AGENDA ITEM
6.2

QUALITY AND SAFETY COMMITTEE

Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lloyd Griffiths, Head of Nursing for CAMHS
Presented by	Lauren Edwards, Director of Therapies and Health Science
Executive Lead	Director of Therapies & Health Sciences
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
PALS	Patient Advice, Liaison Service
TL	Ty Llidiard Tier 4 CAMHS Inpatient Unit
YP	Young People/Person

HoN	Head of Nursing for CAMHS
iCTM	Improvement and Innovation CTM (Cwm Taf Morgannwg)
LSU	Low Secure Unit
NG	Nasogastric
PMVA	Prevention and Management of Violence and Aggression
PICU	Psychiatric Intensive Care Unit
WHSSC	Welsh Health Specialised Services Committee
NCCU	National Collaborative Commissioning Unit, part of WHSSC
HIW	Healthcare Inspectorate Wales
QAIS	Quality Assurance and Improvement Service
QI	Quality Improvement
SI NRI LRI	Serious Incident Nationally Reportable Incident Locally Reportable Incident

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide committee members with an update on quality, safety and experience matters in Ty Llidiard (TL), the Tier 4 CAMHS Inpatient Unit within Cwm Taf Morgannwg University Health Board (CTMUHB).

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 TL is in enhanced monitoring arrangements with WHSSC. The focus of the monitoring relates to concerns regarding the service specification and culture/leadership. Positive feedback continues to be received from WHSSC regarding the visibility and oversight of improvements at TL, as well as the reporting standards and progress being made.

2.2 TL was de-escalated to Level 3 monitoring by WHSSC in December 2022, with a clear pathway for future further de-escalation awaited.

3. Quality Assurance

3.1 Patient Safety Incidents (Oct-Dec 2022)

3.1.1 There were 36 incidents reported during this reporting period: 15 in October, 12 in November, and 9 in December.

3.1.2 32 (89%) of these incidents were assessed as being low or no harm, with 4 being assessed as moderate harm. No incidents we assessed as being above moderate harm (i.e. Severe or Catastrophic).

3.1.3 During December, there were no incidents relating to NG feeding. These type of incidents have accounted for the majority of incidents reported at TL over the last 2 years. The TL team are analysing this trend in order to understand the ongoing reduction in NG related incidents and whether this can be attributed to the improvements made in the clinical management of this client group.

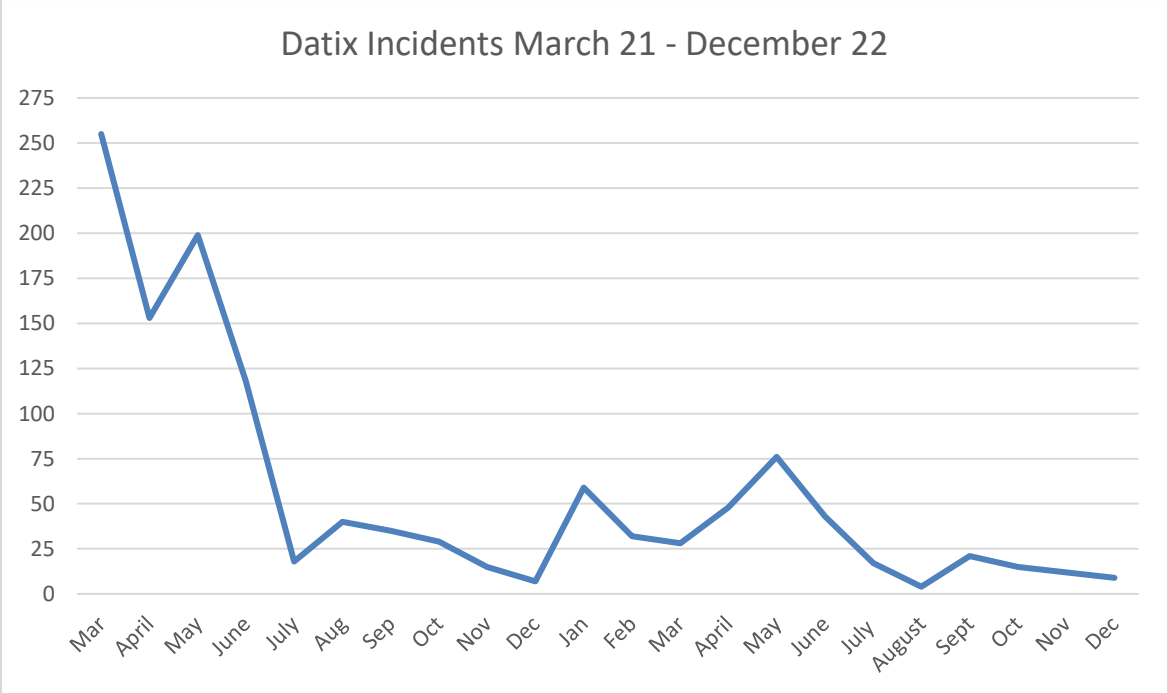


Table 1: Nine month summary of incidents by sub-type, grouped by severity and date reported

		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Total
None	Absconding or missing patient/service user	1	2	1	0	0	1	0	1	0	6
	Aggressive/threatening behaviour	1	0	1	0	0	1	1	0	0	4
	Anti social behaviour	0	0	0	0	0	0	1	0	0	1
	Breach of patient / service user confidentiality	0	0	0	1	1	0	0	0	0	2
	Consent process for examination or treatment not / inadequately followed	1	0	0	0	0	0	0	0	0	1
	Inappropriate behaviour / attitude	2	1	0	0	0	0	0	0	0	3
	Mental Health Act Administration	0	0	0	0	0	0	1	0	1	2
	Non-medical equipment	0	0	1	0	0	0	0	1	0	2
	Patient clinically challenging behaviour	1	0	0	0	0	0	0	0	0	1
	Patient/service user refuses / fails to take / discontinue the examination / treatment / medication.	4	4	1	0	0	0	0	1	0	10
	Physical assault (physical contact)	0	0	0	0	0	0	1	0	0	1
	Provision of diet (enteral)	7	15	3	2	0	0	0	0	0	27
	Restrictive practices	13	39	21	6	0	19	5	5	0	108
	Safeguarding - Child	1	0	0	0	0	0	0	0	0	1
	Self-harm / self-injurious behaviour	8	0	5	0	0	0	0	1	1	15
	Staffing	0	1	0	0	0	0	1	0	0	2
	Treatment or procedure issues	0	2	0	0	0	0	0	0	0	2
	Total	39	64	33	9	1	21	10	9	2	188
Low	Absconding or missing patient/service user	0	0	0	1	0	0	0	0	0	1
	Aggressive/threatening behaviour	0	1	0	1	0	0	2	0	1	5
	Contact with object or animal	0	1	0	0	0	0	0	0	0	1
	Harassment	0	0	0	1	0	0	0	0	0	1
	Healthcare Acquired Infection (community, primary care or hospital)	0	0	1	0	0	0	0	0	0	1
	Healthcare record	0	0	0	1	0	0	0	0	0	1
	Inappropriate behaviour / attitude	1	0	1	1	0	0	0	0	0	2
	Patient/service user refuses / fails to take / discontinue the examination / treatment / medication.	1	0	0	2	0	1	0	1	0	5
	Physical assault (physical contact)	0	0	0	0	0	0	0	0	3	3
	Provision of diet (enteral)	0	1	0	0	0	0	1	0	0	2
	Restrictive practices	0	1	0	0	0	0	0	2	0	3
	Self-harm / self-injurious behaviour	7	8	7	0	0	0	0	0	1	23
	Struck against or by an object	0	0	0	0	1	0	0	0	0	1
	Total	9	12	9	7	1	1	3	3	4	49
Moderate	Absconding or missing patient/service user	0	0	1	0	0	0	0	0	0	1
	Aggressive/threatening behaviour	0	0	0	1	0	0	1	0	1	3
	Clinical assessment, clinical diagnosis	0	0	0	0	1	0	0	0	0	1
	Environmental hazards / issues	0	0	0	0	0	0	1	0	0	1
	Physical assault (physical contact)	0	0	0	0	0	0	0	0	1	1
	Safeguarding - Child	0	0	0	0	1	0	0	0	0	1
	Total	0	0	1	1	2	0	2	0	2	8
Total		48	76	43	17	4	22	15	12	9	246

3.2 Complaints

3.2.1 There were no open or new complaints during this reporting period.

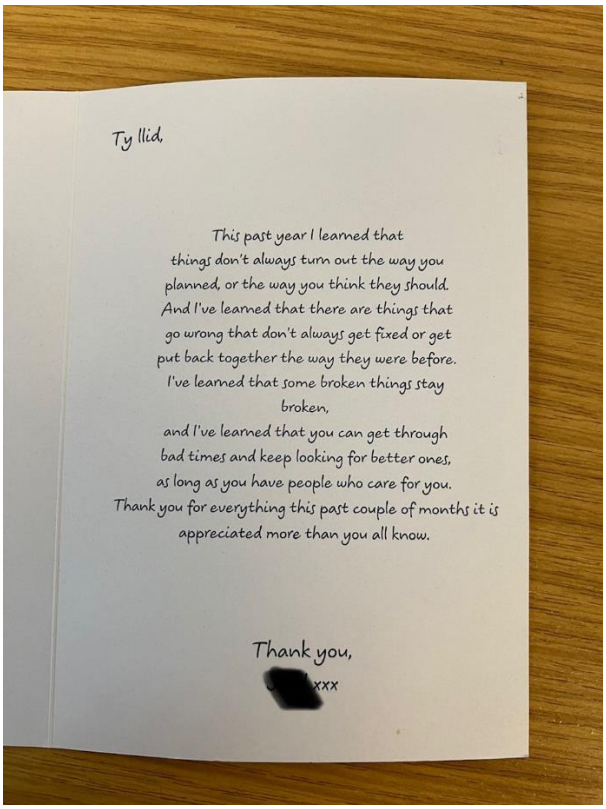
3.3 Compliments

3.3.1 Understanding the experiences of our YP and their families during their admission to TL is an important source of learning and the team are striving to increase feedback month on month.

Ty Llidiard Written Compliments

2022											
Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
2	3	1	3	4	5	4	4	3	2	4	5

3.3.2 Below is a compliment received from a YP who was discharged from TL in December (shared with permission). All compliments are shared with the team at Ty Llidiard. There is a board in the staff room where compliments are shared and a monthly newsletter for colleagues is being developed, which will include a compliments section.



Ty llid,

This past year I learned that
things don't always turn out the way you
planned, or the way you think they should.
And I've learned that there are things that
go wrong that don't always get fixed or get
put back together the way they were before.
I've learned that some broken things stay
broken,
and I've learned that you can get through
bad times and keep looking for better ones,
as long as you have people who care for you.
Thank you for everything this past couple of months it is
appreciated more than you all know.

Thank you,
[redacted] xxx

3.4 **Current open SIs (NRI or LRI)**

3.4.1 There were no new or open LRIs or NRIs during this reporting period.

3.5 Ombudsman complaints

3.5.1 There were no new or open Ombudsman cases during this reporting period.

3.6 Claims/redress cases

3.6.1 There were no new or open claims/redress cases during this reporting period.

4. People's Experience/co-production

4.1 The HON has been engaging with *Parents Voices in Wales* to create a forum where past service users and their loved ones can provide feedback and contribute to co-produced improvement initiatives. Positive feedback has been received about the approach being taken across Ty Llidiard and the willingness to listen to, value, and work with people with lived experience.

4.2 The TL team facilitate weekly community meetings (open to all YP on the ward) to seek the views of our YP on what is done well and what can be improved. These meetings continue to be well-attended by the YP and have resulted in valuable insights, including their experience of ward rounds, suggestions for activities, and how access to mobile phones can be improved.

4.3 During these meetings, suggestions have been made by the YP about the type of therapeutic activities that they would like to see delivered

at TL. This has led to the development of a co-produced Activities Timetable. This timetable is delivered by the newly created Activity Coordination team and therapies team. The activity co-ordinators are now supernumerary and there is evening cover. This ensures that opportunities for meaningful activity are consistent and protected. The timetable changes regularly in response to individual needs and the requests of the YP.

4.4 The YP requested Pet Therapy sessions; in response the TL education and activity teams arranged visits from alpacas and Cody the therapy dog. These visits are primarily recreational activities, however important links have been made with the potential for some of our YP to undertake work-type placements on the farm in the future.

4.5 It is anticipated that positive experiences of engagement and co-production gained by the YP during their admission will result in them being more confident and willing to support future co-produced TL service projects and recruitment processes following their successful discharge.

4.6 The HON continues to invite the family members of the YP admitted to TL to share to their experiences, feedback and suggestions for improvement. Several family members have expressed an interest in joining a future group of people with lived experience to help with TL's improvement journey in a coproduced way. The feedback received was that they would prefer to be involved after their loved

ones have been discharged from TL. As a result, business cards with contact details have been developed as a means of supporting keeping in touch.

4.7 The above progress represents an important development in TL's culture of openness, engagement and co-production and the commitment to embed the philosophy of "Nothing about me, without me".

5. Quality Improvement

5.1 Since August 2022, a quality improvement group has been established to develop and monitor the various pieces of quality improvement work being undertaken in TL. The group meets every Monday to discuss and review the ongoing improvements and changes that have been made or are in progress.

5.2 Nurses on duty, the Ward Manager, the Quality Safety and Risk lead, Locality Manager, Specialist Social Worker, Consultant Psychiatrists and Therapists are encouraged to attend so that there is a multi-disciplinary approach to problem-solving and decision-making. It is through this group that many of the improvements now in place have been identified and implemented. The ideas and changes discussed in this group are shared with the young people in their community meeting to seek feedback and input.

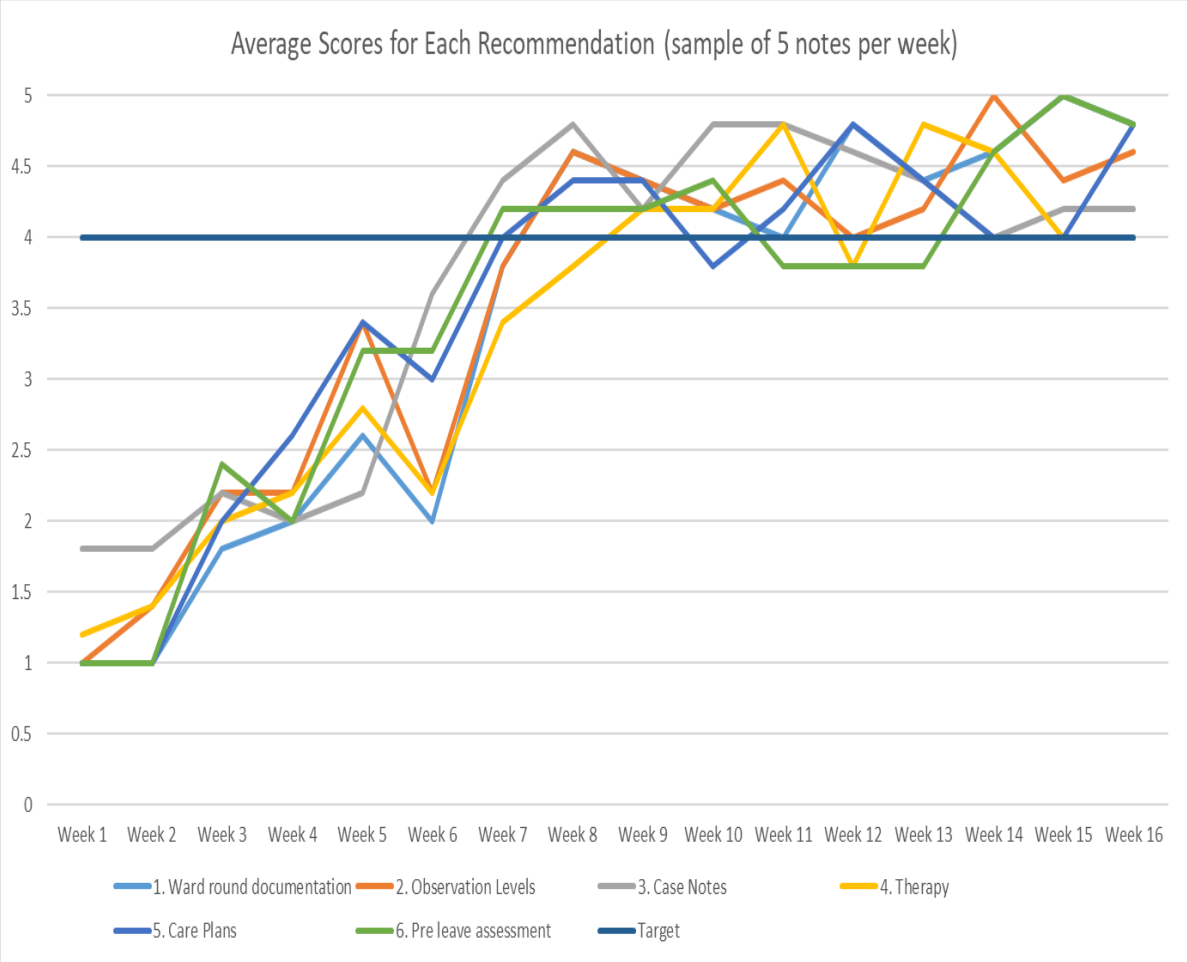
5.3 The improvements and initiatives that have been developed by the group are discussed and supported by the iCTM Team.

5.4 The TL quality improvement group has developed a QI measurement tool to monitor the 6 main areas covered in both the HIW and the QAIS Supportive Review in March 2022.

5.5 The QI measurement tool uses a 5 point Likert scale to assess the clinical documentation against the 6 recommendations. The target is to achieve an average score of 4 out of 5 for each of the 6 categories, and an average total score of 24 out of 30. A trajectory has been devised to achieve this by week 10 (currently in week 5). The audits will continue until there is adequate assurance that the improvements consistently are embedded in practice (minimum of 12 weeks after compliance).

5.6 The work has been well received by both WHSCC and NCCU. Members of QAIS attended TL in November 2022 for an unannounced visit. During the visit they checked the documentation improvements and were pleased with the progress, describing progress as "significant".

5.7 The average scores from the 5 sample sets of notes each week are outlined in the graph below. The TL team aimed to meet the improvement target by week 10, but actually met the target in week 7. The graph demonstrates that standards have been maintained.



6. Improvement Board

6.1 A monthly Improvement Board chaired by the Executive Director of Therapies and Health Science (DoTHS) continues to oversee the implementation of changes required to enable colleagues to

consistently deliver high quality care and the best outcomes and experiences for the YP and families we care for.

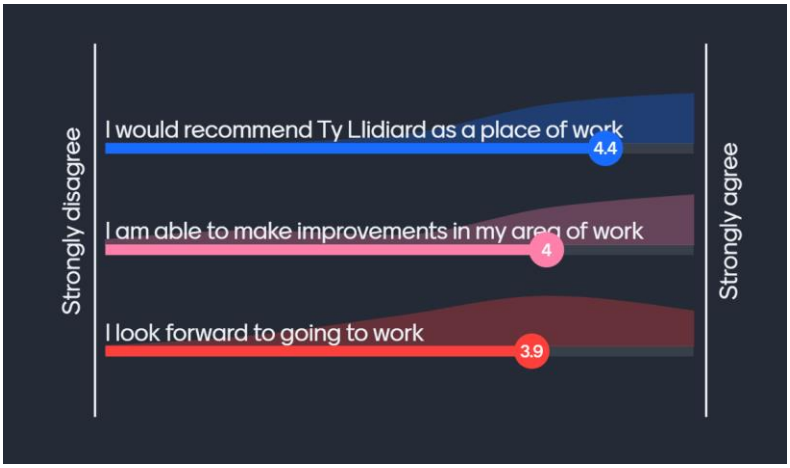
6.2 Monthly escalation meetings continue with colleagues from WHSSC, in addition to regular meetings between the CTMUHB and WHSSC executive leads for TL. Significant improvements have been made to the reporting format for the escalation meetings, resulting in ongoing positive feedback from WHSSC and de-escalation from level 4 to level 3 in December 2022.

6.3 Appendix 1 provides an overview of progress made against the Integrated Improvement Plan for Ty Llidiard. This improvement plan contains actions relating to the escalation status with WHSSC, along with wider improvements targets to ensure continuous service improvements for the benefit of our young people, their families, and our colleagues.

6.4 WHSSC have advised that they will provide a clear roadmap for further de-escalation for Ty Llidiard, until routine monitoring status is achieved. WHSSC have requested that QAIS undertake a piece of work to review referral and admission trends for Ty Llidiard. WHSSC colleagues felt that de-escalation to Level 3 was appropriate whilst this review was underway. The results of this review is expected in January 2023.

7. Colleague Experience

7.1 On 14th December 2022 the first of two "Team Ty Llidiard" away days were held, which included members of all staff groups from TL. The day included team information sharing and team building exercises. Colleagues were asked to complete a short online survey about working at TL. The results are below;



8. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

8.1 TL is in Level 3 escalation with WHSSC, who raised concerns in April 2022 regarding the Quality Assessment and Improvement Service (QAIS) report findings and progress in relation to the Escalation Action Plan. Although WHSSC remain assured by the progress being made, the scale and nature of changes required continue to require sustained support and focus within CTMUHB.

8.2 Changes to the clinical model within TL and improvements relating to leadership and culture within the unit have resulted in significant investment in clinical posts from a range of professional groups. Good progress continues against recruitment plans, but national shortages in some specialist areas pose an ongoing risk to recruitment.

8.3 As part of the improvement work within TL, changes to the layout of the unit have been suggested by the National Collaborative Commissioning Unit (NCCU). The senior leadership team have met with the Director of Quality and Mental Health/Learning Disabilities from the NCCU to explore what such changes could look like.

Phase 1 has been approved and will commence in January 2023. Phase 2 has been designed and costed at circa £700k, a SON has been completed and submitted but is as yet unapproved.

9. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)

Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care Dignified care Effective Care Individual Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required as no changes to service provision articulated
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Estates work suggested by WHSSC/QAIS will be associated with significant capital requirements
Link to Strategic Goals	Improving Care

10. RECOMMENDATION

10.1 Members are asked to **NOTE** the progress outlined in this report and the key risks identified

APPENDIX 1

Progress against Integrated Improvement Plan

Summary of progress and status of actions within the updated Integrated Improvement Plan est July

	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start	Total
Summary of all actions in Ty Llid plan December	19	12	13	0	5	49
Summary of all actions in Ty Llid plan October	13	18	12	0	6	49
Summary of all actions in Ty Llid plan September	8	28	4	0	7	47

Workstream theme: Caring and compassionate, safe and effective care					
	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
To ensure there is a comprehensive and robust multi-disciplinary clinical leadership team who will lead a multi-disciplinary workforce to best meet the needs of the young people and to support good patient experience and outcomes	4	1			
To embed a whole system approach to care and treatment planning and risk assessment and ensure these are up to date, coproduced, individual and person centred and meet the best practice guidelines as set out in the Mental Health (Wales) Measure 2010.	1		5		2
To create an effective MDT infrastructure to support daily review of care and treatment planning and inform therapeutic interventions	2	1	2		1
To ensure there are appropriate processes and policies that support safe and effective care delivery	2	1	4		
To create a training strategy to support all colleague to provide safe and effective care delivery	1		1		2
Total	10	3	12	0	5

Work stream theme: Calm and Confident Leadership and Culture					
	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
To create a psychologically safe environment where colleague feel that their voices are heard	2	2			
To create an ethos of collective and calm leadership where everyone takes responsibility for delivering safe, reliable and effective care for patients	3	2			
To cultivate a culture of openness, transparency and confidence where our values and behaviours are a lived reality for everyone	3	2	1		
Total	8	6	1	0	0

Work stream theme: Environment fit for purpose					
	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
The environment is safe for colleague and young people and is conductive to therapeutic care	1	3			
Total	1	3	0	0	0