Improving acute inpatient psychiatric care for adults in England

Interim report

July 2015

The Commission
to review the
provision of acute
inpatient psychiatric
care for adults

Contents

Consultation

Please:

- Let us have your views on whether the five main themes described in this report
  are the best ones for the Commission to concentrate its future work on
- Provide us with any additional information or data that may be useful for our deliberations
- Offer us examples of good practice and possible improvements in these five areas

The consultation is open until Tuesday 1st of September 2015.

Online completion – www.caapc.info

Requests for hard-copy of consultation survey:

- **By post** – Commission on Acute Adult Psychiatric Care, 21 Prescot Street, London, E1 8BB
- **By email** – information@caapc.info

Foreword from the Commissioners

In January 2015 the Royal College of Psychiatrists asked us to review the provision of acute inpatient psychiatric care for adults and make recommendations for improvement.

As Commissioners we are considering inpatient services in the context of the whole system of mental health provision and within the wider social environment more generally. We are also seeking to operate in as open and inclusive fashion as possible, drawing on evidence and experience from a wide range of people and sources.

We are publishing this interim report on services in England for consultation and are particularly keen to hear from people who have already offered us their views

in order to understand whether the five main themes described in this document are the best ones to concentrate on, what additional data or information might be helpful, and what best practice or improvements might be appropriate.

The consultation is open until 1st September 2015. Details of how to take part are shown opposite.

We plan to publish our final report in early 2016.

Lord Nigel Crisp
Chair of the Commission

Summary

This interim report is based on the Commission's initial observations about acute inpatient psychiatric services for adults in England and its discussions with patients, carers, advocates, health and social care professionals and policy makers.

Five main themes have emerged:

1 The so-called bed or admission crisis is very significantly a problem of discharges and alternatives to admission and can only be addressed through changes in services and the management of the whole system.

2 There is a spectrum of pressure and performance ranging from units with demoralised staff who are trapped in a constant process of crisis management to those where staff work purposefully to deliver high quality care and services.

3 Although the Commission heard many positive stories of care, it is clear that many patients and carers feel disenfranchised and excluded. There is a need for greater engagement and implementation of best practice.

4 There is a significant data and information shortfall, with inconsistent definitions and processes and a lack of agreed outcomes. This makes it very difficult to understand what is happening throughout the system, to measure variation and to bring about improvements.

5 In many services there is a need for greater staff support, training and motivation in order to improve care and services.

The Commission will be deepening its understanding of each of these themes over the next few months prior to publishing a final report and making recommendations for improvement in early 2016.

Introduction

This report summarises the Commission's early findings and sets out its plans for the remaining stages of its work. It is published for further consultation and comment, particularly from people who have already engaged in some way with the Commission.

The Commission has benefited enormously from meetings with patients, carers, advocates, health and social care professionals and policy makers, and from the written evidence that many people have provided. At this stage it is particularly interested in further comment on whether the five themes identified are the right ones for it to concentrate on, what additional information or data might be useful, and in learning of examples of best practice in each of these areas.

The Commission is conscious that there have been many reviews, reports and publications of guidance in recent years about improving mental health services and that there is real potential for confusion. It plans to build on what is already there, rather than to add to the complexity, and to focus on implementation and bringing about improvement. However, it believes there is also the need for both a renewed vision of the purpose and nature of inpatient services for the future, and a strategy for getting there.

Acute inpatient psychiatric care is part of the wider system and can't be seen in isolation. This renewed vision and strategy therefore needs to sit within the wider vision and strategy for the whole of mental health, and the Commission is very pleased that NHS England has appointed a Mental Health Task Force to create this vision and strategy in line with the *Five Year Forward View*. This Interim Report focuses solely on England and provides evidence for the Task Force.

At the outset it is essential to place the Commission's work in the context of the enormous need to promote mental health and well-being and provide safe, effective mental health care. It is also vital to recognise the importance of making practical progress on the journey towards parity of esteem between mental and physical health.

It is clear that the demands being placed on mental health services are growing: in 2013/14 the number of people in contact with secondary mental health services increased by almost 10 percent from 1,590,332 in 2012/13 to 1,746,698 in 2013/14, whilst the number admitted as inpatients fell very slightly[1]. Looking behind the figures, there is a large number of individuals who are in pain and distress and whose suffering also affects their families and communities. Evidence from patients, carers and staff is that not all are receiving the care they need.

Moreover, people with mental illnesses often don't receive the care they need for their physical health. There is a large mortality gap between those with mental illnesses and those without: mental illnesses are the largest cause of years of life lost to disability; and people with mental illnesses often suffer from addictions and related problems being, amongst other things, the biggest users of tobacco in the country[2].

This is a time of opportunity for mental health services. There is greater political and, importantly, public awareness of the challenges services are facing. The Commission aspires to help those affected by mental illness and those who work in the field to seize the chance to make significant improvements in one of the most difficult areas of healthcare. It has set out to seek continuing engagement from all sectors involved in mental health in the conviction that its analysis and recommendations will be improved through their involvement. It is already clear that there are many examples of best practice across the country which can be spread to the whole.

The five main themes

Five themes emerge from the Commission's early work in England:

1   The so-called bed or admission crisis is very significantly a problem of discharges and alternatives to admission and can only be addressed through changes in services and the management of the whole system.

2   There is a spectrum of pressure and performance: ranging from units with demoralised staff who are trapped in a constant process of crisis management to those where staff work purposefully to deliver high quality care and services.

3   Although the Commission heard many positive stories of care, it is clear that many patients and carers feel disenfranchised and excluded. There is a need for greater engagement and implementation of best practice.

4   There is a significant data and information shortfall with inconsistent definitions and processes and a lack of agreed outcomes. This makes it very difficult to understand what is happening throughout the system, to measure variation and to bring about improvements.

5   There is a need for greater staff support, training and motivation in order to improve care and services.

The Commission would stress that these problems are not universal; however, it believes that many (and perhaps all) of these themes will be familiar to people working within mental health. The key task is making improvements in all of them throughout the whole system.

The Commission sees its role in the next few months as being to:

• Analyse and understand these problems properly

• Describe the purpose of inpatient care within the whole adult acute care pathway, setting out a new and re-invigorated vision for the service

• Identify best practices in services, commissioning and quality improvement

• Make practical recommendations for improvement in these five areas

• Offer advice on the configuration of services.

Chapter 1:
The nature of the problem

1.1 The purpose of acute inpatient psychiatric care

The Commission's starting point is that the provision of acute inpatient services has to be seen within the context of the whole system of mental health provision and within the wider social environment more generally. In our Call for Evidence the Commission explicitly asked about the purpose of acute admissions, recognising that only about 6% of people using secondary mental health services were admitted as inpatients last year[3].

Box A describes the responses to this question and the working definition that it will use.

Box A:
The purpose of acute inpatient psychiatric care

Responses to the Commission's Call for Evidence generally emphasised the role of acute inpatient care as part of a therapeutic pathway towards recovery, rather than as an episode defined by coercion or containment (although the provision of a safe space for assessment during acute illness was often seen as an important starting point towards recovery, as well as ensuring that people did not pose a risk to themselves or others).

Working definition

Against this background the Commission has taken the following as a working definition: the purpose of acute inpatient care is to provide treatment when a person's illness cannot be managed in the community, and where the situation is so severe that specialist care is required in a safe and therapeutic space. Admissions should be purposeful, integrated with other services, as open and transparent as possible and as local and as short as possible.

Many people made the point that admission needed to be as short as possible – minimising disruption to normal life as well as costs. They argued that:

- If people are admitted for longer than clinically necessary they can become institutionalised, finding it harder to resume normal life (including loss or difficulty of finding work, benefits and a place to live)

- Recovery and rehabilitation need to occur as close as possible to where people live – for example, training people in 'activities of daily living' while in acute inpatient settings does not adequately equip them to use these skills in the community

- Costs are often far higher in hospital.

1.2 Bed numbers, alternatives to admission and discharges

There is a major problem with admissions in many parts of the country and there are significant numbers of people having to travel long distances for care. However, as this chapter shows, the situation is more complex than simply being about a shortage of beds.

Box B (overleaf) shows that there has been a long-term reduction in psychiatric beds in England. This is the result of policies to introduce a more community-based model. Box B also shows that there have been significant problems in recent years with out-of-area placements, over-occupancy and the raising of admission thresholds to ration care – which suggest that the reduction in bed numbers may have gone too far.

Box B:
Acute bed numbers[3]

There has been a long term reduction in bed numbers 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

- There was a 39% reduction in the number of inpatient psychiatric beds in England between 1998 and 2012.

Reported problems

- 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.

- A 2013 Freedom of Information 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%.

- 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.

However, Commissioners were also told that significant numbers of patients were admitted because of a lack of alternatives and that many had their discharges delayed. The Commission therefore undertook an England-wide survey of consultants in charge of adult acute wards in order to understand the problem better. This survey (described in Box C) revealed that many patients being treated on acute adult wards could have been treated elsewhere, and that there were major difficulties in discharging patients when they were ready to leave.

The survey showed that:

- Consultants on 92% of participating wards reported treating patients who could have been treated by other services if they had been available

- In practice, this meant there were around three patients on each ward who could have been treated in another setting

- The most commonly identified alternative services which were unavailable were crisis houses, rehabilitation services, personality disorder services, day services, and general community provision.

Delayed discharges were identified as an equally significant problem. The Commission's own survey shows on average that 16% (roughly one in every six inpatients) in participating acute psychiatric wards was *clinically well enough* to be discharged but could not be discharged due to other factors. In three participating wards this rose to 38% of all inpatients.

Several different reasons were given for these levels of delayed discharge, although a lack of suitable housing (ranging from local authority housing to supported accommodation) seems to be a fundamental driver. This was identified in 49% of cases of delayed patient discharge – almost four times as many as the next most significant factor (problems with transfer to a rehabilitation unit at 14%).

Box C:
Survey of Acute Adult Psychiatric Wards

Methodology

Surveys requesting a 'snap shot' of bed usage at the time of receipt were sent to 56 NHS mental health trusts in England for completion between 12th May and 3rd July. These were sent via each trust's Medical Director's office (or similar) to a lead consultant for each acute inpatient ward in the trust.

Responses

Completed surveys were received from 79% of mental health trusts. Returned surveys described activity in 119 acute wards – an estimated 28% of all such wards in England[i].

Findings

- an average bed occupancy rate of 104% for each ward (range 57% – 147%, includes on leave patients)[ii]
- 91% of wards operating above 85% occupancy rate[iii]
- 16% of patients per ward could have been treated in an alternate setting[iii]. Most common alternate settings named were crisis houses, rehab services, and personality disorder services[iv].
- 16% of patients per ward were identified as having their discharges inappropriately delayed[3]. Most common causes of delayed discharges were issues with housing, issues transferring patients to rehab services and community team capacity/resources[iv].
- 38% of Consultants said that there were not enough beds[v]
- 28% reported there would be enough beds if improvements were made in other services[v]
- 28% felt there were enough beds in their local area[v].

The main factors affecting pressures on beds were availability of housing (39%) and quality/resourcing of community teams (30%).

During its evidence gathering, the Commission heard from a number of people that patients were often placed in a more highly intensive and expensive care setting than they needed to be. While little routine data exist, currently unpublished research findings were shared with the Commission suggesting that, for example, some people who could be better looked after in primary care were being cared for by community teams. Similarly, some of those in the care of specialist services could equally be cared for by community teams, while a number of people admitted as inpatients could have been cared for outside hospital teams[4].

It was very notable that most respondents in meetings and in the Commission's survey felt the number of beds was not the main issue and that any new investment should go elsewhere. Interestingly, over half the consultants who looked after beds (56%) – and were therefore more directly affected by bed numbers than community based staff – said that they either had enough beds or that they would have enough beds if improvements were made to other services. Members of the two Trust Boards whom the Commission has met both emphasised their strategic intent to develop more services in the community.

1.3 Care pathways and alternatives to admission

The Commission has held many discussions about the acute care pathway and care pathways in general. It noted that there did not appear to be standard definitions in use by respondents. In addition, the Commission heard that there is wide variation across the country in the type and range of services providing alternatives to admission, and also in the clinical and organisational practice of these services. While services must be flexible in order to reflect local need, this does make it more difficult to apply any level of standardisation to patient pathways, or to establish well understood and well-defined roles for different services on the pathway.

However, eight common themes stood out as being the essential factors in designing and managing an effective and high quality acute care pathway. These are shown in Box D. This interim report will not cover all these factors and, in any case, the Commission notes that the NHS England Mental Health Task Force will shortly be publishing findings concerning the whole pathway. However, the Commission repeatedly heard that there are either not enough services on the acute care pathway which provide alternatives to inpatient admission or that access to these services is variable. Moreover, it was told that NHS Trusts with separate bed management teams, resourced with experienced staff, and focused on improving the overall acute care pathway (rather than just focusing on inpatient bed numbers) have fewer difficulties with their acute care bed base.

Several respondents reported that the situation has become more difficult recently due to funding cuts and restructuring, with the result that some services are no longer operating as originally intended.

Box D:
Essential factors in effective and high quality acute care pathways

1 Management systems: managing admissions, discharges and flow
2 Alternatives to inpatient admission
3 Integrated pathways
4 Effective (and evaluated) crisis coverage
5 Housing
6 Commissioning
7 Policing and the relationship with the social justice system
8 Staff training and morale

Examples were provided of community psychiatric nurses (CPNs) carrying huge caseloads, or crisis teams only having time for assessment activities rather than for the provision of community-based treatment. Furthermore, while bed numbers have continued to decline across the country as a whole in some areas this appears to have happened in parallel to reductions in community mental health services. Changes in bed numbers are largely obvious and transparent, whereas cuts to community services are often invisible, because they are not reported in any national datasets.

This wide variation in services provision is shown by the survey of Crisis Recovery and Home Treatment Teams described in Box E.

Box E:
Crisis Resolution and Home Treatment

In a 2006 national survey of Crisis Resolution and Home Treatment teams[5], 243 CRHTs were identified. In the study, the main barriers to providing more effective CRHT services identified were a lack of staff, low availability of crisis beds, lack of housing and the absence of a well-coordinated 'whole system' response.

Additionally, evaluation of the services provided by CRHTs was lacking. Although approximately three-quarters of CRHTs claimed to be evaluating the efficacy of their services, only a third were able to provide details of any evaluation. A third were not involved in gate-keeping referrals, and only two-fifths offered 24/7 home visits. All of these factors will presumably affect the usage of inpatient beds.

Some evidence suggests that CRHTs can reduce use of hospital beds and costs with comparable outcome and patient satisfaction. A recent systematic review, for example, found that extended opening times and a psychiatrist's presence in the team were likely to increase a CRHTs' ability to prevent hospital admissions.

Communication and integration with other mental health services were stressed by stakeholders as being highly important. There was however no consistent evidence about the components of CRHTs that appear to be most effective.

The Commission's survey of acute wards revealed the critical importance of housing in the care of people with mental illnesses yet here too there is a great deal of variation around the country. The Commission heard of examples where housing associations had invested in considerable numbers of purpose-built flats designed specifically for people with mental illnesses. These housing associations have developed formal relationships with local mental health trusts to provide community support to the residents of this housing provision. This includes input from psychiatrists, community psychiatric nurses and occupational therapists. These housing developments are supported by local government grants, ongoing access to housing benefit, and subsidies from other commercial development activities undertaken by the housing association. However, these examples are not the norm. Box F sets out the key role of housing in recovery.

Box F:
The key role of housing in recovery

- People with mental health problems need good quality housing and appropriate support to facilitate their recovery and to improve their ability to live independently in the future.
- Around 62% of homeless people have a mental health problem[6].
- Data from the Mental Health Minimum Dataset found that at the end of December 2014, only 59% per cent of people aged 18-69 treated under the Care Programme Approach (a national system which sets out how secondary mental health services should help people with mental illnesses and complex needs) were recorded as being in settled accommodation[7].
- Despite the importance of good quality housing and appropriate support, people with mental health problems are twice as likely as those without to be unhappy with their housing, and mental ill health is frequently cited as a reason for tenancy breakdown[8].
- Having secure and settled accommodation, with the right kind of support, can have a positive impact on the lives of people with mental health problems by:
  - lowering the frequency of unplanned admissions onto psychiatric wards and the rates at which community mental health services are used
  - reducing the rates at which people with severe mental health problems become homeless (thereby reducing the use of homelessness shelters)
  - improving well-being among people with severe mental health problems[9].
- Good quality housing and/or supported accommodation services should therefore be a key component in a whole-system care pathway for people with mental health problems, providing the basis for individuals to recover, receive support and in many cases return to work or education.

Finally, it is important to highlight problems with the commissioning of some services. The fact that different types of service are commissioned by different organisations (such as Clinical Commissioning Groups, NHS England and local authorities) can lead to difficulties in coordination and mean that there are not always incentives to move people to the right services. Moreover, the Commission has heard that public, voluntary and private sector providers are generally subject to different types of contract, with implications for value and the quality of care. There is clearly a need for a considerable development of commissioning.

Chapter 2:
Pressure and performance

2.1 Variations in pressure and performance

The Commission has been struck by variations in the pressures experienced in inpatient wards in different parts of the country and by the variations in performance. It notes that there is a spectrum of pressure and performance – from services which are trapped in a constant process of crisis management to those where staff work purposefully delivering high quality care and services.

The Commission has seen and heard of services and wards that are at different ends of this spectrum, with most presumably falling somewhere in-between. At one end are wards where crisis management and pressure affect everyone – patients, carers and clinical staff. Here patients told us they were stuck in locked wards with nothing to do; pool tables had been banned for safety reasons and access to smoking areas was heavily restricted. The Commission heard of one site where a gym was supposed to be available for patients to use, but went unvisited as staff could not be spared to escort patients there. Patients were cut off from normal life and in many cases (where both parties would have welcomed it) their carers had not been part of their assessment.

Ward staff often complained of being under pressure with no scope to do anything with the patients other than carry out routine observations and, in the opinion of patients, often ended up "hiding" in the office. Many doctors felt pressurised, with little discretion, chasing beds and practicing defensive medicine. This was the picture which so many people – professionals as well as patients – told us was simply unacceptable. It is obviously not part of any therapeutic pathway.

At the other end of the spectrum, the Commission has also seen and heard of wards where people felt care was delivered more purposefully. Patients talked to us about the way they were engaged in activities and ways of thinking about recovery and focusing on the future. Many spoke positively about peer supporters of different kinds helping them. Ward staff spoke about the merits of having different professions available and working together, particularly the involvement of psychologists as well as nurses. Psychiatrists took a positive view about the specific nature of their role – and what only they could contribute – and about reaching out to the community.

The spectrum ranges from situations where people can only react to circumstances, trapped in a constant process of crisis management, to ones where everyone is enabled to be pro-active, taking initiative and shaping the future. As well as understanding and addressing the reasons for these pressures at the worse end, the Commission also recognises the need for supporting leadership and organisational development.

The Commission has not attempted to diagnose the causes of these variations and to attribute them to regional variation, funding, management and leadership or any other causes. Its task here, as elsewhere is to determine how to secure systematic improvement and to address the particular needs of acute inpatient services as part of the whole system, considering in particular how wards can move up the spectrum towards the best standards and care.

2.2 Standards of quality and care

There has been an enormous amount already written about standards and quality of care. Accreditation services for both inpatient wards and Crisis Resolution and Home Treatment teams are available, for example, and clear standards of practice have been developed. Additionally, the Care Quality Commission also assesses wards.

A small working group of Commissioners and others has reviewed the available material and set out conclusions in three areas:

- What a good quality acute service looks like – as shown in Box G
- The important role and responsibilities of the core leadership team
- The key messages for commissioners of services

However, the question remains why these standards and approaches are not being applied and achieved throughout the country. The question of how to achieve improvement will be addressed in the next stages of the Commission's work.

2.3 Leadership

To achieve good quality care, each inpatient ward and Crisis Resolution Home Treatment team needs a core leadership team to include, as a minimum:

- a ward manager
- consultant psychiatrist
- other senior professionals on the ward, for example, consultant psychologist and senior occupational therapist.

These individuals should form the leadership team and:

- have a shared vision and agreed purpose
- be clear about each other's roles, spending time together to develop this understanding, and being able to walk in each other's shoes. The ward manager needs to understand clinical processes and be able to provide feedback. The consultant psychiatrist needs to take responsibility not just for individual patients but also for the whole system of care. They need to provide leadership that pulls the elements together.
- have daily contact with ward staff
- understand the core business of the ward. They need to see patients and their families as the primary focus, and may need coaching skills and support to break through problems via links with commissioners and other agencies.
- possess change management skills. Trusts should use one method, stay with it and support it with metrics. Time is required to embed change. Staff need to be clear on the vision; high quality care is provided on wards with high staff engagement. There should be true multidisciplinary working and regular touch points to ensure work is on track.

Box G: What a good quality acute service looks like

The Commission believes that good acute care services (encompassing inpatient services, as well as crisis resolution and home treatment teams) all have the following elements:

1 **A philosophy of care** which is holistic, person-centred, facilitates recovery and is underpinned by humanity, dignity and respect.

2 **Staff who see understanding their patients as a key purpose of their work.** The role of acute care staff is to sit alongside the patient, being both empathic and enabling change. Patients should expect their experiences to be validated and where possible understood.

3 **A full complement of staff with the skills to ensure patients have access to the care they need to get as well as possible as quickly as possible.** In practice this means access to psychiatrists, psychologists, occupational therapists, pharmacists, dieticians, physiotherapists and nursing staff.

4 **An holistic assessment process which includes a full social and psychological history.** Different professionals should collaborate to consider:
   – an individual's symptoms and the severity of their illness
   – risks posed to the individual or others
   – personal and family history, previous life trauma and social functioning
   – the patient's views (including any advance statements and/or decisions)
   – any history of previous care (focusing on past history of illness, interventions which have worked and those which have not, and the strengths of the person)
   – alcohol and drug misuse
   – social circumstances and social care needs
   – safeguarding issues concerning children and vulnerable adults
   – physical health needs as well as mental health needs.

5 **A clear and understandable care pathway.** This should deliver a full range of evidence-based biopsychosocial and physical interventions which focus on the patient's recovery.

6 **Inpatient wards which are welcoming and calming environments.** There should be zero tolerance for violence on the ward, with staff trained to recognise when patients are becoming disturbed and to act to alleviate the reasons behind this. All episodes of both verbal and non-verbal aggression should be reviewed on a daily basis by staff, and measures put in place to prevent a recurrence.

7 **Staffing.** All staff should receive an annual appraisal, personal development planning and clinical supervision at a minimum of every eight weeks (or more frequently, as per professional body guidance). Staff should have clear clinical supervision guidelines which include a system of auditing the supervision. Staff should have access to training to cover all aspects of their work, including care planning, therapeutic interventions, use of the Mental Health Act and engagement with individuals and their families.

8 **Outcome measures.** Mechanisms should be in place for the routine collection of data and information to demonstrate that the care provided is of good quality. All measures should have a recovery focus and include, as a priority, patient and carer feedback. The data should be regularly reviewed by service leaders and used to drive forward change.

2.4 High Quality Care – Key messages for commissioners

The Commission also feels that work of the Joint Commissioning Panel for Mental Health is particularly helpful, and its key messages are reproduced below[10].

1   Commissioners should have as their standard that they commission acute care services that they would recommend to family and friends.

2   There should be evidence of patient and carer involvement in the commissioning.

3   Commissioners should commission a range of services in the acute pathway, including beds, intensive care and crisis resolution and home treatment teams.

4   Commissioners should ensure there are sufficient resources available within the acute patient pathway to enable patient choice and for individuals to be close to home.

5   Facilities in the acute setting should be available 24/7.

6   There should be clear entry and discharge criteria.

7   Commissioners should ensure service providers collect, collate, analyse and act on data.

8   Clear standards of communication should exist with primary care.

9   The full range of NICE approved interventions should be available for patients in the acute care pathway.

10 Commissioners must ensure that acute care pathway providers meet their statutory duties under the Mental Health Act and Mental Capacity Act in accordance with the relevant Codes of Practice, and that all care is underpinned by humanity, dignity and respect.

Chapter 3:
Patient and carer experience

3.1 Overview

The Commission heard from and met a large number of patients and carers. It set up a small working party to look in more detail at the experiences of patients and carers and to look in particular at the views and experiences of people from BME communities, who are often over-represented as patients in acute inpatient psychiatric care. This group visited a number of sites and held events to hold individual discussions and wider focus groups with staff and patients. The working group also conducted an online survey with people with experience of inpatient acute mental health services, asking them how services could be improved, and what steps could be taken to both prevent inpatient admissions from taking place, and to ensure successful discharge. Key messages from the survey are described in Box I.

The personal experiences of patients and carers present a very mixed picture, ranging from awful to excellent and from shocking to inspirational. Commissioners were given several examples which suggest that some groups are particularly disadvantaged, including people from BME backgrounds and LGBT people. The Commission also notes that the needs of individual patients and different groups of patients varies enormously, and that services need to reflect this better. This is a complex and difficult area where "one size does not fit all".

Much of the evidence received by the Commission suggests the need for opening up wards to some extent – helping patients, their carers and families (where appropriate) to be more engaged, involving peer supporters and community groups and reducing the total separation that often exists between the outside community and the inside of a hospital or psychiatric unit.

This chapter highlights a range of issues which led the Commission to conclude that, although it heard many positive stories of care, it is clear that many patients and carers feel disenfranchised and excluded. There is therefore a need for greater engagement and implementation of best practice. Here, as with the wider issues of quality, there is good guidance available but it is not always followed.

3.2 The views and experiences of patients and carers

Whilst these problems are not universal, there are some common themes that run through the evidence from patients and carers.

Among respondents to the online survey, around one-quarter of comments described an overall lack of acute inpatient psychiatric beds and shortages of staff. Respondents reported finding it difficult to access a bed when one was needed, and had sometimes been moved to a private service or another part of the country. However, overall, patients and carers were less concerned with addressing questions about the *precise number* of inpatient psychiatric beds that might be required in England, and instead were far more concerned about the quality of treatment that a person might receive once in an inpatient setting. It was suggested that if existing inpatient beds were used more effectively and efficiently, this would either meet demand or reduce the need to increase the number of beds in many areas.

Additionally, emphasis was often placed on investment in better quality community services in some areas rather than investing in inpatient beds. However, this should not be to the detriment of inpatient services already in existence.

Patients and carers called for a wider range of therapies and treatments to be made available to inpatients including positive ward activities, psychological therapies, interventions targeting improvements in physical health (covering smoking cessation, guidance on alcohol and drug use, healthy eating, and physical exercise), and the overall monitoring of patients' physical health and wellbeing. It was noted that this expansion of a wider range of interventions would require parallel investment in the training of frontline staff to deliver them

It was suggested that recovery plans should include the identification and referral of patients to other forms of social support (such as welfare and debt advice) which would help people get back on their feet – rather than just being discharged.

The majority of respondents said that all therapies, interventions and treatments should be clearly explained to patients. This also applied to communication with patients about their rights upon admission to the ward.

Some patients and carers referred to the need for choice of treatment. The majority of psychiatric care is conducted on a voluntary basis, and it is fundamental that there is adequate provision of services across the acute care pathway so that psychiatric patients can exercise their legal right to choice, and take greater control of their own care.

There was a great deal of support in much of the evidence received for the provision of more alternatives to inpatient admission, such as crisis houses, crisis focused day services, NHS drop in listening centres and crisis telephone lines. Training for the police to prevent avoidable detention under the Mental Health Act was also noted.

It was also pointed out that urgent and emergency care services – particularly accident and emergency departments and the ambulance and police services – are all too often the first point of contact for people experiencing a mental health crisis. It was therefore suggested that greater investment in crisis care was needed and that closer relationships needed to be built between psychiatric and emergency services. In particular it was argued that there was a need for more liaison psychiatry services located within urgent and emergency care services which could provide immediate support to people experiencing a mental health crisis.

3.3 Black and Minority Ethnic Group Patients and Carers – Focus Group

One of the commissioners attended an event specifically designed to get the views of patients and carers from BME backgrounds with the core objective of clarifying how the NHS needs to use mental health budgets to respond to the needs of people from these communities. The event was designed to create a psychologically safe space for open dialogue about the controversial issue of race and mental health. It brought together participants from many different backgrounds and sectors, recognising that innovation comes from building new connections between different ideas and approaches. The event produced the recommendations shown in Box H.

The focus group was, on the whole, more concerned about the quality of treatment of patients once in hospital rather than whether there were enough beds available in acute mental health settings. Across the board, there was the feeling that BME patients received an inferior service from the NHS and that there was a lack of understanding and empathy with regard to their differing needs.

Box H:
Focus group recommendations about services for people from BME communities

- Clear and robust policies should be developed to prevent discrimination of patients from these backgrounds

- Staff should be trained to understand the different needs of people from BME backgrounds who have mental health problems. This should be monitored, and interventions conducted to reduce bias as necessary.

- Carers should be engaged with in both community and inpatient settings, and involved in care planning if this is mutually desired by them and the patient.

3.4 Peer support, advocacy, and carer involvement

The use of peer support workers is a relatively new phenomenon. However, peer support as a routine part of mental health provision remains in its infancy. While its impact is still difficult to evaluate, more trusts appear to be introducing peer support workers into both community and acute inpatient settings on the basis that they provide a different perspective of care from the staff they work alongside. This expansion is perceived as positive by many organisations and individuals who engaged with the Commission, who thought that placing trained peer support workers in every clinical team could result in a cultural change where a stronger emphasis was placed on individual recovery.

Patients and carers believed that all individuals should have access to advocacy services so that they can be helped to discuss any issues that they might have, free from concerns about discrimination. Patients should be informed of how they can make a complaint (whether formally or informally) if they are not happy with any treatment or service they have received, whether through local advocacy groups, or through nationally recognised organisations.

People who are detained under the Mental Health Act or on supervised community treatment are entitled to access Independent Mental Health Advocacy (IMHA) services. Commissioners of acute care should ensure that providers inform eligible individuals about IMHA and enable advocates to meet with them.

Carer involvement (within appropriate parameters) was also seen as key to the delivery of high-quality inpatient services. In particular, it was felt that better communication with families and carers was necessary to enable more joined-up care, and that families and carers should be involved in the drawing up of patient care plans when this is mutually desired.

3.5 Staff attitudes and training

The behaviour and attitudes of staff often featured in the evidence that the Commission received. Reference was also made to positive experiences, but also to incidents and events that involved staff involvement in discrimination, stigmatising comments and behaviours, or practices that did not treat patients and carers with due respect or dignity.

The most common area of difficulty identified was from experiences shared by patients and carers from black and minority ethnic backgrounds, although discriminatory behaviour by staff was also reported by patients from other groups, such as gay and lesbian patients.

Patients and carers made the recommendation that inpatient services should focus more on the needs of people from black and minority ethnic backgrounds, and by extension those from other minority or 'protected characteristic' groups. This includes the development of policies to prevent discrimination against these groups, and to promote staff receiving cultural competency training. Cultural competency refers to an individual's ability to interact effectively with people of different cultures, with the demonstration of cultural competence being therefore reflected in an ability to understand, communicate with, and effectively interact with people across cultures.

Some respondents noted that inpatient staff should be appointed for their cultural values as well as their experience and knowledge.

Many reported problems regarding the lack of properly trained staff with enough time to treat them sensitively, with patience and empathy. Patients felt strongly that they wanted permanent staff with whom they could build a relationship. They also wanted staff who could communicate clearly with them.

3.6 An inpatient environment which is safe, therapeutic, and conducive to healing

Patients and carers reported that the environment of many acute psychiatric wards was not always conducive to recovery, and indeed could have a negative effect on an inpatient's wellbeing and mental health. Instead patients stated that they wanted wards to be safe, therapeutic, clean and homely.

Access for visitors was sometimes problematic. This could be improved by more flexible visiting hours and care being provided in local facilities so that patients are near to their homes, families and communities.

Box I:
Summary of findings from patients, carers and staff

- There is no need for more acute beds in many MH hospitals, if the beds they currently have are used more effectively and efficiently.

- Inpatient care should be seen as a last resort, with patients receiving high quality care in the community for as long as possible.

- More resources should be put into the community to develop and improve services.

- Services for black and minority ethnic people with mental health issues should be sensitive to their needs and the needs of their carers.

- All nurses need regular updating and additional training and development in terms of how to treat patients with mental health challenges, for example CBT training.

- All mental health professionals, particularly those located in inpatient care, should have in-depth training to address and extinguish stigmatising and discriminatory attitudes and behaviour.

- There must be greater investment in a range of therapeutic interventions and activities for patients both in hospital and community settings.

- Carers must be more involved in the care of patients, and given support and help to manage relatives and friends in the community.

- In many places the whole inpatient care environment should be radically changed in order to become a safe space which is conducive to healing.

Chapter 4:
Data and Information

4.1 Overview

Many people to whom the Commission spoke seemed to be aware of the types of problems described in this report but the data to support their perceptions are often not available or very difficult to find. The Commission heard repeatedly that data are not only difficult to identify or find, but that different areas have varying services, operational policies, and definitions which make the aggregation and comparison of data difficult at both local and national levels. Moreover, some of the existing national data collection systems do not adequately collect data which would be useful in managing services.

Delayed discharges or delayed transfers of care are a good example of this. According to the Department of Health a delayed transfer of care occurs when a patient is clinically ready to be discharged from acute psychiatric care, but whose discharge is delayed for another reason[11]. A patient is defined as being ready for transfer when (a) a clinical decision has been made that patient is ready for transfer; (b) a multi-disciplinary team decision has been made that patient is ready for transfer and (c) the patient is safe to discharge/transfer. There is however no standardised definition of what it means for a patient to be (psychiatrically) 'safe or fit to discharge', and the words "safe' or 'fit' are arguably too vague to be of use, because the nature of psychiatric care is often the management of risk and hence involving unpredictability, fluctuation, and rapid change, with some mental illnesses operating in cycles of relapse and recovery. The definition is therefore open to wide interpretation.

Poor data for decision making is undermining both the ability of individual units to manage their services effectively and the ability of those planning and commissioning services to understand the full picture and shape the whole system to the best effect. A lack of consensus about which outcome measures to use to measure the effectiveness of clinical care also compounds this problem.

There are potential improvements on the way. The commitment to providing waiting time information by 2020 will require new data collection systems. Moreover, the Commission has been informed that the Mental Health Intelligence Network (which currently collects data on the levels of demand, access and outcomes for primary care), will be extended to secondary mental health services.

There is currently very little relationship between need, identification of illness, training requirements and integration of services. It would also be helpful to see a data flow analysis of criminal justice input into medium secure services, acknowledging that patients with the same diagnosis and presentation might be seen by an adult acute service in one area and a forensic service in another. The paucity of data in mental health can be contrasted with the cancer pathway, where all points of contact are mapped and analysed.

This lack of data has the perverse effect of making it easy to focus on bed numbers where the data are available and to record the significant decline in numbers over the past decades. As a result this has shaped much of the dialogue about acute adult psychiatric care. By contrast, it is difficult to understand the changing nature of community services outside hospital from looking at the available data.

Chapter 5:
Staff support, training and motivation

5.1 Overview

The Commission has noted that some wards have placed great emphasis on supporting, training and motivating their staff, recognising both that new skills are needed in a changing service and that the quality of the service depends on the face-to-face contact and relationships developed by staff members with patients and on their judgements and commitment to the work. The Commission has also been very grateful for the opportunity to meet many dedicated and highly skilled people during the course of this review.

The Commission has taken evidence from both health and social care professionals and has seen evidence of the same spectrum of experience and practice from awful to inspiring, reactive to pro-active described earlier. The task here, as elsewhere, is to secure systematic improvement and to address the particular needs of acute inpatient services as part of the whole system.

Many respondents have told the Commission about problems with recruitment and about high levels of vacancies and use of bank and agency staff. Many also expressed views about the need to ensure there is an appropriate skill mix of staff on wards. Moreover, as noted in previous chapters, there are concerns in some areas about the attitudes and skills of staff members.

There appears to be a good case for arguing that, as and when beds are closed, some of the resulting savings should be reinvested in wards to improve staffing and the environment for those patients who need to be admitted and to provide a better environment for the staff and carers looking after them.

5.2 Staff wellbeing

The Commission has been struck by the difference between the services it has visited and heard about those which clearly have high levels of staff morale and wellbeing and those which do not.

Good levels of staff wellbeing can improve patient experience and outcomes. Good team dynamics, co-worker support, job satisfaction, a positive organisational climate, organisational support, low emotional exhaustion and positive supervisor support are all factors in promoting staff wellbeing.

Conversely, high caseloads, too much administrative work, poor supervision and some of the inherent challenges of working in acute mental health settings with very unwell patients are factors associated with poor morale and wellbeing, which unsurprisingly can lead to increased levels of sickness absence – which is deleterious to patient care.

Violent incidents on acute inpatient wards can also lower morale, and it is plausible that an increase in the acuity of patient illness on wards (arising from the raising of admission thresholds in order to compensate for fewer beds being available) could worsen this. Furthermore, evidence suggests that poor quality ward environments are also associated with poor staff morale[12,13]. The Commission notes with concern that research conducted by the Royal College of Physicians in 2011 found that only 46% of NHS trusts had a plan or policy to promote staff wellbeing[14].

Chapter 6:
Next steps

6.1 Overview

The five themes described in the previous five chapters will shape the future work of the Commission and feed into its final report in early 2016. They will be taken forward within the framework of the *Five Year Forward View* and will take account of the findings of the NHS England Mental Health Task Force which is currently developing a vision and strategy for mental health.

The Commission sees its role in the next few months as being to:

- Analyse and understand these problems properly

- Describe the purpose of inpatient care within the whole system, setting out a new and re-invigorated vision for the service

- Identify best practices in services, commissioning and quality improvement

- Make practical recommendations for improvement in these five areas

- Offer advice on the configuration of services.

The Commission is aware that there a number of issues that it has not been able to review fully and others which it has not yet addressed. Its work plan over the coming months will include activity in each of the five main areas:

1 The nature of the problem

a Undertaking a more in depth study in an area of the country in order to understand what is happening in more detail both within acute inpatient services and across the acute care pathway

b Understanding how the operation of legislation affects services

c Developing indicators for good care pathway and inpatient service management

d Identifying indicators and warning signs which show whether inpatient provision is adequate

e Considering the financial implications of different models of care

2 Pressure and performance

a Reviewing different models for systematic quality improvement across and within services

3 Patient and carer experience

a Undertaking further research and identifying best practice

b Understanding the needs of different patient groups

4 Data and information

a Identifying improved methods for data collection and management both from the study described in 1a above and from examples of best practice around the country

5 Staff support, training and motivation

a Quantifying better the levels of vacancies and use of bank staff

b Identifying good practice in workforce management (including skill mix, training and support).

Appendix 1: Methodology

Call for Evidence

From February to March 2015, the Commission issued a 'Call for Evidence' focusing on the value, purpose, and current state of both inpatient care and services offering alternatives to inpatient care within community settings. The Commission specifically asked for case examples of good and poor practice, and recommendations for improvement. The Call or Evidence received a total of 162 completed consultation responses from people with lived or clinical experience and from organisations such as the King's Fund, Royal College of Nursing, Mind and Rethink.

Advisory Group meetings

The Commission also established and met with three advisory groups, consisting of patients and carers, frontline staff and senior figures from mental health policy respectively.

Site visits

The Commission has visited various mental health services to speak with patients, carers and staff.

Working Groups

The Commission established three groups to lead key elements of its investigation:

- **Quality and Quality Improvement** (Denise Porter, Laurence Mynors-Wallis, Ruth Briel, Alison Brabban and Mary-Jane Tacchi). This group worked to identify the core factors that inform high-quality practice on inpatient wards, and along the acute care pathway.

- **Patient, Carer, and Staff Experience** (Yvonne Coghill, Mary Riddell, Robert Milligan and Jacqui Dyer). Members visited a range of sites to hold individual discussions and wider focus groups with staff and patients, and also conducted their own online consultation with people with lived experience.

- **Service Models and Patient Flow** (Darlington Daniel, John Bacon, Anne Campbell, Michael Brown, Jacqui Dyer, Merran McRae, Ranga Rao). This group consulted with a wide range of experts, and undertook literature reviews, focus group research, and webinars to identify the critical success factors and barriers to running a high quality, effective and patient-centred acute psychiatric care pathway and services.

Survey of Acute Psychiatric Wards

Surveys requesting a 'snap shot' of bed usage at the time of receipt were also sent to 56 NHS mental health trusts in England for completion between 12th May and 3rd July. Completed surveys were received from wards from 79% of mental health trusts, describing activity in 119 acute inpatient wards.

Additional evidence

Additional evidence was received from NHS Providers, the Independent Mental Health Services Alliance, the Mental Health Providers Forum, South London and Maudsley NHS Foundation Trust, North East London NHS Foundation Trust, Camden and Islington NHS Foundation Trust, Central and North West London NHS Foundation Trust, East London NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Coventry and Warwickshire Partnership NHS Trust, North Essex Partnership University NHS Foundation Trust, Oxford Health NHS Foundation Trust and Northumberland, Tyne and Wear NHS Foundation Trust.

The Commissioners

The Commission is chaired by **Lord Nigel Crisp** (Independent member of the House of Lords, formerly Chief Executive of the NHS in England and Permanent Secretary of the Department of Health from 2000 to 2006).

Lord Crisp is joined by 14 Commissioners:

- **Anne Campbell** (Former Chair of Cambridge and Peterborough NHS Foundation Trust)
- **Darlington Daniel** (Associate Medical Director, Havering Integrated Care Directorate)
- **Denise Porter** (Carer and Trustee of Rethink)
- **Jacqui Dyer** (Expert by Experience, carer, and co-chair of Mental Health Taskforce for England)
- **John Bacon** (Former Chair of Sussex Partnership NHS Foundation Trust)
- **Laurence Mynors-Wallis** (Medical Director of Dorset NHS Foundation Trust)
- **Martin Barkley** (Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust)
- **Mary Riddell** (Political columnist and interviewer for the Daily Telegraph)
- **Merran McRae** (Chief Executive of Calderdale Council)
- **Michael Brown** (Mental Health Coordinator, College of Policing)
- **Paul Farmer** (Chief Executive of Mind, co-chair of Mental Health Taskforce for England)
- **Peter Carter** (Chief Executive and General Secretary of the Royal College of Nursing)
- **Robert Milligan** (Independent advocate and Expert by Experience)
- **Yvonne Coghill** (Senior Programme Lead for Inclusion NHS Leadership Academy).

The Commission is supported by the Policy Unit at the Royal College of Psychiatrists. However, the Commission and its work remain wholly independent of the Royal College.

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Notes

i In three cases multiple responses were received from the same ward as more than one consultant psychiatrist worked across the ward. This will explain the larger number of consultants compared to the number of wards.

ii Based on 114 ward responses. Figure includes six wards with some beds from other specialties. Excluded were four wards where the figure could not be calculated due to the data provided. For three wards, where two consultants responded for the same ward, the response from the second consultant was not counted. An outlier ward was also excluded. Beds shut for refurbishment were not included in bed numbers calculations. Ward occupancy figure includes patients on leave and may include some patients on long term leave.

iii Based on 109 responses. Figure includes six wards with some beds from other specialties. Excluded were four wards where the figure could not be calculated due to the data provided. For three wards, where two consultants responded for the same ward, the response from the second consultant was not counted. An outlier ward was also excluded.

iv Based on 122 valid responses from individual consultants. The number of consultants will be larger than the number of wards because some responses were excluded from bed occupancy, alternate setting and delayed discharge calculations.

v Based on data from 110 valid responses from individual consultants. Figures listed in the main text do not add to 100% as 5% of responses did not give an opinion on numbers of beds in their local area.

The Commission
to review the
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inpatient psychiatric
care for adults

More information about
the Commission, including
its Terms of Reference, is
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