ABM University Health Board	
Date of Meeting: 1st February 2018 **Name of Meeting: Quality & Safety Committee** **Agenda item: 2.1**	
Subject	Mental Health and Learning Disabilities Service Delivery Unit Report
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1.0 Situation

The purpose of this report is to outline the key Quality & Safety issues facing the Service Delivery Unit (SDU) and the work that is ongoing to address these.

2.0 Assessment

2. Infection Control Issues

2.1 Infection Control Incidents

There have been 4 infection control incidents in the last 12 months across the SDU:

- 2 cases of C Difficile both of which were successfully treated
- a patient with scabies on admission
- one outbreak of sickness and diarrhea affecting 4 people

2.2 Anti-microbial prescribing

The Anti-microbial audit has identified improving performance over the months with the use of stickers being effective in informing and reminding prescribers of the correct drugs to use. Reports on anti-microbial prescribing are discussed at Quality and Safety meetings for review and to ensure that actions agreed are undertaken and effective.

2.3 Hand Hygiene

Hand Hygiene training for the delivery unit has been over 91% for the last 3 months showing a high level of commitment from the ward staff to ensure that they are maintaining excellent infection control standards.

2.4 Flu

Flu Vaccination levels for staff on 19th January 2018 was 50.2% which is an improvement on the positon from the year before. To ensure that all staff are offered and encouraged to take up flu vaccinations Locality Managers are completing a ward by ward audit and developing action plans with ward managers to improve update.

1. Environmental Safety of the premises

There are a number of challenges regarding the environmental safety of premises across the SDU. These relate mainly to:

- **Cefn Coed** – a large part of the main building has been decommissioned during the past year with the only services in the main build being the two

acute adult wards and the assessment and ECT suites. Whilst every effort is being made to make the ward environments as appropriate as possible the limitations of the Victorian build/design of these wards needs to be acknowledged. The option appraisal for the provision of these services was revisited in the Summer of 2017 and the Delivery Unit is now working with Executive Directors to agree the next steps.
It is also important to note that a large part of the building is now unoccupied with inherent security risks and deterioration to the environment due to reduction in heating/lighting to the area. To improve security the previous main entrance to the hospital has now been closed and plans are in place to board up ground floor windows and change locks in the old part of the hospital.
The Cefn Coed Decommissioning Board and Service Improvement Project Group are responsible for monitoring the decommissioning programme and environmental issues in the hospital.

- **NPT & Glanrhyd Site –** during the last 12 months Environmental Groups have been established on both the Neath Port Talbot (NPT) and Glanrhyd sites to provide assurance that environmental issues are being managed and addressed. A meeting with the NPT site colleagues and the PFI partner is planned regarding some issues on the NPT wards. The Glanrhyd site has recently submitted an application for Green Flag status.

- **Garngoch site –** The site of the former Garngoch Hospital now houses Ty Einon (Community Mental Health Service). The site has represented a security challenge during the past 12 months. Meetings have been held with Police and Fire Service. To improve the situation new gates have been installed on the site, windows boarded up in the old hospital building and regular estates walkabouts are in place.

- The SDU also has a well established Health & Safety Committee which unresolved issues can be escalated to if necessary.

2. Patient Feedback

A Task & Finish Group has been set up to implement the engagement strategy that has been developed by the Local Partnership Board. The implementation plan covers the 4 key areas laid out in the strategy:

- Information
- Involvement
- Recruitment & Training
- Deciding Together

In addition each of the Localities within the SDU is setting up a local patient experience group that will support the implementation of the strategy and to ensure feedback on services including patient & family experience.

3. Compliance with National Patient Safety Alerts

The SDU has improved the governance arrangements for receiving and circulating NSPAs across its services. Whilst many of the NSPAs relate more to the Acute Hospital setting rather than to Mental Health & Learning Disabilities Services all alerts are received and logged by the SDU's Quality and Safety Team before

circulation. A register of alerts received is reported to the SDU's Health & Safety Committee each month and a log of actions taken to mitigate any risks maintained.

4. Unscheduled Care Target

The SDU contributes to the Health Board's unscheduled care target in a number of ways:

- Participation in daily conference call to deal with any interface issues between SDU eg: assessment delays, in-patient transfers
- The Psychiatric Liaison Service works closely with the Acute Hospitals now providing a service until 10pm on weekdays and 8am-4pm at weekends. The service is able to respond to referrals from ED within 1 hour and on the same day for urgent ward referrals.

5. Risk Register

The Mental Health & Learning Disabilities SDU operates with 4 Localities and a Corporate Team. Each Locality has developed its own Risk Register which feeds up into the SDU Risk Register. The Register can be described as "a log of all the risks that may threaten the success of the SDU in achieving its declared aims and objectives". The key objective is to ensure that all risks are identified and logged and that following consideration of any existing controls that are in place, whether other options exist to further reduce or eliminate the risk. The Risk Register is a dynamic document and forms part of the SDU Board and Quality & Safety Committee each month.

The risks currently assessed as having a risk score of 16 or above which the SDU would wish to bring to the attention of the Quality & Safety Committee are:

Risk	**Risk Score**	**Mitigating Actions**
Workforce- specifically nurse staffing in older peoples' services	16	• Modernisation of older peoples' services which will lead to a reduction of inpatient beds and a shift to a community services model • Rolling advert for nursing posts • Recruitment Open Days • Development of alternative roles • Strengthening links with University.
Acute Adult Wards Cefn Coed Hospital	16	• Wards have been relocated into the optimum part of the site and redecorated. • Service improvement plans are in place for both wards which are monitored via the CCH improvement Group. • Option appraisal exercise to relocate the wards off site.
Capacity in Acute Adult Services	16	• There are currently 74 Acute Adult beds across the three Localities of the SDU. Occupancy rates are currently running at 95%. In order to mitigate risks beds are used flexibly across the localities and escalation processes are in place to manage demand and capacity.

6. **Mortality Reviews**

PHW 1000 Lives Improvement, the NHS Delivery Unit and HIW jointly lead an improvement programme on *'Sharing the Learning from Untoward Incidents'* in Mental Health, Learning Disability and related NHS services. The programme includes people of all ages, with analysis focused upon suicide, self-harm, homicides and other serious untoward incidents. The programme is coordinated by a National Steering Group (NSG) which meets quarterly.

During 2016, the NSG reviewed the findings and implications of the NHS England commissioned report into the deaths of people with LD and MH problems at Southern Health NHS Foundation Trust1 and the recent CQC review of mortality investigation processes. The NSG recommends that all Health Board's now establish systems and capacity for routinely undertaking Mortality Reviews for all specialist mental health and learning disability services, across NHS inpatient and secondary care community services. To this end, an All Wales Mortality Review Pilot has been designed to test out a methodology for undertaking Mortality Reviews in each Health Board.

The Mental Health and Learning Disabilities SDU is participating in the All Wales Mortality Review Pilot. It is intended that the Pilot study will run for 6 months during 2017-18 with a review at 3 months.

To assist the Pilot projects across Wales, the NSG has adapted Mortality Review tools currently used in NHS physical healthcare inpatient services in Wales and developed proposals for their piloting in all Health Board's during 2017. In addition to testing the utility of the Mortality Review tools, the pilot aims to identify potential implementation issues, including how easy or difficult it is to integrate within wider Health Board Mortality Review processes.

A report of the national findings will be prepared for both the All Wales Senior Nurse Group and the Mortality Review Programme Board before the financial year end.

A Pilot Mortality Review Project team has been established, led by Dr. Rhonwen Parry and Dr Richard Maggs. Key to the progression of the project will be the continued support from Anne Biffin ABMU Medical Directors team, to assist in the roll out of Part One Mortality. Reviews, across the Health Board and assist the Unit in setting up reports to review progress.

The pilot study is in 3 parts:

- To pilot the nationally standardised Mortality Review Stage 1 Form
- To pilot the amended Mortality Review Stage 1 Form in Health Board Mental Health/Learning Disabilities secondary and tertiary service and inpatient facilities for a period of 6 months
- To pilot a new Mortality Review Stage 2 Form in Mental Health/Learning Disabilities secondary community services and inpatient facilities.

7. How are we doing against Health Board Quality priorities?

The SDU has made progress against the Health Board's Quality Standards

- **PROMs and PREMs:** Reflecting on the difficulty in getting adequate returns from a service with low turnover of patients, the SDU is investing in a Patient Experience Strategy which will pull together information from patients in each locality including ensuring that patients, families and carers have opportunities to participate in the development and implementation of the strategy.
- **Suicide Prevention:** The SDU is involved in the Western Bay Suicide Prevention Strategy working with other agencies. All suicides within the service are investigated and lessons learnt from the investigations are implemented and shared via the Quality and Safety Committee. A recent presentation to assurance and learning demonstrated how lessons had been learnt and service changes implemented to reduce risk.
  Pressure areas: The SDU has had 10 pressure areas in 2017 none of which was SI reportable. All pressure areas are scrutinised and lessons learnt shared with staff via an update letter. Key learning is that wards need to ensure that they have access to suitable mattresses ordering additional equipment as it is used by patients and that families need to be kept up to date.

8. Serious Incident Group (SIG)

The SDU has a well established Sentinel Incident Group chaired by the Unit Medical Director. During the past 12 months the membership and terms of reference for the group have been reviewed and strengthened.
SIG is responsible for ensuring that all unexpected or avoidable deaths, including suicides by a person in receipt of mental health care at the time or in the past 12 months, are clinically reviewed by a Clinician not previously involved in the patient's care with formal reports being presented at SIG for scrutiny and discussion. Any lessons learned identified by the review are documented in a "Lessons Learned" Matrix which is widely shared across the Delivery Unit.

9. Health and Care Standards

The Health Care Standards have been expanded to include work undertaken on Service modernisation and work undertaken to meet the Health Boards Recovery and Sustainability Plan. Progress has been made across a number of standards. The improving Timely Access standard was the only area to score 2. This standard has been scrutinised in more detail with an improvement in performance as a result.

Other standards are progressing with specific achievements in 3.2 communicating effectively and 3.3 Quality improvement, Research and Innovation and 7.1 Workforce

10. HIW Reviews

During 2017 a number of unannounced and planned visits were made to services and wards within the SDU.

Site	Service	Nature of Visit	Date of Visit	Immediate Concerns identified Yes/No	Report received from HIW Yes/No
1.Neath Port Talbot Hospital	Ward F – Acute Adult Service	Unannounced	18th & 19th May 2017	No	Yes – action plan submitted by DU

	Ward G – Older Peoples Mental Health				
2. Glanrhyd Hospital	Taith Newydd- Low Secure Unit Angelton Clinic – Older Peoples Mental Health	Unannounced	25th & 26th July 2017	No	Yes – action plan submitted by DU.
3. Glanrhyd Hospital	Caswell Clinic – Medium Secure Unit	Unannounced	2nd & 3rd August 2017	No	Yes – action plan submitted by SDU
4. Community	Swansea (Area 2) Community Mental Health Team	Thematic Review	14th & 15th September	No	Report received on 22.12.17 and Action plan submitted on 19.1.18- awaiting confirmation of assurance from HIW.
5.Cefn Coed Hospital	Derwen & Celyn Wards (Older peoples)	Unannounced	26th September 2017	No	Yes – action plan submitted by SDU
6. Princess of Wales Hospital	Ward 14 (Acute Adult) and PICU	Unannounced	21st November 2017	No	Yes – action plan submitted by SDU

Overall feedback from these visits was positive with patient experience described as “caring”, “good”, “high standard”, “dignified” and “positive”.

- No issues of immediate concern were identified from any of the visits
- The monitoring of the Mental Health Act was described as “good” or “excellent” in all cases.
- Some issues were picked up relating to environment and facilities- these are being addressed through the action plans.
- The reviewers considered that “safe & effective care” was being provided.
- Some areas were identified where documentation could be improved.

- Management & Leadership was described as “good”, “visible”, “with a good MDT approach”.

During 2015 and 2016 HIW conducted a thematic review of NHS Learning Disability (LD) Services in Wales. This review included inspections of 3 Community LD teams and the 12 residential units managed by AMBU. In August 2017 HIW wrote to the Interim Chief Executive of the Health Board requesting an update on progress against the improvement plans that had been submitted following these visits. A comprehensive update was provided on a thematic basis by the 8th September deadline and HIW have confirmed assurance on the basis of the update given. The issues identified from the HIW visits have been widely shared at forums and staff briefings across the SDU and a newsletter is being developed.

11. Quality Improvement in Wards and Clinical Areas.

There are 3 clinical areas that the SDU has identified as areas of potential concern and where there is now targeted improvement work going on. These are:

- Acute Adult Mental Health Wards
- Older People’s Wards at Cefn Coed Hospital (Ysbryd y Coed)
- Gelligron & Forge Community Mental Health Teams

The Quality Improvement work initiated in these areas is in part based on previous work undertaken on areas considering to be performing strongly in Caswell, Taith Newydd and Angelton Clinic.

Adult Mental Health Wards

The Unit Nurse Director and Unit Medical Director are sponsoring a Quality Improvement Programme that:

- Has a focus on 5 acute mental health wards and PICU
- Involves the whole MDT
- Includes the development of a ward based quality improvement plan which will be led by the Ward Medical Lead, AHP Lead and Ward Manager working as Quality Improvement Leads
- Includes measurement and improvement teams to feedback progress to UMD and UND
- Involves external facilitators and Senior Clinical Nurses providing ongoing support to the Quality Improvement Leads to deliver on the quality improvement plans.

A series of SDU wide workshops will be set up to support the implementation of the Improvement Plan. This will include workshops related to QI methodology and workshops identified as part of the individual improvement plans being developed by wards eg: record keeping, concerns & redress, serious incident training, developing engagement with families and carers.

This approach will support wards to continuously improve, respond positively to the themes identified, develop staff skilled in improvement methodology and enable the SDU to evaluate a specific programme of improvement work to consider how further improvement work can be rolled out.

Older People’s Wards Cefn Coed (Ysbryd y Coed)

A Quality Improvement project has also been initiated in the Older People’s Wards at Cefn Coed Hospital. This has covered the following areas:

- Standardised approach to audit compliance and organisation of single audit action plan for all wards completed and in place from Oct 2017.
- Patient flow – DTOC meetings now in place overseen by Clinical Leads who also join DTOC revalidation meeting to link with LA partners to assist patient flow.
- Team Nursing in place – to ensure the right nurse attends ward rounds
- Standardised proforma in place for ward handover to ensure governance and that actions and communication from ward rounds
- 15 STEPS completed in 2 out of 3 wards (to complete end of Jan 2018) with agreed action plan for YYC
- Band 5 reflective practice sessions implemented since Set 2017 facilitated by Lead Nurse for Quality and Consultant nurse
- Dementia Champions identified and trained – Dementia Care Team working with these to agree forward work plan
- All Ward Managers from YYC have attended Footsteps leadership programmes
- 2 Clinical Leads currently attending Nurse Leadership and management course
- Falls group is in place on all wards and is producing individual MDT plans for individuals at risk
- Clinical psychologist and assistant Psychologist appointed to dedicated roles in YYC – will lead on a roll out of a proactive preventative approach to individuals who challenge in OPMHs
- Band 4 OT techs out to advert for dedicated roles in relation to Fail proof activity in OPMHs
- Baseline assessment of the Triangle of Care model undertaken in January 2018 – action plan produced identifying opportunities to improve carer involvement and co-production of care.
- Carers leaflet, welcome letter and information pack for carers being co-produced with carers.
- Customer Care 5 star experience undertaken.

Gelligron & Forge Community Mental Health Teams

A review of the Gelligron & Forge Community Mental Health Teams was commissioned by the SDU Directors following a critical incident that raised concerns about patients' access to services and the allocation of the Care Co-ordinators in line with the Mental Health (Wales) Measure 2010.

The review was undertaken jointly with Neath Port Talbot County Borough Council and specifically looked at:

- Patient Flow and capacity management
- Staff management and arrangements for clinical supervision
- Integrated working between health and local authority staff
- Multidisciplinary Team working
- Making best use of administrative resources.

The report was published in September 2017 and 5 areas requiring immediate assurance were identified and actioned. These were:

- Ensuring that all patients were allocated a care co-ordinator and that the care co-ordinator is actively engaged with the patient.

- A concern about the Out Patient environment at NPT Hospital
- A Health & Safety review of the CMHT premises
- A review of administrative resources and processes.

An improvement plan has been developed to deal with all the issues that have come out of the review and this is being monitored via a multi-disciplinary Project Group Chaired by the Unit Nurse Director.

12.15 Step Challenge

The previous 15 step challenge undertaken by members of the Health Board's Quality & Safety Committee took place in March 2017 with members visiting Gwelfor (Rehabilitation & Recovery) and Ysbryd y Coed (Older peoples).
The main issue on Gwelfor was about the large "goldfish bowl" office at the front of the ward which acted as a barrier. This has now been removed and the staff office relocated with the foyer being re-developed into a recreational area for patients and their visitors.

The three wards in Ysbryd y Coed were all visited and described as clean, pleasant and well presented with welcoming staff who were prepared to discuss successes and challenges openly. As indicated above there has since been a HIW visit to Ysbryd y Coed with an action plan developed that forms part of the continuous improvement for these areas.

In addition to the 15 step challenges undertaken by Executive colleagues the SDU has introduced its own 15 step Programme led by the Senior Clinical Nurses.

3.0 Recommendations

The Quality and Safety Committee is asked to note the contents of this report.