Meeting Date	**26 May 2020**	**Agenda Item**	**3.7**
Report Title	**Mental Health & Learning Disabilities – Preparedness for COVID 19**		
Report Author	Janet Williams, Associate Service Director		
Report Sponsor	David Roberts, Service Director		
Presented by	David Roberts, Service Director		
Freedom of Information	Closed		
Purpose of the Report	The purpose of this paper is to provide assurance to the Quality & Safety Committee about the arrangements in place to manage the challenges presented by the COVID 19 pandemic within the Health Board's Mental Health & Learning Disabilities Services.		
Key Issues	• Governance arrangements • Identification of essential and non-essential services • Highlight of key risks >20		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to: • **CONSIDER**

Mental Health & LD Services – Preparedness for COVID19

1. Introduction

The purpose of this report is to provide assurance to the Quality & Safety Committee on the preparedness of the Health Board's Mental Health & LD services for COVID 19 by describing the governance arrangements in place, the key risks that have been identified and mitigating actions in place.

2. Governance & Management Arrangements

The Delivery Unit established a COVID 19 Incident Response Centre in early March led at that time by the Associate Service Director (Operations) and now by the Service Director. The key role of the Incident Response Centre was to co-ordinate the Delivery Unit's overall response across the wide geographical spread of its services.

The Incident Response Centre operates within the Health Board's overall incident response with daily silver meetings in the Delivery Unit which include Local Authority partners as well as Health Board staff and participation in the Health Board's daily Gold meetings. (Both have stepped down to 3 times a week currently). This included strengthening of management cover at weekends across the 3 Localities – Swansea, Neath Port Talbot and Specialist Services.

The role of the co-ordination centre is to oversee all key components of the Delivery Unit's response.

In addition there is a National (Wales) Mental Health Incident Group with weekly calls involving Service Directors and Nurse Directors. This has been particularly useful in understanding the national picture, sharing best practice, problem solving and interpreting national guidance.

3. Risk Issues

The Delivery Unit has developed a separate Risk Register to record the additional risks that have emerged as a result of COVID 19.This is regularly reviewed by the Delivery Unit Management Board. Risks >20 are indicated below:

Risk	Context	Mitigation
Management of outbreak in an inpatient ward or Unit.	COVID 19 is an acute respiratory illness and all inpatient areas within the DU are staffed with RMNs/LD Nurses and specialist doctors.	Additional training via ANP & Consultant Physician from Morriston Hospital. Rosters bolstered where possible with RGNs and additional locum medical staff. Advice via Medical Registrars in Acute Units. Daily ICP advice.

Lack of piped Oxygen to all inpatient areas	COVID 19 patients often have high oxygen requirements.	Increased supply of bottled oxygen to all areas.

4. Essential Services

The Delivery Unit has been able to maintain all essential services during the pandemic despite the staffing challenges that have presented. Community caseloads have been RAG rated jointly by Health & Local Authorities in both Mental Health & LD services to ensure that those patients deemed to be at highest risk are prioritised.

A weekly situation report is submitted to Welsh Government detailing the status of all services to provide assurance about sustainability of services.

In addition, the Delivery Unit's Psychology Service has played a key role in providing psychological support to staff across all 5 Delivery Units in the Health Board and supported the work of the Fatalities Cell in providing support for bereaved families.

5. Personal Protective Equipment

The Delivery Unit has set up a central receipt & distribution point for PPE under the leadership of one of the Lead Nurses. Whilst there were some challenges early on with supply, the situation is now much improved with adequate supplies in the central store and at ward & unit level. The geographical spread of in patient facilities within the Delivery Unit has presented a challenge and the assistance of volunteers in delivery of PPE to our units has been much appreciated.

6. Outbreak of Infection Ysbryd y Coed

Ysbryd Y Coed is a 60 bed / 3 ward Older People's Mental Health Unit that provides care and treatment of individuals with both organic and functional illnesses.

At the end of March 2020 there was an increased incidence of positively tested patients in the Unit. Overall during the period of infection 31 patients & 42 staff tested Covid positive.

Significant preparatory work had been undertaken by the service who were working with the recognition that, given the age demographic of the population and their comorbid physical and mental health presentations, they would firmly sit within the high risk category for Covid 19. Associated with this was an understanding that the survival rate following Covid 19 contact could be poor and linked to the fact that many of the individuals had active DNAR's in place – an early analysis noted that only 4 patients had no DNAR.

The early actions included: an environmental review identifying a single ward for isolation; upskilling a predominantly RMN workforce to provide generalist nursing interventions; review of the medical cover; sourcing of PPE & other equipment e.g. suction machines, drip stands, oxygen (including attempts to obtain a piped supply; IPC advice / guidance. Welcome assistance was provided by colleagues from across the Health Board.

Due to the cluster outbreak a series of strategy review meetings were held, chaired by the Executive Nurse Director of Nursing & Patient Experience. The outcome of these meetings commended the work that had been undertaken by the Locality & Ward team in managing the care and treatment of the patients on the unit, noting particularly the low fatality rate given the high risk demographic of the patients.

A report to these meetings, presented by Public Health Wales, identified that the infection source was likely to have been a visitor or staff member, although the primary source could not be formally identified.

There are currently no infected patients on the unit which has subsequently been opened to admissions with a re-designed pathway to manage potential cross-infection and one of the wards identified as the single access point for the Delivery Unit.

7. Future Planning

Work is well advanced in planning for a possible second surge.

From an in patient perspective isolation areas were created at the beginning of the incident in all in-patient areas so that confIrmed and suspected cases could be isolated. These will remain in place.

In order to free up space for acute admissions to Neath Port Talbot Hospital the Older Peoples' Mental Health Ward (Ward G) has been temporarily relocated to the vacant suite at Tonna Hospital and will remain there for the foreseeable future.

For LD and Older Peoples Mental Health services the Delivery Unit has already moved to a single point of entry for new admissions and work is progressing to do this for Adult Mental Health also which will include having a single assessment suite for S136 admissions for Swansea & NPT.

In the Out Patient setting face to face patient contacts have been reduced and replaced with digital alternatives. These new ways of working will be evaluated and where appropriate incorporated into the Delivery Unit's Out Patient modernisation plan going forward.

8. FINANCIAL IMPLICATIONS

The Delivery Unit has reviewed the impact of COVID on its cost base and has produced a financial impact forecast as part of a Health Board submission to Welsh Government. Where possible, risks and opportunities have been quantified for inclusion in the forecast. The main impacts for the Unit are as follows:

- Loss of income, especially training income from the provision of training to external customers.

- In Pay additional medical staffing rotas have had to be put in place in response to COVID and costs arising from the redeployment of staff. A

number of services have been taken down or reduced and staff temporarily redeployed to other services and notably to inpatient services. This will lead to increased enhancement costs from staff that were not previously rostered.

- The majority of the Unit's non-pay expenditure relates to the provision of continuing health care and there has been an assessment of additional CHC expenditure. Any additional expenditure at this time will largely arise from the joint funding arrangements with local authorities for disputed cases during the COVID outbreak. The impact on all commissioned services continues to be assessed.

- There will also be an impact on savings delivery and all savings as included in the Unit's IMTP have been reviewed and a charge included in the forecast for those schemes that cannot now be delivered.

- The Unit will maintain a risks and opportunities log that will be supplementary to the forecast and any items that crystallise from that log will then be included for value in the forecast.

9. RECOMMENDATION

The Quality & Safety Committee are asked to receive this report.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Financial Implications		
Legal Implications (including equality and diversity assessment)		
Staffing Implications		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
Report History		
Appendices		