases in the Service Group to end of March 2022 is not to exceed 5. Action plan below:

Please 9. see attached.

Improving End of Life Care

The Service group have taken part in the NATIONAL AUDIT OF CARE AT THE END OF LIFE (NACEL) – Round 3 Mental Health work stream

Please 10. see attached.

The data collection is now complete.

Suicide prevention

The Service Group has undertaken a review to the approach for training in the assessment and recognition of suicidal presentations, with Dr Rhonwen Parry securing the expertise of Professor Kate Davidson to undertake a series of 'Train the Trainer' events at the beginning of 2021/22. The below is an update report that outlines the objectives of the training. The training outcomes are currently being reviewed through the Service Group Learning and Development Committee to agree the next phase of implementation.

Please 11. see attached.

Reducing Injurious Falls

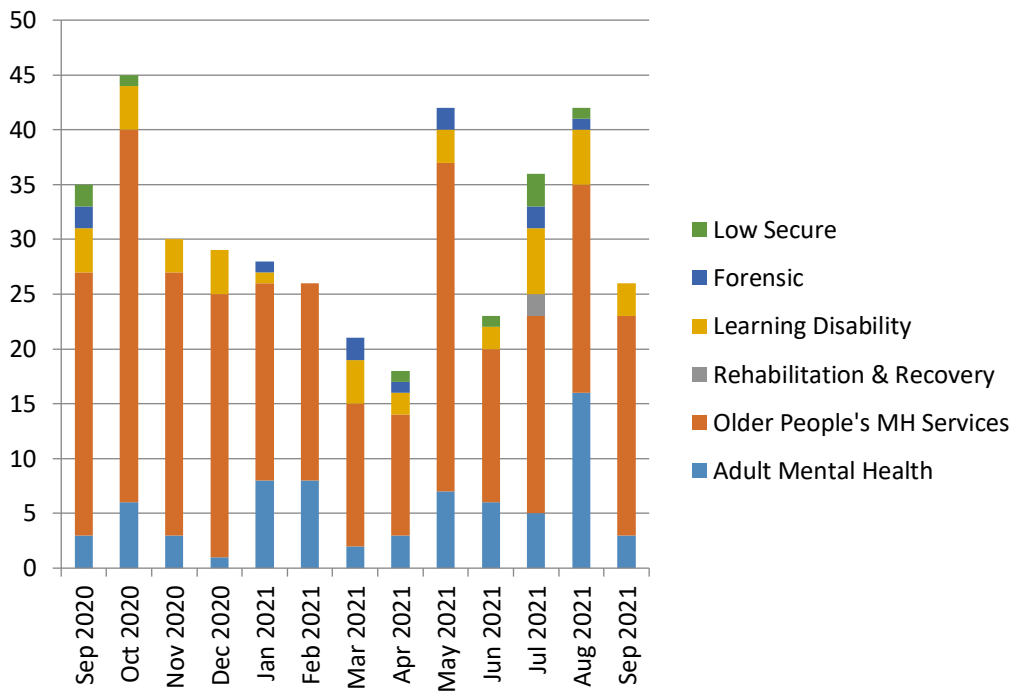
Individual RCA reviews of a small number of falls resulting in #NOF was undertaken. Given that the falls occurred over a limited timescale it was agreed that a thematic review would also be undertaken based on the initial reviews. The thematic approach proved to be productive as it highlighted that a collective consideration of the falls identified sleep deprivation as a common feature in all of the circumstances.

To support staff to consider what this may mean in practice when working to improve patient safety a Lunch and Learn event was used to disseminate the learning:

Please 12. see attached.

It is noted that falls across the Service Group occur for the most part in Older peoples mental health services.

Inpatient falls by month and Speciality



Progress Against Health and Care Standards 2021/22

Work is currently being undertaken on the Health Care Standards. An initial review of the data collected would indicate that the Service group is on course to be able to demonstrate that all standards have been maintained at last year's levels. Whilst work has been ongoing to improve standards the pressure on the staff from the impact of COVID may have reduced the potential to fully implement all improvements. It is envisaged that the work reported above will represent some of the key achievements over the last 12 months.

Patient Experience Update

The Service Group Quality and Safety Committee received quarterly updates from the service on progress on patient's experience work as per the below:

Please 13. see attached.

The Service Group has also now successfully progressed the '5x5' initiative that was previously piloted in 2018 through the securing of Mental Health Service Improvement Funds to establish a team of Service User and Feedback staff. Modifications to the original pilot have been made to ensure that the model is 'fit for purpose' in a local context. A significant amount of work has been undertaken with the Health Board Patient Feedback Team to adapt the previous 'Friends & Family' tool to ensure that it has greater applicability to our services and its Service Users. The rollout of the programme of work continues and we anticipate that we will be in a good position moving into the next year to provide more robust data regarding what people think of our service. The greater detail of this will be achieved through the contacts made by the team through interviews conducted with patients or carers.

Please 14. see attached.

Any Other Issues to Bring to the Attention of the Committee

SBU HB Safeguarding Committee Exceptions Report

The Service Group continues to be a full participant in the HB Safeguarding Committee. The latest report from the Service Group is attached below for reference.

The key points to note are:

- Increased use of CAMHS emergency bed during reporting period – utilised 8 times.
- ESR reporting of training linked to safeguarding suggests a reduction in compliance for the MH&LD SG. The MH&LD Committee is working with the Corporate Team to fine tune the requirement around this training so it can be accurately focused in accordance with the intercollegiate document provides a clear framework of training competencies for all healthcare staff. (RCN 2019)

Please 15. see attached.

Bespoke safeguarding training for managing reports of historical abuse being rolled out initially in CRHTT with plans to work with Corporate Team for it to be extended across SDG.

MH&LD Service Group report on Safeguarding & C-19 identified no safeguarding concerns directly linked to safeguarding concerns.

Recommendations

Members are asked to:

Note the contents of the report

Note appendices one to 15 in resources section