

# **The Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults in England, Wales and Northern Ireland**

Background briefing paper



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## Executive summary

The Royal College of Psychiatrists (RCPsych) has established an independent Commission to review the provision of acute inpatient psychiatric care for adults in England, Wales and Northern Ireland. This is in response to widespread concern about whether there are sufficient acute psychiatric inpatient beds and alternatives to admission available for patients. The purpose of this background briefing paper is to introduce the key issues, but not to pre-empt the work of the Commission by making recommendations.

Acute psychiatric inpatient services provide treatment and care in a safe and therapeutic setting for patients in the most acute and vulnerable stage of mental illness, and whose circumstances or acute care needs are such that they cannot, at that time, be treated and supported appropriately at home or in an alternative, less restrictive setting.

As the result of explicit policy decisions the number of acute adult psychiatric beds has significantly fallen over recent decades. In England the total number of available mental illness beds (ie for all ages and for all specialities) dropped from a peak of roughly 150,000 beds in 1955 to roughly 22,300 in 2012. In Northern Ireland the number of adult psychiatric beds fell from 1272 in 1998/99 to 584 in 2012/13, and in Wales the number of adult psychiatric beds fell from 2586 in 1989/90 to 771 in 2013/14. This pattern of psychiatric bed reductions has been mirrored internationally, and to a lesser extent by the provision of physical healthcare beds in the UK.

Linked (but not necessarily parallel) policy initiatives have seen the expansion and development of ‘functionalised’ community mental health teams, which were intended (amongst other things) to reduce the number of inpatient admissions by intervening earlier and/or more intensively before an inpatient admission became necessary. Although these teams began to emerge in the 1980s, it should be noted that they were underfunded until strategies like the 1999 National Service Framework gave them heightened prominence.

Comprehensive historical funding and staffing data are difficult to find for all three countries. It can be said with some certainty that total funding for mental health (ie all areas of mental health, not just inpatient care) increased in each country from the early 2000s for *roughly* a decade (reflecting the fallout of the 2008 global financial crisis), following which budgets have fallen in real terms. It is not possible to drill down into the Welsh or Northern Irish total budget figures to the level of adult acute mental health care, but available data for England show that there was a 59% increase in real terms spending between 2000/01 – 2011/12 on adult mental health services, with increases taking place each year until 2011/12 (when there was a decrease of 1%). However, during this period the proportion of the overall mental health budget spent on inpatient services fell from 19% to 11.9%. In England the number of full-time equivalent (FTE) consultants working in General Adult psychiatry increased by 37% between 2003-2013 (again, figures are regrettably unavailable at this level of detail for Northern Ireland and Wales).

For many people, community-based services can achieve both better clinical outcomes and higher levels of patient satisfaction than other models of care. However, there will always be a need for some inpatient bed provision, and there are warning signs that there are not

enough acute adult psychiatric beds in some areas. For example, the number of patients in England travelling out of their local NHS trust area for emergency mental health treatment more than doubled in two years from 1301 in 2011/12 to 3024 in 2013/14, and a 2013 FOI request found that the average inpatient ward bed occupancy figure in England was 101% in August of that year, with some wards running at 138%.

There is however also evidence that patients whose care could take place in the community are being inappropriately admitted as inpatients in some areas. For example, the Audit Commission reported in 2010 that admissions to English adult psychiatric inpatient units varied sixfold across providers and that 15% of the (then) stock of inpatient beds could be decommissioned if the worst performers could achieve the median figure of occupied bed days.

What remains uncertain is the amount and type of inpatient and community provision necessary to ensure that all patients receive safe and effective treatment in the appropriate setting.

# 1. Introduction

This section introduces the:

- **Commission on Acute Adult Psychiatric Care**
- **Purpose of inpatient care**
- **Historical context of inpatient care**
- **Debate around 'too few' or 'too many' beds**
- **Potential warning signs of a 'beds crisis'.**

## Introduction to the Commission on Acute Adult Psychiatric Care

The Royal College of Psychiatrists (RCPsych) has established an independent Commission to review the provision of acute inpatient psychiatric care for adults in England, Wales and Northern Ireland. There is evidence - some quantified, some anecdotal - of difficulties with admissions, lengthy waiting lists, variable-quality services for patients in the community, long distance transfers of patients to access emergency care, high ward occupancy rates and resulting high stress levels amongst patients, their families, carers and staff.

The Commission is independent of the RCPsych and has been asked to review the situation, examine the causes of these pressures and make recommendations for improvement. In doing so the Commission will consider inpatient services in the context of the whole system of mental health provision, and within the wider social environment more generally. It will operate in an open and inclusive fashion, drawing on evidence and experience from a wide range of people and sources.

The Commission's remit covers England, Wales and Northern Ireland. It will seek to identify and respond to similarities and differences between and within these administrations. Scotland is excluded from the Commission's scope as it is undertaking its own programme of work to review psychiatric beds. The Commission's scope does not include CAHMS services, forensic services or specialist adult services (such as perinatal or dementia) as these services are commissioned separately and are subject to different service pressures and constraints.

The purpose of this background briefing paper is to introduce the key issues, but not to pre-empt the work of the Commission by making recommendations.

## Historical context

The number of NHS psychiatric beds in England and Wales reached a peak of roughly 150,000 beds in 1955.<sup>1</sup> It is plausible that the organic evolution of the NHS explains why so much psychiatric care historically took place in inpatient settings rather than in the community.<sup>2</sup> The number of psychiatric beds has dramatically fallen in England and Wales since this point – a process known as *deinstitutionalisation*.<sup>3</sup> Northern Ireland has also experienced a period of deinstitutionalisation, although for unclear reasons it started later.

Whilst acknowledging that there have been problems with the provision of community care during the period of deinstitutionalisation, it seems safe to say that *at one point at the national level of all three countries* there were more people being treated as inpatients than there needed to be, meaning that there were too many inpatient beds. This is reinforced by evidence that, for many people, community-based services can achieve both better clinical outcomes and higher levels of patient satisfaction than inpatient models of care.<sup>4 5 6 7</sup> However, it is an unavoidable truth that there will always be some circumstances when care cannot be provided in any setting other than an inpatient ward. What currently remains uncertain is the amount and type of inpatient and community provision necessary to ensure that all patients receive safe and effective treatment.

Concerns about the number of adult inpatient psychiatric beds are not a recent phenomenon. In 1997 Shepherd et al raised concerns about a shortage of inpatient beds and high ward occupancy rates in England.<sup>8</sup> Professor Paul Lelliott (now Deputy Chief Inspector at the CQC, responsible for mental health) went significantly further in 2006, arguing that 'psychiatric bed numbers [in England] are close to the irreducible minimum if they have not already reached it.'<sup>9</sup> Upon becoming President of the Royal College of Psychiatrists in 2008, Professor Dinesh Bhugra spoke about the pressure on beds in many inpatient units, describing many as 'unsafe, overcrowded and uninhabitable' to the point that he 'would never use them, and neither would [he] let any of [his] relatives do so'.<sup>10</sup> Norman Lamb MP (Care Services Minister) admitted in 2013 that 'there is clearly, in some parts of the country, a shortage of beds'.<sup>11</sup>

### **Too few beds? Or enough beds - but poorly managed?**

It is unclear whether some areas have a genuine shortage of beds, or if there would be enough beds if more alternatives to admission were available and/or the current stock of beds was correctly managed.

A 2014 study by Green and Griffiths reported a 39% reduction in the overall number of inpatient psychiatric beds in England between 1998 and 2012. During this time admissions for bipolar disorder, schizophrenia, dementia, depression and OCD reduced, whereas admissions for PTSD, eating disorders and alcohol-related disorders increased. The reduction in the number of people admitted with depression was especially stark, with a 50% reduction over the period examined. Despite the decrease in inpatient admissions, there was no commensurate increase in Community Mental Health Team (CMHT) activity. The authors suggest it is therefore unclear where the care of some patients who would previously have been treated as inpatients – for example many people with depression - now occurs.<sup>12</sup>

Inpatient services cannot be viewed in isolation, and there is evidence that some admissions are unnecessary. Johnson for example argued in 2009 that better community services, reductions in the number of delayed discharges and increased provision of alternatives to admission could legitimately further reduce the need for inpatient services.<sup>13</sup>

Research by the Audit Commission in 2010 identified a sixfold variation in admission rates to English psychiatric inpatient units, and suggested that 15% of the (then) stock of inpatient beds could be decommissioned if the worst performers could achieve the median figure of occupied bed days.<sup>14</sup>

A 2012 retrospective review of bed usage in one English mental health trust over a 32 month period found that approximately a third of the patients admitted onto an inpatient ward could potentially have been cared for in a community setting. The authors suggested that this reflected inadequacies in how admissions were gatekept by community teams.<sup>15</sup>

However, Green and Griffiths point out in their 2014 study that they found that CMHT activity had little effect on local admissions, although the number of inpatient beds did.<sup>16</sup>

It is important to note that if these ‘wrong’ patients (who could be cared for in community settings) can be successfully identified and not admitted as inpatients then this does not necessarily mean that bed numbers can automatically be reduced; it is plausible that they may be utilised by the ‘right’ patients who are presently not being admitted but who should be.

## **Current warning signs**

Quirk and Lelliott have suggested that underlying inadequate bed provision is manifested by high occupancy levels, high numbers of out-of-area referrals, strategies to ration care by raising admission thresholds (which results in an inpatient population with much higher levels of morbidity,<sup>17</sup> with negative consequences for patient outcomes), the establishment of waiting lists and the practice of sending people on leave prematurely so that their beds can be used for new admissions.<sup>18</sup> Other indicators could include the increased use of mental health legislation,<sup>19</sup> and premature discharges to make room for new admissions (also known as being discharged ‘quicker and sicker’).<sup>20</sup>

Recent snapshots of care suggest that many of these warning signs are coming to pass, although as the majority of the evidence relates to England it is difficult to evidence the situation in Wales and Northern Ireland beyond anecdotal accounts.

### Current Evidence of the System under Strain

- A 2013 FOI request by *Community Care* found that the average inpatient ward bed occupancy figure in England was 101% in August of that year, with some wards running at 138% (achieved via 'hot-bedding' where the beds of patients on temporary leave are used for new admissions).<sup>21</sup>
- In 2014 the BBC revealed that the number of patients in England travelling for emergency inpatient mental health treatment had more than doubled in two years from 1301 in 2011/12 to 3024 in 2013/14. One was sent 300 miles, from Devon to West Yorkshire.<sup>22</sup>
- In a 2014 survey of RCPsych Trainees, 37% said a colleague's decision to detain a patient under the Mental Health Act had been influenced by the fact that doing so might make the provision of a bed more likely, and 18% said their own decisions had been influenced in such a way. 24% reported that a bed manager had told them that unless their patient had been sectioned they would not get a bed.<sup>23</sup>
- An analysis of English coroners' reports between 2012-2014 by *Community Care* found that seven suicides and one homicide had been linked to a psychiatric bed not being available.<sup>24</sup>
- A 2011 study observed both a >60% increase in involuntary psychiatric admissions and a >60% reduction in the number of psychiatric beds (NB: excluding learning disability and older people services, but including all other mental health beds) in England between 1998-2008, and sought to establish if there was a statistical relationship between the two. The authors developed a model which predicted one extra involuntary admission for every two non-secure beds closed in the preceding year.<sup>25</sup>
- A recurrent theme in Mind's 2011 inquiry into acute and crisis mental healthcare was patients being told that they did not meet the admission criteria for services, either because they were 'not ill enough' or even 'too ill' in some cases.<sup>26</sup>



## 2. Inpatient care for adults

This section describes the:

- purpose and definition of inpatient care
- acute care pathway
- a conceptual model of how inpatient psychiatry services ‘work’
- different elements that constitute *specialist* inpatient care
- alternatives to inpatient care.

### The purpose of inpatient care

The Department of Health has offered the following description of the purpose and aim of adult acute inpatient care.

#### The Purpose of Inpatient Care

*The purpose of an adult acute psychiatric inpatient service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness. It should be for the benefit of those service users whose circumstances or acute care needs are such that they cannot at that time be treated and supported appropriately at home or in an alternative, less restrictive setting.<sup>27</sup>*

In theory, psychiatric patients will be treated in an inpatient setting only when their illness cannot be managed by either General Practitioners in ‘Primary Care’ or by mental health teams based in the community. At the point of needing to be treated in hospital, patients are often in crisis, afraid and vulnerable. In many cases they will be at risk of self-harm or suicide, and have significant needs which can only be met via the concentration of specialised resources that an inpatient setting will offer.<sup>28</sup> It is important to bear in mind that it should be the severity of the symptoms and the associated risks that result in an inpatient admission – whether voluntary or involuntary – rather than the specific diagnosis itself.

Only a very small number of people with a mental illness will actually be treated on an inpatient ward. In 2012/13 only 6.6% (105,224) of the 1,590,332 people who accessed secondary mental health services in England spent some time as a psychiatric inpatient during the year.<sup>29</sup>

### Acute inpatient services

Noting that there had historically been wide variation in what constituted an acute inpatient bed, the NHS Confederation Mental Health Network worked with a range of partners (including the RCPsych) to produce the following illustrative definition in 2012.

### **What is an Acute Inpatient Service?**

*An inpatient service is defined as a unit with 'hospital beds' that provides 24-hour nursing care. It is able to care for patients detained under the Mental Health Act, with a consultant psychiatrist or other professional acting as responsible clinician.*

*This does not mean that all, or even a majority of, patients will be detained. All units should have access to the full range of skills of the multi-professional team.*

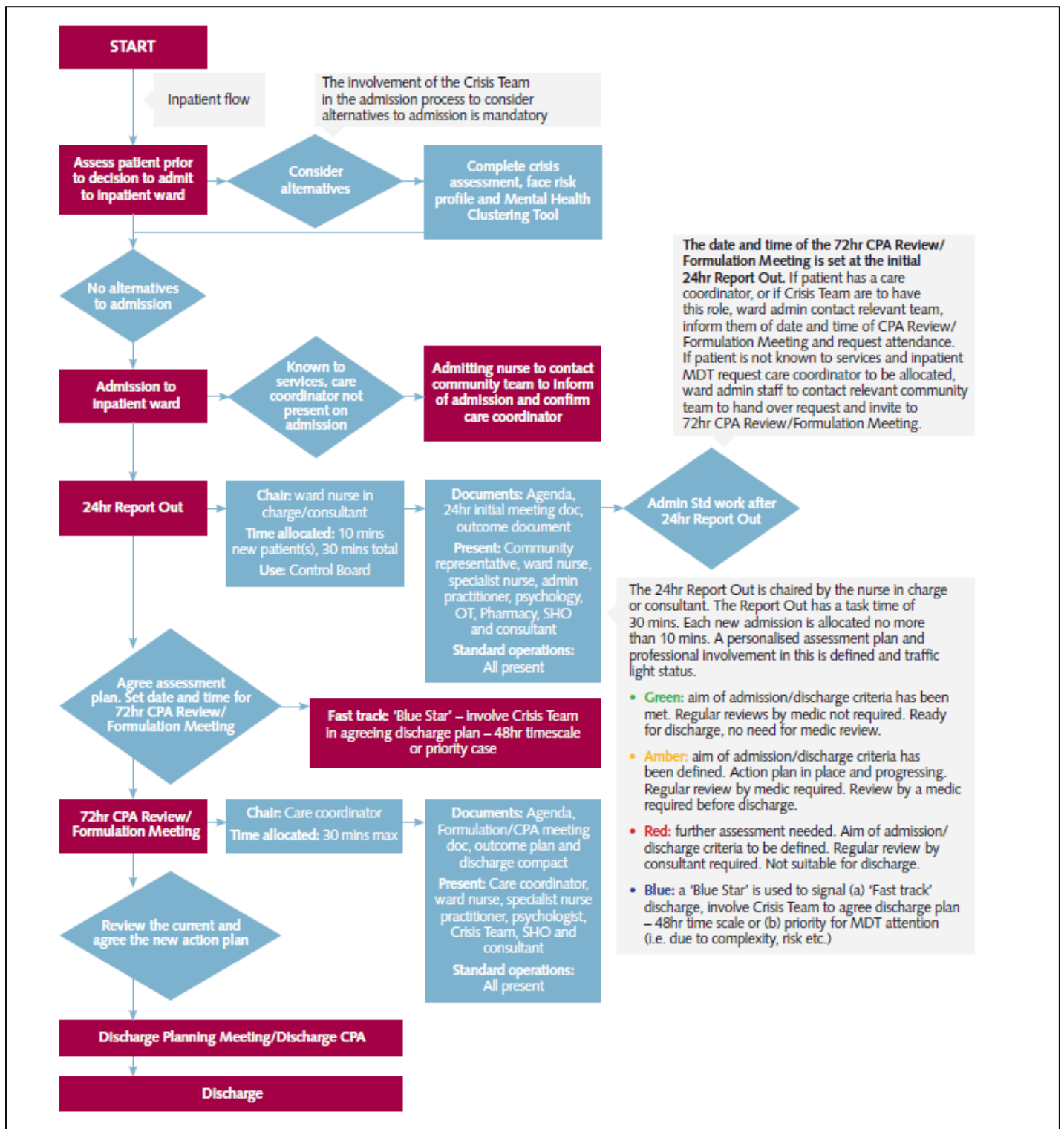
- *Such a unit may be in a hospital campus or a community setting. Such inpatient units may be provided by NHS or independent sector providers. Day-to-day needs for food, utilities and so on are provided by the 'hospital' rather than by benefits.*
- *Beds (inpatient) need to be distinguished from placements registered for the provision of care [which] provide accommodation, usually a room in a multiple occupancy facility, and a care/support package funded by health and social services (occasionally privately). This affects residents' benefit status and they are not tenants.*
- *The most well-known and used type of bed or ward in adult mental health is the acute, in this case, an acute bed for adults of working age (18–65) for males or females. Acute inpatient wards provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness.*
- *In order to provide evidence-based care a full range of disciplines, including pharmacists, psychologists, occupational therapists and housing and social care colleagues, need to be commissioned.*
- *Patients will usually spend fewer than 90 days on an acute inpatient ward, although problems with discharge may mean that this is not achieved in practice. Patients may be informal or [detained under the relevant mental health legislation].*

*Some areas will sub-divide acute wards into assessment and short-term admission and longer-term treatment wards.<sup>30</sup>*

### **The acute care pathway**

It is helpful to consider inpatient care within what is known as the 'acute care pathway'. This term refers to a patient's admission, progress and discharge from inpatient services, and/or those services designed as an alternative to hospital admission, for example crisis teams. An example of what a 'good' acute pathway could look like is depicted in Figure One below, although it should be remembered that in practice there are many variations to this model both between and within England, Wales and Northern Ireland in terms of implementation. This figure has been taken from guidance published by the Joint Commissioning Panel, where further information about the pathway can be found.<sup>31</sup>

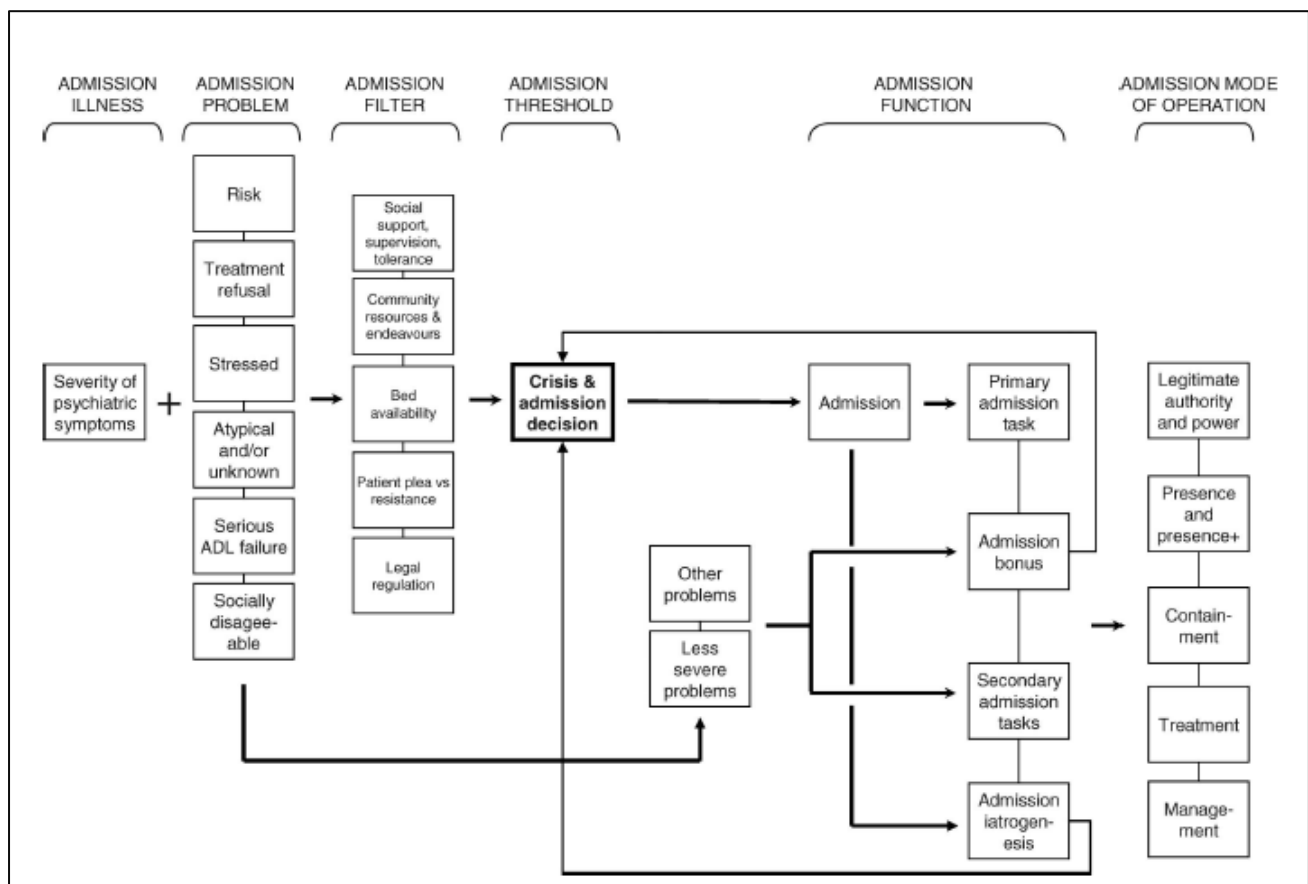
Figure one: The Acute Care Pathway.<sup>32</sup>



## A conceptual model of the functions of acute inpatient psychiatry

Bowers et al added to the literature in 2009 by describing a conceptual model of the current (rather than necessarily ideal) roles and/or functions of acute psychiatry (see Figure Two below).

**Figure Two: Bowers et al's conceptual model of acute psychiatry<sup>33</sup>**



**Key components of their model are summarised below:**

**Admission illness:** Although the existence of a mental illness is a precursor to every admission, it is by no means necessarily sufficient on its own (although admission is more likely for those with more severe symptoms). In practice, a combination of severe symptoms plus an 'admission problem' need to be present.

**Admission problem:** A severe admission problem might prompt admission even in the absence of severe symptoms being present. Although risk (to self or others) is the pre-eminent factor, others such as whether the person is refusing treatment or experiencing a period of stress (brought on for example by bereavement) can also be significant. It should be noted that such factors can occur concurrently.

**Admission filter:** External factors such as whether the person has a supportive family caring for them and the availability of community support are considered alongside internal factors such as the number of beds available at the time, plus the patient's views on admission.

**Admission decision:** The individual who makes the final decision will be influenced by their own knowledge, attitudes and experiences, thereby bringing 'an idiosyncratic element to who gets admitted and for what reasons.'

**Admission function:** An important distinction is made between the 'primary admission task' and the 'secondary admission task'; the former will reflect efforts to address both the Admission Illness and Admission Problem(s) and the latter more opportunistic efforts to resolve longer-term problems (such as chronic physical ill health) unconnected with the admission decision itself. There may also be a more short-term 'Admission Bonus' connected to the admission but not in itself a justification for it, such as an opportunity to adjust medication. A fourth function of admission is the avoidance of harm such as institutionalisation or stigmatisation.

**Admission mode of operation:** These elements distinguish the operation of inpatient care from community care. 'Legitimate authority' (either explicit via legal detention or implicit from the inpatient medical setting) facilitates the particular goal sought. 'Presence+' describes the proximity between staff and patients which can lead to therapeutic relationships developing. 'Containment' and 'Treatment' speak for themselves, and 'Management' describes the coordination of relevant activities.<sup>34</sup>

## **Specialist inpatient beds, alternatives to inpatient admission and functionalised community mental health teams**

The Commission will focus on the provision and management of acute adult beds, but it needs to be recognised that these beds exist alongside a range of other specialist inpatient beds, services designed as alternatives to hospital admission, community mental health services and social support (such as supported housing) available.

### **Specialist inpatient beds**

Although the Commission will only consider adult acute beds in depth, it is important to be aware of the wider range of more specialist beds available.

#### **Psychiatric intensive care units (PICUs)**

PICUs provide care for patients who cannot be managed safely on an acute ward. The NHS Confederation Mental Health Network has provided the following definition:

*A PICU is a type of psychiatric inpatient ward. These wards are secure, meaning that they are locked and entry and exit of patients is controlled. Staffing levels are usually higher than on*

*an acute inpatient ward, usually multi-disciplinary and sometimes with 1:1 nursing staffing ratios. They usually receive patients who cannot be managed on the acute inpatient wards due to the level of risk the patient poses to themselves or to others. In some cases patients may also be referred from prisons or rehabilitation wards. Patients will usually be detained under the [relevant mental health legislation].*

*The patient's length of stay is normally short (ranging from a few days to a few weeks, depending on the patient's needs) and patients are usually returned to the acute inpatient ward as soon their risk has reduced and the more intensive treatment has started.*

*The admission for PICUs is usually due to a new episode or to an acute exacerbation of the patient's existing condition. There is often a corresponding increase in risk to themselves or others, which does not enable their safe, therapeutic management and treatment in an acute ward.<sup>35</sup>*

## **Rehabilitation beds**

The NHS Confederation Mental Health Network has provided the following definition for rehabilitation services:

*"Rehabilitation units are provided for adults with severe and enduring mental health problems who have ongoing symptoms and functional impairments and cannot manage independent community living, even with support. At any time, around 1 per cent of people with schizophrenia receive inpatient rehabilitation. Delayed recovery may be due to treatment resistance, cognitive impairment, severe negative symptoms, co-morbid physical long-term conditions (such as diabetes, COPD) substance misuse and challenging behaviours.*

*This is a relatively small group but, with such complex mental health needs and lengthy admissions, associated costs are high. There is good evidence that with suitable rehabilitation even those with the most challenging needs progress to supported community living.*

*Almost all NHS trusts in England provide generic rehabilitation services. Around 60 per cent are provided in a community setting and 40 per cent are hospital based. These units accept referrals direct from acute admission wards and occasionally from secure services. The aim of treatment is to develop skills for a successful return to community living with appropriate support. Community-based units provide a more homely environment than hospital-based units and usually support clients to carry out domestic tasks, whereas these tasks are performed for clients in hospital units. The average size is 14 beds and the usual length of stay is one to two years."<sup>36</sup>*

A survey of English trusts and Welsh health boards in March 2014 found that 31 provided 'High Dependency Rehabilitation' beds. The number of beds provided ranged from 16-209, with a median figure of 34. The Chair of the RCPsych Faculty of Rehabilitation and Social Psychiatry has commented that there is 'a very clear link between the disinvestment in rehab beds and (1) backing up on acute wards, (2) revolving door admissions to acute beds and (3) increased use of OATs (with all the quality and increased cost issues inherent with

this). This amounts to a fundamentally poor use of resources across the mental health system.<sup>37</sup>

### **Forensic/Secure services**

Forensic mental health services are provided for (a) individuals with a mental disorder (including neuro-developmental disorders) who (b) pose, or have posed, risks to others and (c) where that risk is usually related to their mental disorder. They may be placed in hospitals (particularly secure hospitals) the community or prison.

Forensic mental health services include high, medium and low secure inpatient care as well as community and outpatient services. Low secure services for adults are provided for those patients who have long-standing and complex problems and cannot be safely or successfully cared for in acute inpatient wards. These patients are usually detained under mental health legislation and present a level of risk greater than that which general mental health services could safely address. Staff working in these settings will have experience in the provision of forensic or rehabilitation services and secure care.

Medium secure services provide inpatient treatment and care for adults with complex mental health problems who have been in contact with the criminal justice system and who present serious risk to themselves or others, combined with the potential to abscond. They provide a level of security suitable for public protection.<sup>38 39</sup>

### **Dementia beds**

These are wards that specialise in the management of severe behavioural disturbance in patients with dementia. These wards are distinct from wards for older adults who have a functional illness. The interventions used include a thorough assessment of the causes of the behavioural disturbance, together with psychological and behavioural interventions to enable the patient to return to a community setting.

### **Perinatal beds**

Perinatal mental health services are concerned with the prevention, detection and management of mental health problems that complicate pregnancy and the postpartum year. These problems include both new onset problems, recurrences of previous problems in women who have been well for some time, and those with mental health problems before they became pregnant.<sup>40</sup>

### **Eating disorder beds**

Eating disorder services are a type of specialist mental health service. They comprise teams of mental health professionals with training in the assessment, risk management and treatment of individuals with various eating disorders. The professions in a team may include doctors, nursing, psychology, psychotherapy, dietetics, occupational therapy, family therapy, social work, physiotherapy and support workers. Services generally offer a 'stepped care' model of treatment, with more intensive support offered to more severely unwell

patients. While most patients will receive treatment in community services, some (mainly those with Anorexia Nervosa) will require an inpatient hospital stay. Specialist services for eating disorders work closely with general mental health services for both children and adults, primary care, voluntary sector organisations (particularly those organisations working specifically with eating disorders such as BEAT), and physical healthcare specialists.<sup>41</sup>

### **Personality disorder beds**

Some specialist personality disorder services are offered on a residential basis (in conjunction with community services) to treat and support severely disturbed adults with severe and complex personality disorders who present with problems such as:

- Self harm
- Suicidal thoughts and behaviours
- Severe dissociation
- Depression and mood disorders
- Eating disorders
- Alcohol and substance misuse
- Effects of trauma and abuse
- Severe problems in relationships
- Breakdown of everyday functioning
- Transient psychotic states
- Extensive use of other health and social care services<sup>42</sup>

### **Alternatives to inpatient admission**

#### **Crisis resolution and home treatment teams (CRHTs)**

A CRHT is a multidisciplinary team that operates on a mobile basis 24 hours a day, 7 days a week. Providing treatment at home for those acutely unwell who would otherwise require hospital admission, the team 'gate-keeps' (assesses the appropriateness) of inpatient admissions, and facilitates early supported discharges. Some trusts have reorganised their structures and provide this function as part of a wider community mental health team (CMHT).<sup>43</sup>

#### **Crisis houses**

The NHS Confederation Mental Health Network has provided the following definition for crisis houses:

*"Crisis accommodation, sometimes referred to as a crisis house, is accommodation with support provision for people who find themselves in significant mental distress and crisis. A crisis house is generally used as a community-based alternative to hospital admission. It usually provides support and respite from the person's usual place of residence. In some*



*cases it may provide 24-hour cover. It will often have in-reach from local NHS-provided crisis resolution and home treatment teams. It is intentionally designed to be a temporary place to reside and may sometimes be a form of respite. It is intended to form part of the pathway to more permanent accommodation as part of a person's recovery.*"<sup>44</sup>

### **Acute day services**

Acute day services provide an alternative to admission for people who are acutely unwell and are a means of facilitating early discharge and preventing readmission. Acute day services may be provided as an integral element of an acute hospital unit or as a stand-alone facility.<sup>45</sup>

## **Specialist community mental health services**

### **Community mental health teams (CMHTs)**

The basis of specialist community mental health services are multi-disciplinary mental health teams. The names and function of these differs in different places in the United Kingdom. In some areas the teams are generic and serve a geographic locality, or a locality based around primary care practices. In other areas services differ between those offering acute assessment and brief intervention and those offering recovery-based care for patients with long-term conditions. The RCPsych has produced a paper on the provision of models of care which recognises that there is no clear evidence to support a particular model of community care, but which sets out the parameters and principles of quality which any service model should adhere to:

### **Parameters and principles of quality for community care service models**

- *Services must be patient-centred and focus on the needs and recovery of the patient.*
- *Services must be responsive and timely, and provide appropriate timescales for response to emergency, urgent and routine referrals, with no substantial wait for routine appointments and no internal waiting lists.*
- *Services must be effective. A range of specific, evidence-based treatment and therapy modalities, appropriate to best practice in managing the clinical work of the team, must be offered by staff with sufficient experience, training and time. This includes relevant skills and training in delivering a range of pharmacological interventions and psychological therapies as well as an understanding of the impact of social factors and how to influence them.*
- *Services must be safe and provide standards of care that ensure patients and their carers do not come to harm.*
- *Services must have access to the range of appropriate resources necessary to deliver the care required.*
- *Services must be caring and provide treatment with kindness and compassion.*
- *Services must be flexible and sensitive to the needs of patients. They must 'own' referrals at the point of access and have processes in place to ensure that patients are not left without appropriate support or fall between services. They must have a robust and audited protocol to ensure that disputes between different teams and parts of the service are escalated, in a timely manner, to a sufficient level that they can be resolved, and that patients' needs are managed within the referring team or the team that has taken the referral until such time as they can be passed on.*
- *Services must be prepared and be able to work across traditional age or geographical divides.*
- *Services must routinely collect clinically relevant patient outcomes and reflect on and respond to the results.*
- *Services must operate seamlessly with primary care and other partners.*
- *Services must be able to demonstrate that they are cost effective and comparable with similar services on the basis of cost and value.*
- *Services must demonstrate a commitment to early intervention across the spectrum of mental disorders, but be mindful of the risk of over medicalisation and the fostering of dependence.<sup>46</sup>*

### **Early intervention in psychosis (EIP) teams**

Early Intervention in Psychosis services specialise in the treatment of people who are experiencing an episode of psychosis for the first time, or who are displaying symptoms which suggest that they may experience an episode of psychosis. Teams are multidisciplinary in nature and there is considerable variation in both conceptual and practical composition.<sup>47</sup>

### **Assertive outreach and treatment (AOT) teams**

Assertive Outreach Teams specialise in treating patients with complex and enduring problems who have found it difficult to engage with conventional services. They are usually based within CMHTs.<sup>48</sup>

### 3. Mental health policy developments in England, Wales and Northern Ireland

This section describes:

- British policy on inpatient mental health care ('pre-devolution'; 1957-1998)
- English policy on inpatient mental health care (1999-present day)
- Welsh policy on inpatient mental health care (1999-present day)
- Northern Irish policy on inpatient mental health care (1999-present day)

#### Pre-devolution mental health strategies

##### Summary

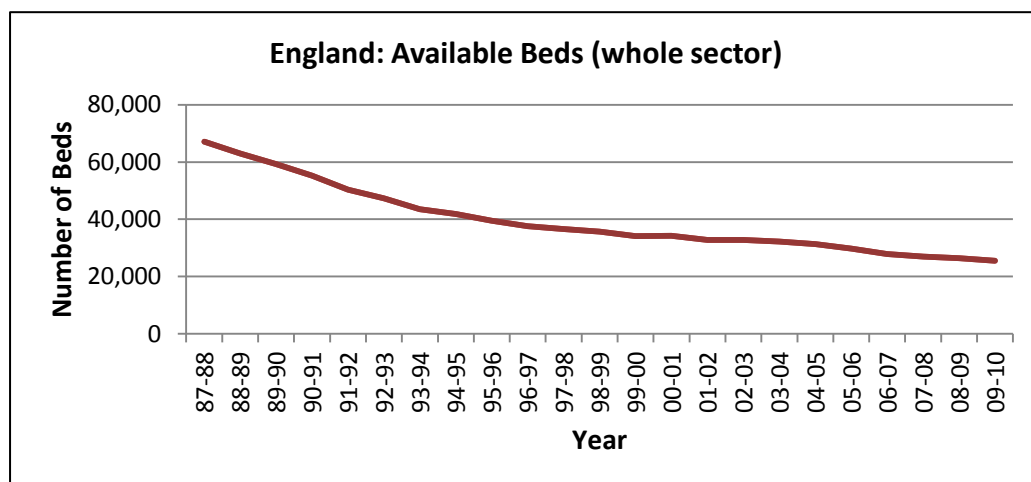
<b>1957</b>	<b>The Percy Commission</b> recommends that, where possible, mental health patients should be treated in the community rather than in hospital
<b>1961</b>	<b>Enoch Powell's 'Water Tower Speech'</b> announces plans to halve the number of mental health beds
<b>1975</b>	The White Paper <b>Better Services for the Mentally Ill</b> calls for more resources to accommodate a shift to community care

Prior to the establishment of the NHS in 1948, responsibility for mental health lay with local authorities. Despite an increase in out-patient care following the First World War to accommodate a glut of soldiers suffering from post-traumatic stress disorder,<sup>49</sup> the vast majority of care took place in inpatient settings. Following the shift to a centrally coordinated system, it increasingly became recognised that much of the care being provided in hospital settings could be provided in the community. The 1957 report of **the Royal Commission on Mental Illness and Mental Deficiency** (also known as 'The Percy Commission') accordingly recommended that 'patients who are fit to live in the community... should not be in large mental institutions such as the present mental and mental deficiency hospitals.'<sup>50</sup> This was shortly followed by **Enoch Powell's 'Water Towers' speech** in which he argued that 'we have to strive to alter our whole mentality about hospitals and about mental hospitals especially. Hospital building is not like pyramid building, the erection of memorials to endure to a remote posterity.' Praising 'advances in psychiatric knowledge and methods', Powell laid out 'a standing challenge to the National Health Service to provide the setting in which that knowledge and those methods can yield their fullest benefit.' He articulated a vision for the number of psychiatric beds to halve over fifteen years, from roughly 150,000 to 75,000.<sup>51</sup>

These announcements heralded significant decreases in the number of acute adult psychiatric beds available in England, Wales and Northern Ireland (see figures 3, 4 and 5).

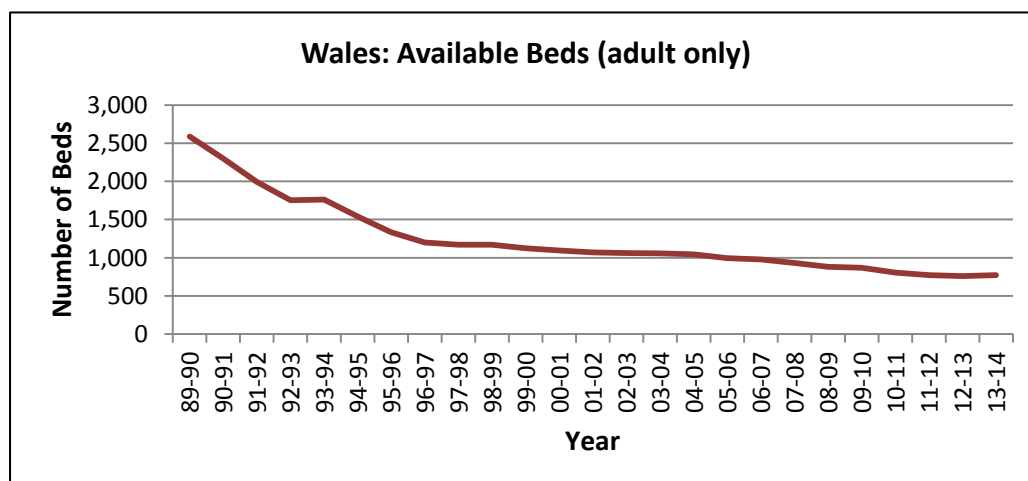
## Decline in beds numbers in England, Northern Ireland and Wales

**Figure three: Average daily bed availability in the entire mental health sector in England 1987/88 – 2009/10<sup>52</sup>**

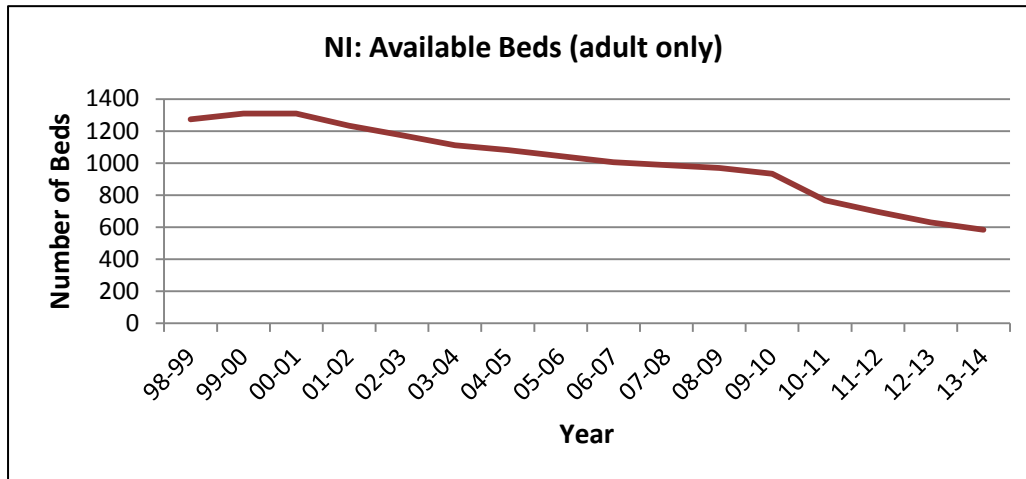


*N:B This includes the total number of mental illness beds (i.e. across all ages and specialities)*

**Figure four: Average daily bed availability for adult mental health beds in Wales 1989/90 – 2013/14<sup>53</sup>**



**Figure five: Average daily bed availability for adult mental health beds in Northern Ireland 1998/99 – 2012<sup>54</sup>**



Deinstitutionalisation was by no means unique to the United Kingdom, with similar policies being introduced in the United States of America, New Zealand, Australia, Scandinavia, Western Europe and some Southern American countries.<sup>55</sup> In America the total number of psychiatric beds fell by 90% between 1970 and 2002.<sup>56</sup>

This process of reducing the number of inpatient beds was given further prominence in the 1975 **Better Services for the Mentally Ill** White Paper,<sup>57</sup> which acknowledged that community services would need to be adequately resourced to cope with such a shift. However, Lester and Glasby note that ‘lack of funds to fully implement community care policies in the face of hospital closures has been... a recurring theme throughout the history of mental health services.’<sup>58</sup>

Curiously given its pre-devolution status at the time (which meant that its health policy was centrally controlled), Northern Ireland lagged behind England and Wales in reducing its stock of psychiatric beds by some years, with decreases seemingly only seriously considered following the 1984 **Mental Health - The Way Forward** report.<sup>59</sup>

## Post-devolution: England

### Summary

<b>1999</b>	<b><i>The National Service Framework (NSF) for Mental Health</i></b> proposes creation of new Crisis Resolution and Home Treatment, Assertive Outreach Teams and Early Intervention in Psychosis teams
<b>2000</b>	<b><i>The NHS Plan</i></b> identifies £300 million of funding to support implementation of the NSF
<b>2007</b>	<b>The Mental Health Act 2007</b> introduces Community Treatment Orders (CTOs) in England and Wales as a measure to reduce the number of ‘revolving door’ readmissions
<b>2009</b>	<b><i>New Horizons: A Shared Vision for Mental Health</i></b> replaces the NSF and aims to increase the efficiency and value-for-money of mental health services
<b>2011</b>	The Coalition government introduce a new strategy, <b><i>No Health without Mental Health</i></b> . It introduces two QUIPP (Quality Innovation Productivity and Prevention) programmes, one to increase the efficiency of the acute care pathway and one to reduce out-of-area placements
<b>2012</b>	<b>The Health and Social Care Act 2012</b> restructures the English NHS, devolving responsibility for commissioning adult acute mental health services to CCGs and establishing NHS England
<b>2014</b>	<b><i>Achieving Better Access to Mental Health Services by 2020</i></b> supersedes previous strategies and earmarks £33million in funding for Early Intervention in Psychosis teams, Liaison Psychiatry services and Crisis Resolution Home Treatment teams

Community mental health services were underfunded until the publication of the ***NHS Plan*** in 2000, which identified £300 million to fund the functionalised community mental health teams – Assertive Outreach Teams, Early Intervention in Psychosis teams and Crisis Resolution Home Treatment Teams – proposed by the ***National Service Framework (NSF) for Mental Health*** in 1999.

The NSF is also noteworthy for acknowledging that ‘it can be difficult to find any type of mental health bed for an urgent admission. There is a need for more intensive care beds in some inner city areas, particularly in London where bed occupancy can exceed 100%.’<sup>60</sup>

In response, the NSF set the standard that:

*“Each service user who is assessed as requiring a period of care away from their home should have*

- *timely access to an appropriate hospital bed or alternative bed or place, which is:*
  - *in the least restrictive environment consistent with the need to protect them and the public*
  - *as close to home as possible.”*

The NSF also emphasised the importance of the relationship between inpatient services and other elements of the acute care pathway/welfare services. It recommended that ‘local health and social care communities should map existing services - inpatient beds and mental health places, together with the other services, such as home treatment or additional 24 hour staffed places, which can either reduce the need for admission or enable earlier discharge. The housing strategies of local authorities should estimate the gaps in the service and the needs for accommodation and support for people with a mental illness.’

The NSF established (amongst other things) a performance indicator assessing the ‘percentage of all inpatients deemed to be in a hospital bed when then need not be, or deemed to be placed at an inappropriate level of security’ without a complementary indicator to assess the number of patients who could not access a hospital bed when one was needed (despite recognising that there were significant shortages in some areas of the country).<sup>61</sup>

The NSF was followed, in 2004, by a five-year progress report on its implementation. This noted the variable progress made with the development of functionalised CMHT teams, and suggested that stable bed occupancy and length of stay figures (reflecting a fall in both admissions and bed numbers) demonstrated that ‘the pressure on acute units from numbers of admissions alone is reducing a little, but that it will have to reduce further before occupancy figures nationally fall to acceptable levels.’



## **Extracts from *The NSF: Five Years On***

### **Standard 4: Specialist Care**

*'The NHS Plan envisaged 220 assertive outreach teams, building on the 170 teams proposed in the NSF. The target was met by the 2003 deadline and by March 2004, 263 teams were in place.*

*The NHS Plan proposed 335 dedicated [Crisis Resolution] teams across England by the end of 2004....In 2000, only 35 specialist crisis resolution teams existed. By March 2004, that number had risen to 168, employing 2,173 staff across the country...64 of the 168 do not operate 24 hours a day, seven days a week.*

*The NHS Plan set a target of 50 early intervention teams by the end of 2004. Validated data show 41 teams nationally and local delivery plans predict full delivery by the target date. However, the existing 41 teams are mostly smaller than was envisaged, and employ in total only 174 staff. Only 3% of LITs considered their service to meet local needs in the 2003 autumn assessment, with a further 34% reporting some level of service, although not adequate for local needs.*

*Investment in assertive outreach, crisis resolution and early intervention has not followed the intentions of the NHS Plan in all parts of the country. There are reports of the dismantling of existing services to provide staff for the new specialised teams. The most up-to-date figures for crisis resolution and early intervention suggest that the NHS Plan targets and target dates may prove too challenging. However, this year's local delivery plans present a more optimistic picture – it is vital that these plans turn into new services.*

*Even in the case of assertive outreach, the target for which has been met, services have been unable in one respect to meet the model set out for them in the mental health policy implementation guide: their hours of availability. Only 96 teams operate a full 24-hour on-call service.'*

### **Standard 5: Hospital and Crisis Resolution**

*'The number of NHS short-stay (acute) beds for adult mental health fell from 14,420 in 1998–99 to 13,740 in 2002–03, a fall of 4.7%, while the number of NHS medium secure beds increased in the same period from 1,750 to 2,060, a rise of 18%. The number of NHS admissions for all mental illness (15–64 years) fell from 135,460 in 1998–99 to 122,260 in 2002–03, a fall of 9.7%. Median length of stay has been stable at around 18–19 days over the same period and average bed occupancy has remained at around 91%. Taken together, these figures suggest that the pressure on acute units from numbers of admissions alone is reducing a little, but that it will have to reduce further before occupancy figures nationally fall to acceptable levels.*

*Although this NSF standard refers to treating people as near as possible to their homes, most services do not have figures for the out of area referral of acute in-patient cases...Nevertheless, non forensic out-of-area placements represent a significant part of the care system for adults with severe and enduring mental illness and there is evidence that in certain instances, the care received outside the NHS is of poorer quality despite being expensive.<sup>62</sup>*

The follow-up policy document to the NSF, ***New Horizons: A Shared Vision for Mental Health***, committed to reduce admissions, bed occupancy, length of stay and the use of out-of-area placements. However, these pledges were clearly contextualised as being ‘value-for-money’.<sup>63</sup>

**Extract from *New Horizons***

**Promising value-for-money interventions**

*More work is being carried out on each of these areas and detailed analysis and information will be available shortly. Improving the quality of care and efficiency of the acute care pathway by:*

- *reducing admission through the involvement of community teams, including crisis and home treatment teams*
- *reducing the use of out-of-area placements by ensuring sufficient high quality local services*
- *improving the procurement of independent sector services*
- *improving the quality of inpatient treatment and discharge planning, including community services and appropriately supported accommodation, to reduce lengths of stay and occupied bed days.*

**The Mental Health Act 2007** introduced Community Treatment Orders (CTOs) in England and Wales as a measure to reduce the number of ‘revolving door’ readmissions. CTOs enable clinicians to compel patients to take medication once discharged from hospital, with rapid involuntary detention threatened if they do not do so. The use of CTOs has been criticised on the grounds that they disproportionately interfere with patient rights to autonomy, and research has demonstrated that they offer no improvement in this respect over less coercive measures such as conventional leave.<sup>64</sup>

In 2011 the Coalition government published ***No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for all Ages***. A key policy development signalled by this document was an explicit intention for mental health to have ‘parity of esteem’ with physical health.

Although this document did boast that ‘the development of community-based services and the widespread integration of health and social care has meant that fewer people need inpatient care and the number of inpatients taking their own life has reduced,’ it acknowledged that this had not been a universal success: ‘[in some areas] the development of functional teams...has led to the fragmentation of care and inefficiencies across services.’ *No Health Without Mental Health* also laid out three areas of mental health being targeted by the broader NHS Quality Innovation Productivity and Prevention programme. Two of these are relevant, and again suggest that admissions (and hence bed numbers) can potentially be further reduced, although with the caveat that beds must be available locally – but particularly to avoid the use of costly out-of-area placements.

### Extracts from *No Health Without Mental Health*

**QIPP Area One:** *the acute care pathway – avoiding hospital admissions through effective joined-up community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided (for example, by action to tackle delayed discharges)*

**QIPP Area Two:** *out of area care – getting better quality and better value through ensuring that appropriate in-area care is available where this is a better solution and commissioning effectively so that care is managed well, in terms of both care pathways and unit costs*<sup>65</sup>

**The Health and Social Care Act (HSCA) 2012** was a highly significant point in English health policy. Responsibility for commissioning adult acute psychiatric services (as well as non-specialised mental and physical health services more generally) was transferred to 211 Clinical Commissioning Groups (CCGs), who in practice often join together in small groups to commission services for a particular locality. The commissioning of specialised psychiatric services (such as inpatient perinatal units) became the responsibility of a new body, NHS England. Both transitions of responsibilities occurred in April 2013.

Although the Secretary of State for Health retained overall responsibility for the NHS, in practice the emphasis placed upon the merits of devolving power during the passage of the HSCA made it unlikely that there would be frequent interventions from central government. However, the Government's action to provide a £250m funding boost for Accident and Emergency services to deal with a 2013/14 'winter crisis' did prompt Lord Bradley to ask in Parliament whether the Government would 'consider making emergency funding available similar to that it made available to A&E departments in the winter to immediately ease the mental health crisis in beds for adults and children?' Speaking on behalf of the Government, Earl Howe replied: 'I am certainly aware that a number of concerns have been raised about the lack of mental health beds and there are occasions when patients do not receive care quickly enough because approved mental health professionals can't locate an appropriate bed. This is essentially a failing of local clinical commissioning.'<sup>66</sup>

The mechanism by which the Government sought to give some direction to NHS England (and via them to Clinical Commissioning Groups) were annual 'Mandates' spelling out headline objectives. Both the 2013-2015 and 2014-2015 Mandates have emphasised the importance of parity of esteem, and directed NHS England (formally known as 'The Board' in the 2013-2015 version) to investigate access and waiting time standards for mental health. The 2014-2015 Mandate additionally set a target of April 2015 for phased implementation of these standards.<sup>67</sup>

**Extract from *The NHS Mandate 2013-15***

*Too often, access to services for people with mental health problems is more restricted and waiting times are longer than for other services, with no robust system of measurement in place even to quantify the scale of the problem. As part of its objective to put mental health on a par with physical health, we expect the Board to be able to comprehensively identify levels of access to, and waiting times for, mental health services. We want the Board to work with CCGs to address unacceptable delays and significantly improve access and waiting times for all mental health services, including IAPT. We will also work with the Board to consider new access standards, including waiting times, for mental health services, including the financial implications of any such standards.<sup>68</sup>*

*No Health Without Mental Health* was superseded in 2014 by ***Achieving Better Access to Mental Health Services by 2020***, which announced £7million funding to commission 50 new inpatient beds for children and adolescents. This followed a review of bed numbers by NHS England (who are responsible for commissioning these beds), and is arguably the first time that a concerted effort has been made to increase bed provision, with the explicit recognition that there were too few inpatients beds available for a group of patients.

**Extract from *Achieving Better Access to Mental Health Services by 2020***

*NHS England are investing £7 million immediately in 50 new inpatient beds and in better case management, to ensure that children with specialist inpatient needs are cared for in appropriate settings. This should bring an end to the unacceptable practice of young people being admitted to institutions far away from where they live, or from being inappropriately admitted to adult wards. The additional capacity should also help to minimise the number of young people who are admitted to restrictive care settings. At the same time, NHS England will work to consider the longer term capacity requirements to ensure that provision for this vulnerable and important group of people is put on a sustainable basis for the future.*

*Better Access for Mental Health Services* also earmarked £33million in funding for Early Intervention in Psychosis teams, Liaison Psychiatry service and CRHTs.<sup>69</sup>

There has also been a significant rise in the number of patients being treated in the independent sector. Keown et al (2008) describe how in 1996-7 involuntary patients in England were 15 times more likely to be in an NHS facility than in an independent hospital, but by 2006 they were only five times more likely.<sup>70</sup>

## Post- devolution: Wales

### Summary

<b>1989</b>	<b>(Pre-Devolution)</b> The Wales Office publishes an <b><i>All Wales Mental Health Strategy</i></b> , establishing multidisciplinary CMHTs, and places an emphasis on secondary mental health services
<b>1999</b>	Decision-making powers relating to healthcare devolved to the Welsh Assembly
<b>2001</b>	<b><i>Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency</i></b> is published placing community care at the heart of adult mental health services
<b>2002</b>	The <b><i>National Service Framework for Adult Mental Health Services</i></b> is published to support the 2001 strategy and the development of functional teams, such as CRHTs
<b>2004</b>	The National Audit Office publishes <b><i>Adult mental health services in Wales: A baseline review of service provision</i></b> highlighting significant gaps in the development of community resources
<b>2005</b>	<b>The Mental Health Measure (2010)</b> is introduced, promising more mental health services within primary care, and enabling all adults discharged from secondary services to refer themselves back to those services
<b>2010</b>	<b><i>Together for Mental Health</i></b> is published, arguing that early intervention services, supported housing and emergency respite services must be offered to avoid unnecessary admissions to hospital

Pre-devolution, the Welsh Office launched an ***All Wales Mental Health Strategy*** in 1989. This established multidisciplinary CMHTs, and placed an emphasis on secondary mental health services prioritising people with severe mental illness.<sup>71</sup>

The Government in Wales Act 1998 devolved decision-making powers relating to healthcare (and other matters) to a Welsh Assembly, with effect from 1999. Further powers to create legislation were added via the Government in Wales Act 2006. Mental health was designated as one of the Assembly's 'top three' health priorities, and there have been several key mental health policy initiatives since 1999 with implications for inpatient services.

The Welsh National Assembly published ***Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency*** in 2001 praised the preceding ten years of deinstitutionalisation as a 'significant development... [Wales] has moved away from large institutional settings to more dignified community settings'.

Initially suggesting that the quality rather than the provision of inpatient services was a prevailing issue, the document noted that 'successful implementation of the Strategy will depend on closure of the remaining large Victorian institutions and replacement with modern facilities so that mental health services are delivered in settings which are fit for purpose.' The Strategy later notes however that 'there has been an increase in bed occupancy in recent years, though the reasons for this are not entirely understood. There have been many occasions recently when mental health services in Wales have been unable to respond to emergencies that require in-patient admission because of a lack of available beds.'

The Strategy endorsed an 'assertive' model of engaging with patients with complex or enduring needs via Assertive Community Treatment, and a broader expansion of CMHT and day hospital provision. It noted that 'even where there are good community-orientated services, there is still a need for in-patient care'.

**Extract from *Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency***

*There now exists a greater risk of violence, towards both staff and patients, within these environments leading to an emphasis on observation and containment thereby reducing therapeutic activity. Patients within in- patient units are much more likely to be severely ill, have a dual or multiple diagnosis and have greater social needs. The complexity of care that such patients require is much greater now than in the past and yet little attention has been given to the development of clinical skills or resources needed to provide quality care in in-patient settings. Providing a local intensive care unit can help to provide a more suitable short-term environment for those who are very disturbed and make the general wards less custodial.*

The Strategy also recommended greater provision of psychological therapies and specialist mental health beds.<sup>72</sup>

In 2004 the Welsh Audit Office published its **Baseline Review of Mental Health Service Provision in Wales**. The Review argued that 'local agencies delivering mental health care services should... increase the provision of community based treatments and support which can provide an alternative to hospital admission and which facilitate safer and speedier discharge from hospital. Central to this is the need to develop crisis resolution services in the community and to ensure that appropriate supported accommodation, day-care services and rehabilitation facilities are available that allows care for people with mental health problems to be provided in the most appropriate setting.'<sup>73</sup>

Following the 2004 Review, the Welsh Assembly published a **Revised National Service Framework**. It proposed that the development of CRHTs and improving inpatient environments (the latter via 'the enhancement of staffing and the reconfiguration of wards') be prioritised.

The NSF advocated a move away from regional planning of bed numbers, arguing that 'where estate developments are being considered this needs to be within the context of the total requirement for beds in Wales rather than solely on a local basis.'

The NSF set out various standards relevant to the provision and quality of inpatient care.

### **Standards relevant to the provision and quality of inpatient care**

#### **Key Action 13**

*Any individual with an identified serious mental illness is to be able to contact local services on a 24-hour basis in order to have their needs assessed and receive appropriate advice, treatment, care and/or support.*

#### **Key Action 21**

*Inpatient and community services are to be provided in fit for purpose environments.*

*These are to offer dignity, privacy and appropriate space and resources for purposeful activity for users and staff. A therapeutic, supportive environment is to be created and properly staffed. All inpatient wards are to offer the choice of single sex environments. People are to be treated in the least restrictive environment possible.*

#### **Key Action 24**

*Each LA/LHB area is to have a range of alternatives to admission and facilities to support individuals after discharge, including day services. This should include supervised short or medium term accommodation with residential care staff on site and mechanisms to support people in their own accommodation.*

#### **Key Action 25**

*A range of specialist services is to be available and accessible across Wales. These should include eating disorder services, mother and baby units, low secure care, liaison psychiatry, neuropsychiatry and early intervention services accessible to each Trust area.*

#### **Key Action 27**

*All areas are to have a comprehensive range of rehabilitation services aiming to maximise the independence and recovery of users. This will include 24-hour staffed slower stream and fast track rehabilitation, with adequate facilities for continuing care for the small numbers of users with such needs. There is to be a range of community rehabilitation services providing multi- agency care for users with long term needs and delivering an assertive community treatment methodology.<sup>74</sup>*

A review of the progress made with the Welsh NSF was completed by the Welsh Audit Office in 2011. It reported the following:

**Extract from Welsh Audit Office Report 2011**

*Assertive outreach services, which target people with severe and enduring mental illness who do not effectively engage with mainstream mental health services, have ... expanded. In 2009 these services were available in seventeen council areas, compared with six council areas in 2005.*

*There has been a shift in resources from inpatient to community services but, although many areas now have a broader range of community services in place, these do not always have adequate capacity. Between 2005 and 2009 there has been a 23 per cent reduction in the overall number of adult mental health beds, and a 14 per cent increase in community staffing levels. However, progress across Wales has been mixed and there is no apparent rationale for the level and mix of inpatient and community resources in different areas.*

*Good progress has been made in establishing crisis resolution and home treatment services, which act as an alternative to hospital admission. The number of council areas covered by this service has increased from nine in 2005 to 18 by the end of 2009, and there were specific plans in place to establish these services in the remaining four council areas.*

*Acute bed occupancy rates have...reduced, from 92 per cent in 2005-06 to 84 per cent in 2009-10. These reductions have corresponded with a reduction in the number of inpatients, by 17 per cent between 2005-06 and 2009-10.*

*There has been far less progress in developing early intervention in psychosis services.<sup>75</sup>*

**The Mental Health (Wales) Measure** was passed by the Welsh Assembly in 2010 and contained two elements which may have a bearing on inpatient services, 'Part 1 of the Measure will ensure more mental health services are available within primary care...[and] part 3 enables all adults discharged from secondary services to refer themselves back to those services.'<sup>76</sup>

The current Welsh mental health strategy ***Together for Mental Health*** was published in 2012. This document continued to endorse a preventative strategy, arguing that 'primary care schemes and investment in community provision would help people to remain as independent as possible with inpatient care used only when needed and for the appropriate length of time.' The strategy acknowledged that more needs to be done with regard to the therapeutic environment within wards, and pointed to the replacement of any remaining 'unsuitable' facilities with 'improved community services supported by modern inpatient units,' rather than just more inpatient facilities on a like-for-like basis.

The strategy signalled that 'psychologically minded' early intervention services must be offered, 'to improve outcomes and to help reduce inappropriate hospital admissions.' Similarly, it advocated the use of supported housing and emergency respite services to



‘support crisis interventions and avoid unnecessary admissions to hospital or inappropriate lengths of stay.’

An (unquantified) reduction in the overall number of admissions was identified as one of the ways in which the strategy’s success would be measured, alongside reductions in the number of delayed discharges and repeat admissions within 30 days.<sup>77</sup>

## Post-devolution: Northern Ireland

### Summary

<b>1999</b>	Decision making powers relating to healthcare devolved to the Northern Irish Assembly
<b>2002</b>	<b>The Bamford Review</b> is commissioned to review mental health and learning disability services in the country
<b>2005</b>	The Bamford Review publishes <b><i>A Strategic Framework for Adult Mental Health Services</i></b> . It supports further deinstitutionalisation but concludes that community services are significantly underdeveloped compared to England
<b>2007</b>	The Bamford Review finishes its programme of work
<b>2009 -2015</b>	A series of action plans are created to implement the Bamford Vision. <b><i>Delivering the Bamford Vision: Action Plan (2009 – 2011)</i></b> aims to redirect resources towards community mental health and reduce the number of long stay patients by 10%. This work is continued in <b><i>Delivering the Bamford Vision Action Plan 2012 – 2015</i></b>

The devolution of powers regarding health to the Northern Irish Assembly took effect in 1999 following the passage of the Northern Ireland Act 1998.

**The Bamford Review** was commissioned in 2002 and concluded its programme of work in 2007. It had been given a broad remit to examine the law, policies and the provision of services relevant to both mental illness and learning disability. The first report published by the Review, ***A Strategic Framework for Adult Mental Health Services (2005)*** highlighted the interdependence of the Review’s objects of inquiry, and acknowledged the process of deinstitutionalisation, positively framing it as being both evidence-based and popular with patients.

**Extracts from A Strategic Framework for Adult Mental Health Services (2005)**

*The success of any reform of adult mental health services is dependent upon the successful reform of the system as a whole. There are many interfaces between adult mental health services and other services... Services in several areas out with adult mental health have historically been less well developed, notably child and adolescent services, forensic services and specialist services within adult mental health.'*

*Over the past 30 years successive local and national strategies and a growing body of research evidence have advocated refocusing of service provision away from hospital settings towards community based provision. This shift reflects the preference of service users for home life over institutional care, for local services over distant ones, for services sensitive to community needs and the pursuit of normalisation and integration. It has led to a strong emphasis on the provision of more and better care in the community, embracing support for primary care services and the development of a spectrum of community facilities and services; the participation of service users and carers as partners in service planning, development, delivery and monitoring.*

However, it then noted that there are '...present shortcomings in service provision...whilst Northern Ireland policy has focussed on the development of community mental health service provision, the pace of development has lagged significantly behind developments in England.' Particular deficits identified were the availability of community alternatives to admission (for both assessment/crisis care), provision of out-of-hours services and the availability of psychological therapies.

The Framework's stated aim was 'to ensure that each person with mental health needs receives appropriate services, where and when he/she requires them. The emphasis is on fitness for purpose.'

Although the emphasis early in the document was on the inadequacy of community mental health services, improving the 'quality and accessibility of inpatient provision' was subsequently listed (alongside provision of a 'substantial' increase in community services) as being of fundamental importance.

The Strategic Framework recognised that 'acute inpatient care is an integral part of mental health services. In the context of well-developed community services, inpatient admission should only be required for people with most severe episodes of mental disorder, typically psychosis and severe depression...Several reports, including reports from service users and from the Northern Ireland Association for Mental Health on inpatient services, have highlighted significant shortcomings and dissatisfaction with current provision.'

Despite access to inpatient services being identified as a problem the document 'envisages a major shift in the centre of gravity of secondary mental health services being achieved over the next 10-15 years. With appropriate development of the full range of community based services it is anticipated that the need for admission to hospital will be much reduced and

the duration of admissions much shorter...the present balance of resource spend is approximately 60% on hospital services and 40% on community services. The recommended developments in community services should be reflected in a reversal of this balance of expenditure within 10 years of implementation of the Strategic Framework...[and] the requirement for acute inpatient provision should reduce to approximately 20 places per 100,000.'

The Framework stressed that 'mental health and social care should be provided in the community unless there is good reason for not doing so.' It proposed increasing the availability of Home Treatment/Crisis Resolution Teams, Day Centres and Assertive Community Treatment teams as alternatives to inpatient admission in a crisis.

**Extracts from *A Strategic Framework for Adult Mental Health Services (2005)***

*Adequately resourced HT teams with clear gatekeeping functions can significantly reduce the pressures on inpatient services and CMHTs while providing users with increased choice of provision at times of crisis.'*

*Acute day hospitals should be considered as a cost- effective option for the provision of acute care both as an alternative to acute admission to hospital and to facilitate early discharge from inpatient care.*

*Present evidence suggests that Assertive Community Treatment (ACT) is a successful alternative to inpatient hospital treatment, enabling service users with the highest levels of disability and greatest vulnerability to be maintained more successfully in community settings.*

The Strategic Framework proposed ten standards to frame its vision, two of which are of particular relevance to the Commission:

**Relevant standards from *A Strategic Framework for Adult Mental Health Services***

**Standard 3. Effective Community Mental Health Services**

- *Comprehensive coverage by CMHTs*
- *CMHTs adequately staffed to a minimum of 50/100,000*
- *Ready access to a range of community resources including independent and user led provision*
- *Accessible and effective range of evidence-based and up-to-date therapeutic interventions*
- *Tier 2 services for people with psychological trauma, eating disorder, personality disorder, disorders of gender or sexuality, women with perinatal mental health problems, deaf people with mental health problems.*

**Standard 4. Effective Crisis Services**

- *Comprehensive provision of 24/7 appropriately resourced Home Treatment Services*
- *A single system of acute and crisis provision including Home Treatment, Day Hospital, Step-up, Step-down and Inpatient services*
- *All services of high quality providing a range of therapeutic interventions, sensitive to gender and cultural needs*
- *A lead clinician or manager with overall responsibility for inpatient services.*

The Strategic Framework offered an insight into the reasons why deinstitutionalisation had taken place later in Northern Ireland than in England or Wales:

*‘Mental health inpatient provision in Northern Ireland, as in the rest of Ireland, is and has been significantly greater than in England. Historically this may have reflected greater commitment from local administration in providing for the most vulnerable in our society. However, the present relatively high level of provision reflects a lack of alternative provision, the result of deficiencies in the current and previous strategies, lack of investment and resources.’<sup>78</sup>*

The Review’s final report ***A Comprehensive Legislative Framework*** was published in 2007. Focusing on legislative changes, it nonetheless noted that “there have been significant developments in community-based care. These have extended alternatives to hospital care and treatment and should result in more local options in less restrictive forms of care. These include Home-based Treatment and Assertive Outreach teams and the further development of social and psychological therapies.”<sup>79</sup>

## 4. Quality measurement and standards

This section describes:

- the Inspection regime used in England, Wales, and Northern Ireland
- quality improvement initiatives in inpatient care

### Inspection regimes

The Care Quality Commission (CQC) is responsible for inspecting mental health services in England.<sup>80</sup>

The Healthcare Inspectorate (Wales) is responsible for inspecting mental health services in Wales.<sup>81</sup>

The Regulation and Quality Improvement Authority is responsible for inspecting mental health services in Northern Ireland.<sup>82</sup>

### Quality improvement

There is currently a paucity of research into the effectiveness of inpatient psychiatric care.<sup>83</sup> However, there have been several initiatives to improve the standard of inpatient care by RCPsych and other organisations.

### RCPsych standards

The RCPsych has produced ***Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental healthcare***. This document set out the following ten standards for inpatient care:

#### 10 “Do the Right Thing” Standards for Inpatient Care

1. Bed occupancy rates of 85% or less
2. Ward size maximum of 18 beds
3. A physical environment that is fit for purpose
4. The ward [must be] a therapeutic space
5. Proportionate and respectful approach to risk management and safety
6. Information sharing and involvement in care- planning
7. A recovery-based approach: Links with the community and other agencies
8. Access to psychological interventions
9. Personalised care: Staffing and daily one-on-one contacts
10. Providing socially and culturally sensitive care<sup>84</sup>

## AIMS

RCPsych has also established **AIMS (Accreditation for Inpatient Mental health Services)**, a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards.<sup>85</sup> Wards are assessed against around 280 standards, which are based on national guidance and best available evidence.<sup>86</sup> Standards are divided into five domains; (general standards; timely and purposeful admission; safety; environment and facilities and therapies and activities).<sup>87</sup>

*“Accreditation entails a rigorous process of self- and peer-review against the standards. This involves an audit of health records, policies and procedures, evaluation of the ward environment and facilities, and structured feedback from ward staff, and patients and carers who have used the service. This data is then collated into a booklet and an external review team will visit the ward and review these areas to validate the self-review data”.*<sup>88</sup>

As of July 2012, 160 working-age wards were enrolled in AIMS. 148 of these were located in England, eight in Wales, plus one each in Northern Ireland, Republic of Ireland, Jersey and the Isle of Man.<sup>89</sup>

## Star Wards

Star Wards is a voluntary scheme for inpatient wards and is run by a service user with experience of being treated under the Mental Health Act. It aims to improve the day-to-day experiences of patients on wards, with a particular focus on increasing the number of therapeutic and recreational activities available to patients, as well as improving the quality of patient conversations with staff. The scheme encourages staff to benchmark themselves against other services and publishes an extensive collection of best practice resources on its website. Wards can also work towards achieving a “Full Monty Award” for implementing 75 best practice ideas.<sup>90</sup>

As of 2013, the scheme had around 651 member wards and 70 wards had achieved the “Full Monty”.<sup>91</sup> Fifty percent of survey respondents reported that Star Wards had a “big or massive impact” on the activities in the ward and on patient satisfaction.<sup>92</sup> Despite this, there were also warnings that the challenging climate since 2009 was limiting the impact and development of the scheme.<sup>93</sup>

## Triangle of Care

The Triangle of Care has been developed by the Carers Trust and sets out six standards that mental health services should achieve to ensure that carers are engaged and supported at all levels of service delivery, from individual care to service planning. The standards are shown below<sup>94</sup>. Since the original publication of the standards in 2010 the Carers Trust has developed a Triangle of Care membership scheme and self-assessment tools to support trusts in working towards the standards and provide recognition to those that achieve all six (England only). To date, there are approximately 26 NHS trusts involved in the scheme.<sup>95</sup>

### **The six standards identified in the Triangle of Care**

- 1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
- 2) Staff are 'carer aware' and trained in carer engagement strategies.
- 3) Policy and practice protocols re: confidentiality and sharing information, are in place.
- 4) Defined post(s) responsible for carers are in place.
- 5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
- 6) A range of carer support services is available.

### **Safewards**

Safewards is a new scheme designed to improve safety on inpatient wards by reducing levels of conflict and seclusion. The scheme utilises ten interventions (below) which can be implemented on wards by mental health nurses.<sup>96</sup> The interventions are based on the 'Safewards Model' - a theoretical framework developed by the Institute of Psychiatry, which identifies six originating domains as sources of conflict and containment: the patient community, patient characteristics, the regulatory framework, the staff team, the physical environment and outside hospital.<sup>97</sup> The Safewards interventions have been supported by the results of a recent randomised controlled trial and the team are now looking to develop the project further.<sup>98</sup>

### **The 10 Safewards Interventions**

1. Clear Mutual Expectations
2. Soft Words
3. Talk Down
4. Positive Words
5. Bad News Mitigation
6. Know Each Other
7. Mutual Help Meeting
8. Calm Down Methods
9. Reassurance
10. Discharge Messages

## 5. Current levels of provision and staffing

This section describes:

- Data on the number and management of adult acute inpatient beds in England, Wales, and Northern Ireland
- Staffing in England

### Total average daily available beds

<u>Country</u>	<u>Number</u>	<u>Year</u>
England - (adult mental illness; NHS only)	13,728	2009/10
England – (every mental health bed; NHS only)	21,822	2014/15
Wales (adult mental illness; NHS only) –	771.8	2012/13
Northern Ireland – (adult mental illness; NHS only)	584.3	2013/14)

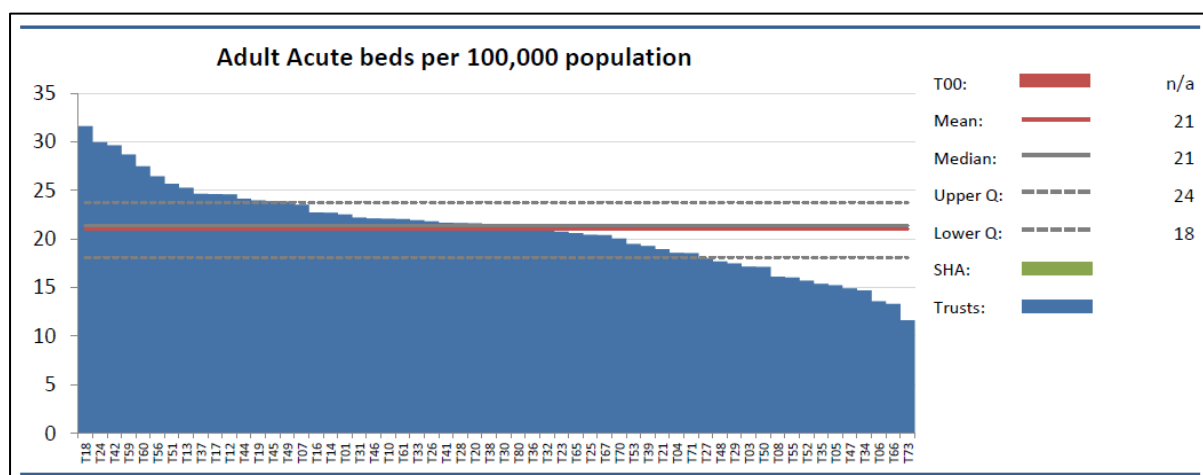
### Data from the 2014 NHS benchmarking exercise

The graphs in this section are taken from the NHS Benchmarking Network's 2014 mapping exercise,<sup>99</sup> and reproduced with their kind permission. The data relate to English trusts and Welsh health boards only, and illustrate the considerable variation between different areas. Different trusts/health boards are represented as the letter 'T' plus a number (eg 'T23') on the x-axis of each graph. The term 'weighted population' refers to the process of adjusting figures to reflect the socioeconomic mix of an area, as this will affect the demands made on the health services. For example, people from areas which are socioeconomically deprived typically have worse health than those living in more affluent areas, and use the health services more often as a result. Please note that the 'T00' and 'SHA' legend in the right hand margin of each graph is an artefact of the way the graphs have been copied and is not of relevance.



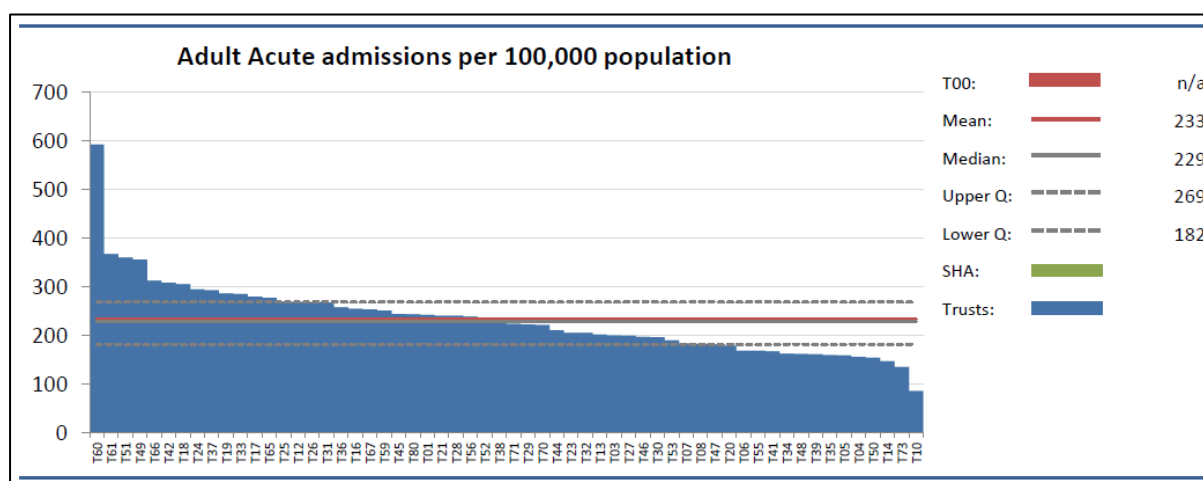
**Figure six: 2014 Adult acute psychiatric beds per 100,000 (weighted) population (England/Wales)**

Provision across the NHS [in England and Wales] ranged from 12 beds per 100,000 (weighted) population to 32 beds per 100,000 (weighted) population, with a median position of 21.



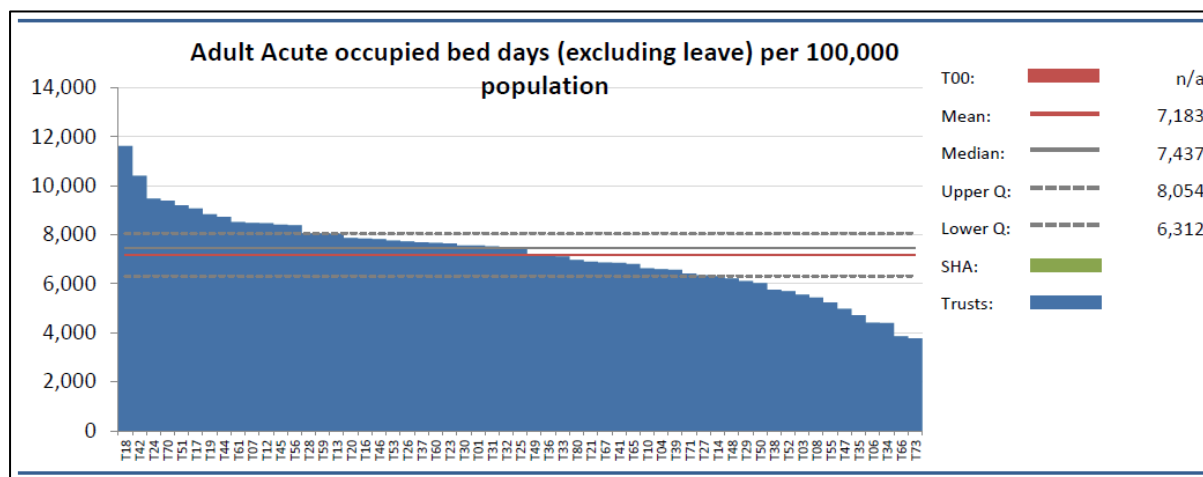
**Figure seven: 2014 Adult acute psychiatric admissions per 100,000 (weighted) population (England/Wales)**

The median position was 229 admissions per 100,000 (weighted) population of working age adults.



**Figure eight: 2014 Adult acute psychiatric occupied bed days (excluding leave) per 100,000 (weighted) population (England/Wales)**

The mean figure was 8.083 bed days per 100,000 weighted population.



## Staffing

Drawing on data from the HSCIC, the Centre for Workforce Intelligence (CfWI) released a report about the English psychiatric workforce in November 2014. It reported that between 2003-2013 the total number of consultant psychiatrists had increased by 41%. This can be compared with a 48% average consultant growth figure in other medical specialties in the same period, and it should be noted that the number of people using secondary mental health services increased by 48% in virtually the same period of time (2003/4 – 2011/12).

Although the consultant psychiatric workforce only accounts for approximately 5% of the mental health workforce, it is still a good indicator of the broader picture. The number of full-time equivalent (FTE) consultants working in General Adult psychiatry increased by 37% between 2003-2013, taking the FTE workforce per 100,000 population figure from 3.2 to 4.1 (the highest figure of the psychiatric specialties; cf. eg old age psychiatry 0.77 to 1.1). It should be noted that in practice there is an uneven distribution across England. The number of vacant training posts in adult psychiatry decreased by 4.8% between 2012-2014.

Turning to the broader English workforce, there was a 33% increase in the number of FTE clinical psychologists and a 2% decline in the number of FTE mental health nurses between 2003-2013. The CfWI linked the reduction in the nursing workforce with reductions in the number of beds available, '...with only partial re-deployment of nurses into community teams. This is likely to put additional pressure on the rest of the mental health team, including psychiatrists'.<sup>100 101</sup>

In 2013 the RCPsych conducted a census of psychiatric staffing which included Northern Ireland and Wales. 78.9% of NHS providers replied, although the response rate from independent providers was poor. As such, the figures are not a comprehensive

representation of staffing numbers. The number of substantive whole-time consultant posts in General Adult Psychiatry as at 31 December 2013 was 31 in Northern Ireland and 52 in Wales. The number of substantive part-time consultant posts in General Adult Psychiatry as at 31 December 2013 was 10.6 in Northern Ireland and 6 in Wales.<sup>102</sup>

The Royal College of Nursing released a report in December 2014 showing that the number of mental health nurses had gone down in England, Wales and Northern Ireland. The number of mental health nurses decreased between 2010 – 2014 by -8%, -1% and -1% respectively. This must be contextualised within increases in the total number of nursing staff, which rose by 1% in each country.

Data for England show a disproportionate drop in experienced nurses. It was hypothesised that this could be attributed to them moving to the independent sector, although it is difficult to be certain as data are not collected on that subject. The RCN report notes that ‘without enough senior nurses there are not sufficient resources in place to deliver therapeutic treatments to support people with recovery, resulting in people not having access to the range of treatments set out in the NICE and SIGN recommendations. An experienced workforce is integral to helping people recover so that they do not need to return to hospital.’<sup>103</sup>

Mental health trusts in England are required to publish safe nursing staffing levels for each of their wards and whether these levels have been met. In addition, NICE are working on formal guidance in this area.<sup>104</sup>

Bowers et al (2009) have argued that motivated staff have moved from inpatient services to community services, drawn by the promise of innovative models of care and better career/training prospects.<sup>105</sup>

It has been estimated that only 50% of nursing staff time is spent engaging with patients, with therapeutic activities only accounting for a small amount of this time.<sup>106</sup> Despite this, staff-patient interaction has been identified by one systematic review as the most frequent antecedent for violence and aggression on inpatient wards, accounting for 39% of the total.<sup>107</sup> A separate systematic review of violence in inpatient wards concluded that ‘harmony among staff (a good working climate) seems to be more useful in preventing aggression than some of the other strategies used in psychiatric wards, such as the presence of male nurses.’<sup>108</sup>

## 6. Funding and commissioning structures in England, Wales and Northern Ireland

This section describes:

- funding levels for mental health in England, Wales and Northern Ireland
- arrangements for planning and commissioning services in these countries

### Funding

#### England

Between 2000/01 – 2011/12 a company called Mental Health Strategies was commissioned by the Department of Health to measure spending on adult mental health services in England. Their research showed that there was a 59% increase in real terms spending during this period, with increases taking place each year until 2011/12 (when there was a decrease of 1%):<sup>109</sup>

Year	Reported Investment	Estimated Unreported Investment	Total Investment	Annual Increase	% Increase
2001/02	4.002	0.160	4.162		
2002/03	4.348	0.274	4.622	0.460	11.1%
2003/04	4.773	0.040	4.814	0.191	4.1%
2004/05	5.309	0.055	5.364	0.550	11.4%
2005/06	5.442	0.262	5.703	0.339	6.3%
2006/07	5.618	0.194	5.812	0.108	1.9%
2007/08	6.066	0.019	6.085	0.274	4.7%
2008/09	6.249	0.046	6.295	0.210	3.4%
2009/10	6.298	0.338	6.636	0.341	5.4%
2010/11	5.780	0.914	6.694	0.058	0.9%
2011/12	5.717	0.912	6.629	-0.066	-1.0%
Increase in the 10 years 2001/02 to 2011/12			2.467		59.3%

The proportion spent on respective services changed over this time period as follows:<sup>110 111</sup>

Area of expenditure	% Share of overall direct spending on mental health	
	2000/01	2011/12
Assertive Outreach Teams	2	2.3
Early Intervention in Psychosis	0.2	1.9
Crisis Resolution and Home Treatment teams	1.6	4.6
Community Mental Health Teams	17	13.7
Inpatient services	19	11.9

Please note that a comprehensive breakdown of all areas of expenditure on adult mental health services in England in 2011/12 is provided in Appendix Three. This is provided to contextualise the above figures, which may seem low when viewed individually.

The amount spent on adult mental health services in 2011/12 was £6.629 billion. This represented 6.31% of the total English health budget that year (£105bn).<sup>112</sup>

The Mental Health Strategies survey was discontinued from 2012 onwards. A BBC Freedom of Information request found there had been real-terms reductions of 2% to the overall amount spent on mental health between 2011/12 and 2013/14 in England, and that the number of referrals to crisis and community mental health teams had risen by 16% in the same period of time.<sup>113</sup>

A 2014 report by Rethink found that 50% of early intervention in psychosis services had their budget cut in the past year, some by as much as a fifth. 58% of these services had lost staff in the past year and 53% said the quality of their service had decreased over the past year.<sup>114</sup>

NHS England and Monitor published guidance in December 2013 for CCGs on what ‘tariff deflator’ – aka level of cuts to services – they should aim for:

- 1.5% for acute services; and
- 1.8% for non-acute services (mental health and community services)

They justified reducing the tariff deflator for mental health/community services in comparison to the acute sector on the grounds that ‘...providers will spend an additional £150 million in 2014/15 to meet requirements linked to the recommendations of the Francis and Keogh reports. These initiatives are specific to acute health services.’<sup>115</sup>

Norman Lamb MP called the decision ‘flawed and unacceptable’,<sup>116</sup> and Lord Victor Adebawale (an NHS England Board Member) said it was ‘bordering on being laughable’.<sup>117</sup>

## Wales

Data are available for the amount spent on 'general mental illness' (as opposed to elderly, child and adolescent and 'other' mental health services) in Wales for the years 2009/10 – 2012/13. They show a decrease from £306.6m to £254.3m in non-inflation adjusted cash terms. The figure for 2012/13 represented 5.9% of the overall Welsh health budget.<sup>118</sup>

## Northern Ireland

Non-inflation adjusted figures for the overall mental health 'Programme of Care' budget in Northern Ireland for the period 2004/5 – 2011/12 are below.

Year	Non-Inflation Adjusted Funding
2004/5	£173m
2005/6	£182.4m
2006/7	£190.8m
2007/8	£197m
2008/9	£222.7m
2009/10	£225.5m
2010/11	£228.0m
[2011/12 data not available]	
2012/13	£227m

The figure for 2012/13 represented 7.69% of the overall Northern Irish health budget.<sup>119 120</sup>

## Commissioning frameworks

### Commissioning in England

#### Overview

Approximately 53 million people live in England and use NHS services. To improve health outcomes and deliver high-quality care, NHS England was established in 2012 (known then as the NHS Commissioning Board) to achieve this by providing national leadership and:

- overseeing and allocating resources to 211 clinical commissioning groups (CCGs) commissioning services in their local area for urgent and emergency care, elective hospital care, community health services, maternity and newborn, and mental health and learning disability services.
- commissioning primary care and directly commissioned services (specialised services, offender healthcare and military healthcare).<sup>121</sup>

#### Commissioning

NHS England oversees commissioning in two main ways:

- through four regional teams and 27 Local Area Teams (LATs) – these teams provide an important link with the national NHS England team, and aim to improve communication between national strategy and local delivery of healthcare. Of the 27 area teams, ten are responsible for specialised services (and some have responsibility for offender or armed forces commissioning). The oversight function for area teams and regional teams (based in North, Midlands & East, London and South) is vital.
- through 211 CCGs (each serving a population of around 250,000 people; these clinically-led local organisations can commission from a range of service providers, including the voluntary and private sectors. CCGs are clinically-led and made up of GP practices in the area they cover, but are also legally required to include a registered nurse, secondary care specialist, and two lay members. CCGs are required to obtain expert advice from a range of health professionals.

#### Delivery

Once commissioned, NHS services can be delivered by a number of different organisations. Provider organisations are predominantly known as NHS Foundation Trusts (not directed by government, and free to make financial decision within an agreed legal/regulatory framework) or NHS Trusts (directed by government, and financially accountable to government). Mental health trusts provide community, inpatient and social care services for a wide range of psychiatric and psychological illnesses. Mental health trusts are commissioned and funded by CCGs. Mental health services can be provided by other NHS organisations, the voluntary sector and the private sector.

### **Other structures**

- Health and Wellbeing Boards – these have an influence on commissioning decisions across health, public health and social care by bringing together local authority, CCG, social care, and local community representatives to analyse, understand and meet local health needs.<sup>122</sup>
- Commissioning Support Units – the 12 CSUs practically assist CCGs through ‘transactional commissioning’ (contract negotiation, information and data analysis), ‘transformational commissioning’ (service redesign). There is no obligation for a CCG to use a CSU’s services.<sup>123</sup>
- Strategic Clinical Networks – funded by NHS England to work in 12 regions, SCNs focus on priority service areas and bring together those who use, provide and commission services (including local government) to support more effective delivery. There is an SCN for mental health, dementia, and neurological conditions.
- Clinical Senates - multi-professional advisory groups of experts from across health and social care, including patients, volunteers and other groups. There are 12 clinical senates, covering the whole of England. Their purpose is to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them in making the best decisions about healthcare for the populations they represent.



## Commissioning in Wales

### Overview

Nearly three million people live in Wales and use the services of the NHS.<sup>124</sup> In Wales, Local Health Boards (NHS) and Social Services (Local Authorities) are the key government organisations commissioning and delivering local mental health services. There are:

- 7 Local Health Boards
- 22 Local Authorities (which contain Social Service units/departments)<sup>125</sup>.

### Commissioning

Commissioning of mental health services (defined as planning a full range of services, ensuring they are available, and monitoring and reviewing their performance) is undertaken mostly at a local rather than national level. The exception to this is the commissioning of highly specialised mental health services (which is overseen by the Welsh Health Specialised Services Committee).<sup>126</sup>

The commissioning of mental health services is reported as often jointly being led at a local level by Local Health Board and Social Services staff, with representatives from other local authority departments (e.g. housing), the voluntary sector, and service user and carer groups.<sup>127</sup>

### Delivery

During this process, it is decided what mental health services will be provided by the NHS and Social Services (sometimes referred to as 'in-house services'), and what services will be contracted to other organisations (sometimes called 'external providers').

In general terms, NHS hospital services are still mainly delivered 'in-house' (by the NHS through the Local Health Boards, although some specialist hospital services are privately provided), while community services are reported as being increasingly contracted out to voluntary and private sector organisations.

Through the Local Health Board, the NHS delivers services at primary care (including the reported 1,900 GPs in Wales), and secondary care (including Community Mental Health Teams, psychiatric hospitals, crisis teams, and home treatment teams).<sup>128</sup>

Highly specialised services provided at a tertiary level tend to be provided at regional or national level, and are overseen by the Welsh Health Specialised Services Committee. These include hospital services for people with an eating disorder, gender dysphoria, and medium secure and secure hospitals.

### Other structures<sup>129</sup>

- 22 Local Service Boards - led by local authorities, these bring together local agencies in partnership to tackle issues that need a common approach (such as difficulties in discharging people from hospitals to social services)

- three National Trusts – these provide national services and include the Welsh Ambulance Service, Velindre NHS Trust (specialist cancer support and other national support services)
- one Public Health Wales NHS Trust (which unifies public health services in Wales)
- 8 Community Health Councils - these monitor and evaluate from the patient's viewpoint the effectiveness of NHS services (including hospitals, GPs, pharmacies, care homes).

## Commissioning in Northern Ireland

### Overview

Approximately 1.7 million people live in Northern Ireland and use the services of the NHS.<sup>130</sup> In Northern Ireland, the Health and Social Care Board is key to the commissioning of local mental health services. Falling under the responsibility of the Department of Health, Social Services, and Public Safety this Board has three main functions:<sup>131</sup>

- arrange or 'commission' a comprehensive range of effective local health and social services through its five Local Commissioning Groups (see 'Commissioning' below)
- work with the five Health and Social Care Trusts in Northern Ireland (see 'Delivery' below) that directly provide services
- manage annual funding received from the Northern Ireland Executive to ensure safe, effective and sustainable services.

Although Northern Ireland has had an integrated structure of health and social care since the 1970s, this integration was strengthened with the 2009 Health and Social Care (Reform) Act.<sup>132</sup>

### Commissioning

The Health and Social Care Board oversees five Local Commissioning Groups.<sup>133</sup> Each of these groups is responsible for assessing health and social care needs, planning health and social care to meet current and emerging needs, and securing the delivery of health and social care to meet assessed needs.

Each Local Commissioning Board covers the same geographical area as its respective Health and Social Care Trust, and draws its membership from primary care, elected counsellors, community and voluntary sector, public health, nursing, social work, and allied health professionals.<sup>134</sup>

Regional commissioning considerations are examined by 13 Commissioning Service Teams (of which one focuses on Mental Health & Learning Disability). These teams work closely with the five Local Commissioning Groups to develop and refine service models and specifications for their area.

### Delivery

There are six Health and Social Care Trusts in Northern Ireland. Five provide local health and social care services in Northern Ireland (see Figure 2), while the sixth is the dedicated Northern Ireland Ambulance Service. The five Health and Social Care Trusts provide a range of mental health services in hospitals, the community, and peoples' homes.

### Other structures<sup>135</sup>

- Public Health Agency – this oversees health and social wellbeing improvement, health protection, public health support to commissioning and policy development,

research and development

- Patient and Client Council – this represents the public’s views and interests, reviews the work of the health and social care services, and provides public information
- Guidelines and Implementation Audit Network – this has a safety and improvement role through regional audit, promotion of good practice, and identification of local gaps and high-risk issues. There is no central body responsible for clinical governance (individual trusts make their own arrangements), and NICE guidelines are reportedly followed throughout Northern Ireland.

## 6. Patients, their Families and Carers

This section covers:

- The patient experience
- Patient involvement in service design
- Carers
- Demographic snapshots

### The patient experience

A survey of English and Welsh psychiatric inpatients conducted by Mind in 2004 suggested significant and widespread dissatisfaction. Half of the respondents said they had been verbally abused during their stay, and a fifth reported that they had been physically assaulted. Fifty-three per cent of respondents thought that the inpatient setting had not helped their recovery, and thirty-one per cent thought that it had actually made their health worse.<sup>136</sup>

The CQC warned in 2010 that inpatient services in England were increasingly custodial in nature, and previous studies have warned of high levels of boredom on inpatient wards.<sup>137</sup>  
<sup>138</sup>

Improvements seem to have taken place in the following years however, leading Marion Janner (founder of the Star Wards programme) to be quoted in the 2012/13 CQC report as follows:

*“What an incredible achievement it is that the majority of patients have positive experiences of inpatient care, including those who are there very much against their will and perhaps believing they aren’t even ill (...it is an incredible achievement, along with impressive safety levels and falling suicide rates.) And these are particularly tough times on mental health wards, with service re-organisation, cuts in staffing and resources and patients’ stress levels being greatly exacerbated by the benefits cuts programme.”<sup>139</sup>*

From January 2015 the ‘Friends and Family Test’ will be expanded to all mental health services in England. This will provide a consistent measure of patient satisfaction.<sup>140</sup>

In 2011 NICE published a clinical guideline on Service User Experience in Adult Mental Health Services (CG136). This identified 15 ‘Quality Statements’ that would typify good care:<sup>141</sup>

1. People using mental health services, and their families or carers, feel optimistic that care will be effective.
2. People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect.

3. People using mental health services are actively involved in shared decision-making and supported in self-management.
4. People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship.
5. People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services.
6. People can access mental health services when they need them.
7. People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.
8. People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
9. People using mental health services who may be at risk of crisis are offered a crisis plan.
10. People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.
11. People in hospital for mental health care, including service users formally detained under the Mental Health Act, are routinely involved in shared decision-making.
12. People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to the service user and regularly see other members of the multidisciplinary mental healthcare team.
13. People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.
14. People in hospital for mental health care are confident that control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force.
15. People using mental health services feel less stigmatised in the community and NHS, including within mental health services.

## **Patient involvement in service design**

Various policy documents (such as Stronger In Partnership: Involving Service Users and Carers in the design, planning, delivery and evaluation of mental health services in Wales)<sup>142</sup> have explicitly encouraged the involvement of patients and carers in the design and

evaluation of services. It is not however clear how successful these initiatives have been. A 2002 survey of mental health trusts in Greater London found that although the majority of services did for example have patient representation on Boards, none fully met the national criteria for patient involvement.<sup>143</sup> Furthermore, research in 2009 (which focused on Northern Ireland) raised doubts about whether the rhetoric of patient involvement has been genuine and/or adequately resourced.<sup>144</sup>

## **Carers**

A 2004 review of what carers 'want' from mental health services found they desired better information and support, and good communication with services. Interestingly, they were in favour of more intensive interventions, in contrast to patients (who typically expressed a preference for less restrictive options).<sup>145</sup>

It has been suggested that the staff working on inpatient wards often do not meet the needs of carers or other relatives. However, dedicated interventions to engage with carers such as a nurse-led family and carers service<sup>146</sup> or a Family Liaison Service<sup>147</sup> have been well received by both carers and staff.

At a recent meeting of the RCPsych Carers Forum, it was strongly impressed upon the Commission Secretariat that carers were also significantly affected by difficulties in accessing beds, as they were being left to care for people with complex and severe conditions. This was described as being both tremendously difficult and stressful.<sup>148</sup>

## Demographic snapshots

### England

The English Mental Health Minimum Dataset provides a useful snapshot of the demography of inpatient psychiatric care in England in 2013/14.

The standardised percentage of people from different ethnic groups admitted to a psychiatric hospital in 2013/14, expressed as a percentage of the total number of people in contact with secondary mental health services, is as follows:

- White: 6.5%
- Mixed: 9.3%
- Asian/Asian British: 7.2%
- Black/Black British: 12.9%
- Other Ethnic Group: 5.9%

Research shows that people from Black or other Minority Ethnic (BME) groups are more likely than average to be admitted to mental health hospitals. Some BME groups also experience different pathways into acute care. It is important to avoid aggregating all ethnic groups together where possible.<sup>149</sup>

Men in the age band 30-39 had the highest number of in-year bed days. The highest number of both admissions and discharges for men was for those in the 30-39 age band, and for women in the 40-49 age band.

Slightly more men were admitted (63,468) and discharged (60,976) than women (57,925 and 55,924 respectively).<sup>150</sup>

### Wales

Although there is not as detailed a report available, the Patient Episode Data (Wales) for 2013/14 indicate that 4492 men and 3647 women were admitted to inpatient mental health services. The mean age of inpatients was 42.4.<sup>151</sup> Ethnicity is not recorded, and age bandings are not as detailed as those used in the English MHMDS.

### Northern Ireland

The Information Analysis Directorate of the Department for Health, Social Services and Public Safety (NI) record gender and age group data for compulsory admissions to psychiatric hospitals (as opposed to all admissions). In 2013/4 545 men and 451 women were compulsorily admitted. The majority (44.7%) of compulsory admissions were in the 18-44 age group.<sup>152</sup> Data on the ethnicity of inpatients are not routinely available.



## 7. Selected evidence

This section looks at selected evidence relevant to:

- **Bed occupancy**
- **Delayed transfers of care**
- **Emergency readmissions**
- **Length of stay**
- **Functionalised community mental health teams**
- **Alternatives to admission**

The below selection is derived from a non-structured rapid evidence assessment exercise, and is intended to encourage discussion rather than to represent a comprehensive summary.

Although inpatient care accounts for a significant amount of mental health budgets, evidence for what works is slim. There are some key areas (discussed below) which are linked to good and poor care, such as bed occupancy, delayed transfers of care, emergency readmissions and length of stay. Some evidence relating to functionalised community teams and alternatives to admission is also discussed.

### **Bed occupancy**

A high or excessive rate of bed occupancy brings risks to patients and others because services are unable to admit patients in an emergency and may discharge others prematurely in order to create an available bed. It can prevent the opportunity to discharge patients on short-term leave. The consequent overcrowding can compromise the safety, dignity and privacy of patients and their clinical treatment. Being moved between beds, wards or even hospitals because of over-occupancy clearly disrupts a patient's care. Staff may find that the demands of bed management divert them from their primary nursing role.

Bed occupancy levels of 10% or more above the RCPsych's recommended figure of 85%<sup>153</sup> have been associated with violent incidents on inpatient wards.<sup>154</sup>

Discussions with the RCPsych AIMS network suggest that any published occupancy figure should be treated with some caution. A ward might have 85% of its beds occupied, but then may refuse to admit further patients on the basis that, for example, there are not enough members of staff to safely accommodate them. The published figure of 85% occupancy would therefore be misleading, as in practice the ward is actually at full capacity. It is not clear how prevalent such circumstances are.<sup>155</sup>

The CQC has now started using bed occupancy as a safety indicator for mental health wards,<sup>156</sup> although it is not clear what occupancy figure they will identify as the benchmark for safe services.

## Delayed transfers of care

High bed occupancy can also arise because of ‘bed blocking’. It occurs usually when there is no local authority placement for a person with complex mental health needs or for a person who is homeless. Patients may remain in hospital for months after their need for hospitalisation has ended while they await transfer to local authority accommodation. In 2003, the government introduced the Community Care (Delayed Discharges, etc.) Act to address the problem of bed blocking in England and Wales. The Act introduced financial penalties for local authorities who failed to provide services to enable a patient to be discharged. However, this only applies to people with physical illness and does not cover people who are cared for in psychiatric hospitals.

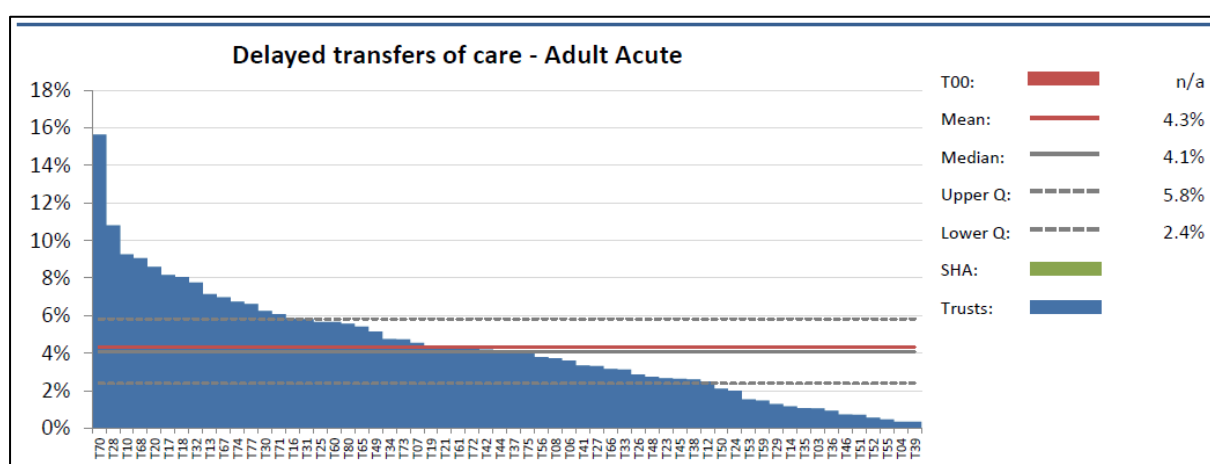
The Department of Health estimated in 2007 that approximately 10% of psychiatric beds were unavailable because of delayed discharges.<sup>157</sup>

Monitor have set a target that delayed discharges should not account for more than 7.5% of total occupied bed days in English trusts.<sup>158</sup>

Delayed discharges can be a useful quality measure as they not only mean that a bed is being unnecessarily occupied, but also increase risks for the patient concerned either in terms of their clinical outcomes or institutionalisation.

### Figure nine: 2014 Adult acute delayed transfers of care (England/Wales)

The number of discharges in English trusts and Welsh health boards that were delayed ranged between 0.3% to 15.6%, with a median figure of 3.8%.<sup>159</sup>



## Emergency readmissions

An emergency readmission is an admission which takes place within 30 days of someone previously being discharged.

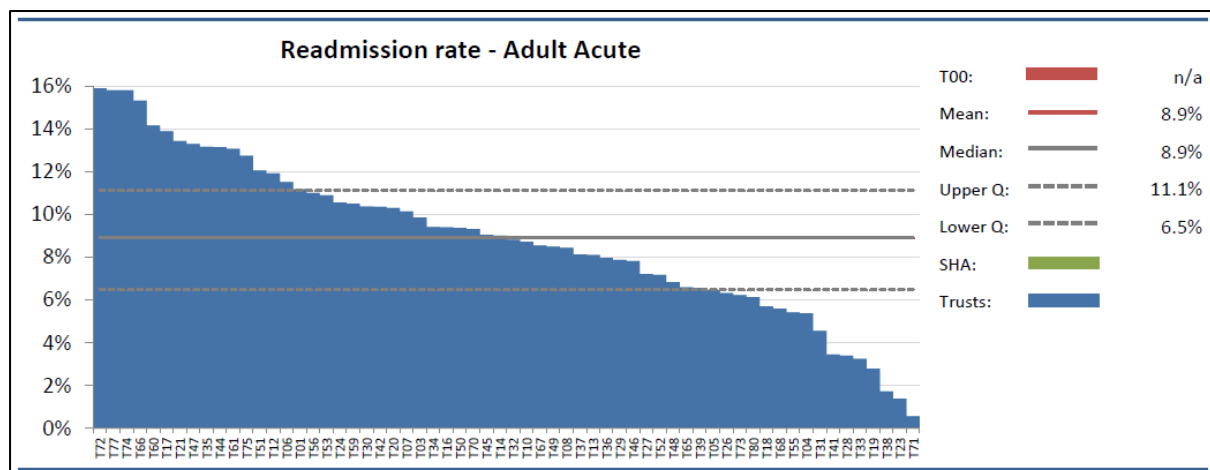
Data from the June and July 2014 Mental Health Minimum Data Set (MHMDS) reports suggest that 9.5% of patients discharged in England were subsequently readmitted within 30 days as emergencies.<sup>160 161</sup>

Interventions can reduce emergency readmissions. A 2013 systematic review by Vigod et al sought to identify interventions which reduced rates of readmission to inpatient psychiatric services. It found that psycho-education and medication education were effective pre-discharge interventions, and that psycho-education, telephone/home visits, having a transition manager and undertaking a structured needs assessment were effective post-discharge interventions. Having a transition manager and a discharge plan were effective 'bridging' interventions. The authors caution that interventions did not work in all settings, suggesting that broader contextual factors are also important. Although the interventions did reduce readmissions in the short term, over a longer period (6-24 months) rates were almost as high as for the control group, suggesting that the effectiveness of the interventions is time-limited.<sup>162</sup>

There is also modest evidence that addressing the stability of a patient's condition and preparing them for discharge can reduce the number of emergency readmissions.<sup>163</sup>

#### Figure ten: 2014 Adult Acute emergency readmission rate (England/Wales)

The rate of emergency readmissions in English trusts and Welsh health boards ranged from 0.6% to 15.9%. The median figure was 8.9%.<sup>164</sup>



#### Length of stay

It is unclear whether short stays are beneficial or not. A 2014 Cochrane Review update sought to resolve the question of whether 'short stays' of under 28 days in inpatient psychiatric units were either beneficial (because patients are less likely to be institutionalised) or detrimental (because a short stay would increase the likelihood of a patient being discharged too early, resulting in a series of 'revolving door' readmissions).

Although the individual studies reviewed were all over 30 years old and of limited quality, the authors felt confident enough to draw a conclusion that planned short-stay admissions do not lead to ‘revolving door’ repeat admissions and/or disjointed care. Short-stay patients were actually more likely to leave hospital on their planned discharge date and some evidence suggested they were more likely to find employment after admission.<sup>165</sup> However, the 2014 National Confidential Inquiry into Suicide and Homicide Annual Report noted:

*‘The first 3 months after discharge remain a time of particularly high suicide risk – this is especially true in the first 1-2 weeks. Between 2002-12 there were 3,225 suicides in the UK by mental health patients in the post-discharge period, 18% of all patient suicides.*

*In our related research, suicide in the first 2 weeks post-discharge has been linked to admissions lasting less than 7 days and to adverse life events.*

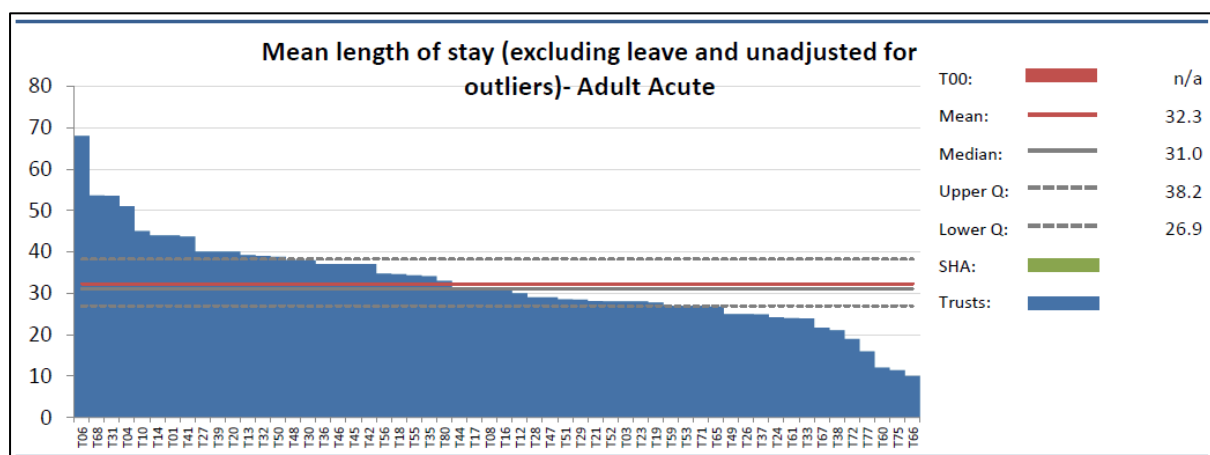
*The link to short admissions is a concern: benefits of reducing length of in-patient stay should be balanced with risks and it should not be an aim in itself.’*

A 2012 study by Douzenis found that physical co-morbidity requiring referral was a significant determinant of the duration of hospital stay.<sup>166</sup>

Psychological provision on acute inpatient wards can reduce length of stay and emergency readmissions, and is valued by both staff and patients.<sup>167</sup>

#### **Figure eleven: 2014 Adult acute mean length of stay (excluding leave and adjusted for outliers; England/Wales)**

The mean length of stay for inpatients across English trusts and Welsh health boards was 32.3 days.<sup>168</sup>



### **The evidence for functionalised community mental health teams**

The evidence base for CRHTs is mixed. Studies have found there to be benefits both in terms of clinical outcomes and practical aspects such as reducing admissions and length of

stay.<sup>169 170</sup> However, a 2011 study by Jacobs and Barrenho compared admission rates in English PCTs before and after the introduction of CRHTs, and after controlling for confounding factors found that the presence of a CRHT did not significantly affect the number of admissions.<sup>171</sup> Analysis by the Audit Commission has also discovered that there is no relationship between either the level of CRHT funding or the number of referrals 'gate-kept' and the number of bed days.<sup>172</sup> It is possible that variation in the way in which teams operate is responsible for the variation in efficacy.<sup>173</sup>

It should be noted that the National Confidential Inquiry into Suicide and Homicide has concluded that the introduction of CRHTs and AOTs played a significant part in reducing the overall suicide rate in the United Kingdom.<sup>174</sup>

A 2009 Cochrane review suggested that there was emerging, (if inconclusive), support for EIP services.<sup>175</sup> Later studies have argued that they are cost-effective, provide better clinical outcomes than generic services,<sup>176</sup> reduce hospital admission and relapse rates, and improve access to and engagement with treatment.<sup>177</sup>

A 1995 meta-analysis examined assertive outreach services targeted at frequently admitted patients. It found that in over two-thirds of studies the number of inpatient days required fell by over half.<sup>178</sup> However, one subsequent study found inpatient bed usage and clinical outcomes measured after 18 months were roughly the same for people treated by assertive outreach teams as for those treated by generic services, although patients reported higher satisfaction with the former.<sup>179</sup>

## **Alternatives to admission**

There is a paucity of research about alternatives to inpatient admission, and as such their efficacy is unclear.<sup>180</sup>

A systematic review of the evidence base for the efficacy of day hospital treatment found it was outdated (with no trials identified occurring after 1986), but found weak (but potentially unreliable) evidence to suggest that they reduced admissions to hospital, although social functioning seemed to be unaffected.<sup>181</sup>

One 2010 study of admissions to inpatient wards in South East England suggested that approximately half could have satisfactorily been treated in crisis houses instead (if they had been available).<sup>182</sup> There is some evidence that crisis houses are preferred by patients over inpatient care, and that the costs/clinical outcomes are identical.<sup>183</sup> A FOI conducted by Community Care in 2014 found that less than a third (29%) of CCGs actually commissioned a crisis house service.<sup>184</sup>

Joint crisis plans do not reduce compulsory admissions. Although two small studies<sup>185 186</sup> have previously found some evidence that joint crisis plans can prevent compulsory admissions, a large 2013 RCT found that the presence of a joint crisis plan did not have a significant effect on compulsory admission rates.<sup>187</sup>

# Appendices

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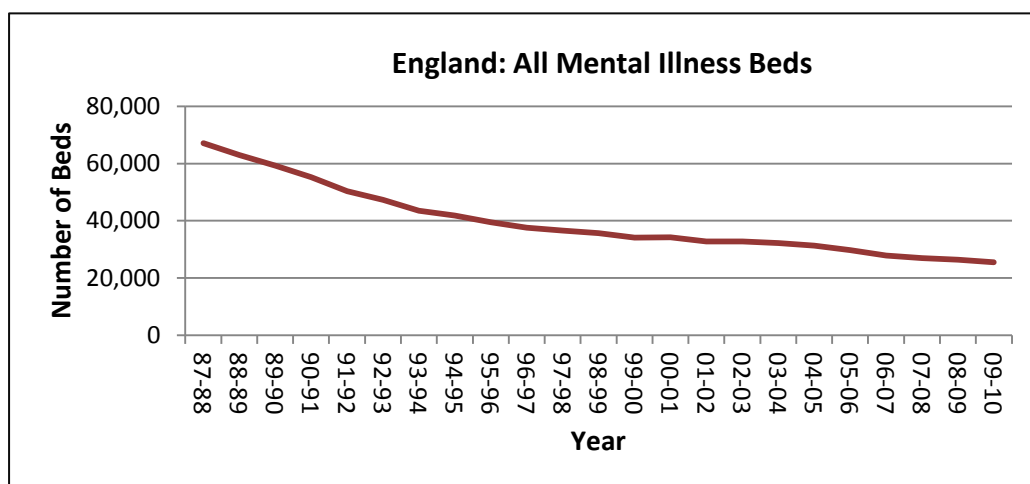
## Appendix 1: Additional data resources

### England<sup>188 189</sup>

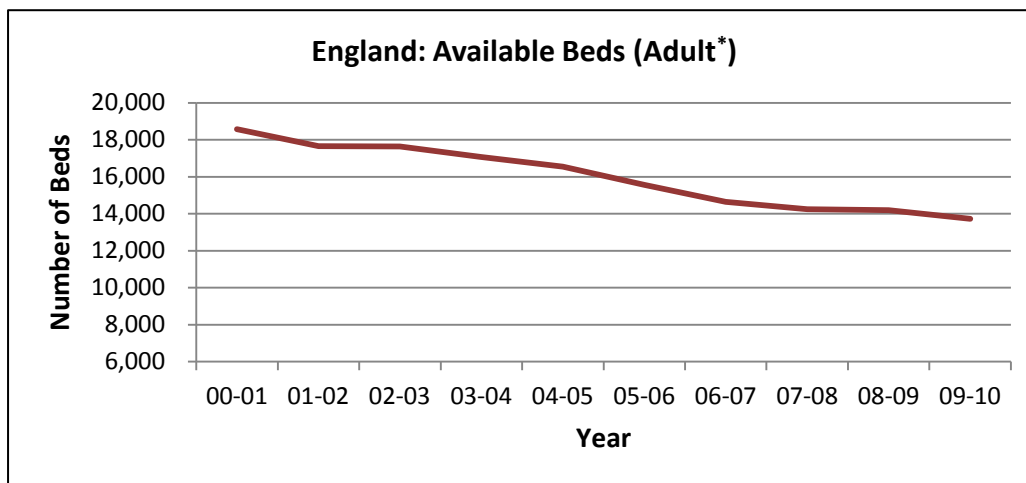
The below data on bed availability and occupancy are taken from the NHS England website. Data for years 1987/88-2013/14 are for all mental illness beds provided across the NHS. There is a sub-set of data presented below from 2000/01-2009/10 which records adult beds (excluding psychotherapy and forensic services, but including specialist services e.g. inpatient perinatal psychiatry and PICUs).

#### Bed availability

Between 1987/88 and 2009/10 the number of beds in the entire mental health sector dropped by 62%. This includes beds in the mental illness, CAMHS, forensic, old age psychiatry and psychotherapy specialities.

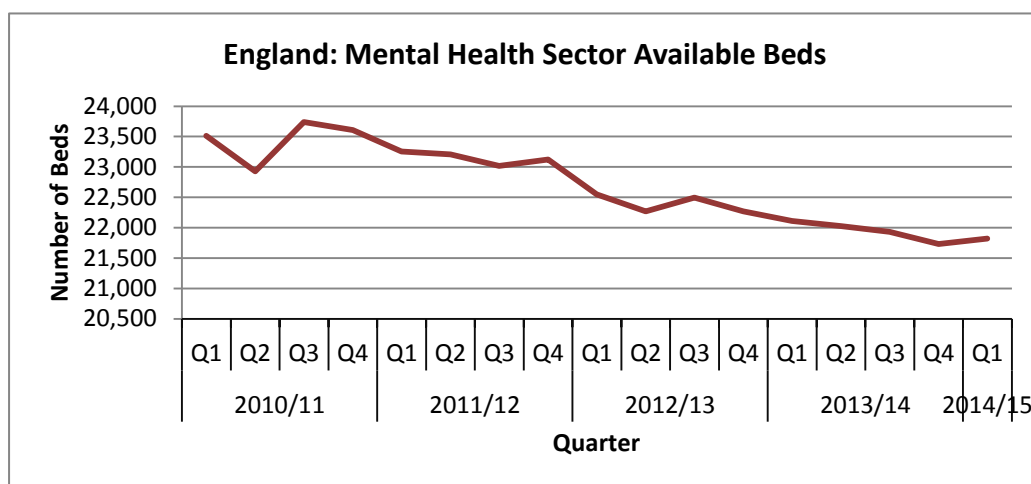


Between 2000/1-2009/10 the number of adult psychiatric beds (excluding forensic and psychotherapy services, but including specialist services e.g. perinatal psychiatry) declined by 26%.



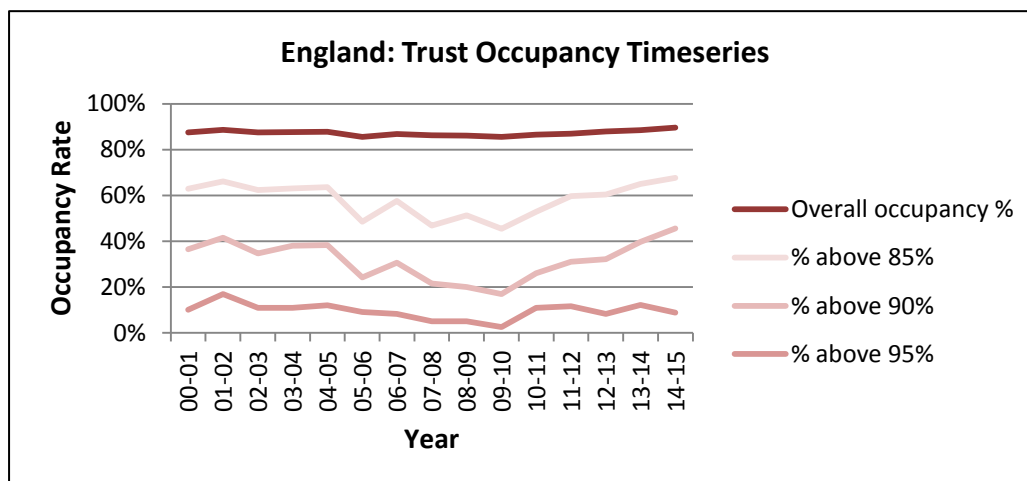
\*excludes forensic and psychotherapy beds but includes specialist services

From 2010/11 the method of data collection reverted to sector-level analysis (ie the total number of all mental illness beds available). Between Q1 2010/11 and Q1 2014/15 there was a 7% decrease in the total number of mental health beds.

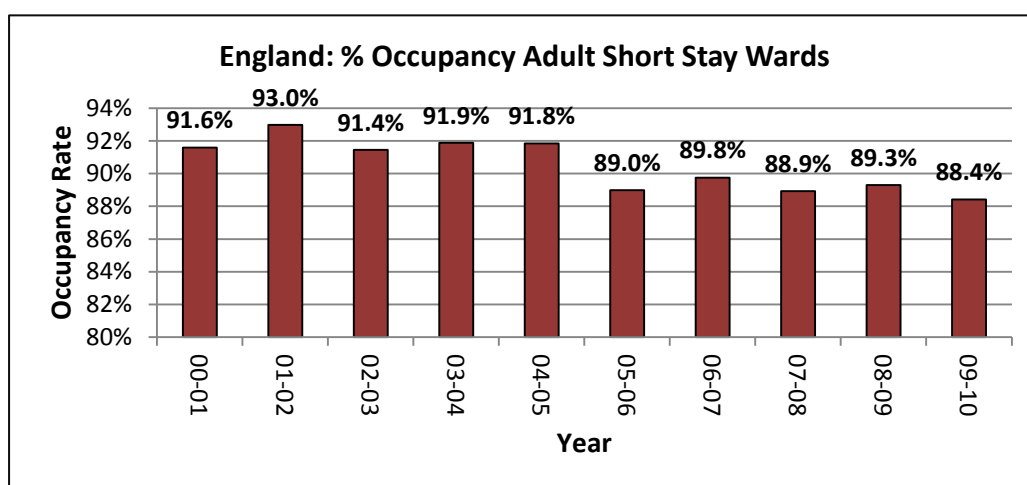


## Average bed occupancy

Bed occupancy data for England show that average overall rates have remained reasonably consistent, although previous decreases in the number of trusts going over 85%, 90% and 95% respectively seem to have reversed from around 2009/10 onwards.

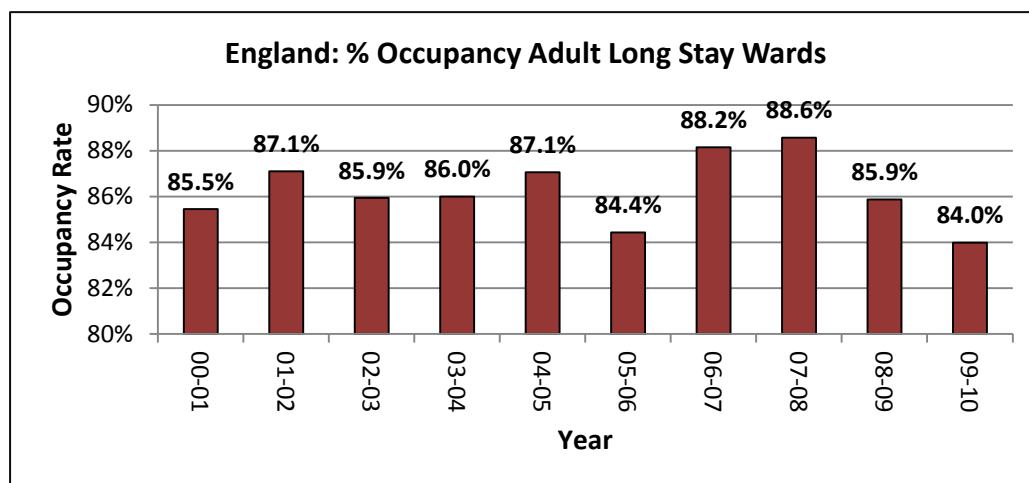


Adult inpatient occupancy rates in 'short stay' wards seem to have been reasonably consistent, especially in the periods 2000/01 – 2004/05 and from 2005/6 - 2009/10.



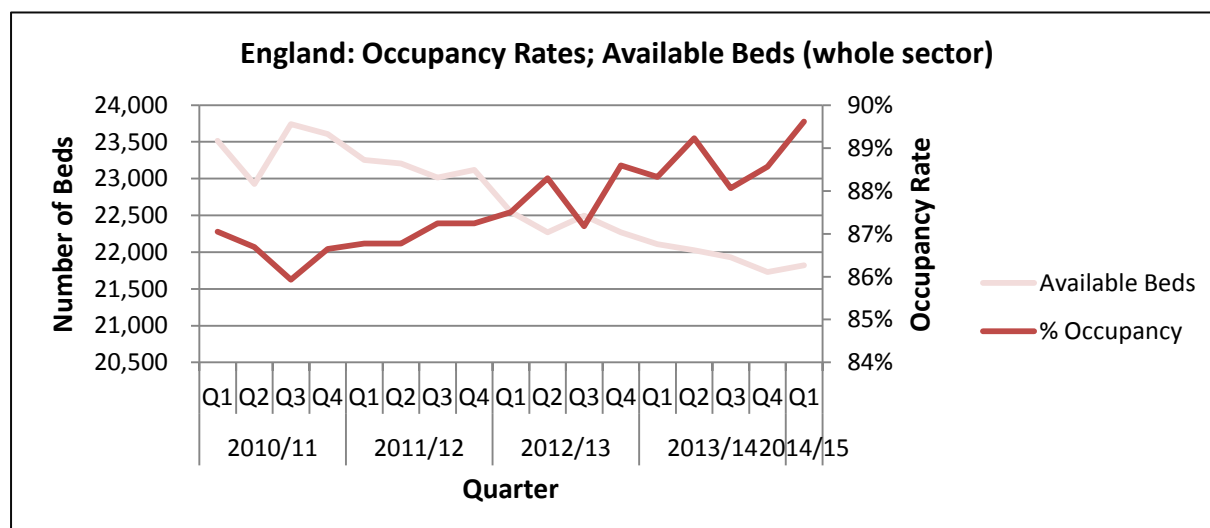


The figures for 'long stay' wards show slightly more fluctuation, but the possible beginning of a trend of reduction between 2008/9 -2009/10.



#### Average Bed occupancy and availability 2009/10 – 2014/15 (Sector)

Although caution should be used when inferring relationships between different sets of data, there seems to be a relationship between the number of available beds and the occupancy level. Although there is a plausible mechanism to explain a causal relationship of this nature – namely that as the number of beds decreases wards become more crowded as demand is either constant or increasing - it is important to remember that the data cover the entire sector rather than just adult acute beds.



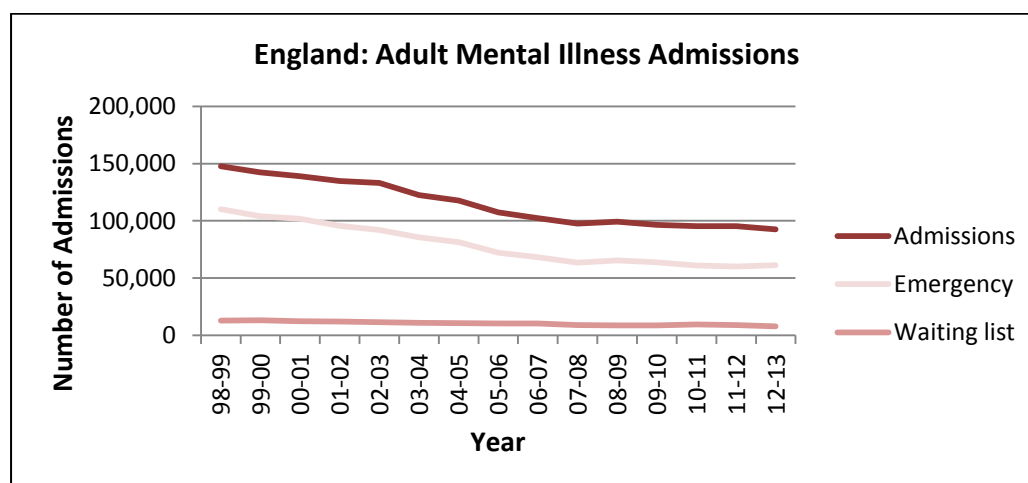
It is noteworthy that two separate Freedom of Information requests focusing on occupancy levels have come up with different figures to those recorded by NHS England. In 2013 *Community Care* magazine found that the average acute inpatient ward bed occupancy figure in England was 101% in August of that year, with some wards running at 138%<sup>190</sup> (achieved via 'hot-bedding' where the beds of patients on temporary leave are used for new admissions). A follow-up investigation in 2014 revealed that acute adult wards had run at an average monthly figure of 101% for the preceding two years.<sup>191</sup> These figures are significantly higher than those published by NHS England. Previous work by the Royal College of Psychiatrists has noted discrepancies between the official figures and those published elsewhere.<sup>192</sup> It is possible that some or all of the difference is due to the FOI requests only targeting acute adult inpatient wards, in contrast to the NHS England figures which are based on a broader set of adult wards.

## Admissions

The below data on admissions, waiting times and length of stay are taken from the HSCIC, and include both NHS care and care funded by the NHS which takes place in independent hospitals between 1998/99-2012/13. The data are for adult acute care. Forensic services, psychotherapy beds and specialised inpatient care (eg perinatal services, PICUs) are not included.

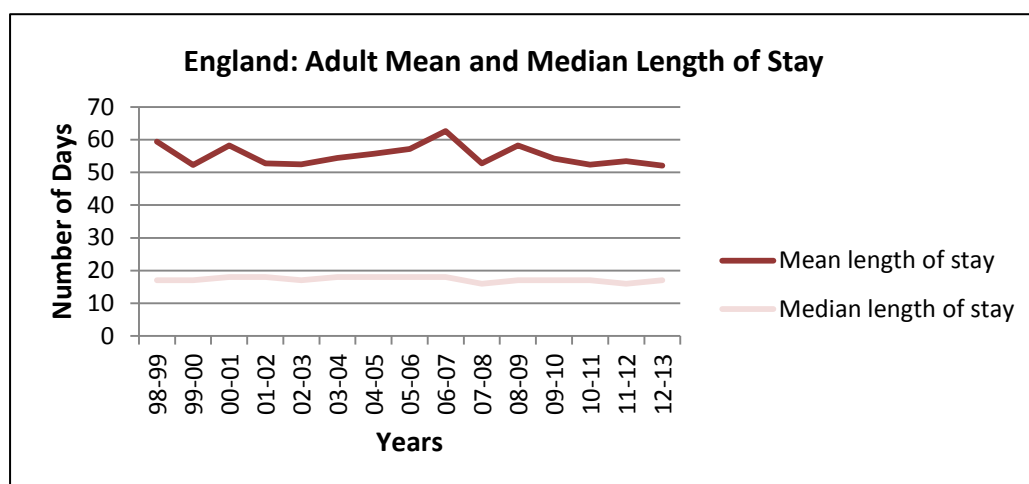
It is important to remember that the data reflect 'headline' national figures, in the sense that the picture at the level of individual diagnoses or trusts will vary. For example, the average length of stay for a person with schizophrenia has increased over this time period, contrary to an overall trend of decline.

There was a 37% decrease in the overall admissions figure between 1998/99 and 2012/13. The number of emergency admissions has decreased by 44%, and a visual inspection suggests that both figures have declined at roughly the same rate. The number of people admitted having been on a waiting list peaked in 1999/2000, falling by 41% between then and 2012/13.



## Length of stay

The median length of stay has remained reasonably constant. The mean length of stay increased between 2002/3-2006/7 to approximately 62 days, but this has since decreased to approximately 52 days in 2012/13.

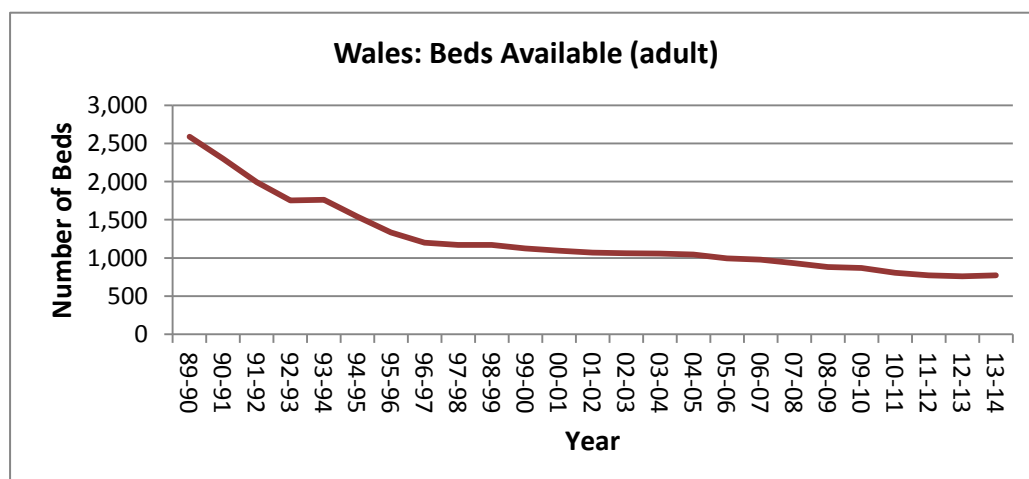


## Wales<sup>193</sup>

The availability and occupancy data below are for adult psychiatric beds, and are taken from Stats Wales. They do not include psychotherapy or forensic services, but may include some adult specialist services (e.g. perinatal beds or PICUs). Data reflect Welsh NHS hospitals only, and do not reflect any Welsh patients being treated in English hospitals.

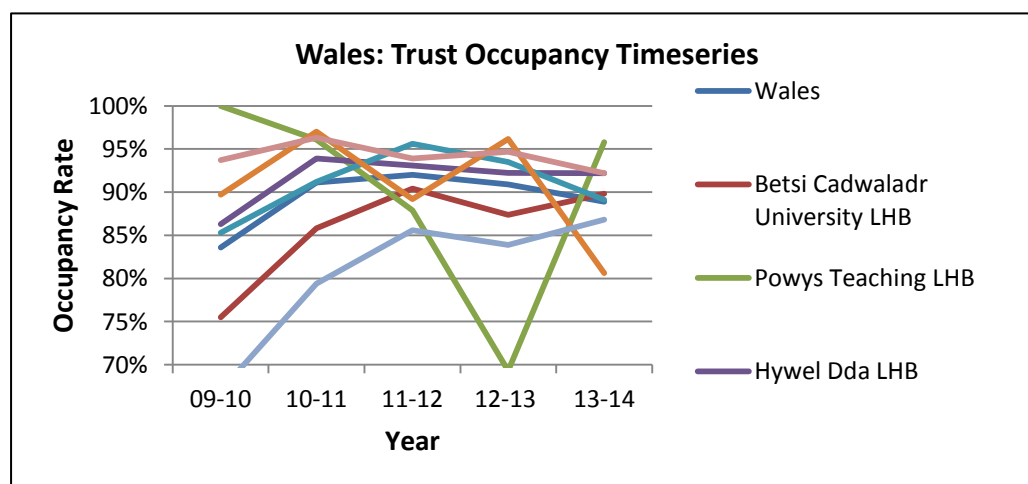
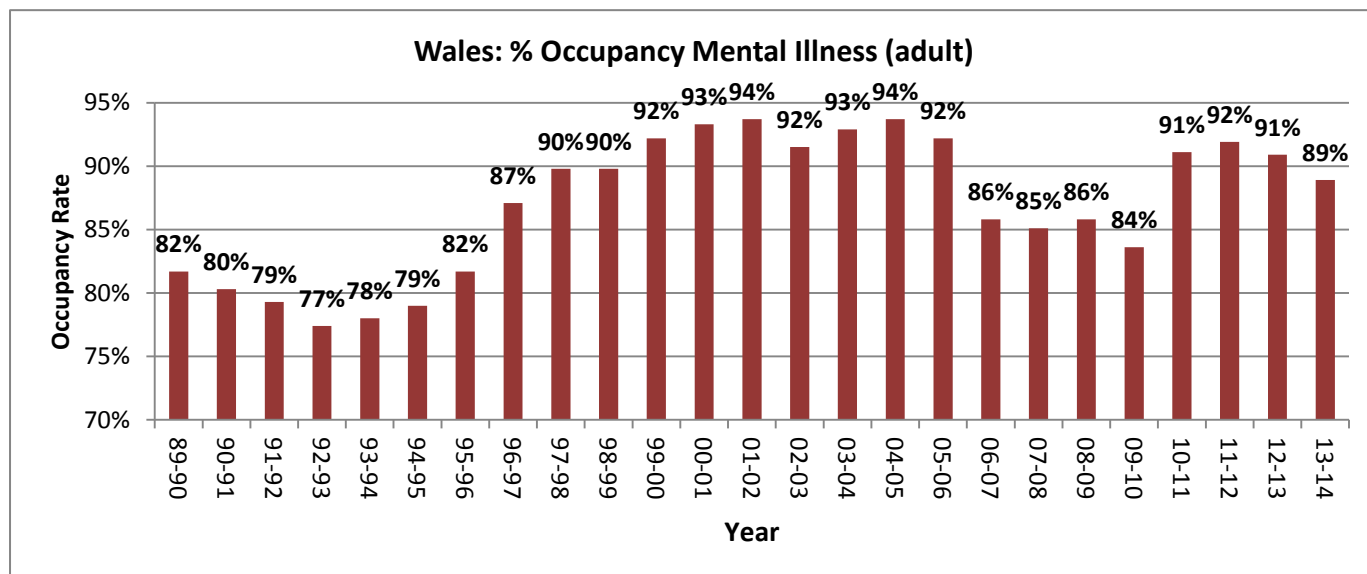
## Bed availability

The number of beds decreased by 70% between 1989/90 – 2012/13, with a very small rise between 2012/13 and 2013/14. The decline was particularly sharp between 1989/90 and 1997/98.



## Average bed occupancy

Wards have been operating at above the RCPsych's recommended figure of 85% occupancy every year since 2010/11, although a possible trend of reduction may be emerging between 2012/13-2013/14.

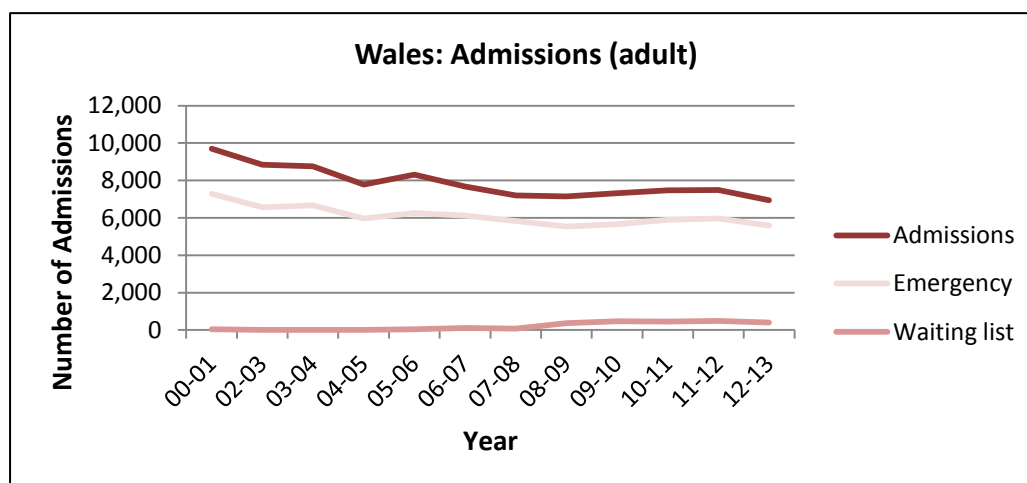


The below admissions, waiting times and length of stay data are taken from the Patient Episode Data (Wales) datasets published on the NHS Wales Informatics Service website.<sup>194</sup> The data do not include adults using psychotherapy or forensic services. Adults using specialist services (such as inpatient perinatal services or PICUs) are also not included.

## Admissions

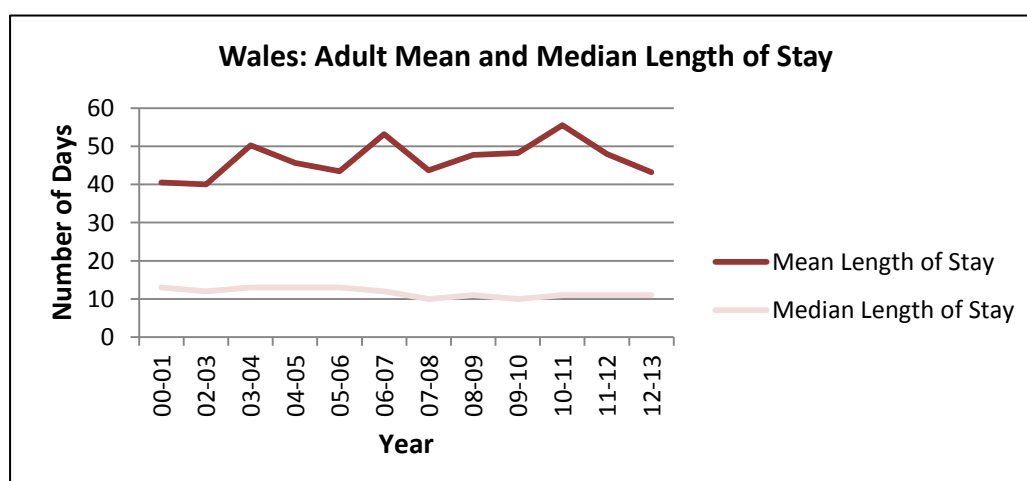
There was a 28.5% decrease in the number of annual admissions between 2000/01 – 2012/13. The number of emergency admissions decreased by 23.4% and the number of waiting list admissions rose by 1171.9% in the same period of time. There was a step change in the latter from 2007/08, with a more than fourfold rise in 2008/09 (from 79 to 364). This

sharply contrasts with the equivalent figures from England, where the number of waiting list admissions fell by 41% between 1998/99-2012/13.



### Length of stay

The median length of stay has decreased from approximately 13 days in 2000/01 to approximately 11 days 2012/13. The mean length of stay figure has fluctuated quite considerably over this period, with a greater degree of variation than the equivalent English figures (Welsh standard deviation 5.3 days as opposed to 3.2 days for English figures). The most recent trend is a decrease in length of stay from 55.5 days in 2010/11 (which is actually the highest figure recorded) to 42.5 days in 2012/13. For comparison, the 2012/13 figure for England is approximately 10 days higher (52.1 days).

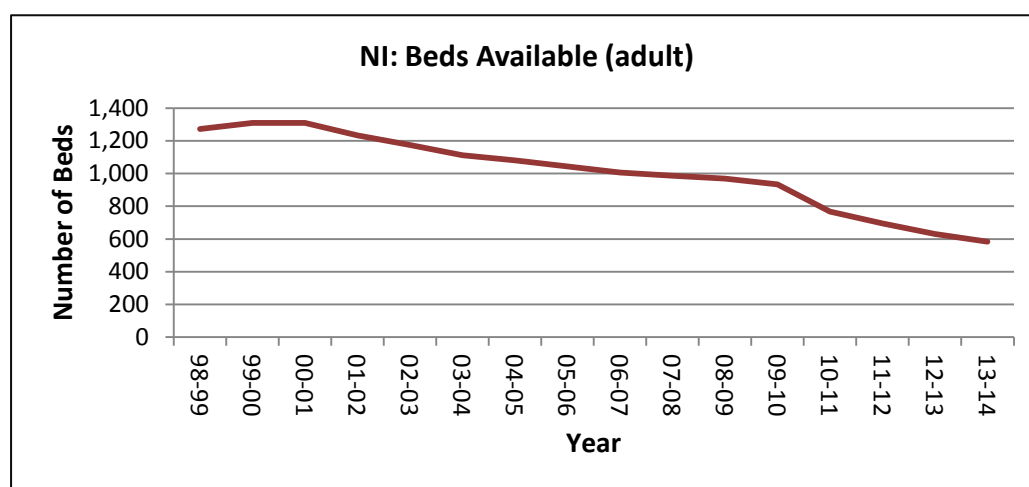


## Northern Ireland<sup>195</sup>

The below data on bed availability and occupancy are taken from the Northern Irish Department of Health, Social Services and Public Safety website. They reflect adult NHS psychiatric beds. They do not include psychotherapy or forensic services, but may include some other adult specialist services (e.g. inpatient perinatal beds or PICUs).

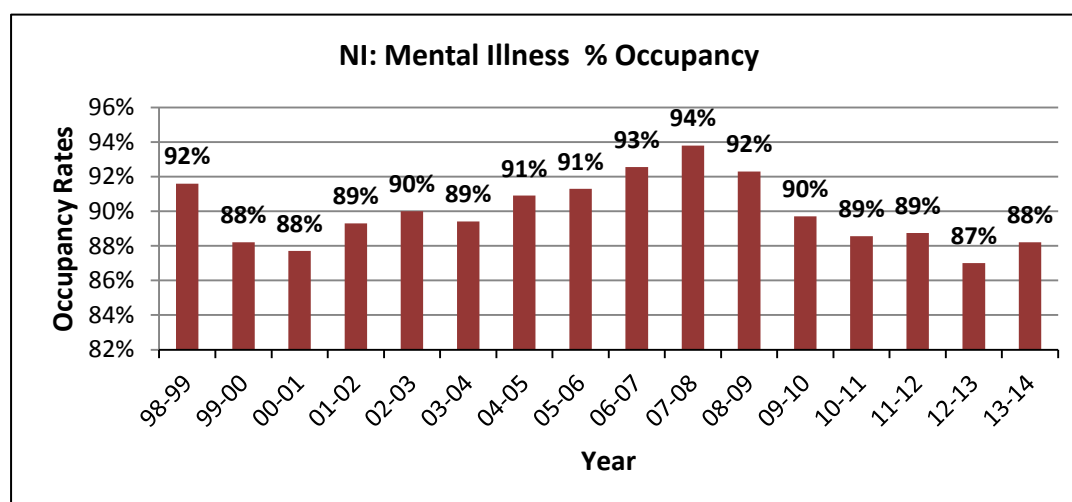
### Availability

Between 1998/99-2013/14 the number of adult psychiatric beds decreased by 54%. It should be noted that Northern Ireland started the process of deinstitutionalisation somewhat later than England and Wales.



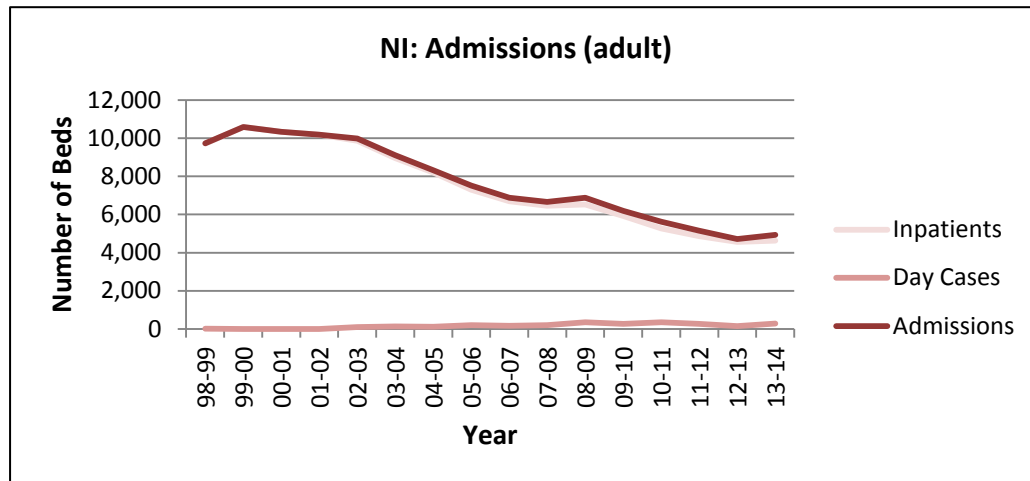
### Occupancy

The occupancy figure has consistently been over the 85% level recommended by the RCPsych. The rate gradually increased from 2000/01, peaking at 93.8% in 2007/08. The rate then fell to its lowest level in 2012/13 (87%). There was a small rise from this figure in 2013/14, but it is too early to say whether this will continue as a trend.



## Admissions

The total number of admissions decreased by 49% between 1989/99 – 2013/14. There was a significant jump in the number of day case admissions between 2001/02- 2002/03 from 0 to 111 admissions. This figure then peaked in 2008/09 at 359 admissions, dropping to 157 in 2012/13. Figures for 2013/14 show a significant rise to 293 admissions.



## **Appendix two: List of acronyms**

<b>AIMS</b>	Accreditation for Inpatient Mental health Services
<b>AOT</b>	Assertive Outreach and Treatment Teams
<b>CCG</b>	Clinical Commissioning Groups
<b>CMHT</b>	Community Mental Health Team
<b>CRHT</b>	Crisis Resolution and Home Treatment
<b>CTO</b>	Community Treatment Order
<b>CQC</b>	Care Quality Commission
<b>CSU</b>	Commissioning Support Unit
<b>EIP</b>	Early Intervention in Psychosis
<b>FOI</b>	Freedom of Information Request
<b>FTE</b>	Full Time Equivalent
<b>HSCIC</b>	Health and Social Care Information Centre
<b>CfWI</b>	Centre for Workforce Intelligence
<b>LAT</b>	Local Area Team
<b>NSF</b>	National Service Framework
<b>PICU</b>	Psychiatric Intensive Care Units
<b>HSCA</b>	The Health and Social Care Act
<b>RCPsych</b>	The Royal College of Psychiatrists
<b>SCN</b>	Strategic Clinical Networks



## Appendix 3: Breakdown of total direct spending on adult mental health in England in 2011/12 Health Services in 2011/12<sup>196</sup>

### ENGLAND WORKING AGE ADULTS SUMMARY 2011/12

Total Investment in Working Age Adults in £'000s =		£6,628,570.71	
	Investment in £'000s	% of Direct Investment	% of Total Investment
<b>Access &amp; Crisis Services</b>	<b>£588,402.00</b>	<b>10.70%</b>	<b>8.88%</b>
A&E Mental Health Liaison Service	£28,290.39	0.51%	
Access & Crisis Services - any other services	£31,174.41	0.57%	
Assertive Outreach Team	£126,821.40	2.31%	
ASW Service	£11,193.68	0.20%	
Crisis Accommodation	£10,619.08	0.19%	
Crisis Resolution Home Treatment Team	£254,594.77	4.63%	
Early Intervention in Psychosis Service	£109,276.84	1.99%	
Emergency Clinics / Walk-in Clinic	£655.52	0.01%	
Emergency Duty Team	£9,766.18	0.18%	
Homeless Mental Health Service	£6,009.73	0.11%	
<b>Accommodation</b>	<b>£527,780.26</b>	<b>9.60%</b>	<b>7.96%</b>
Accommodation - any other services	£22,958.32	0.42%	
Adult/family Placement Scheme	£5,634.75	0.10%	
Board and Lodgings Scheme	£1,996.57	0.04%	
Hostel	£8,292.08	0.15%	
Local Authority and Registered Residential Care Home	£354,067.78	6.44%	
Staffed Group Home	£18,601.70	0.34%	
Supported Housing	£113,004.47	2.06%	
Unstaffed Group Home	£3,224.59	0.06%	
<b>Carer's Services</b>	<b>£26,865.22</b>	<b>0.40%</b>	<b>0.41%</b>
Carers' Support Group	£2,598.74	0.05%	
Carers' Support Service	£13,998.04	0.25%	
Carers' Support Workers	£4,315.93	0.08%	
Self-help, Mutual Aid Group for Carers	£652.79	0.01%	
Short-term Breaks/Respite Care Service	£5,299.72	0.10%	
<b>Clinical Services</b>	<b>£971,705.10</b>	<b>17.68%</b>	<b>14.66%</b>
Acute Inpatient Unit/Ward	£654,576.76	11.91%	
Clinical Services - any other services	£43,402.14	0.79%	
NHS Day Care Facility	£22,738.90	0.41%	
Psychiatric Liaison Service - Gen Med, Surg & Palliative Care	£9,758.43	0.18%	
Psychiatric Outpatient Clinics	£82,668.77	1.50%	
Specialist mental health services	£158,560.10	2.88%	
<b>Community Mental Health Teams</b>	<b>£756,124.49</b>	<b>13.76%</b>	<b>11.41%</b>
Community Mental Health Team	£756,124.49	13.76%	
<b>Continuing Care</b>	<b>£644,231.56</b>	<b>11.72%</b>	<b>9.72%</b>
24 Hour Nurse Staffed Care	£110,236.22	2.01%	
24 Hour Staffed Care - Non NHS Registered Nursing Home	£149,613.27	2.72%	
Continuing Care - any other services	£91,318.44	1.66%	
Rehabilitation or Continuing Care Team	£59,867.94	1.09%	
Residential Rehabilitation Unit	£233,195.69	4.24%	
<b>Direct Payment</b>	<b>£30,525.16</b>	<b>0.56%</b>	<b>0.46%</b>
Direct Payments	£30,525.16	0.56%	
<b>Employment/Day/Resource Centres</b>	<b>£131,650.85</b>	<b>2.40%</b>	<b>1.99%</b>
Day Centres/Resource Centre/Drop-in	£98,409.38	1.79%	
Education and Leisure Opportunity	£4,570.51	0.08%	
Employment Scheme	£26,700.00	0.49%	
Individual Placement Scheme (DWP Funded)	£2.00	0.00%	
Women-only community day services	£1,968.96	0.04%	
<b>Home Support Services</b>	<b>£110,083.03</b>	<b>2.00%</b>	<b>1.66%</b>
Home/Community Support Service	£72,983.66	1.33%	
Housing support	£37,099.37	0.67%	

	Investment in £'000s	% of Direct Investment	% of Total Investment
<b>Mental Health Promotion Services</b>	<b>£3,297.49</b>	<b>0.06%</b>	<b>0.05%</b>
Mental health promotion	£3,297.49	0.06%	
<b>Other community and hospital professionals</b>	<b>£89,376.11</b>	<b>1.63%</b>	<b>1.35%</b>
CDW workers	£7,237.23	0.13%	
Gateway workers	£4,432.01	0.08%	
Other community and/or hospital professional team/specialist	£20,426.45	0.37%	
Primary care mental health worker	£44,604.72	0.81%	
STaR workers	£12,675.71	0.23%	
<b>Personality Disorder Services</b>	<b>£35,892.17</b>	<b>0.65%</b>	<b>0.54%</b>
Personality disorder service	£35,892.17	0.65%	
<b>Psychological Therapy Services (IAPT)</b>	<b>£213,363.32</b>	<b>3.88%</b>	<b>3.22%</b>
IAPT Employment Support	£9,767.15	0.18%	
IAPT High Intensity Therapy	£123,645.32	2.25%	
IAPT Low Intensity Therapy	£79,950.86	1.45%	
<b>Psychological Therapy Services (Non IAPT)</b>	<b>£172,244.06</b>	<b>3.13%</b>	<b>2.60%</b>
Psychology Therapies and Counselling Services	£119,423.22	2.17%	
Psychology Therapy Services - any other services	£12,513.83	0.23%	
Specialist Psychotherapy Service	£32,649.82	0.59%	
Voluntary/Private Counselling and/or Psychotherapy Service	£7,657.20	0.14%	
<b>Secure Services and PICU</b>	<b>£1,056,309.14</b>	<b>19.22%</b>	<b>15.94%</b>
Low Secure Service	£422,462.54	7.69%	
Medium Secure Service	£485,219.96	8.83%	
Psychiatric Intensive Care Unit	£136,394.60	2.48%	
Secure Services and PICU - any other services	£12,232.04	0.22%	
<b>Services for Mentally Disordered Offenders</b>	<b>£72,394.48</b>	<b>1.32%</b>	<b>1.09%</b>
Community Forensic Service	£25,511.01	0.46%	
Criminal Justice Liaison and Diversion Service	£7,713.01	0.14%	
Mentally Disordered Offenders - any other services	£7,846.36	0.14%	
Prison Psychiatric Inreach Service	£31,324.10	0.57%	
<b>Support Services</b>	<b>£66,374.87</b>	<b>1.21%</b>	<b>1.00%</b>
Advice and Information Services	£10,136.44	0.18%	
Advocacy Services	£20,143.60	0.37%	
Befriending and Volunteering Schemes	£4,387.07	0.08%	
Patient Advice and Liaison Service PALS	£2,838.43	0.05%	
Self-help and Mutual Aid Group	£4,084.99	0.07%	
Service User Groups	£5,387.43	0.10%	
Staff-facilitated Support Groups	£3,291.11	0.06%	
Support Services - any other services	£16,105.80	0.29%	
<b>Grand Total for Direct Costs</b>	<b>£5,496,619.31</b>	<b>100.00%</b>	<b>82.92%</b>
<b>Capital Charges</b>	<b>£157,466.35</b>		<b>2.38%</b>
CAPITAL CHARGES - ADULTS	£157,466.35		
<b>Indirect costs and overheads</b>	<b>£974,485.05</b>		<b>8.88%</b>
INDIRECT COSTS AND OVERHEADS - ADULTS	£974,485.05		
<b>Grand Total for Adult Investment</b>	<b>£6,628,570.71</b>	<b>100.00%</b>	<b>100.00%</b>

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