Shared learning bulletin

Quality assurance review

Introduction

An assurance review was undertaken following several patient safety investigations at a Trust providing Child and Adolescent Mental Health Services (CAMHS). The review was aimed at examining the present-day situation; to assess whether, and to what extent, patient/client care is now being provided in ways compliant with current standards and expectations.

The review was split into two workstreams:

a) A practice audit of current clinical practice.
b) An audit of the Trust's governance of patient safety incidents, complaints and safeguarding events.

Audit frameworks were developed in collaboration with Trust staff, based on Trust policy and national guidance. The audit sample was based on criteria similar to those identified during the original patient safety investigations.

Key findings

A good level of assurance was found for:

- Clinical practice with CAMHS offered to complex cases
- Governance of quality concerns with the services
- Overall governance of quality within the services

The Trust has implemented substantial changes in service structure, practice and delivery in the past five years. This has included developing joint working practices with a neighbouring trust and local Integrated Care Boards (ICBs), overhauling its approach to complaints, patient safety incidents and safeguarding, and revising the service offer to young people. The Trust now offers:

- CAMHs crisis and liaison teams, operating 24/7, which offer short-term help and support.
- Intensive home treatment (IHT) teams, which work with young people to offer increased support at home, to prevent admission where possible, and facilitate discharge planning and home leave.
- Intensive Positive Behaviour Support (IPBS) multidisciplinary teams, working with young people who have a learning disability and or autism, and their families, to provide behavioural support following the positive behaviour support (PBS) framework.

Underpinning these changes is a change in organisational culture. Emphasis has been placed on joint working, sharing ideas, and creative and flexible thinking; all of which are aimed at improving the service user experience, and supporting them and their families. Our audit results indicate positive changes in this respect.

Clinical Care

Good practice included:

- Planning and implementation of transition arrangements for children moving to adult services.
- Discharge planning and communication between inpatient and community teams.
- Robust approaches to risk management, including risk formulation, documenting relevant information and involving the service user and their family.
- Robust care plans, detailing all areas of need and reflecting risk assessment; community care plans included evidence of formulation and psychological support.
- Listening to and involving young people and their families in their care.
- Regular multidisciplinary meetings, with prompt referrals and follow-up with other agencies/services.
- Implementation of trauma-informed practices, including recognition of key risk and protection factors for vulnerability and adverse childhood experiences.
- Identification and appropriate escalation of safeguarding concerns; attendance and engagement in child protection meetings.
- Appropriate documentation and responses to race, ethnicity, gender and religion, including any reasonable adjustments and preferences recorded.
- Detailed documentation of complex presentations, tailored care plans, and consideration of reasonable adjustments.

Governance of patient safety incidents, complaints and safeguarding events

The Trust demonstrated a robust approach to its governance of patient safety incidents, complaints and safeguarding events. It attributed the improvement in these workstreams to substantial and ongoing development work which included:

Patient Safety incidents

The Trust has an ongoing programme of work to support the implementation of the Patient Safety Incident Response Framework (PSIRF) and systems approach to investigations. There is no longer a backlog of incidents, and the Patient Safety team has made itself more visible across services e.g. routinely attending After Action Reviews (AARs). The Patient Safety team holds a monthly review meeting, looking at cases that involve other organisations, with a view to improving joined up working, reducing duplication and providing families with joined-up responses.

Complaints

The Trust has restructured its complaint service to place emphasis on local resolution, a change underpinned by an ongoing Trustwide complaint training programme. The Trust demonstrated a substantial reduction in the number of complaints being managed by the Complaints department, and in turn, an improvement in complaint response times.

Safeguarding incidents

The Safeguarding team has taken steps to make itself more visible to Trust services. The team attends and reports into several meetings; something identified as an effective means of facilitating dialogue with services. As part of the introduction of a new IT system, the team provides a one-day safeguarding training package, for which they have received positive feedback.

Learning Quadrant

The questions below are intended to support reflection on how the learning from this review could be applied to the reader's practice – whether that is in individual clinical work, or in wider governance and service/system management.

Individual/Team practice

- Have I involved the service user and their family in developing their risk assessment and care plan; are their views and opinions reflected?
- Have I ensured the risk assessment and care plan are tailored to the needs of the individual?
- Have I adopted a trauma informed approach to my practice?
- Have I kept detailed records of my meetings and assessments?
- Do I take an MDT approach to my cases, ensuring other teams and services are involved as needed?
- Have I offered psychological training and advice, as appropriate, to service user family members and carers?

Governance focused learning

- Does our governance structure enable easy reporting and tracking of complaints/safeguarding events/patient safety incidents?
- Is there sufficient monitoring of any changes in practice to the management of complaints, patient safety incidents and safeguarding?
- Are there effective mechanisms in place to test and challenge complaint responses to ensure they are comprehensive and address all points raised?
- Does quality assurance of patient safety incident investigations explore the methodology and analysis documented in reports?
- Are trust services able to maintain business as usual during substantial changes to IT systems?

Board assurance

- Are we assured that programmes of change are underpinned by robust training, appropriate resources, and support to practitioners and service leads?
- Are we able to demonstrate an effective reporting pathway from ward to Board; is there a mechanism and opportunity to explore concerns in detail?
- Are we assured that our management of complaints, safeguarding events and patient safety incidents is in line with expected practice?
- How are we assured that we are supporting service users and their families in line with expected practice?
- Are we assured that practitioners have ready access to trauma informed training?
- Is training provided to staff positively received and impactful?

System learning points

- Do we, as a system, ensure service users with complex presentations receive care tailored to meet their needs?
- How do we support children to transition from CAMHS to adult services; what mechanisms are in place to enable effective transitions?
- Is there sufficient availability and access to psycho-educational training and advice for families and carers?
- Do we offer 24/7 access to crisis services for children / young people and their families?
- How do we ensure service demand and waiting times do not become a barrier to care?
- Do we offer intensive home treatment to prevent admissions, where possible, and facilitate discharge planning and home leave?