Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	13 June 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Mental Health and Learning Disabilities Services Outcome of Self-Assessment of Adult Inpatient Discharge Arrangements
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations.
SWYDDOG ADRODD: REPORTING OFFICER:	Becky Temple-Purcell, Assistant Director of Nursing Mental Health and Learning Disabilities.

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides assurance of existing arrangements and further planned actions to improve arrangements that support the delivery of safe, effective, and timely care surrounding discharge of patients from inpatient mental health services into the community within Hywel Dda University Health Board.

A recent self-assessment process has been undertaken by the Mental Health and Learning Disabilities Directorate against Health Inspectorate Wales (HIW) recommendations generated through a review of discharge arrangements in Cwm Taf Morgannwg University Health Board. A range of improvement actions have been identified and will be undertaken and monitored through the Mental Health and Learning Disabilities Directorate.

A key action is to establish a Discharge Review Task and Finish Group as a temporary sub-group of the Mental Health and Learning Disabilities Quality, Safety and Experience Group to:

- Undertake formal benchmarking against NICE guideline for transition between inpatient mental health settings and community or care home settings (NG 53)
- To oversee improvement, work specific to discharge planning and process, consider opportunities for coproduction and application of Quality Improvement methodology for specific projects
- To share and develop consistent practice across services
- To provide regular reports to Mental Health and Learning Disabilities Quality, Safety and Experience Group

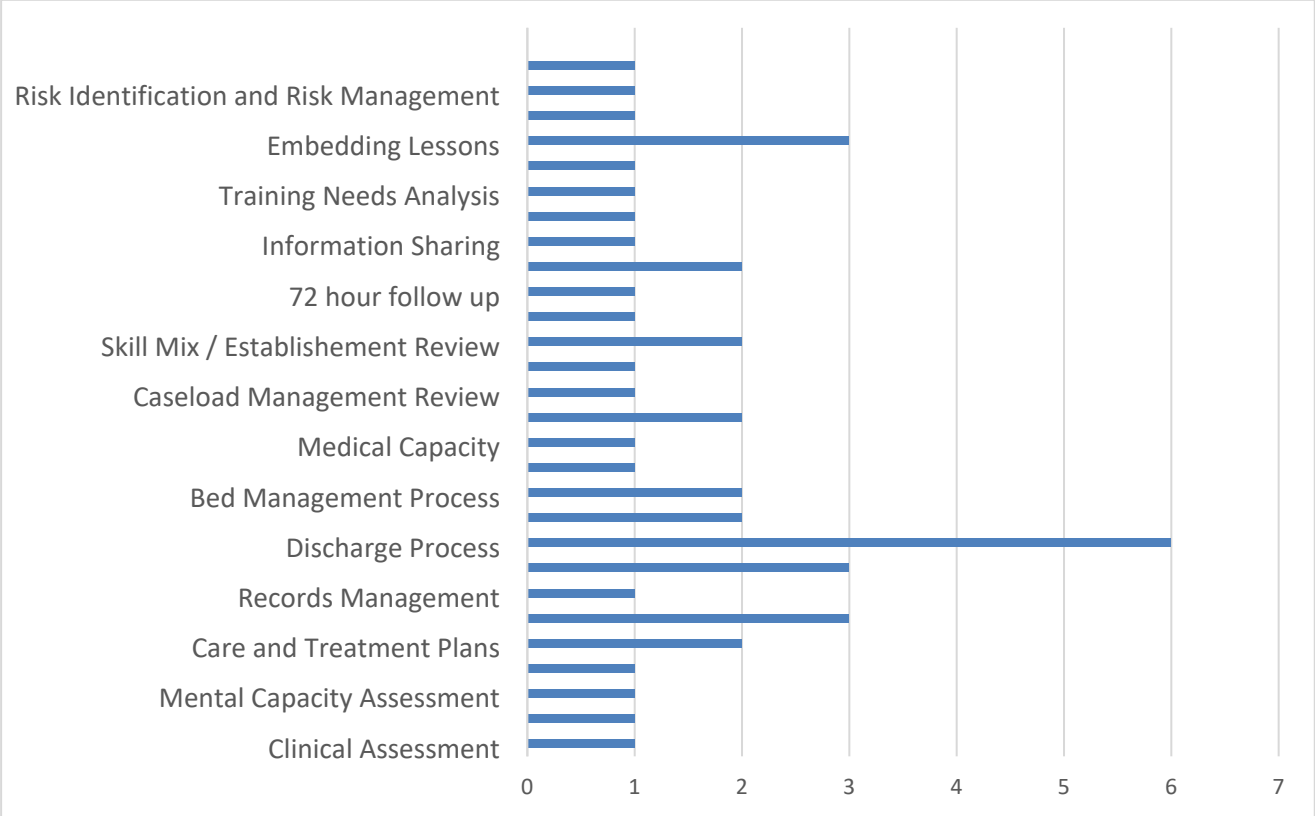
Cefndir / Background

On 7 March 2023, HIW published a report following a review undertaken to assess the quality of discharge arrangements in place within Cwm Taf Morgannwg University Health Board (CTMUHB), for adult patients being discharged from inpatient mental health services to the community. The review generated 40 recommendations. Full details of the report can be accessed through the HIW website WWW.HIW.Org.Uk

Due to the serious nature of the concerns identified within CTMUHB, HIW requested that each health board undertake a self-assessment against review recommendations and complete an equivalent improvement plan to provide HIW with assurances on local discharge arrangements.

Recommendations generated by the review were broad in focus with a wide range of themes applicable beyond mental health services. Figure 1. provides a breakdown of recommendations represented as themes. Discharge process was the most commonly represented theme, featuring in 6 of the 40 recommendations.

Figure 1. Recommendation Themes



HIW will review the Health Boards improvement plan and seek further clarity as required which may include site visits. Information provided will be referenced by HIW when considering its risk-based approach to inspection, reviews, and escalation. Once the improvement plan has been approved, it will be published on the HIW website.

Asesiad / Assessment

The enclosed Improvement Plan (Appendix A) provides details of the Health Boards current position against each of the 40 recommendations and further actions identified through the self-assessment process to address gaps in assurance and was shared with HIW as required on the 5 May 2023.

The self-assessment process was undertaken with engagement of the wider team across the Mental Health and Learning Disabilities Directorate to ensure a service wide approach (beyond adult mental health services) to maximise learning and improvement. Evidence of existing practice was sought against each of the recommendations, which involved review of policies,

processes and procedures, training activity, plans and strategies. Information from existing feedback processes, for example from serious incidents, incident management, local audit, complaints, advocates, inspections, reviews and staff surveys was used to triangulate evidence.

The self- assessment process highlighted strong compliance against 3 recommendations, limited compliance against 4 recommendations and partial compliance against 33 recommendations.

Self-Assessment	Recommendation
Strong compliance	3, 5,16
Limited compliance	6,9,23,24
Partial compliance	1,2,4,7,8, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40.

A range of improvement actions have been developed to address gaps in assurance. A number of existing directorate level actions from a recent Audit Wales Review of Governance are identified as relevant to the recommendations and are referenced within the improvement plan. These relate to clinical audit, organisational risk management, and development of a directorate engagement and organisational development plan and directorate recruitment and retention plan.

Delivery of the improvement plan will be overseen and monitored through the Mental Health and Learning Disabilities Directorate Quality, Safety and Experience Group and will be discussed within internal professional forums. Themes will be shared for discussion with the Mental Health Partnership Board.

Improvement actions have been added to the Health Boards Audit Management and Tracking (AMaT) system and will be monitored through open action tracker reports reviewed at a directorate and health board level.

Argymhelliad / Recommendation

For the Quality, Safety and Experience Committee to receive this report for assurance of existing arrangements and further planned actions to improve arrangements that support the delivery of safe, effective and timely care surrounding discharge of patients from inpatient mental health services into the community.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.25 Review and approve work plans for Sub-Committees to scrutinise and monitor the impact on patients of the Health Board's services and their quality.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Current waiting time challenges and risks across the Mental Health and Learning Disabilities directorate are reflected on the health boards corporate level Risk Register (Risk 1032). The impacts of vacancies on service capacity is held as a risk on service level risk registers within the Mental

	Health and Learning Disabilities Directorate for specific teams (Risk 1612). Sustainability of the medical workforce in response to difficulties and challenges experienced in recruiting doctors and retention risks associated with the age profile of the existing Consultant workforce is held as a service level risk on the Mental Health and Learning Disabilities Directorate Risk Register (Risk 1525). Risks in relation to the quality and capacity of the estate to deliver services is held as a service level risk on the Mental Health and Learning Disabilities Directorate Risk Register (Risk 839 and 1260). Current deficits as a result of being unable to recruit to specialist psychology roles is held as a service level risk on the Mental Health and Learning Disabilities Risk Register (Risk 138).
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	4c Mental Health Recovery Plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NICE guidelines for Transition between inpatient mental health settings and community or care home settings (NG 53).
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod:	Content of self-assessment reviewed by Executive Quality Review Panel 18 April 2023.

Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Mental Health and Learning Disabilities Quality, Safety and Experience Group to oversee and monitor the improvement plan.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Yes
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Yes
Cyfreithiol: Legal:	Yes
Enw Da: Reputational:	Yes
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Improvement plan

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board)

The table below details the areas we require assurances from your health board, on the relevant issues/areas within your adult mental health services.

Recommendation 1		
The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Performance against the assessment accountability within the Mental Health (Wales) Measure is routinely monitored by the MH/LD Directorate with oversight through all of the MH/LD directorates committees. Quarterly reports are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures providing oversight of ongoing actions to improve. Current waiting time challenges and risks are reflected on the health boards corporate level Risk Register (Risk 1032). A Comprehensive Assessment Tool (CAT) was launched April 2023 to deliver consistent assessment standards, including expected timeframes for assessment, across Inpatient and Community Adult and Older Adult mental health pathways, capturing clinical assessment information within electronic care records in a way that can be more easily audited. Documented guidance is in place to underpin practice and training is being delivered to support implementation.		

Initiatives to improve physical health monitoring are taking place at a service level eg Tool being piloted as a standard clinic form for Clozaril Clinics within CMHTs, Clinical Pharmacy roles being trialled to support Physical Health Clinics in Early Intervention in Psychosis Teams. Further Actions a) Development of standards for physical health screening to be incorporated into Service Specifications. b) Further development of Care Partner to capture physical health screening in line with above standards through electronic forms. Please see overarching Clinical Audit Action (Recommendation 34)	Senior Nurse Quality Assurance and Practice Development Senior Nurse Quality Assurance and Practice Development	September 2023 November 2023
Recommendation 2		
The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.		
Health Board Action(s)	**Responsible officer**	**Timescale**
WARRN is used as a standardised approach to formulation based risk assessments across the MH/LD Directorate. A cohort of WARRN trainers deliver monthly training sessions for initial and refresher training. The presence of a WARRN is verified through Care and Treatment Planning audits undertaken monthly by team leaders. The MH/LD Directorate is linked into All Wales work surrounding development of a national approach to safety planning.		

Further Action c) Review of WARRN training provision and monitoring of uptake to inform longer term, sustainable approach and ability to provide targeted practice development in response to lessons learnt from SI's. Please see overarching Clinical Audit Action (Recommendation 34)	Assistant Director of Nursing, Mental Health and Learning Disabilities	September 2023
Recommendation 3		
The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.		
Health Board Action(s)	Responsible officer	Timescale
The Health Board has an established Mental Capacity Act team and Best Interests Assessors in place. Staff identified through the Health Boards mandatory training needs analysis receive MCA training. Training compliance is monitored through team, directorate and board level structures (eg BAPG, Improving Together Sessions). Directorate compliance with MCA training is currently 91.85% as of 26/04/23. Documented guidance for staff is in place through Mental Capacity Act Practice Guideline (811). Approved MCA documentation is uploaded to the Electronic Patient Record by the MCA team on completion. A structured approached to auditing consistency in practice and documentation of this is undertaken by the MCA Team. There are no themes from Serious Incident reviews or complaints or concerns feedback that indicate inconsistencies in practice.		

Recommendation 4		
The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Routine offer of Carers Assessment is built into the Comprehensive Assessment Tool referenced in recommendation 1 and is explicitly referenced in its accompanying guidance. Documentation of routine offer of Carers Assessment is incorporated into CAT forms on the Electronic Patient Record. WARRN and Care and Treatment Planning Reviews also prompt staff to offer Carer Assessment and document outcomes to this. The Health Board is signed up to the Investors in Carers scheme and all teams across the MH/LD Directorate are actively benchmarking services against the schemes standards. There are Carer Leads on all Inpatient Wards and specific support for dementia carers can be accessed through Admiral Nurses and Dementia Wellbeing Teams. Further Action d) All teams to compile evidence folders for certification against Investors in Carers standards by a September 2023 and commence implementation of an annual review process. Please see overarching Clinical Audit Action (Recommendation 34)	Heads of Service for MH/LD Services	September 2023
Recommendation 5		

The health board must ensure that patient care and treatment plans:
a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010;
b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.

Health Board Action(s)	Responsible officer	Timescale
An audit framework is in place to measure both a) and b) across MH/LD Directorate Services. Monthly Care and Treatment Plan audits are carried out by Team/Ward Leads and quality assurance of this is undertaken through the Quality Assurance and Practice Development Team. Quarterly reports are provided to the Health Boards Mental Health Legislation Scrutiny Group then Mental Health Legislation Committee and reported through Quality Safety and Experience structures. A digital signature that is timed and dated is applied at the point of closure on the Electronic Patient Record. Training in relation to Care and Treatment Plans is provided monthly via MS Teams by the CTP lead within the Quality Assurance and Practice Development team. Recent reports received by committee structures give substantial assurance on having valid Care and Treatment Plans in place across Adult and Older Adult Mental Health services. Service owned actions are being undertaken to improve levels of assurance across CAMHS and LD services which are being monitored through the Mental Health Legislation Scrutiny Group and reported to Mental Health Legislation Committee and Quality Safety and Experience structures.		

Recommendation 6
The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.

Health Board Action(s)	Responsible officer	Timescale
Daily Board Rounds plus scheduled Ward Rounds take place across Inpatient areas. The structure, format and approaches to quality assurance of Ward Rounds vary across services. There is feedback to indicate that short notice for Ward Rounds impacts on Service User and Carer involvement. Further Action e) Coproduce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring. Please see overarching Clinical Audit Action (Recommendation 34)	Assistant Director of Nursing MH/LD	September 2023

Recommendation 7
The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.

Health Board Action(s)	Responsible officer	Timescale
A range of systems and practices underpin prompt communication and information sharing between inpatient and community teams during the discharge process:- - MDT attendance by Ward & CMHT (Care Coordinators) - Pre-discharge Care and Treatment Planning Meetings - Directorate wide access to Electronic Patient Records		

- Current pilot of Medicines Transcribing and e-Discharge (MTeD) system - Daily Bed Conferences and Acute Pathways meetings that involve inpatients, community, liaison, local authority and Police representatives to discuss patient flow - Sector Approach within OA Mental Health Services promoting continuity of care Further Actions f) Establish a discharge review task and finish group in order to undertake a baseline assessment against NICE guidelines for Transition between inpatient mental health settings and community or care home settings (NG 53). g) And review the health boards current Discharge Policy (# 370 Discharge and Transfer of Care Policy) to ensure additional standards that underpin safe practice in MH discharges (in line with NICE guidelines) are incorporated. Please see overarching Clinical Audit Action (Recommendation 34)	Assistant Director of Nursing MH/LD and Assistant Medical Director MH/LD Assistant Director of Nursing MH/LD and Assistant Medical Director MH/LD	September 2023 September 2023
Recommendation 8		
The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.		
Health Board Action(s)	Responsible officer	Timescale
There are a range of mechanisms that support embedding practice for timely and effective communication and information sharing relating to patient discharge process however no single specific training to outline expected standards in place that is monitored.		

Further Action h) Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Senior Nurse Quality Assurance and Practice Development	October 2023
Recommendation 9		
The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.		
Health Board Action(s)	Responsible officer	Timescale
There are a range of current practices in place in relation to the documentation of inpatient MDT meetings which are supported by admin roles. Further Actions as per recommendation 6.		
Recommendation 10		
The health board must ensure that adequate administrative support is available within inpatient mental health units.		
Health Board Action(s)	Responsible officer	Timescale

All Inpatient Wards are supported by Ward Clerk roles. A recent Quality Improvement project was undertaken by the MH/LD Directorate to focus on releasing Ward Management time spend on admin tasks. This led to a pilot of a new band 4 admin role to complement existing band 2 Ward Clerk roles. Further Action i) Full roll out of Band 4 Admin roles to ensure consistent cover across all wards.	Business Support Manager	September 2023
Recommendation 11		
The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.		
Health Board Action(s)	Responsible officer	Timescale
Mechanisms to prompt patient, family, carer and/or advocate views to inform inpatient care and discharge plans are incorporated within Care and Treatment Planning process and within the Comprehensive Assessment Tool and guidance. The Electronic Patient Record has functionality to enable sensitive information (potentially provided by patients, family, carers) to be recorded separately. All inpatients are offered advocates on admission which is documented in the Electronic Patient Record and routinely monitored by the MH/LD Directorate. Quarterly reports to provide assurance on practice surrounding the offer of advocates are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures. Advocates regularly visit wards and participate in Ward Review/MDT Meetings.		

Inpatient services operate a 'named nurse' model which promotes engagement with patients, family, carers and / or advocates to inform person-centred care planning. Inpatients are allocated a community Care Co Ordinator prior to discharge to support discharge planning. We will develop an auditing mechanism to routinely audit records to be assured that family carers and advocates are able to provide their views to inform inpatient care and discharge planning. Further Actions as per Recommendation 7.		

Recommendation 12
The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.

Health Board Action(s)	Responsible officer	Timescale
Crisis plans are jointly developed between ward/community staff (CMHT/CRHT), patients, families / carers and /or advocates through discharge planning and cover plans for the next 7/14 days including 72 hours follow up (by who and when), medication /crisis numbers and details of any other actions agreed. A Service User information leaflet to support person centred crisis planning has been developed and is currently being piloted. Comprehensive Assessment Tool (CAT) and Care and Treatment Plans (CTP) are reviewed and updated at transfers of care (including discharge from inpatients).		

An updated Care and Treatment Planning review tool has been developed and is in the process of being implemented. The tool is incorporated within the Electronic Patient Record and is covered within CAT Training and guidance. Older Adult Mental Health Services have a Clinical Risk Management Lead monitoring high-risk presentations and transitions (admissions/discharges) to support & upskill Care Coordinators. Further Actions as per recommendation 7.		
Recommendation 13		
The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.		
Health Board Action(s)	Responsible officer	Timescale
A discharge checklist is in place across MH/LD inpatient services. This is completed during the discharge process to record information associated with the completion of discharge tasks and notifications. Once complete this is scanned and uploaded to the Electronic Patient Record. Further work to strengthen assurances around consistency and effectiveness of this process will be undertaken through the below actions. Please see overarching Clinical Audit Action (Recommendation 34) Further Actions as per Recommendation 7.		

Recommendation 14		
The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Please see response to recommendation 13. The health board has a daily bed conference (twice daily Monday – Friday), originally established in the pandemic and now an embedded process, to review and proactively manage bed utilisation, availability, access and discharge which has MH/LD directorate wide multi-disciplinary input from services across admission and discharge pathways, MH/LD commissioning roles and multi-agency representation (including Police and Local Authority reps). Action notes are made and shared following bed conferences to ensure communication of key outcomes. Electronic Patient Records are updated with patient specific information. Older Adult mental health services also participate in additional discussions about regional admission needs across daily Acute Pathway Meetings (Multi Agency and Health Board wide). MH/LD Inpatient Senior Nurse roles and the Out of Hours Clinical Coordinator provide additional support with coordination of discharges in more unusual circumstances. Further Action as per Recommendation 6 and 7.		
Recommendation 15		

The health board must provide assurances on the arrangements in place to ensure that patients have access to inpatient beds when required and the mitigations against risks associated with using beds already allocated to other patients who are on section 17 leave.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Please see response to recommendation 14 in relation to bed conferences and daily Acute Pathways Meetings. MH/LD Inpatient Senior Nurse roles and the Out of Hours Clinical Coordinator lead on coordination of risk based MDT decisions in the event of contingency plans needed for patients that require return to hospital from leave. Escalation processes are in place to support out of area bed / placement requests. Use of out of area placements by the MH/LD directorate are low. Further Action j) Strategic review of bed utilisation to inform prediction / trajectories of future need, support removal of delayed transfers of care, to enable service planning and responsiveness.	Director of Mental Health and Learning Disabilities	December 2023
Recommendation 16		
The health board must ensure arrangements are in place to allow for regular discussions between inpatient and community teams in relation to patient flow in and out of the inpatient units.		
Health Board Action(s)	**Responsible officer**	**Timescale**

Please see response to recommendation 15.		
Recommendation 17		
The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.		
Health Board Action(s)	**Responsible officer**	**Timescale**
The health boards policy on Discharge and Transfer of Care incorporates definitions and guidance on delayed discharges. Delayed discharges in MH/LD directorate are operationally reviewed at a service level through the daily bed conference process referenced in the response provided to recommendation 15. Delays are identified and actions to address delays are agreed and reviewed with escalation as needed. Monthly reports of delayed transfers of care are produced and reported to the MH/LD Business Planning and Performance Assurance Group. Further Action as per Recommendation 15.		
Recommendation 18		
The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.		

Health Board Action(s)	Responsible officer	Timescale
The health board has a Health Records Management Strategy and Health Records Management Policy, currently under review, which are accessible to all staff on the health boards policy and procedures sharepoint site which includes management and storage of paper records. A central storage facility is in place along with an electronic process for retrieval and tracking of paper clinical records. A number of paper clinical forms are still in use within inpatient mental health services for example NEWS charts, medication charts, MHA paperwork, MFRA falls assessments and Post falls review, Oral Risk assessment, PSPS, Observation and engagement charts. These are scanned on to the Electronic Patient Record system for access on completion or on discharge. Further work is needed to support full transition to paper free clinical records across the MH/LD Directorate. Further Actions k) Develop procedural guidance and standards for uploading paper records to the Electronic Patient Record across the MH/LD Directorate l) Scope actions needed to implement full transition to paper free clinical records across the MH/LD Directorate and feed into the health boards digital strategy work.	Senior Nurse Quality Assurance and Practice Development Assistant Director of Nursing MH/LD	August 2023 September 2023
Recommendation 19		
The health board must provide assurances on the electronic patient clinical records systems in place, within its mental health services, to allow for essential information to be shared electronically between inpatient and community services.		

Health Board Action(s)	Responsible officer	Timescale
The MH/LD Directorate operates a consistent Electronic Patient Record (Care Partner) across all of its services. The system allows access to contemporaneous records across inpatient and community services and has business continuity plans to guide staff in the event of system outage. Further Action m) Development of process to enable timely access of clinical records for temporary staff eg temporary staff log ins that are issued locally.	Assistant Director of Nursing MH/LD	November 2023
Recommendation 20		
The health board must implement actions to mitigate against risks associated with staff from different teams being able to accessing patient information in a timely manner.		
Health Board Action(s)	Responsible officer	Timescale
Access to Care Partner is overseen by the MH/LD Directorate. Access to information is immediate to all teams in all locations when it has been added to Care Partner. Further Action as per Recommendation 19.		
Recommendation 21		

The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010.		
Health Board Action(s)	Responsible officer	Timescale
Details of discharge plans, including 72 hour follow up are included in discharge Care and Treatment Plans. The inpatient Discharge Checklist includes the need to check and record that discharge notifications have been completed and shared with relevant people. METeD, a system that digitally transfers discharge notifications and details of medication on discharge to GPs is currently being piloted for full roll out across the MH/LD directorate. Standard templates for discharge letters are in place. These require review to ensure they are reflective of NICE guideline standards for Transition between inpatient mental health settings and community or care home settings (NG 53). Work to strengthen assurance of consistency in quality and timeliness of discharge letters and discharge summaries being shared is required. Feedback indicates a regular theme of these not being shared in a timely way. Patient information leaflets outlining rights to re-refer are in use. Scrutiny of trends in cases that re-refer to services and referrals from GPs that could have re-referred themselves under the Mental Health (Wales) Measure 2010 is undertaken through the MH/LD Legislation Scrutiny Group. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)		
Recommendation 22		

The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.

Health Board Action(s)	Responsible officer	Timescale
Please see response to recommendation 21. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)		

Recommendation 23

The health board must ensure that discharge summaries are completed and sent out to a patient's GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.

Health Board Action(s)	Responsible officer	Timescale
Please see response to recommendation 21. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)		

Recommendation 24

The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Planning for 72-hour contact is undertaken as part of the Care and Treatment Planning process for discharge alongside crisis planning. Please see response to recommendation 12. There is no current system to routinely track and monitor compliance with 72 hour follow up. Previous audit gave good assurance of consistent achievement of this standard. There are no current learning themes from reviews or feedback in relation to 72 hour follow up. Further work is needed in this area to ensure documented standards and to strengthen routine assurance. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)		
Recommendation 25		
The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.		
Health Board Action(s)	**Responsible officer**	**Timescale**
MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts.		

Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions n) Review the health boards safe staffing escalation process to ensure this is fully reflective of processes across the MH/LD directorate. o) Review application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services. p) Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation. q) Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	All Assistant Director of Nursing MH/LD	July 2023 September 2023 November 2023 December 2023

Recommendation 26		
The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.		
Health Board Action(s)	Responsible officer	Timescale
The MH/LD directorate currently utilises monthly reports on caseload activity and referral rates to monitor capacity needs across community teams at a service level as well as Care and Treatment Planning compliance. A caseload weighting tool is in place, intended for use at a team level within management supervision where discussions about caseload take place and clinical documentation is reviewed and audited. Further work is needed to gain assurance surrounding the use and effectiveness of the caseload management tool. Vacancies are being evaluated to ensure staff are utilised and recruited to the areas required. Staff vacancies have been moved between teams to support areas with higher levels of referrals and care coordination. The impacts of vacancies on service capacity is held as a risk on service level risk registers for specific teams. (Risk 1612) There are currently no delays with allocation of care coordinators. An escalation process is used to highlight and promptly address delays as they occur. There are known breaches to the current 28 day standard for routine assessments of referrals into Adult CMHTs. Breaches are reported to the MH/LD directorate Mental Health Legislation Group which is overseen by the health board Mental Health Legislation Committee. All referrals are screened through a Duty System to review urgency which involves direct contact with the patient.		

There are no OAMH waiting lists associated with referrals to CMHT. Further Action r) Review application of MH safe staffing principles and version 3 of All Wales Staffing Levels for use across community teams. s) Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	Assistant Director of Nursing MH/LD Adult Mental Health Head of Service	September 2023 September 2023
Recommendation 27		
The health board must ensure CRHT's have appropriate facilities to allow staff to undertake the full requirements of their roles.		
Health Board Action(s)	Responsible officer	Timescale
The MH/LD Directorate has an established Accommodation Strategy Group that meets monthly. Its remit is: • To ensure that services experiencing the greatest demand and growth are able to access suitable estate. • Govern and oversee the repurposing of current MH&LD estate to minimise impact on service delivery. • Improve access to accommodation to enable sustainable service provision in order to increase efficiency and maximising clinical time. • Ensure MH&LD accommodation is safe and appropriate in which to delivery therapeutic/clinical interventions.		

• Act as the point of escalation for risks, issues and actions to the MH/LD Business Planning and Performance Assurance Group. • Progress appropriate Capital bids in collaboration with partner agencies and ensure MH&LD Estate is included in Health Board maintenance and refurbishment schedules. • Report formally, regularly and on a timely basis to the MH&LD BP&PAG on options, plans and progress relating to the Group's activities. • Ensure appropriate escalation arrangements are in place to alert the Hywel Dda University Health Board (HDUHB) Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of HDUHB. • To monitor the completion of Point of Ligature Audits, ensuring they are reviewed and completed in a timely manner. • To receive the requests for environmental improvements required and agree a prioritisation process for completion of essential works. CRHT services have identified a current risk in relation to being able to access space within emergency departments which is held on the service risk register. Progress has been made with now just one locality to be resolved. Further Action t) Resolve CRHT access to space within all emergency departments.	Adult Mental Health Head of Service	July 2023
Recommendation 28		
The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.		

Health Board Action(s)	Responsible officer	Timescale
Please see responses to recommendation 6 and 7. Further Actions as per Recommendation 6 and 7 Please see overarching Clinical Audit Action (Recommendation 34)		

Recommendation 29
The health board must take action to ensure there is sufficient medical capacity across all mental health teams.

Health Board Action(s)	Responsible officer	Timescale
Actions to ensure sufficient medical capacity across all mental health teams are ongoing within the directorate and active approaches to recruitment and retention are underway through active and frequent review of medical vacancies at the MH/LD Directorate Business Planning and Performance Assurance Group (BPPAG) and Workforce Group, targeted, refreshed, national recruitment campaigns, provision of relocation packages, implementation of a Clinical Fellowship Model, post graduate development support. The MH/LD Directorate holds a risk on its risk register in relation to sustainability of the medical workforce across the MH/LD Directorate (Ref 1525) in response to difficulties and challenges experienced in recruiting doctors and retention risks associated with the age profile of the existing Consultant workforce. The risk is currently mitigated through service awareness and plans to manage impacts through service level risk registers, recruitment, and development of complimentary workforce (for example Advanced Practitioners and introduction of Physicians Associate roles), implementation of an escalation process in the		

event of medical deficits and through attendance at HEIW Workforce Meetings. The risk is reviewed and updated regularly. Further Action (q) as per Recommendation 25		
Recommendation 30		
The health board must ensure therapies staff working within its mental health services have sufficient facilities to enable them to undertake the full requirements of their relevant roles.		
Health Board Action(s)	Responsible officer	Timescale
The MH/LD directorate currently holds service level risks on its risk register in relation to the quality and capacity of its estate to deliver services (Risk 839 and 1260). An Accommodation Strategy Group meeting has been established within the MH/LD directorate with the Property Team, IT and Heads of Service to maximise current capacity and source potential solutions. (Please see response to recommendation 27). Arrangements with private providers are in place to hire suitable venues in which staff can deliver therapeutic interventions. The health boards Occupeye system has been used in key areas and data analysis is informing discussions to maximise space optimisation. The MH/LD directorate are engaging in all known developments across the three counties. Mapping work continues across MH/LD properties in terms of capacity, fit for purpose and condition completed.		

Greater consideration of digital formats for delivery of services is being made and supported through regular meetings with the Digital Director and Informatics team. We will work with the HB digital strategy team to ensure there is a specific focus on developing digital services for mental health services.		
Recommendation 31		
The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.		
Health Board Action(s)	Responsible officer	Timescale
Capacity and demand work across mental health therapy services is underway to strengthen capacity where needed and develop flexibility in use of skills. Therapy workforce plans are in place across each MH/LD service speciality. Current deficits as a result of being unable to recruit to specialist psychology roles is held as a service level risk (Risk 138). Mitigations and actions include: -Cross Directorate cover to ensure that there is no inequity in the availability of services across both specialities and localities. -Upskilling the wider multi-disciplinary workforce to deliver interventions under the supervision of psychology and psychotherapy and use of CBT Therapy roles. -Continued efforts to recruit to psychology roles and plans for a ‘grow your own’ scheme coming into place during 23/24 for 3 funded places on the Clinical Psychologist programme. Waiting lists are frequently reviewed to identify and reassess individuals and 'Keeping in Touch' processes are in place. A continued focus on recruitment and retention to include therapy roles across MH/LD directorate will be undertaken through the MH/LD Workforce Group.		

Further Action (q) as per Recommendation 25		
Recommendation 32		
The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.		
Health Board Action(s)	**Responsible officer**	**Timescale**
A range of developments to ensure that MH/LD directorate inpatient and community mental health staff have the appropriate knowledge and skills to effectively undertake their role are being undertaken including delivery of training to support risk assessment and suicide prevention through WARRN and STORM training. Further work is needed to provide a systematic approach to this to ensure needs are fully assessed and gaps identified, sustainable methods of provision planned and mechanisms for monitoring applied. Further Action u) Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Assistant Director of Nursing MH/LD	November 2023
Recommendation 33		
The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.		

Health Board Action(s)	Responsible officer	Timescale
The Psychological Wellbeing Service is widely promoted by team leaders via Workforce Advisers monthly sickness absence catch up meetings with Team Leaders and during sickness absence meetings and through completion of All Wales Sickness Absence Training. Regular 1:1 meetings are held with managers and the workforce operational team advisers, ensuring appropriate wellbeing advice is given on a case by case basis so they can cascade this information to their staff members. Managers are supported to actively engage and refer staff to Occupational Health for appropriate support. Further Action v) Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to include consideration of effective communication mechanisms that will gather feedback to inform, shape and promote wellbeing support.	MHLD Directorate Triumvirate Management	March 2024

Recommendation 34
The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.

Health Board Action(s)	Responsible officer	Timescale
Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group.		

Further Actions w) Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- - Testing assurance of consistent implementation of CAT and Physical Health Screening - Testing assurance of appropriate completion of WARRN - Routine reporting and monitoring of compliance with routine offer of carers assessments - Audit of compliance with Ward Round (MDT Review) standards - Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards - Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans - Testing assurance of the quality of discharge letters - Routine reporting and monitoring of compliance with 72 hour follow up x) Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme. y) Training of relevant staff to be provided in order to utilise Audit and Management and Tracking (AMaT) once clinical audit programme has been agreed z) Update reports on progress of the clinical audit programme to be provided to MHLD QSEG in order to provide oversight on outcomes.	Associate Medical Director MH/LD Consultant Nurse, MHLD Consultant Nurse, MHLD Consultant Nurse, MHLD	December 2023 December 2023 December 2023 March 2024
Recommendation 35		

The health board must ensure that there is a robust and sustainable audit action management plan in place within its mental health services, to ensure actions are monitored and to assure itself that implemented improvements are being sustained.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Please see overarching Clinical Audit Action (Recommendation 34)		
Recommendation 36		
The health board must ensure arrangements are in place to routinely review and update mental health policies and procedures, which includes sharing any updated documents with all staff across the mental health services as a whole.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Written Control Document Group exists to review all new policy and procedural documents and to systematically review and update existing polices. Developments are shared via Global Emails and through Forums such as Ward Manager, Community Manager and Professional Nurse Forums. Further Actions		
aa) Strategic review of forward plan for written control documents across MH/LD services for 2023/24 to identify co dependencies and establish integrated planning and development for documents that span pathways and services.	Assistant Director of Nursing MH/LD	September 2023
bb) Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated	MHLD Directorate Triumvirate Management	March 2024

approach to embedding lessons, promoting safety culture and sharing practice and policy updates.		

Recommendation 37		
The health board must ensure that risk registers are routinely reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Risk Management Framework and Risk Management Strategy in place, which were reviewed and updated 2022/23. These are supported by a series of process and procedural documents available to all Health Board staff via the Assurance and Risk webpage on the staff intranet site. The Assurance and Risk Team support the wider Health Board in terms of risk management and risk training by way of a business partnering approach. The MH/LD Directorate has access to an Assurance and Risk Officer, who is certified with the Institute of Risk Management (IRM), and provides monthly risk reports from Datix via MHLD QSE and BPPAG meetings which are attended by all Heads of Service as well as Directorate leads. The Assurance and Risk Officer also provides risk management training in terms of technical risk management as well as the use of the Datix system to key staff within the Directorate. Risks are scrutinised by Executive Directors via departmental Improving Together sessions which commenced in January 2023. Further Action cc) MH/LD Directorate to hold a "risk workshop" in order to review and challenge where necessary the existing risks on the risk register to ensure mitigating actions, milestones and expected outcomes are clearly articulated.	Triumvirate Management / MHLD Assistant Directors	July 2023

Recommendation 38		
The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.		
Health Board Action(s)	**Responsible officer**	**Timescale**
Social Worker identified incidents are currently reported on Datix via health board managers as direct system access is not currently in place. Further Action dd) Review options for enabling Social Workers who provide a service on behalf of the health board to have direct access to DATIX, establish a process to implement this which includes routine access to DATIX for all new Social Workers joining mental health teams and processes to amend access when moving or leaving the team. Identity existing Social Workers to set up system access and training to enable full use of DATIX and feedback mechanisms within the system.	Assistant Director of Nursing MH/LD	July 2023
Recommendation 39		
The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.		
Health Board Action(s)	**Responsible officer**	**Timescale**

The health board has an Incident, Near Miss and Hazard Reporting Procedure and dedicated SharePoint site which can be accessed by all staff. The procedure details roles and responsibilities within the incident management process which for incident mangers includes ensuring feedback to staff who have raised the issue and reported an incident. This includes staff who may have raised concerns through the Speak Up Safely Process. A feedback mechanism is incorporated within the DATIX system which facilitates direct feedback to the incident reporter following the incident review process. Performance against the incident management process is reported and tracked through a board wide performance dashboard which is accessible to all staff via the health boards intranet. Incident management performance is overseen at a directorate level by MH/LD Business Planning and Performance Assurance Group and at a board level through Exec Led Quarterly Improving Together sessions with each directorate leadership team. Standards of system completion are addressed through ongoing engagement with incident reviewers, training and via Ward Manager and Community Manager Forums. MH/LD directorate level incident themes and trends are reviewed by the MH/LD Quality, Safety and Experience Group. Further Action ee) Amend the service line reporting template for MH/LD Quality, Safety and Experience Group to include service line data in relation to incident management process to strengthen consistency of reporting, oversight and monitoring of compliance with Datix incident management and feedback process.	Assistant Director of Nursing MH/LD	July 2023
Recommendation 40		
The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.		
Health Board Action(s)	Responsible officer	Timescale

Improvement planning meetings are facilitated by the Quality Assurance and Practice Development Team as standard following completion of all Level 4 and 5 incidents which include senior stakeholders and services involved. Where needed, follow on review meetings are also booked to review and ensure implementation. Further cascade of learning and consistent embedding of actions are delegated to service managers for operational implementation. Forums including Ward Manager, Community Manager, Professional Nurse Forums are used to discuss themes from learning and communication methods such as 7 minute briefings are used where wide cascade is needed. Further Action ff) Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	MHLD Directorate Triumvirate Management	March 2024

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Rebecca Temple-Purcell

Job role: Assistant Director of Nursing Mental Health & Learning Disabilities

Date: 5 May 2023