Meeting Date	19th February 2019	**Agenda Item**	**2.2**
Meeting	Quality and Safety Committee		
Report Title	Mental Health and Learning Disability Service Delivery Unit Exception Report		
Report Author	Shelley Horwood, Quality and Safety Manager		
Report Sponsor	Hazel Powell, Unit Nurse Director		
Freedom of Information	Open		
Purpose of the Report	This report sets out Mental Health and Learning Disabilities Delivery Unit's progress against the Health Board quality and safety objectives and provides assurance regarding patient safety and patient experience within the unit. The report should be read in conjunction with the performance information included in Appendix 1.		
Key Issues	• Patient safety incidents and learning • Concerns and patient experience • Risk issues • Planned improvements		

Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	

Recommendations	Members are asked to: • **NOTE** this report

MENTAL HEALTH & LD SERVICE DELIVERY UNIT
ANNUAL QUALITY AND SAFETY COMMITTEE BRIEFING REPORT

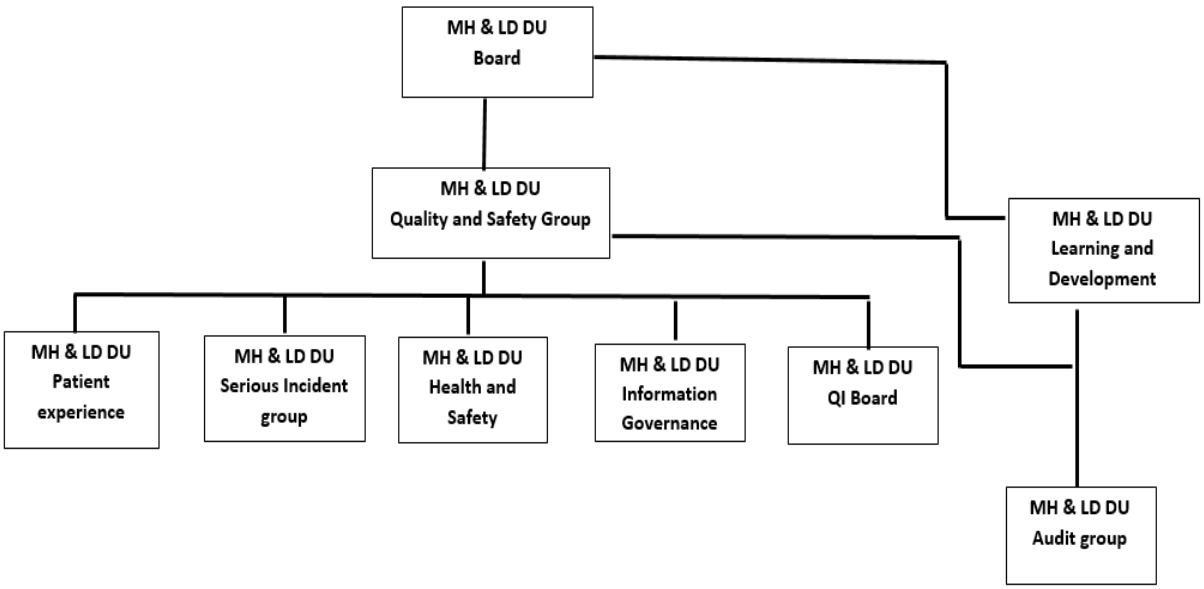
1. INTRODUCTION

Quality and Safety within Mental Health and Learning Disability Service Delivery Unit is overseen through the Unit Quality and Safety Committee. Assurance reports are provided to the group from sub committees and learning is shared across the unit via this forum.

2. BACKGROUND

2.1 Unit Governance and Assurance

The Quality and Safety Committee is accountable directly to the Unit Management Board and also provides reports to the Health Board's Assurance and Learning Group. The assurance structures underneath Quality and Safety Committee are shown below.



Clinical Audit

There are 7 audits registered within the Unit for the current year, in addition the DU participates in the:

- Prescribing Observatory for Mental Health (POMH-UK which provides a national service to assist clinical services to improve the service and quality of their prescribing.

- National Clinical Audit of Psychosis (NCAP): a three-year improvement programme to increase the quality of care we provide to people with psychosis.
- National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH): a cross UK audit of the circumstances surrounding those with mental health problems who commit suicide producing a range of reports on the risk factors and treatment improvements to reduce levels of harm.
- National Falls audit: a new project developing a database to facilitate research into the causes and potential service improvements in falls management.

Learning from audits is shared in Quarterly Audit events chaired by the Audit Lead who is a Consultant Psychiatrist in Learning Disabilities.

Ward Quality Assurance Audits

There is a programme of internal review where staff from a range of disciplines undertake peer review of services using the 15 step methodology. Further work is being undertaken to ensure robust reporting and governance for the outcomes of the reviews to be monitored at DU level.

Inspections and reports

During 2018 Health Inspectorate Wales made the following unannounced visits to wards with the Mental Health & LD Delivery Unit:

6th March 2018	Suite 2, Tonna Hospital
15th March 2018	Calon Lan Ward, NPT Hospital (as part of wider review into All Wales Substance Misuse Services)
19th & 20th June 2018	Clyne & Fendrod Wards, Cefn Coed Hospital

It is pleasing to note that no issues of immediate assurance were identified on any of the visits. Detailed action plans were drawn up following the visits which were approved by HIW and are monitored via the Delivery Unit structures.

Management of Serious Incidents

During 2018 the Welsh Government's Delivery Unit undertook an intervention into systems and processes for the management of Serious Incidents within the Health Board. The subsequent report contained some specific recommendations about the management of Serious Incidents within Mental Health & LD and a specific action plan has been drawn up to meet these including:

- A revised Terms of Reference and membership of the Serious Incident Group (SIG).

- Adoption of the Health Board's RCA methodology for investigations and template report.
- Appointment of a Serious Incident Investigator

It should be noted that there has been an increase in the number of Serious Incidents reported during the last 12 months, due to a WG requirement to report as Serious Incidents the deaths of any patient who has had contact with mental health or LD services in the 12 month period prior to their death. Mental Health & LD also has a higher number of SIs graded as major or critical than any of the other Delivery Units in the Health Board.

Time Frame	**No of SIs Reported**	**%age graded major or critical**
April 2017- March 2018	25	84%
April 2018- Sept. 2018	26	85%

Risk Register

There are 46 open risks on the Delivery Unit Risk Register of which 3 are currently graded at 20 or above:

There are currently 15 high level risks there of which score over 20 or above:

1. Expansion of prison population at HMP Parc without any increase in mental health in-reach resources.
2. Lack of treatment/clinical rooms at Cefn yr Afon and Specialist Residential Units.
3. Risk of patients self harming on inpatient units.

The Risk Register is reviewed monthly at the Delivery Unit's Management Board in order that the Board can be made aware of any new risks or escalation of scores for existing risks and mitigating actions.

2.2 Patient Safety

Serious Incidents

In the quarter ending 31st December 2018 there were 11 serious incidents reported by the Delivery Unit:

Incident	Swansea	NPT	Bridgend	Specialist	Outcome

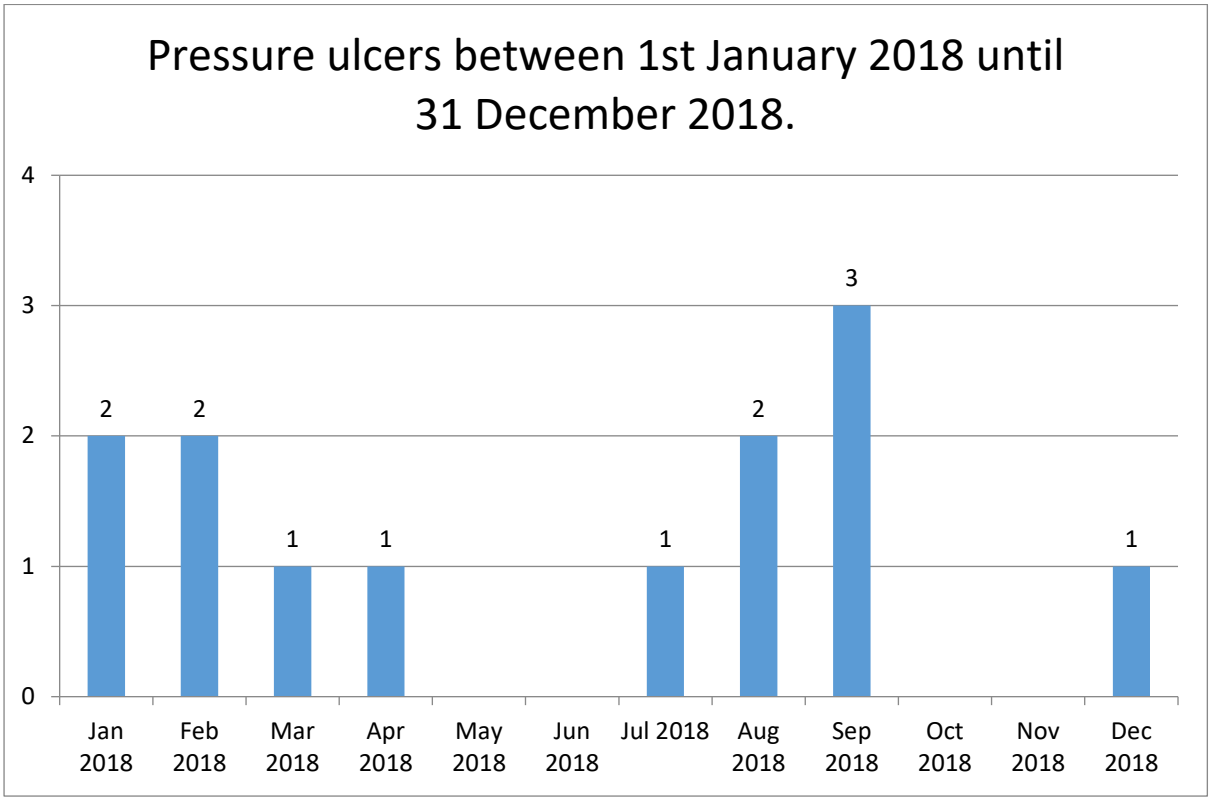
Fractured neck of femur	1	0	0	0	Correct falls management in place- no failures identified.
Unexpected death of community patient	5	2	3	0	Still under investigation

Following the investigation of a Serious Incident the RCA report is considered by the multi-disciplinary Serious Incident Group which is chaired by the Unit Medical Director. A member of the Health Board's Serious Incident Team also attends this meeting to provide an element of independent scrutiny. Any failings identified are captured in a "Lessons Learned" matrix which is shared across the Delivery Unit.

Incident Management

The Unit has 5 incidents overdue for investigation and 37 incidents overdue for closure. This number will decrease with the appointment of an Investigator and a strengthening of administrative support within the Quality & Safety Team.

Pressure damage



The Delivery Unit has had 13 pressure areas during 2018, none of which have been reportable as serious incidents. All pressure areas are reviewed by a Scrutiny Panel.

The themes identified through Scrutiny Panel Review are:

We Learned	Action taken
Misidentification of pressure ulcers	Staff awareness training delivered by TVN Training in correct identification of grading Information leaflet on identification shared across all Localities
IR not completed promptly (awaited TVN confirmation of grading)	
Lack of immediate provision of pressure relieving equipment	Spare air flow mattress now available within units
Patient not cooperative with prevention due to cognition	Skin bundle to be completed on admission Where possible full involvement of MDT in Scrutiny Panel
Sudden deterioration in physical health and end of life	

Falls

There were 54 falls with harm recorded in the quarter ending December 2018 reflecting an ongoing reduction in the number of falls across the unit.

The Delivery Unit has a ward based falls review structure which feeds into a monthly Delivery Unit wide falls group led by the Head of Physiotherapy.

Work has been undertaken to cease the use of lap straps in falls prevention across all ward areas and these will be taken out of use by the end of March 2019.

Infection Outbreak

No infection outbreaks were reported in the quarter ending December 2018.

In April 2018 the Delivery Unit reported one case of C Difficile which was managed and did not spread to other patients. Learning with regards to antibiotic prescribing was shared.

Within Caswell Clinic one patient developed food poisoning after consuming an uncooked chicken snack brought in by the relative of another patient. The policy for bringing food items into the Unit has now been changed.

2.3 Patient Experience

A pilot study has been undertaken within the Delivery Unit to ensure that service users and their families have a simple and easy opportunity to provide comments or complaints on services delivered. This is known as the “Five by Five” approach to gaining patient feedback where patients are asked five specific questions in relation to their mental health care via telephone interview.

A Task and Finish Group was set up involving service users in the coproduction of the questions to be asked and the areas of service delivery to be targeted initially.

The questions were accompanied by a Likert scale and were:-

1. I was happy with the waiting time to get help with my care and treatment?
2. I had enough information about the care and treatment plan and the role of my care co-ordinator
3. I wanted to be more involved in decisions made about my treatment and care
4. I believe that the experience of care and treatment helped me in achieving my goals in my treatment plan:
5. Is there anything that can be improved?

The areas identified for inclusion in the pilot were an adult acute in patient ward, an Adult Community Mental Health Team, an Older people’s community team and the Crisis Resolution Home Treatment Team.

The process involved identifying people who had received discrete episodes of care within a month such as a care and treatment plan review or an outpatient appointment. At the point of care patients were asked if they would consent to a telephone interview in the next couple of weeks to gain their feedback and those names were then provided to the pilot from which a random selection was made for interview.

The study was launched in October and ran for a 4 months period. The outcomes are currently being compiled covering uptake, efficiency of process, time taken to undertake regular surveys, skills and knowledge required by interviewer and service provision feedback themes gathered.

Initial findings have been that the engagement in the pilot was variable but the number of people agreeing to be interviewed was higher than might be expected from a postal survey. It would be possible to scale the process up for all service areas but there will be infrastructure requirements for the approach to run effectively.

Complaints Performance

The Unit achieved 100% compliance with the 30 working days response target during the period 01/10/18 – 31/12/18. Our complaints response performance has steadily improved and we have been 100% compliant with the target for the past six months.

Communication to patients is the most common theme within the concerns received. Quality improvement projects are being implemented across the localities to improve communication.

Compliments

During the period 01/10/18 – 31/12/18 the unit recorded 32 compliments about our services, the majority of which were in relation to the behaviour and attitude of the staff and the support provided to patients. . We recognise that this figure only reflects a small proportion of the total compliments received and will be looking at how to promote recording compliments on DATIX across all of wards in order to have a more accurate reflection of patient and family experience.

2.4 Improvement

The Quality Improvement (QI) work continues to be embedded across the DU. There is a QI Programme Board that meets bi-monthly to provide scrutiny, support and share learning for all the QI programmes being undertaken across the DU.

In addition there are monthly QI forums for all staff to network and have peer support in relation to QI methodology and data collection. A further QI event was held on 11th February where services shared their improvement journey to date. This included staff and carer stories.

We have completed a series of workshops focusing on using the feedback available to us from incidents, concerns, complaints, compliments, internal and external review, staff and carer stories. These were facilitated by Jane Williams, Quality & Safety Manager from the WG Delivery Unit.

2.5 Quality & Safety Indicators

The Delivery Unit has been working on a revised set of Quality & Safety Indicators that best fit the type of services provided which will be introduced from 1st April 2019 and inform future reports:

Quality & Safety Indicator
Patients detained under MHA as %age of all admissions
Patients detained under MHA who abscond
Patients “sleeping out” due to lack of bed capacity in acute wards
No of episodes where restraint is used or medication given under restraint
Incidents of Violence & Aggression against staff
Incidents of Violence & Aggression between patients
No of Serious Incidents recorded in Delivery Unit
No of Patients subject to DOLS
Percentage of days Wards are locked by ward within each Locality
No of POVAs recorded by Locality

No of incidents of falls in inpatient setting a) Number of falls recorded as Serious Incidents
Grade 3 or 4 pressure areas reported in inpatient setting
DTOCS by service area
Incidents of Self Harm occurring in inpatient areas
Safer Staffing Levels
No of medication errors
Ligature Risk Assessments by ward
Number of out of Area Placements
Training Compliance
ETOC Compliance
Percentage of patients who are provided with a copy of their care plan
Outstanding HIW actions

3. Financial Implications

No direct financial implications.

4. RECOMMENDATION

The Quality and Safety Committee is asked to note the contents of this report and raise any specific queries resulting from it with the Unit.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
	✓	✓	✓	✓	✓		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
Quality, Safety and Patient Experience							
Included within body of report.							
Financial Implications							
None							
Legal Implications (including equality and diversity assessment)							
The Unit is required to work within the parameters of Putting Things Right the guidance for dealing with concerns about the NHs in Wales.							
Staffing Implications							
None							
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)							
The Unit actively promotes patient involvement and co-production to support people in achieving their well-being goals.							

Report History	Annual paper to Quality and Safety Committee
Appendices	Appendix 1 Unit Quality and Safety Dashboard for Q1