Llywodraeth Cymru
Welsh Government

Mental Health Summit – Inpatient Care

30 November 2023

Summary of Key Issues, Actions and Next Steps

Report produced January 2024

Background

There are quality and safety issues in mental health inpatient care across NHS Wales, the focus of this summit was to consider the risks and solutions related to inpatient care within mental health services.

The summit highlighted concerns and allowed public body leads to share information on inpatient care and inpatient settings. Health boards were encouraged to share best practices and agree outcomes for safety improvements for the long-term transformation of acute mental health care services.

Strategic context and welcome, aims and objectives

The NHS Executive National Director of Mental Health opened the summit, setting out the rational for the summit.

She recognised that inpatient teams across Wales are working really hard and there is good practice being seen.

However, feedback from staff, service users, inspection reports and NRIs tell us that while some people have positive experiences, others do experience avoidable harms. These harms are as a result of procedural issues such as approaches to risk assessments and lack of follow up on discharge, unsafe environments including ligature risks and relational issues such as a lack of therapeutic support and a person centred focus.

Over the decade 2010-2020, over a quarter (28%) of people who died by suicide did so in in-patient settings, the period immediately after discharge or whilst under the care of crisis resolution/home treatment teams. She reiterated the importance of providing safe care and asked the group to consider how the NHS Wales patient safety programme could support this work further.

Mental health inpatient services

The NHS Executive Assistant Director of Mental Health presented slides summarising relevant data on inpatient services. In the last 12 months adult admission rates ranged between approximately 550-700 per month with occupancy at 89.6%, the median length of stay ranged between 11-14 days. For older adults the admission rates ranged between 100-150 per month with occupancy at 89.9% and the median length of stay between 36-67 days.

The NHS Executive had recently undertaken a rapid review of the prevalence of incidents between 2017 and 2022. This was a longitudinal study using information drawn from patient safety incident reports submitted to the Welsh Government and the then Delivery Unit.

The review highlighted the following findings:

- There was an increase in incidents between 2021/2022.
- 77% were male, 73% of patients were known to mental health services and 64% were ‘informal status’.
- Most patients had a risk assessment completed. However, this was not always updated.
- Most were deemed low risk and over half were under ‘general observation’.

- Some wards had changed their admissions profile during the pandemic for infection control, where wards had changed function, some staff were less familiar with the patient profile.
- Not all staff on duty were familiar with the ward environments or procedures when the incident occurred e.g., temporary, bank or agency staff.
- Most incidents in the ward were in isolated areas such as bedrooms.

The recommendations from the report were:

- Further work to be undertaken by Welsh Government and the NHS Executive to strengthen the processes for assessing suicide risk to ensure that these are collaborative, consistent, timely and updated at each point of admission, discharge, or transfer of care.
- Health boards must ensure there is clear and recorded rationale where a decision is made to escalate or de-escalate observation levels. This decision must be based on a review of the risk assessment.
- Health boards must ensure that environmental risk assessments are undertaken where the function of the ward changes.
- Health boards must ensure that all staff are suitably trained and experienced to manage the patient profile. Where temporary staff are used health boards must ensure that they are orientated to the ward environment, patient risks and procedures to manage incidents.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) recommendations were also presented at the Summit, they are:

- Removal of low-lying ligature points.
- Ensuring pre-discharge leave and discharge planning address adverse circumstances the patient may be returning to.
- Improve the in-patient experience and enhance the therapeutic relationship to reduce risk.

Ligature management was discussed, and all health boards confirmed

- Ligature audit is undertaken annually.
- Internal structure and forum to provide oversight.
- Programme of work to support anti-ligature management (some areas report improving the relationship with estates department has made a difference).
- Local policy in place - ‘All Wales Principles and Standards for Ligature Management’ is ready to be implemented.

The following points related to staffing were raised:

- Safe staffing legislation does not apply to mental health, although many health boards report following the principles.
- Health boards report a high number of inpatient staffing vacancies resulting in a reliance on bank and agency staff.
- There is limited provision of psychology in inpatient services.
- Considerations of alternative staffing roles within inpatient wards – e.g., peer workers, dedicated inpatient psychology, band 4 apprentices and transition workers is a focus.

Group discussion

The following points were raised by attendees:

- There are concerns with rapid turnover of staff and reliance on locums which leaves inpatient units in unstable positions at times.
- There has to be a balance between making wards safe, risk management, and making them therapeutic.
- There is no active process to follow if a patient becomes uncontactable during discharge follow up and there is a need to better understand protocols.
- The launch of the National Staff Retention Programme.

Emerging safety themes

The NHS Executive Deputy Director for Quality and Safety presented slides to the group highlighting emerging safety themes:

- The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) report emphasises that suicide is now recognised as the leading cause of death for mothers between the six-week and twelve-month mark following pregnancy.
- An NHS Wales National Coordinating group for sexual safety was formed in July 2023 by the NHS Wales Executive. The most apparent finding of the sexual safety incident review was the hugely disproportionate rate at which these incidents occurred in mental health care settings, with nearly half of the incidents reported taking place there.
- 53% of MH&LD HIW inspections undertaken in the last 2 years have identified medication issues, some of the common findings were shared with the group.

Ministerial Expectations

The Deputy Minister recognised the pressures in the system that continue to grow, and thanked attendees for the work they are undertaking to support some of the most vulnerable people in Wales. She reminded the group that we have a duty to constantly improve the quality and safety of the care we provide and given the high degree of vulnerability in our service users this is even more important in acute mental health settings.

The Deputy Minister said she was keen to hear from health board colleagues about the challenges they face in providing safe care. She informed the group that she wants a number of outcomes and actions to be agreed following the summit and for each health board to commit to working with the NHS Executive on firm plans for safety improvements and the long-term transformation of acute mental health care.

Moving Forward: A Mental Health Patient Safety Programme for Wales

The Mental Health Development Lead for Wales Improvement Cymru presented slides on the Mental Health Patient Safety Programme for Wales. There is an initial focus on inpatient settings and will include discharge arrangements and implementation of the anti-ligature standards. How this will be achieved, and the evidence based for change was shared with attendees. Summit attendees were given the opportunity to identify which areas should be a priority focus and asked to take part in the design and approach to implementation, this will be done via

workshops on 1 February 2024 and 5 March 2024 with nominees from each health board.

Discussion and way forward

There was a group discussion facilitated by the NHS Executive about the biggest challenges facing services and what differences could be made following the presentations at the summit. The group shared the following:

- Workforce:
  - Important to make staff within services feel more valued.
  - The importance of supporting staff, including when going through inquests and coroner processes.
  - Staff undertaking the right training.
  - Workforce must be involved in discussions as they are the experts in this field.
  - There is a need for us to consider the whole inter-disciplinary workforce model in inpatient wards.
  - There are opportunities to consider how newer roles can support ward staff alongside efforts to increase mental health nurses and other roles that are currently holding a lot of vacancies, such as peer roles. The NHS Executive said there are good models emerging that can be shared in the future.
  - Improving quality and patient safety in inpatient settings within the current financial and workforce challenges is difficult, it would be helpful to bring the lived experience and MDT into the overarching leadership of the work.
  - Ensuring workforce see inpatient care as a career choice, not a stepping stone to other services.
  - Ensuring we have leaders who foster compassionate cultures which enable people to thrive is fundamental to services.
- Patients must be kept safe.
- The pressure on bed space was raised as a concern.
- The importance of the environments being therapeutic as well as safe.
- There are big safety challenges in OPMH inpatient settings with providing safe physical healthcare.
- OPMH wards are struggling to balance reducing ligature risks and providing safe care for frail patients.
- Concerns were raised around ligature risks, and some of the statistics that had been shared at the summit.
- Across some mental health sites in England, they have introduced digital observation systems.
- The use of different types of therapy that have proved to be successful, such as music therapy and art psychotherapy.
- There is variation but some really good practice and ideas at local level. How can that be brought together to create a national quality learning, planning and improvement environment to support and add value to services and for patients.
- The relationship with the Police, some health boards reported this is an area that could be improved.

Other comments raised at the summit:
- It would be helpful if a programme board was created.
- The draft mental health strategy includes mention of quality statements for mental health.

- It would be helpful if in future attendees from the summit could discuss issues in smaller groups and report back.

The Deputy Minister closed the summit and thanked all attendees for their honest reflections on the challenges services are facing. She recognised health boards are working with difficult financial challenges and high demand on services but was clear that the commitments made at the summit must be taken forward.

Commitments

The following expectations and actions were set:

- Health boards to provide an update on mental health inpatient settings at next Welsh Government Joint Executive Team (JET) meetings in 2024.
- Progress to be made with a mental health quality statement and inpatient safety programme by April 2024, including a focus on workforce and person centred safety planning.
- Further summit to be arranged for mid-2024 to follow up on actions and progress of this summit.
- Health boards to nominate one executive level and two operational leads to attend workshops on 1 February 2024 and 5 March 2024, and support with co-designing the new programme and the launch of the new anti-ligature standards locally.

Appendix 1

Attendees

Ministerial	
Lynne Neagle MS	Deputy Minister for Mental Health and Wellbeing

Welsh Government	
Jeremy Griffith	Director of Operations
Olivia Shorrocks	Head of Major Conditions
Matt Downton	Head of Mental Health and Vulnerable Groups
Steve Clarke	Nursing Officer for Mental Health & Learning Disability
Caroline Lewis	Head of Escalation and Intervention
Luke Solomon	Senior Performance and Escalation Manager
Kate O'Neill	Performance Officer

NHS Executive	
Ciara Rogers (Chair)	National Director of Mental Health
Dave Semmens	Assistant Director of Mental Health
Cathy Dowling	Deputy Director for Quality and Safety
Gareth Lee	National Director of Performance & Assurance
Sharon Cooke	Quality Performance Improvement Manager

Aneurin Bevan University Health Board	
Leanne Watkins	Chief Operating Officer (COO)
Chris O'Connor	Divisional Director for Mental Health & Learning Difficulties (MH & LD)
Richard Morgan-Evans	Deputy Director of Operations
Michelle Forkings	Divisional Nurse for MH & LD/Associate Director of Nursing MH & LD
Kolade Gamel	Service Group Manager, Family & Therapies
Patrick Chance	Consultant in Old Age Liaison
Amy Mitchell	Divisional head of Occupational
Helen Dodoo	General Manager, MH & LD
Rebecca Goode	Head of Operational Transformation

Jo Green	Senior Planning and Service
Nadine Gould	Improvement Divisional Nurse, MH & LD
Jennifer Winslade	Director of Nursing
Tracey Partridge-Wilson	Assistant Director of Nursing
Linda Alexander	Deputy Director of Nursing
Hannah Evans	Director of Strategy, Planning &
Hayder Al-Hassani	Consultant Psychiatry & Clinical Director for Adult Services
Nicola Lewis	Clinical Director & Joint Head of Psychological Services
Gemma O'Brien	Joint Clinical Director for AMH & Cons. Clinical Psychologist
Kathryn Walters	Joint Head of Psychology, Counselling, and Arts Therapies

Betsi Cadwaladr University Health Board	
Iain Wilkie	Director for Mental Health & Learning
Alberto Salmoiraghi	Medical Director MH/LD
Carole Evanson	Interim Director MH/LD
Adrian Jones	Deputy Director of Nursing

Cardiff & Vale University Health Board	
Neil Jones	Clinical Board Director, Mental Health
Daniel Crossland	Director of Operations, Mental Health
Mark Doherty	Director of Nursing, Mental Health
Tara Robinson	Deputy Director of Nursing, Mental
Adam Wright	Operational Planning and Performance Director
Rebecca Aylward	Deputy Director Therapies and Health Science

Cwm Taf Morgannwg University Health Board	
Julie Denley	Deputy Chief Operating Officer
Elaine Lorton	Service Director – Mental Health
Ana Llewellyn	Nurse Director for Primary and Community Care and Mental Health
Andrea Davies	Head of Psychology
Lisa Davies	Assistant Director of Transformation – Mental Health and Learning Disabilities
Mary Self	Clinical Director
Natalie Bell	Deputy Head of Occupational Therapy
Elizabeth Beadle	Assistant Director of Transformation

Ana Riley	Assistant Director of Finance
Sara.E.Mason	Head of People

Hywel Dda University Health Board	
Liz Carroll	Director of Mental Health & LD
Rebecca Temple-Purcell	Assistant Director of Nursing Mental Health & LD
Kay Isaacs	Assistant Director of MH&LD
Angela Lodwick	Assistant Director of MH&LD
Warren Lloyd	Associate Medical Director CAMHS
Nicky Thomas	Service Lead Occupational Therapy Mental Health

Powys Teaching Health Board	
Ben Shooter	Consultant Psychiatrist, Interim Clinical
Louisa Kerr	Assistant Director of Mental Health and Learning Disabilities

Swansea Bay University Health Board	
Deb Lewis	Chief Operating Officer
Ebony Smith	Executive Support Manager
Janet Williams	Service Director
Dermot Nolan	Associate Service Group Director for
Richard Maggs	Consultant Psychiatrist
Stephen Jones	Nurse Director

Improvement Cymru	
Andrea Gray	Mental Health Development Lead for Wales Improvement Cymru
Dominique Bird	Deputy Director and Head of Quality Improvement

WHSSC	
Emma King	Senior Specialised Services Planning Manager for Mental Health and Vulnerable Groups

DHCW	
Sam Hall	Director of Mental Health

Heidi Morris	Head of Community and Mental health information services

NCCU	
Shane Mills	Clinical Director
Colette Rees	Head of Planning and Programme Design and Delivery
Kate Burton	Deputy Director of Transformation and Commissioning

HEIW	
Ainsley Bladon	National Implementation Lead - Strategic Mental Health Workforce Plan
Angie Oliver	Deputy Director of Workforce and OD

Appendix 2

Slide presentations – these will be sent separately.