

Inquiry into Suicide Prevention

Ymchwiliad i Atal Hunanladdiad

Ymateb gan Bwrdd Iechyd Prifysgol Hywel Dda

Response from Hywel Dda University Health Board

Mental Health and Learning Disabilities Directorate

Quality Assurance and Practice Development Team

Clinical Governance Framework including learning from untoward incidents.

The Mental Health and Learning Disabilities Directorate within Hywel Dda University Health Board (MHLDD HDUHB) have carried out a thematic review of all the Untoward Incidents (UI) reported and investigated within the Directorate from April 2016 to the current date. The themes identified have informed a work plan for the Quality Assurance and Practice Development Team (QAPDT). The QAPDT was formed in January 2017 with a remit of service improvement, learning from events with a robust mechanism for assurance of implementation of the lessons learned and sharing of good practice across all teams.

The team have led on benchmarking the incidents as described above against the National Confidential Inquiry Suicide Homicide 2016 20 year review which provided Quality/Safety Standards for organisations. These standards were set with an evidence base that demonstrated through adopting these standards organisations reduced the levels of suicide within their organisation. The QAPDT has benchmarked their local findings against these standards and generated an action plan to address areas for improvement in service provision/standards as well as share good practice across teams.

The mechanism for engaging staff at all levels of the organisation has been established and is being rolled out in a phased approach across the directorate. This includes Quality Assurance and Practice Development workshop sessions/clinical governance meetings which are attended by local team leader and clinicians on a monthly basis. The teams are engaged in contributing to improvements within services such as written control documents, audit development and compliance, spot checks and developing clinical excellence in line with NICE guidance and local and national lessons learned.

The QAPDT focussed upon managing the investigations in line with the Welsh government expectations in relation to timeliness of completion (60 days) as well as the improved quality of the investigation process and final report. In house training has been delivered to investigators and the approach to investigations has proactively engaged staff from all disciplines and levels as well as carers and families as appropriate.

Further information relating to the development of this process is noted below as it is noted within the quality/safety standards of the NCISH 2016 that those Trusts/Health Boards who implement a robust way of managing UI's have reduced incidents of suicides due to the learning effect.

The implementation of learning and assurance associated with this has identified a gap in data collection and resource available to analyse the themes of the audits. This is being taken forward as a business proposal to the Senior Management Team.

The regional fora for suicide and self harm prevention is being actively attended by the Head of Nursing for MH&LD and the fora has been tasked with providing Welsh Government with a regional action plan to Welsh Government as to how the Suicide and Self harm Strategy will be implemented in early 2018. Following this a local forum co chaired by Health (Head of Nursing MHL) and Local Authority (Head of Service) leaders is being established within the HDUHB area. This will create an action plan at a local level which will include key stakeholders including carers, service user representatives and 'first responders' in order to address local priorities such as identifying and reducing the means to suicide locally such as bridges, railways, multi storey buildings. This will be linked in with the partnership groups already in operation.

### Themes for learning

Action plans from investigations closed since April **2016** have been reviewed and actions are underway and monitored through the local quality assurance meetings which have been set up as part of the clinical governance structure. The themes which have emerged are as follows:

1. **Carer involvement** at assessment and risk management planning;
2. **Quality risk assessment and contingency planning** (issues around accuracy of risk assessment, no or insufficient contingency planning, actions taken by teams (i.e. discharge) do not correlate with risk identified)
3. **Documentation** (rationale for decision making and MDT discussions, accuracy and timelines of CTP etc)
4. **Clinical interventions** and access to psychological therapies (little or no evidence of interventions by staff teams, pathway unclear/waiting lists etc)
5. **Discharge/DNA/engagement process** (unclear **rationale** for discharge, opt in letters and DNA following with immediate discharge even though significant risk identified).

### **Carer involvement at assessment and risk management planning;**

Investors in Carers Workshops continue to be held with excellent uptake from teams. All inpatient wards are on track to achieve their Bronze award by January 2018. Some wards are working towards their Silver award.

Community teams are making progress with achieving the Bronze award and some have already achieved this.

The Triangle of Care is currently being piloted in a Crisis Team and an Older Adult Inpatient Unit to be rolled out after review of the pilot during April 2018. This includes assessment of carer needs and identifying a 'care plan' for the carer themselves. Joint work with non statutory provider is in place.

The 15 Steps Challenge is being rolled out with the first challenges having taken place on acute mental health wards. An engagement event is taking place in early December to encourage more carer and service user representatives to sign up and join the challenge team from across MH and LD services. This event is being supported by local non statutory providers although led by HDUHB. The 15 steps challenge is part of the governance framework adopted from NHS England as good practice. The

challenge has derived from a carer's experience of walking into a ward and 'sensing what kind of care her daughter would receive within 15 steps of walking into the ward'. This experience has been translated into a toolkit which prompts questions of the challenge team which is made up of service user/carer representatives and senior staff from the organisation with a view to provide constructive feedback from a service user/carer perspective.

This event is being organised by QAPDT and will form part of the governance arrangements around service user and carer representatives visiting wards. Further dates for 15 steps will be set after this training is completed.

An Audit tool for documentation review has been developed (further detail under 'documentation' and begun roll out in September 2017 which captures carer involvement in Care and Treatment Planning (CTP) process.

Consent to share and confidentiality processes workshop is required to provide clarity and improve confidence of staff in this area.

### **Quality risk assessment and contingency**

WARRN Training – There has been an increased promotion of risk management training with an assessment of need for priority areas to take this training. There has been 100% increase in WARRN training of clinical staff across teams with a plan to roll out further over the coming two years.

Training and support is offered on a team by team or individual basis when in relation to the use of care partner where requested.

STORM training is available to staff which is prioritised for crisis team staff and trainers require an update in the training they are delivering in line with the latest version of STORM.

### **Documentation, CTP and Care partner**

Training/workshops have been carried out for teams in relation to CTP and Care Partner.

In response to lessons learned from incidents, audits and inspections and in agreement with managers through QA forums, the monthly audit for case records has been agreed to be reinstated.

The monthly audit has been updated to reflect timeliness as well as quality of documentation standards against the Delivery Unit, Health Inspectorate Wales and MHA Measure (2010), lesson learned, service user, carer and staff feedback. A workshop session has been delivered to operational managers to ensure clarity of standards within the audit and consistency in their individual assessments.

This has been rolled out across Adult MH community teams since October 2017 with the remainder of the directorate being rolled out in a phased approach. Quality assurance meetings will monitor compliance, performance and improvement plans.

This audit will be carried out monthly and provides immediate results to the team leader.

The audit auto populates graphs and charts for prompt analysis and review in conjunction with Audit department.

The workload that this is generating will require review and additional corporate team support.

### **Clinical interventions**

One CRHT in a rural setting has carried out a focussed piece of work in order to raise awareness and confidence of staff in the use of clinical interventions such as emotional coping skills and crisis management and seen a marked reduction in the number of referrals made to TDS. There is agreed consultation advice and support being provided by TDS. This will be rolled out across all teams and needs analysis for skill development is required.

Training needs analysis required and the Head of Nursing is in process of re-evaluating the mandatory training requirements of staff groups and roles as well as the reporting and monitoring structures of said training.

### **National Confidential Inquiry for Suicide & Homicide**

The learning from the investigations has been benchmarked against quality/safety indicators recommended within the 20 year review. An action plan has been formulated and presented to QSEASC in September 2017. This is a high priority piece of work. Local teams are being made aware of common themes and actions required through QAPD meetings and some pro active work has already been rolled out in Ceredigion and Llanelli. All work streams carried out by the QAPD Teams are informed by lessons learned and pro active improvement.

### **There are a number of work streams underway in relation to learning from events:**

#### Investigation process

The process for managing the investigation process has been refined with significantly shorter turnaround on investigations than there has been historically. The investigation process now includes clinical teams, carers and implementation of lessons learned. The quality of the investigations has improved with recommendations and actions being embedded into practice.

The clinical governance structure now in place across adult mental health services sets the framework for review and implementation of the actions.

Immediate assurance/improvement actions have begun to be taken as a result of incidents occurring. The immediate actions during quarter 1 consisted of:

- Circulation of relevant policies and procedures to teams with a request for assurance that all team members had read and understood;
- posters displayed in relevant clinical areas;
- training arranged as required; and
- spot checks following the awareness raising.

Spot checks are being carried out in responses to lessons learned and a planned audit and spot check cycle is now in development.

#### *Investigation training*

There has been a request for additional training in RCA and investigation process for staff as there is a limited number of staff formally trained.

An in-house training programme was provided during September. Positive feedback has indicated further date is in the diary. With the staff trained, a rota system for completing investigations is being adopted for allocation and support from operational service leads. This has increased the pool of investigators for Serious Incident investigations. The team has developed a toolkit for all involved in the investigation process and actively engages the clinical teams to contribute to and engage in the lessons learned.

### **Training/workshops – delivered**

Investigation workshop – delivered to Medical staffing as part of the post grad session. This provided update on investigation process as well as a workshop session where medics scrutinised the documentation for current serious incidents investigations. This valuable continuation has been fed back to investigators of the cases. This is encouraging medical staff to be more involved in the management of investigations, understanding the lessons learned and implementing the action plans as well as role modelling good practice. Medics are engaged in developing the process further and supporting teams to improve standards within practice.

### **Quality Assurance meetings/workshops**

The Quality Assurance meetings are underway for Adult Services with positive feedback from teams. These meetings are being rolled out across the rest of the directorate over the coming year. These forums provide an opportunity for communication and discussions relating to clinical issues which have a direct impact upon the quality of the services being delivered and received.

During 2017 all localities have unscheduled care provision on a 24/7 basis. This provides an opportunity to prompt assessment and treatment in line with NSISH standard.

The police triage team is in place over a 4 day period currently with a view to progressing this further.

Joint working with general health colleagues has been agreed in order to develop a training package for general health nurses.

Joint working with general health colleagues in order to develop pathways and formal communication between services as well as transfer documentation. Risk assessment when there is a change of clinical environment and observation and engagement of patients on general wards to have an identified risk of suicide/self harm.

Roll out of co occurring substance misuse and mental health training is on schedule to be completed by April 2018.

The quality assurance meetings are part of a wider governance structure/framework which has been introduced across the directorate during 2017. The structure includes

a clinical incident review group, a written control document group, a patient experience, carer experience, a safeguarding and medication optimisation group. Communications are shared through these groups and into the Health Board channels.

## **Talk To Me 2: Suicide and Self-Harm Prevention Strategy 2015-2020**

In Hywel Dda we have made good progress towards the Talk To Me 2: Suicide and Self-Harm Prevention Strategy 2015-2020 (T2M2).

### **We have:**

- Met the requirement to attend the Regional forum over the last 3 years
- A plan to develop a job description and person specification for a Talk to Me 2 Coordinator to drive the work required from delivering the T2M2 strategy. Resources for this post are already being committed
- Committed to a delivery group on suicide and self-harm prevention in the early days of the LMHPB

### **Our challenge now going forward is to:**

- Engage with the Regional Partnership Board and the Health Board, and possibly the local health and well-being boards, to ensure high level commitment to drive the strategy and action plan
- Make sure those driving this work have the passion and resources to prioritise it and are able to bring the right people to the table to make the decisions required
- Local Mental Health Partnership Boards are responsible to report on action plans, supported by Regional T2M2 groups.

The Contact Detail for the Mid & South West Wales Chair: Robert Goodwin, [REDACTED] (PA). The National Advisory Group on suicide and Self-harm monitors progress, and produces an annual report. The Welsh Government monitors statistics on suicide and self harm rates, admissions to hospital and population mental health well-being scores. We can all work together to improve wellbeing. The strategy and action plan can be found at:

<http://gov.wales/topics/health/publications/health/reports/talk2>