SUMMARY REPORT	ABM University Health Board
Health Board	**Date: 25th May 2017** **Agenda Item: 2 (vii)**

Subject	Older Persons' Mental Health
Prepared by	Hazel Powell, Unit Nurse Director Gareth Bartley, Head of Partnerships and Development
Approved by	David Roberts, Service Director
Presented by	Rory Farrelly, Chief Operating Officer/Director of Nursing & Patient Experience

Purpose

The purpose of this report is to present developments within Older Persons' Mental health Services.	**Decision**	
	Approval	
	Information	**x**
	Other	

Promoting and Enabling Healthier Communities	Delivering Excellent Population Outcomes	Demonstrating Value and Sustainability	Securing a Fully Engaged and Skilled Workforce	Providing Effective Governance and Partnerships
	x		**x**	

Executive Summary

The report provides an outline of the key findings from external reviews and UK Benchmarking exercises from 2016-17 and outlines the work being undertaken within the Delivery Unit to respond to these findings.

Key Recommendations

1. Receive the key findings of the Older Persons' Mental Health In-Patient Services Delivery Unit Assurance Review
2. Note the actions taken forward in response to the recommendations within the Older Persons' Mental Health In-Patient Services Delivery Unit Assurance Review and UK benchmarking work

Assurance Framework

The actions being taken forward in response to the recommendations within the Older Persons' Mental Health In-Patient Services Delivery Unit Assurance Review are monitored through the Delivery Unit Quality and Safety Committee.

Next Steps

MAIN REPORT		ABM University Health Board
Health Board		**Date: 25th May 2017** **Agenda Item: 2 (vii)**
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1. Purpose

The purpose of this report is to present developments within Older Persons' Mental Health Services. The report provides an outline of the key findings from external reviews and UK Benchmarking exercises and outlines the work being undertaken within the Delivery Unit to respond to these findings.

2. Background

Two enquiries have been undertaken in recent years into the quality of care provided to older people with a mental health problem within Welsh NHS hospitals. The First, 'the Andrews' review', investigated the care provided to frail older people, many of whom had mental health problems, on general health wards in Abertawe Bro Morgannwg University Health Board (2014). The second, 'the Ockenden review', investigated the quality of care provided on the Tawel Fan ward at Glan Clwyd Hospital in Betsi Cadwaladr University Health Board (2014).

Both of the reviews were established in response to concerns raised by families about the quality of care provided to relatives on these wards. Their findings led Welsh Government to seek assurance that the quality of care being provided to older people with mental health problems in Wales is of an acceptable standard. It arranged a series of spot checks to be carried out in approximately half of the older people's mental health units in Wales. The findings of these visits were published in a Welsh Government statement (2015). Health Boards were required to take immediate and longer term action in response to their individual spot check reports.

In order to examine the extent to which improvements have been made the Welsh Government Delivery Unit (WGDU) was tasked to undertake an assurance review. It was to include every NHS specialist older people's mental health unit in Wales, focussing on the delivery of progress against the spot check reports and the governance mechanisms in place to assure the quality of older people's mental health services.

The Welsh Government carried out a review of ABMU Older Peoples Mental Health In-Patient Services between the 6th and 16th June 2016.

Key findings

- Robust revised governance arrangements were in the process of being developed.
- Least restrictive practices should be used to manage the risk of patient falls.
- There was significant variance in practice between individual wards and localities.
- There were pockets of excellence in the development of care and treatment plans for patients.
- There was an absence of an agreed service model and the provision of 13 wards risks being unsustainable.
- Overall the care on the wards was of a good standard with some examples of excellence.

Actions taken in 2016-17:

- Locality action plans for Older People's Mental Health Services in Swansea, Neath Port Talbot and Bridgend Locality developed which include quality improvement plans using PDSA methodology - monitored through the quality and safety committee and Welsh Government Delivery Unit 90 day reviews.
- Welsh Government review team presented the review findings to each locality, enabling teams to hear feedback directly linked to the services within their locality and first-hand the findings and examples of good practice that the review team found across the whole of Wales.
- Mental Health and Learning Disability Delivery Unit published a special edition newsletter focuses on the Older Persons Mental Health In-Patient Services Delivery Unit Assurance Review in March 2016 which is attached to this report.
- A review of the use of lap straps carried out by Head of Occupational Therapy and Head of Physiotherapy in response to findings relating to restrictive practice. Findings to be presented to Delivery Unit Quality and Safety Committee in May 2017.
- Active engagement in the older persons' mental health inpatient community of practice that has been established to enable continuous improvement through sharing the learning from the spot checks across all Health Boards and the findings and recommendations of the DU assurance review.

Actions to be taken in 2017-18:

- Hold an Older Person's Mental Health Services Sharing Success and Celebration Event in June 2017. This event will share the improvement work being carried out across the 3 localities and include an awards ceremony with awards for Support Worker, Outstanding Contribution, Team of the Year and Patient/Family Centred Care.
- Four members of staff nominated to undertake Dementia Care Mapping Training supported by the All Wales Community of Practice.
- Lecturer in Dementia Studies at the University of South Wales has commenced on an Honorary Contract as a Nurse Consultant in Older Peoples Services to support the improvement work being undertaken as part of the Locality action plans.

3. Benchmarking

In 2016/17 the Delivery Unit continued to participate in the UK Benchmarking work.

Mental health benchmarking indicates that inpatient services for older people are above average in the number of overall beds per 100,000 over 65s population : 92 compared to benchmark average of 48 with more admissions per 100,000 population : 1,019 admissions against benchmarked median of 174. In addition the benchmarked number of registered nurses per 10 beds is below average 5.3 against average of 7.2 and the cost per older adult bed is below average £75k against average of £132k.

Continuing with the existing distribution of resources is unsustainable and quality is at risk of being compromised. This indicates that our model of care is out-of-line with current practice across the UK where there are less NHS beds per head of population and a greater range of community services.

This was also highlighted during a review by the Welsh Government's Delivery Unit which stated that despite judging the overall care on the wards to be of a good standard with some examples of excellence they were:

> "*not assured that the current service model consisting of 13 wards is sustainable in relation to the staffing establishment required. There are significant limitations in access to the full multi-disciplinary team and these limitations do not appear to form part of wider workforce planning considerations."*

The review included all the Older People's Mental Health services wards, these are:

Swansea Locality	Celyn ward, Cefn Coed Hospital Onnen ward, Cefn Coed Hospital Derwen ward, Cefn Coed Hospital Suite 3, Tonna Hospital
Neath Port Talbot Locality	Ward G, Neath Port Talbot Hospital Suite 1, Tonna Hospital Suite 2, Tonna Hospital Suite 4, Tonna Hospital
Bridgend Locality	Ward 1 Angelton, Glanryhd Hospital Ward 2 Angelton, Glanryhd Hospital Ward 3 Angelton, Glanryhd Hospital Ward 15 Princess of Wales Hospital Ward 21 Princess of Wales Hospital

The overarching principles for service delivery in Mental Health and Learning Disability continues to be a stepped care approach providing a range of interventions

for people with varying needs offering the minimum required to enable people to thrive.

The model of service provided to people with mental health problems should cover health and social care requirements throughout the service users whole journey and when they require it. The pathway of services required has a domino effect and interdependencies between services and health and social care. This may require more than one specific area needing to be considered when looking at change to ensure that it is effective and sustainable.

Actions taken in 2016-17:

- The delivery unit engaged with clinicians through externally facilitated workshops on the future direction of services and what the key building blocks for the delivery of safe and supportive services would be. Importantly there was confirmation from the clinicians involved that the change necessary to take us forward amounted to significant transformation.
- The outcomes from our engagement work were also consistent with the issues already identified within the Western Bay collaborative and within the multi agency Mental Health and Learning Disability Commissioning Board who agreed the following in January 2017.
- *Change of service model for older people mental health services*
  The model of service provided to older people with mental health problems should cover health and social care requirements throughout the service users whole journey and when they require it. The pathway of services required has a domino effect and interdependencies between services and health and social care. This may require more than one specific area needing to be considered when looking at change to ensure that it is effective and sustainable.

Actions to be taken in 2017-18:

- Clinical Review commencing 19th June 2017: To further support the work the Delivery Unit have commissioned an external clinical review of its Older current OPMHS service and provide:

  - A consolidated report reviewing all options and making recommendations for change in the service model.
  - Production of a balanced and weighted scorecard to inform service development
  - An initial impact analysis – focusing on workforce, financial considerations and clinical development

4. Conclusion

The learning from the external review and participation in the benchmarking exercise has identified a number of actions that are being taken forward to improve services now and a need to significantly change our service model to deliver sustainable person centred services going forward.

5. Recommendations

The Board is asked to:

- Receive the key findings of the Older Persons' Mental Health In-Patient Services Delivery Unit Assurance Review
- Note the actions taken forward in response to the recommendations within the Older Persons' Mental Health In-Patient Services Delivery Unit Assurance Review and position in relation to the UK benchmarking work.

Mental Health and Learning Disability Delivery Unit

Older Adults Mental Health Services

Special Edition Newsletter March 2017

This special edition newsletter focuses on the Older Persons Mental Health In-Patient Services Delivery Unit Assurance Review.

Inside this issue

Background to the Review

Two enquiries have been undertaken in recent years into the quality of care provided to older people with mental health needs within Welsh NHS hospitals. The first, 'the Andrews review', investigated the care provided to frail older people, many of whom had mental health needs, on general health wards in our own Health Board (2014). The second, 'the Ockenden review', investigated the quality of care provided on the Tawel Fan Ward at Glan Clwyd Hospital in Betsi Cadwaladr University Health Board (2014).

Both of the reviews were established in response to concerns raised by families about the quality of care provided to relatives on these wards. Their findings led Welsh Government to seek assurance that the quality of care being provided to older people with mental health problems in Wales is of an acceptable standard.

In order to examine the extent to which improvements have been made the Welsh Government Delivery Unit (WGDU) was tasked to undertake an assurance review. It was to include every NHS specialist older people's mental health unit in Wales, focussing on the delivery of progress against the spot check reports and the governance mechanisms in place to assure the quality of older people's mental health services.

The Welsh Government carried out field visits to Abertawe Bro Morgannwg University Health Board between the 6th and 16th June 2016.

Key Messages

- Robust revised governance arrangements are in the process of being developed.
- Least restrictive practices should be used to manage the risk of patient falls.
- There is significant variance in practice between individual wards and localities.
- There are pockets of excellence in the development of care and treatment plans for patients.
- There is an absence of an agreed service model and the provision of 13 wards risks being unsustainable.
- Overall the care on the wards is of a good standard with some examples of excellence.

Improving Services

We were very grateful to Phil Chick and Dave Semmens from the review team agreeing to present back to each locality the review findings in December 2016. This enabled teams to hear feedback directly linked to the services within their locality and hear first-hand the findings and examples of good practice that the team found across the whole of Wales.

Each locality has developed an action plan laying out how they are responding to the recommendations from the review.

These will be monitored both through the Mental Health and Learning Disability Governance structures and through the Welsh Government 90 day monitoring and review process.

The first monitoring visit took place on the 23rd January 2017 which included Phil Chick and Dave Semmens from the Delivery Unit revisiting two wards within the Swansea locality. They found evidence of environmental improvements with efforts to improve an already good environment having been progressed since the initial assurance visit. There was evidence of efforts being made to enhance activities and stimulation on the wards.

Initiatives to improve the culture on the wards were described. Managers were seeking to involve the whole ward team in improving person centredness and described steps to improve the manner in which everyday tasks are undertaken to improve this, for example work to look at the use of language during handovers.

Many of the changes are in their infancy with others being planned. It is great that the team were able to see the positive impact beginning to come through from the work that has been done and this reflects the great work and efforts of the teams within these areas – well done all.

Examples of Service Improvements

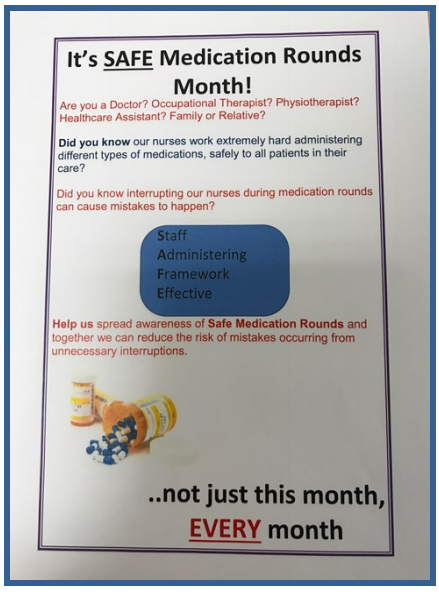
BRIDGEND LOCALITY

Recommendation

- ***To continue to develop systems and processes that support the learning from patient safety incidents, claims and complaints, which leads to continuous improvement in care and services as part of the revision of governance arrangements.***

In December 2016 there was a cluster of medication errors across the inpatient service. Key themes identified included constant interruptions, noise and distraction. As a result of investigations into these errors an action plan was devised.

In line with the Health Board values and behaviours relating to working together and always improving, staff were invited to medication management sessions where the issues in conducting a safe medication round were explored. These sessions provided us with the key themes and led to the development of a Safe Medication Round pilot.



- **An information poster was developed aimed at information sharing with families and relatives.**
- **E mail sent to support services including pharmacy and other health professionals.**
- **All telephone calls were diverted to the unit clerk during breakfast and lunchtimes.**
- **Logs are maintained to record number of interruptions and validity of these.**

This is an ongoing four week pilot on Ward 2 Angelton Clinic, which commenced on the 10th February 2017. The result of this pilot could see this initiative being implemented across all inpatient wards in the Bridgend locality.

SWANSEA LOCALITY

Recommendation

- ***To roll out some of the excellent examples of person centred, failure free activities that are based on individual assessment, to ensure that this is consistently embedded across all of the ward areas.***

As we all know the rugby season is well and truly upon us, in the spirit of team work the quest for continuing improvement is as much applicable on Derwen Ward as it is on the pitch. As a multi-skilled team we thrive to make the patients' day as fulfilled and holistic as we possibly can.

Following the Delivery Unit visit one of the key objectives was to make activities/engagement more people centred and individualised.

What has helped us as team to decide what to do?

- Getting to Know You booklets
- Talking to the patients/relatives
- Observation

To go that extra mile, just like the players do in training we have been participating in 'Themed Rugby Weekends' which includes watching the match, having themed food nights relating to the country of the team and creating an atmosphere for the gentlemen to enjoy and relax.

Furthermore, as the spring season is fast approaching we have our gardening club which includes enthusiastic staff members and patients who have a particular interest in all things green.

Last year we had a vegetable patch donated to Derwen and we are growing our own vegetables which can be incorporated into our weekend themed food nights.

We have also started to re-vamp our garden ready for the next few months. We are re-vamping our flowers, decorations and in the process of developing games for the summer months. Anyone is welcome to join in!

NEATH PORT TALBOT LOCALITY

Recommendation

- ***Improve the quality of older person's mental health assessment and care and treatment planning, with emphasis on ensuring plans are outcome focused, developed in partnership with patients and their carers, and person centred in nature.***

Brief Outline

Within OPMHS in Tonna Hospital the Delivery Unit team identified a Care and Treatment Plan (CTP) which they considered to be an excellent example of person centred, outcome focused care planning. The aim for NPT locality was to raise the quality of CTPs across OPMHS to ensure that care and treatment planning was the cornerstone of care delivery.

Progress to Date

- The CTP identified as a good example of quality care planning has been anonymised and shared with all registrants within OPMHS (inpatient and community service areas) within the locality.
- The example has also been discussed and shared within the NPT locality Mental Health Measure (Wales) 2010 meeting.
- Community in Practice, Performance Improvement Manager, and (Welsh Divisional Unit) is also a member of the Mental Health Measure Wales (2010) meetings being held within the locality. He will also circulate examples of good practice in regards to CTPs to increase the resource available for staff and hence enhance opportunities for learning.
- Links have been established between NPT locality and the University of South Wales and there are plans for the

university to deliver a workshop on recovery focused care in the older person. This will again provide opportunity for learning and increased knowledge and skills to contribute to the CTP process and quality service delivery.

An audit programme commences in April 2017. This CTP audit programme will be rolled out across the whole locality and not OPMHS in isolation. The audit is designed to examine quality of CTPs in regards to person centred, recovery focused care. This process will produce quality outcomes measures from which ongoing actions and quality assurance plans will be based.

These examples are just a few of the initiatives that are happening in our services and these achievements should be celebrated, but we must not lose sight that there remains much to be done and each locality is working hard to deliver on their action plan to ensure that we provide high quality person centred services to older people and their families within our mental health services.

MOVING FORWARD

Dementia Care Mapping – Public Health Wales are working towards developing and delivering a 'Once for Wales' training programme for DCM including a train the trainer programme to provide in country sustainability. Delivery Unit staff have been nominated to take part.

Work on **Mortality Reviews** in Mental Health is continuing. This will of course impact on Older Adult Mental Health Services as will the work to enhance **Liaison Psychiatry.**

The Older Peoples Mental Health Services Community of Practice provides an opportunity for sharing initiative and good practice and supporting improvement across Wales. The Delivery Unit has a number of representatives who regularly attend, if you are interested in finding our more please contact Jill Luckwell on Jill.Luckwell@wales.nhs.uk