Service Groups' Highlight Report for Quality and Safety Committee

Meeting Date:	25th October 2022
Service Group:	Mental Health and Learning Disabilities Service Group
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Sponsor:	Stephen Jones Nurse Director MHLD Service Group
Presenter:	Stephen Jones Nurse Director MHLD Service Group

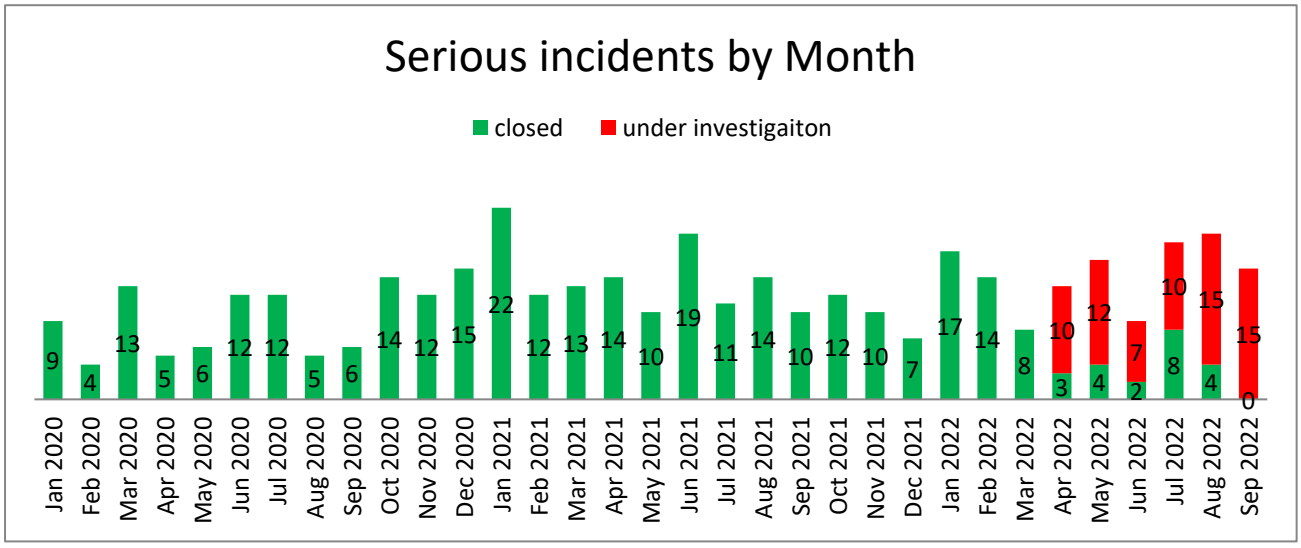
Summary of Quality and Safety issues since last report to the Committee (Reporting period: 1st July 2022 to 30th September 2022)

Serious Incident Position

During this period, there have been a total of 52 deaths of individuals known to MHLD Services:
Mental health - 31 (12 of which are suspicious of suicide)
Learning Disability - 15
Drug related deaths – 6

There is a proportionate investigation carried out in relation to the circumstances of each case. For LD cases, a peer review takes place for all deaths (including natural causes) to identify any learning and for the more complex cases, this would be escalated to full review. A similar process is followed for drug related deaths, both in CDAT and MH. Findings from potentially accidental overdose in these cases, can still identify learning for the Service Group.

The current position for the Service Group can be viewed in the graph below:



There are currently 72 open cases of which 5 (4 for MH and 1 for LD) are currently running overdue of the 120-day target for closure. The investigations are all well underway and nearing completion with the aim of these being presented at the November Serious Incident Group.

We are currently preparing a response on the Service Groups position relating to the NHS Delivery Unit report on learning from inpatient deaths “Rapid Review of Suspected Suicides of Psychiatric Inpatients April 2017-March 2022”.

As an outcome of this review, preliminary findings from the NHS Delivery Unit identified that there appeared to be an increase of Suicides across Wales. As a result, all HB’s have been asked to examine this and provide detail on the total number of suicides by year.

Total numbers of confirmed and suspected suicides open to MHLD Services = 57 (39 confirmed suicides and 18 suspected suicides) The suspected suicides are those that are awaiting inquests and therefore the cause of death is yet to be determined.
This total of 57 is broken down as follows:

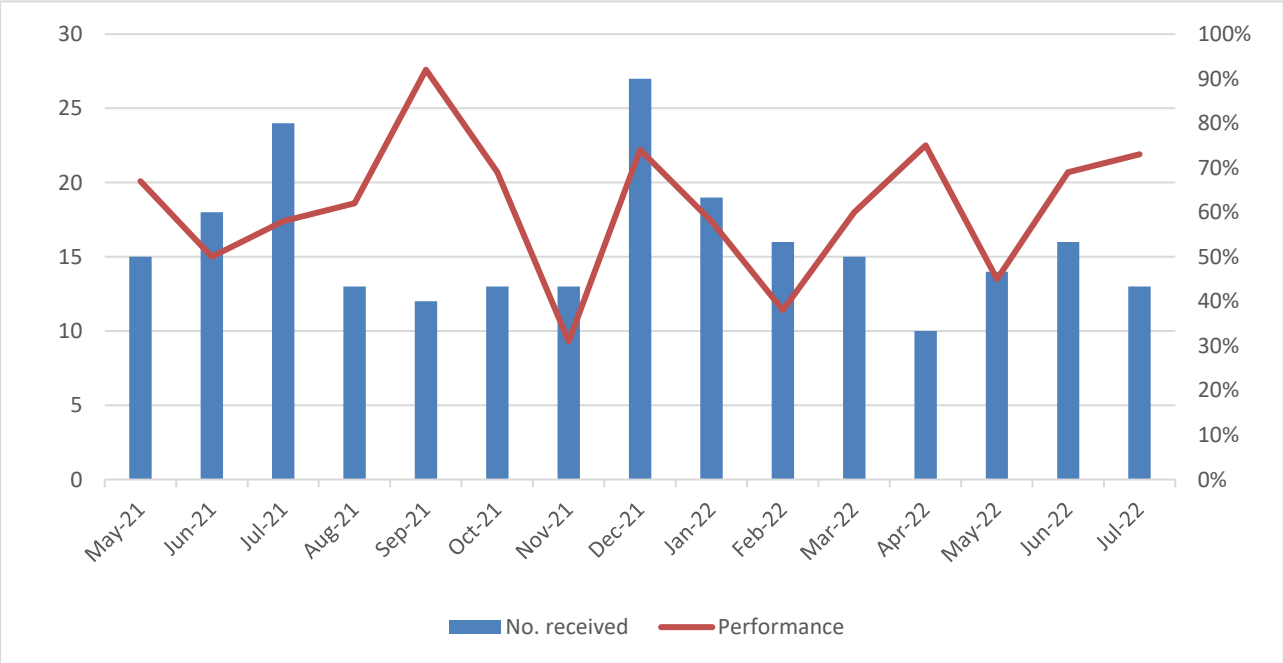
- 2019 / 2020 – 17 confirmed suicides (following inquest) & 1 suspected suicide (inquest TBC).
- 2020 / 2021 – 16 confirmed suicides (following inquest)
- 2021 / 2022 – 6 confirmed suicides (following inquest) & 2 suspected suicides (inquest TBC).

April 2022 to present – 15 suspected suicides (inquest TBC).

This information has been shared with the NHS Delivery Unit.

Complaints position

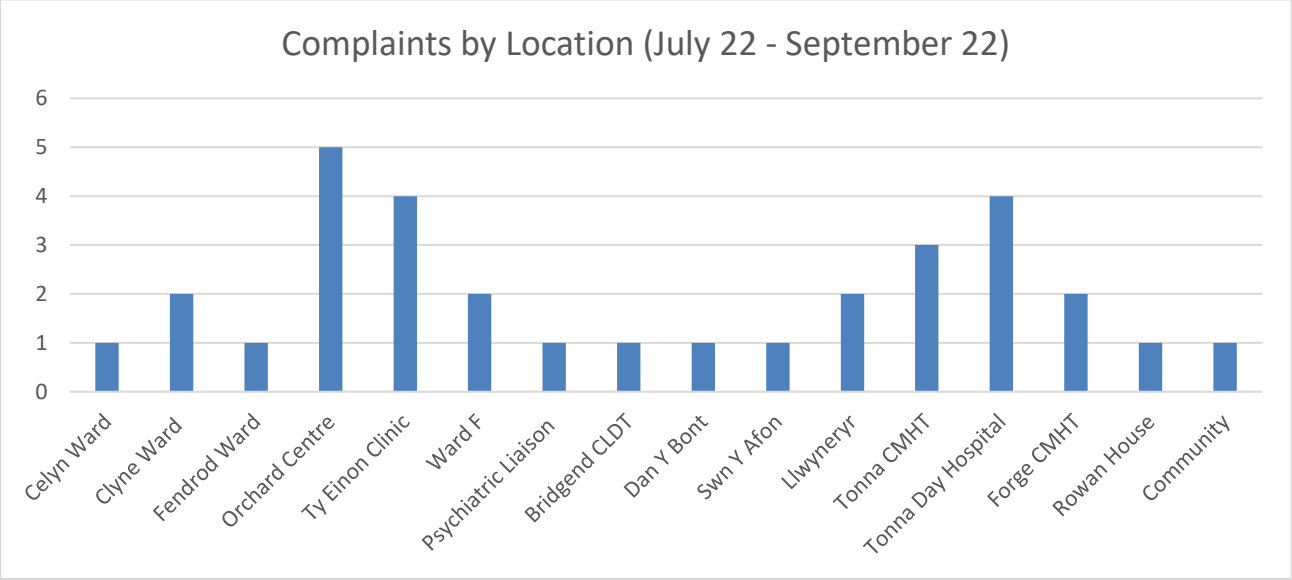
The current position for compliance against the 30 working day target is shown in the graph below:



The service group has an overall improving picture with complaints within the Adult Mental Health Directorate in particular having made improvements to their performance. Weekly meetings are in the diary between the Quality and Safety Team and the leads for Adult Mental Health to monitor progress.

The other directorates are offered support as required dependent on the complaints they have received.

There has been a recent recruitment to a 10-hour post specifically to support the investigations and responses for complaints within the Adult Mental Health Directorate. This is the area where we are experiencing the majority of our complaints and the post will enable further improvement in performance in this area.



Whilst we are striving to improve the performance with the 30 working day target, our focus has also been on the quality and satisfactory resolution for the complainant with the aim of reducing some of the re-opened cases.

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

Quality Assurance and Nurse Director Unannounced Reviews

During Jan/Feb 2022, the MHLD Service Group ratified their Quality Assurance Framework, setting out the infrastructure for monitoring, assurance and governance.

Part of this framework are the Nurse Director's Unannounced Reviews. These reviews are co-ordinated by the Nurse Director's office with a review team of clinicians, senior leaders and relevant specialists who carry out an unannounced review on a clinical area or team.

6 reviews have been conducted since April and reported via the MHLD Quality and Safety Committee.

The Directorate Leads are now producing actions plans, which will be presented and monitored over the next quarter via the MHLD Quality and Safety Committee.

Health Inspectorate Wales Inspections and Reports

The MHLD Service Group have been subject to the following HIW reviews in 2022:

2 HIW Unannounced Inspections
Dan Y Deri and Llwyneryr Learning Disability Units March 2022.
Tawe Clinic - Clyne and Fendrod adult mental health wards March 2022.
The action plans are in place for these reviews and are monitored via the MHLD Quality and Safety Committee on a quarterly basis. The immediate action plan for Dan y Deri and Llwyneryr has been completed and accepted by HIW.

1 HIW report relating to Swansea HMP
Local review of the Quality Governance Arrangements in place within Swansea Bay University HB, for the Delivery of Health Care Services in HMP Swansea June 2022.
A joint action plan with the Primary Care Service Group has been developed. The Mental Health areas of the review are monitored Quarterly via the MHLD Service Group's Quality and Safety Committee.

1 National Review
National Review of Mental Health Crisis Prevention in the Community March 2022.
An action plan is in place and is monitored quarterly by the MHLD Quality and Safety Committee.

Patient Safety Alert 13 – Ligatures and Ligature Point Risk

The PSA 13 Ligature and Ligature Point Risk Assessment Tools and Policies was presented at the MHLD Service Group Quality and Safety Committee in September for sign off, noting and cascading to the Divisions. The Service Group monitor monthly compliance with ligature risk assessments in all clinical areas and compliance currently sits at 100% as at 7th October 22.

Developmental Review Summary Caswell Clinic and Taith Newydd

A review by the Royal College of Psychiatrists for Secure Services has been undertaken. The draft report has been received, however awaiting the final report to be published. A response to the draft to be submitted to the Royal College of Psychiatrists by 31st October 2022. This will be monitored via the MHLD Quality and Safety Committee.

Clinical Audit Subgroup and Nice Guidance

The Clinical Audit Subgroup meets on a bi-monthly basis and last met on the 6th September 2022. During this meeting, three new audits had been approved and seven audits had been agreed to be closed following outcomes and learning being submitted. The return for the National Clinical Audit and Outcome review program for the National Clinical Audit of Psychosis: Early Intervention in Psychosis Audit Report was shared for noting and the Part A and Part B findings were discussed. Part A has since been submitted to the Clinical Audit and Effectiveness Team for submission nationally, with Part B submission deadline by November 2022.

NICE guidance: ***New and updated***

The Clinical Audit Subgroup reported a list of NICE guidance that are relevant to the MHLD Service group and had been prepared for discussion. The Group identified relevant clinical

staff to lead on the review of these and to report back actions for the Service Group if required to take actions forward in relation to these.

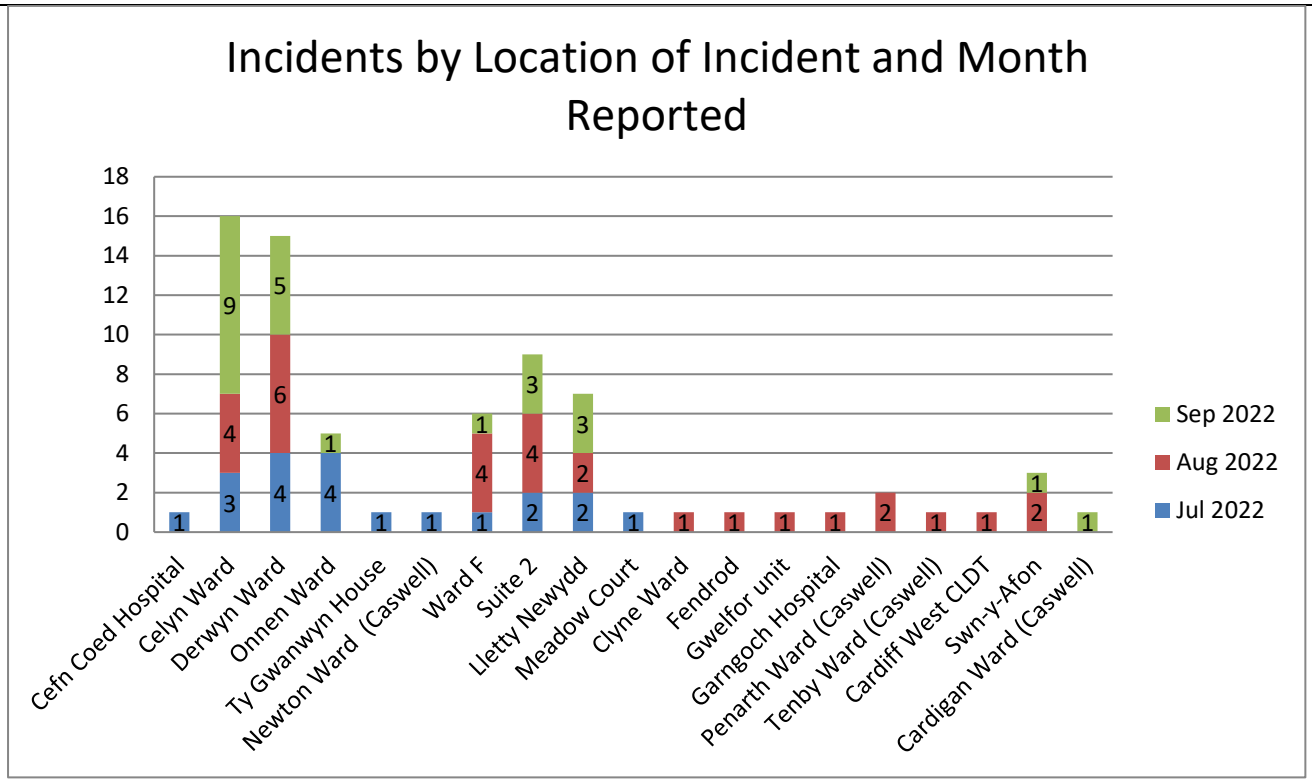
Progress Against Annual Plan Quality and Safety Priorities 2021/22 (as applicable) Quality Priorities: reduction in healthcare acquired infections; improving end-of-life care; sepsis; suicide prevention; and reducing injurious falls.

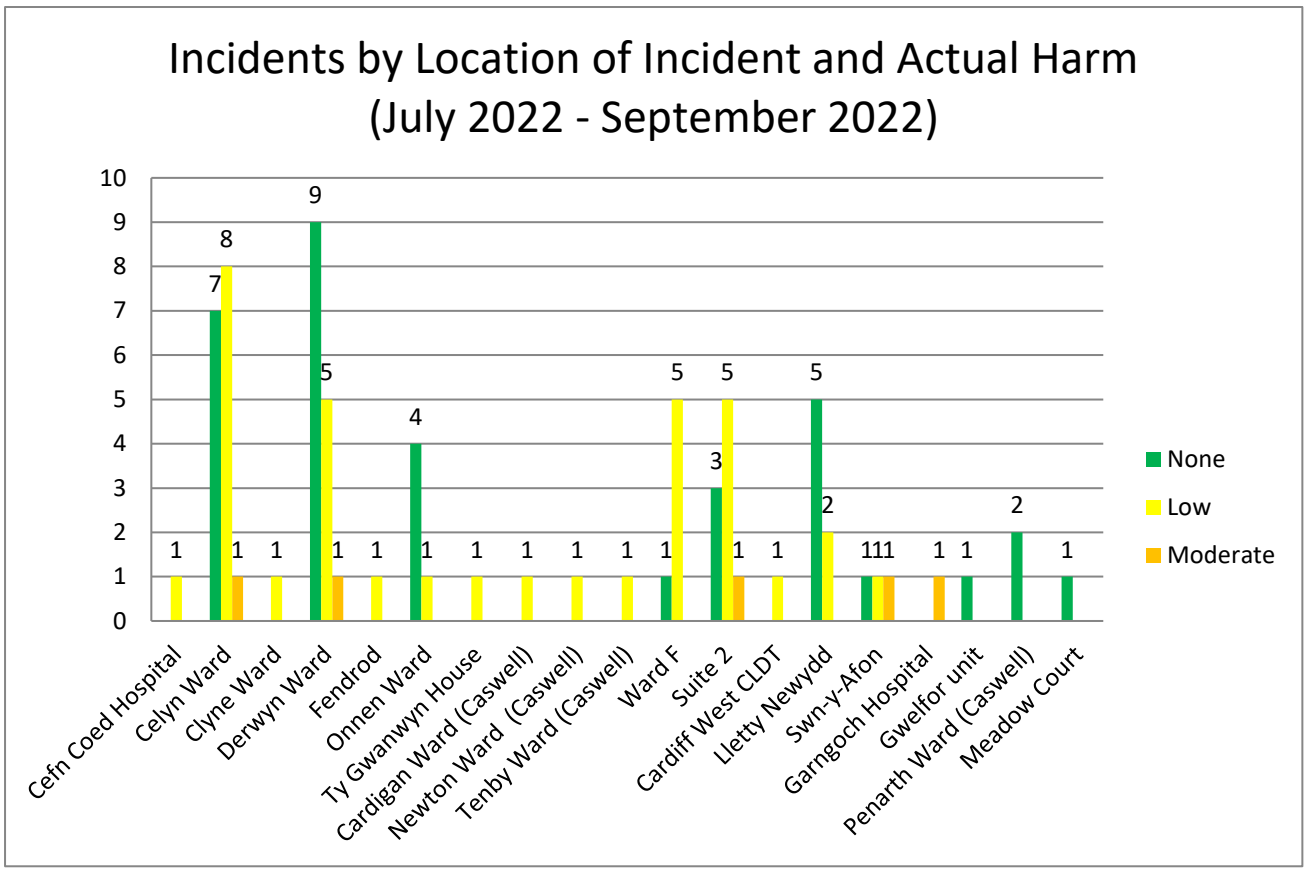
Infection Prevention and Control

MHLD IPC meetings are held on a bi-monthly basis, with dedicated input from the corporate IPC team.
The HCAI Action plan is being monitored and reviewed by the group, and communicated within the Divisions and Directorates via their Q&S governance structures.
A learning forum supported by the IPC team is being introduced to discuss any immediate IPC advice, identify areas of good practice and an opportunity to identify any learning points.
Hand hygiene training has been a key component and following a paper being approved by SMT additional/bespoke training has been secured for the MHLD Service Group to work towards an improvement in compliance.

Falls

During this reporting period the number of falls by locations, can be seen in the first graph and the location of incident and actual harm can be seen in the second graph below:





The Service group falls meeting last held in September 2022 continues to monitor and scrutinise falls data from the MHLD Service Group. During this meeting restrictive practices were identified within 5 separate care plans across the Service Group, these care plans were discussed, monitored and scrutinised. It was agreed that Eleri D'Arcy (Corporate Quality Improvement Lead for Falls) will join the MHLD Service Group Falls meeting going forward. Falls champions are also being identified for each of the Directorates.

End of Life Care

Report from the National Audit of Care at End of Life (NACEL) Round 3 for MH was published in July 2022. The findings from this will be presented at the next MHLD Service Group Clinical Audit event on the 17/10/2022.

The key findings showed that, on the whole there was parity between Mental Health Services and the Acute and Community Services, with Mental Health underachieving in the following areas:

- Governance
- Workforce/specialist palliative care
- Staff reported feedback

These are likely due to the fact that death rates are lower in Mental Health and therefore may not have the established links with Palliative Care pathways
Where Mental Health Services excelled and scored higher than Acute/Community Services were:

- Communication with the dying person/their families and others
- Involving the person/their families in the decision making processes
- Taking into consideration the persons needs and the needs of their families and the impact this has on their experience of care

An action plan will be developed following the presentation and monitored via MHLD Quality and Safety Committee.

End of Life champions have now been trained for all inpatient OPMH areas during quarter 1. With the plan for all other inpatient areas across the MHLS Service Group for completion during quarter 2 and 3, and community services during quarter 4. Progress against this is being monitored and reported at the Corporate End of Life Steering Group meetings.

SEPSIS

Head of Nursing for Quality and Governance has met with the HB Quality Priority Lead, to discuss expectations from the MHLD Service group
An audit on the use and implementation of NEWS across the service group is under development. This has been an area of learning identified from findings of serious incidents and investigations of complaints. The HB Quality Priority Lead is supporting this piece of work.

Suicide prevention

The launch of the Sharing Hope Campaign took place on 23rd September 2022. The Campaign is an Arts in health programme for staff using arts and creative activities where staff can find ways of expressing themselves, connecting with peers and sharing stories. It aims to offer safe spaces to heal, recover and come out stronger together.

An action for each Service Group from the Quality Priority Suicide Prevention Steering Group, was to provide assurance to the Assistant Director for Health & Safety that all anti-ligature risk assessments are completed across each Service Group. This action was achieved, with 100% compliance against the ask, and was reported on by end of August as requested.

World Mental Health Day was held on 10/10/2022 – throughout all of the week, a variety of events have been held virtually by the MHLD Service Group. These events have included sessions from guest speakers, internal presentations and celebrations to mark the occasion.

Progress Against Health and Care Standards 2021/22

Data continues to be captured across the Service Group, in line with the Health Care Standards.
Awaiting formal guidance on the format of the feedback required for 2022/2023

Patient Experience Update

Bespoke Mental Health and Learning Disability Feedback Survey

Within MHLD Service Group we have a bespoke survey to capture feedback from Service Users and Carers. During this reporting period July to September 2022, 44 interviews were conducted. 32 were interviews with Service Users, 3 interviews with Carers and 9 interviews with family members.
From these interviews 97.67 % rated the overall experience they received as “Very good” or “Good”, and 2.33% rating “Neither good or poor”.

Friends and Family Test

The Nationally recognised Friends and Family Test continues to be available for individuals who chose to provide feedback via the external facing Health Board website. During this reporting period July to September 2022, 6 online feedbacks were received via this platform. 4 reported an overall experience of “Very Good”, which equates to 66.67% and 2 reported “Neither good or poor” – 33.33%.

OPMH survey for the NHS DU

The Service User Feedback and Involvement team have been working with the Directorate Manager for OPMH and the NHS Delivery Unit, in gathering feedback from Service users over the age of 65 years on accessing OPMH services. This is an all Wales initiative. This bespoke feedback was sent out to 67 individuals and has resulted in 26 completed interviews from service user’s/family members to date. Further interviews are planned with the analysis and report to follow.

Digital stories

The Service User Feedback and Involvement Team have been working with service users and carers to produce digital stories. Three have been completed over recent months, with another two under development. It is the aim of the service group to be able to have a bank of stories in order to present one at each of the Quality and Safety Committee meetings from January 2023 onwards.
The team have also been working with two clinical teams (one within secure services and one within the LD division) to produce induction digital stories for the placements. The aim is that these digital stories be shared with service users transitioning to the placements to ease anxiety and stress leading to the transfer.

Staff recognition

Over the last year the Service User Feedback and Involvement Team have been working on an agenda item for the MH/LD Service Group Management Board. This has produced 10 staff/team digital stories. It also allows for the welcome of new members of staff to the service group and thanks to the staff leaving the service group.

Any Other Issues to Bring to the Attention of the Committee

Aligning Quality and Safety agenda with the Corporate Patient Safety Group structures

The Service Group has established governance processes that had previously reported to the Health Board QSGG. Given the recent amendments to the governance and reporting structure within the Health Board Corporate Team the MH/LD Service Group took this opportunity to review its own governance and reporting structures.

Therefore, throughout Quarter 1, we have undertaken work to ensure that our internal Service Group Quality & Safety Committee has the mechanisms to report to the new Health Board Structures. This has resulted in our Quality and Safety Committee agenda and internal reporting aligning to the Health Board Patient Safety Group and its sub group structure.

The new agenda for the Service Group Quality & Safety Committee is attached below – each of the subgroups and leads have been tasked with updating accordingly, including their membership and terms of reference. Through Quarter 2 the plan is to embed the refreshed MH/LD Quality & Safety agenda and associated subgroups which report to the committee.

Through this new agenda, the ask on the reporting has a focus on exceptions, whilst identifying and sharing learning and associated risk.


Agenda Q&S Draft proposal.docx


Exception report draft format.docx

Recommendations

Members are asked to:

Note the content of this report